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Budget Execution in the Health Sector in Lao PDR

Technical Note

Executive Summary

Strong budget execution practices are central to ensuring universal health coverage (UHC) by 2030, an important target of the Sustainable Development Goals. Delivery of health services is dependent on effective budget execution practices that ensure financing flows to identified health priority areas. Health financing reforms therefore should focus on ensuring budget execution rules and practices facilitating this objective.

Poor budget execution rates have long been recognized as a major issue in many health sectors in low- and middle-income countries (LMICs). This indicates that the poor quality of the budget rules and practices being applied in these countries are strongly linked to the poor health outcomes being achieved.

The causes for poor budget execution can be rooted in weaknesses in the overall Public Financial Management (PFM) system as well as more health sector specific issues. General PFM issues could be delays in budget releases, diversion of resources to other sectors, or rigid appropriation rules that do not allow enough flexibility to respond to changing circumstances. Health sector specific problems might include low quality planning and budget preparation processes, unrealistic revenue and expenditure estimates, bureaucratic cash disbursement approval processes, or procurement processes that do not comply with recognized good practice.

Overall, the budget execution rate in the Lao PDR health sector is good. Budget execution by the Ministry of Health (MOH) outperforms the rest of government. However, a closer analysis of the performance of the MOH's budget execution identified some issues. Health spending by the central level performs much better than by the provincial level.

The most concerning aspect of analyzing the performance of the health sector budget execution is the lack of information available to the public and the poor quality of record keeping, which is often inaccurate, incomplete, or absent. The MOH does not produce any public estimates of planned technical revenues, which means it is impossible to assess whether revenue targets have been achieved. Budget plans and actuals are aggregated at such a high level, that it is not possible to measure the actual performance of individual departments or health programs. Accountability for instances of poor budget execution therefore cannot be enforced with key budget execution documents having no accompanying narrative to describe and explain the cause. External audit reports prepared by the State Audit Organization may be a useful source of information to better understand the budget execution issues but they are not publicly available.

Areas of concern in PFM in Lao PDR are wages and salaries as well as the budget implementation of the national health insurance (NHI). Wages and salaries are typically the most predictable and well executed part of any government's budget. However, in the health sector budget wages and salaries do not perform as well as other budget categories (this is consistent with other government sectors). The relatively poor budget execution rates for wages and salaries are due to poor budget preparation practices. Making detailed information on human resources available to planners as well as increasing the level of detail in budget templates and budget submissions would potentially significantly improve both budget planning and execution. Challenges with PFM of the NHI are apparent in the budget execution rates and capital expenditure by the provincial governments has routinely exceeded the budgeted level.

Financial management (FM) is typically weaker at the provincial level leading to weaker budget execution. Frequent budget overspends of the capital expenditure budget at the provincial level are likely due to a strong aversion to underspends which could impact the level of future availability of capital expenditure budgets. Weak oversight of the implementation of the capital expenditure budget by the MOH and the lack of proper project implementation progress reports may also be factors. This indicates that a thorough assessment of provincial level capacity is required with a focus on development of training programs (particularly for accounting and finance staff) to support further decentralization efforts.

Areas where strong budget execution performance is evident can partly be explained by the special allowances available in the health sector. Health facilities, which make up 67 percent of the MOH budget, can raise revenue and carry unspent funds into future years. Health facilities also have a lot of flexibility over the management of invoices. The MOH budget has been largely ringfenced, which gives the health sector protection from in-year budget cuts and some greater surety over budget availability in the past. However, the government is struggling to manage its large public debt burden. This means that a future health sector budget freeze or cut cannot be ruled out under the continuing Public Financial Management reform process.

Many of the budget execution issues identified in this technical note are well known by the government but not all reform plans are credible or adequate to address the challenges they pose. There have been few assessments of financial transparency in Lao PDR and the current public financial management reform plans do not highlight the need for increased transparency. This suggests that stronger commitment to increased transparency and dedicated reforms that target improved accountability are needed.

A rollout of new information management systems is underway in the health sector, and this will facilitate improved accuracy, completeness, and timeliness of financial reporting. However, significant improvements in financial and performance reporting will require ongoing capacity building and a better alignment across the planning, budgeting, and financial reporting cycle. There are some hopeful signs of improved reporting with the National Health Insurance Fund report on budget implementation and forward planning and the National Health Statistics Report.

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Abbreviations

CBHI	Community Based Health Insurance
CH	Central Hospital
DH	District Hospital
DHIS2	District Health Information Software
DHO	District Health Office
DoF	Department of Finance
DoF (health)	Department of Finance, within the Ministry of Health
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFIS	Government Financial Information System
HANSA	Health And Nutrition Services Access Project
HEF	Health Equity Fund
HF	Health Facility
IFMIS	Integrated Financial Management Information System
IPD	Inpatient Department
LAK	Lao Kip
Lao PDR	Lao Peoples Democratic Republic
MNCH	Maternal, Neo-natal and Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
NHA	National Health Accounts
NHI	National Health Insurance
NHIB	National Health Insurance Bureau
NSDEP	National Socio-economic Development Plan
NSSF	National Social Security Fund
ODA	Official Development Assistance
OOP	Out Of Pocket
OPD	Outpatient Department
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PH	Provincial Hospital
PHO	Provincial Health Office
SASS	State Authority for Social Security
SHP	Social Health Protection
SSO	Social Security Organization
THE	Total Health Expenditures

Terms Used in This Report

Term	Relevant definition
Budget Law	Is the approved budget for both the central and provincial governments. It is the enacted budget, published after the approval of the National Assembly.
Official Gazette	Is a summary of actual expenditure for both the central and provincial governments. It provides a comparison between the revised budget and actual expenditure.
First level budget unit	Budget for the unit is managed by the Ministry of Finance.
Second level budget unit	Budget is managed by the ministry or department to which they belong.
Decentralisation	Total budget for provincial governments and central ministries is passed at the same time with details in the Budget Law. Ministries exist at both the central and provincial government levels and report to either the Minister responsible in the National Assembly or the Provincial government. The Ministry for Health at the central level can be referred to as the parent ministry for the provincial Ministry of Health. Parent ministries set policies and procedures for ministries at the provincial level.

Notes

Most data used to calculate budget execution rates is sourced from the publications, Budget Law, and the Official Gazette from the years 2015/16 to 2019. Some adjustments have been made in the interests of accuracy and comparability. Figures in the Budget Law do not always equal the budget plan figures presented in the Official Gazette. In some cases, total spending does not equal provincial plus central level spending. A full list of the data used to calculate budget execution rates and notes on adjustments are included in annex 5.4. Foreign capital spending has been excluded (effecting the totals) as foreign capital spending is not included Budget Law. The budget execution rate is based on comparison of the planned budget and actual spending as this is the budget information communicated to ministries and therefore the basis on which spending units prepared their annual plans.

This technical note is a health financing analytics activity of Lao PDR Health Programmatic Advisory Service and Analytics. It is generously funded by the Japan Policy and Human Resources Development (PHRD) Grant. This technical note makes up part of a series of analytical pieces commissioned jointly by WHO and the World Bank as part of the health budget execution program of work, supported by the IMF and financially supported by GAVI.

This technical note was prepared by Grant Beveridge, Chanhsy Samavong and Soulaxay Bounthideth with the direction and guidance of Emiko Masaki, Hamish Colquhoun and Moritz Piatti-Fünfkirchen. Any errors are the authors own and should not be attributed to the World Bank.

Introduction: Public Financial Management in the Health Sector in Lao PDR

Strengthened financial systems lead to fiscal sustainability, operational efficiency, transparency, accountability, and improved outcomes in the health sector. Governance matters.
The World Bank is committed to improve Public Financial Management (PFM) across its operations: in systematic country diagnostic; in country partnership framework; investment lending and program for results; in knowledge products and advisory work.
This second PFM Policy note focuses on Budget Execution and outlines key developments that have occurred since the first PFM Bottlenecks policy note was published:

- Finalization and endorsement of the Heath Sector PFM Manual by the Minister of Health.
- Implementation of the Health Sector Accounting System.

Evidence shows that increased openness and transparency combined with better quality and more timely financial reporting about budget execution leads to better governance and accountability. This is because:

- The planning process has more comprehensive information on which to base decisions on strategic priorities for increasing access to quality health services for the poor and vulnerable.
- The necessary changes to budget allocations, to reflect those priorities, are more evidence based.

Ongoing PFM Reforms

The Government of Lao PDR is committed to achieving Universal Health Coverage by 2025 and has embarked on major health financing reforms to expand population and service coverage and to improve financial protection.
The Ministry of Finance (MOF) is leading the implementation of these reforms aimed at improving the efficiency of resources allocation, linking policy to budget through medium term planning, setting of aggregate ceilings and timely ministerial ceilings communication, budget execution and control, strengthening financial management information systems implementation and others are already rolling out at an early stage.
In collaboration with the MOF the Ministry of Health (MOH) is contributing to the reform of the management process.

Health Sector PFM Manual

MOH has taken the initiative to develop and implement the Health Sector PFM Manual. The manual summarizes the financial management related legislation and regulations and provides practical guidance on their implementation. It focuses on strengthening the health sectors overall control environment by ensuring consistent application of internal controls and good quality supporting documentation. This is key to addressing the quality gaps between the central and subnational levels across the health sector.

Health Sector Accounting System (HSAS)

MOH in close consultation with MOF has begun to implement the HSAS which aims to increasingly computerise the planning, budgeting, financial reporting processes. This will lead to:

- Significant efficiency gains as manual excel based processes are replaced and duplicate data entry is eliminated.
- More reliable, accurate, and timely planning, budgeting, and financial reporting for internal and external users.
- More comprehensive financial information on MOH and health sector by facilitating reporting against the health sector priority programs and the inclusion of budget and actual external financing information.

These developments are complimentary. Together they will help address many of the weaknesses identified in previous PFM assessments, including the need for:

- 8More openness and transparency of information.
- More integrated planning, budgeting, and financial reporting processes.

- Better governance and accountability.

Health Financing Overview

1.1 Background

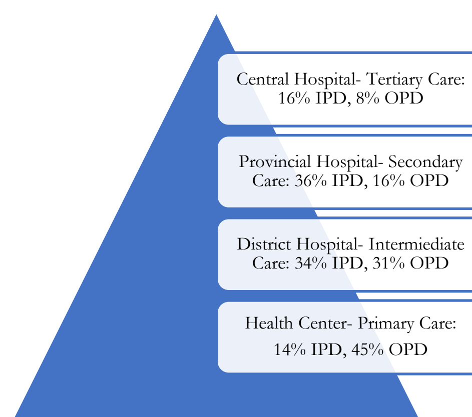
From the 1980s, the Lao health system transitioned from a government-funded public system providing free services, to a health financing system relying partly on user fees charged for services delivered at public health facilities. As a result, out-of-pocket payments (OOP) gradually increased to reach 48.6 percent of total health expenditures in FY2011. In order to reduce fragmentation in health financing and to address financial barriers to access to health services, the government established a unified NHI scheme in 2016 to expand social health projection coverage to the whole population and to integrate the free health services for the poor (Health Equity Fund, or HEF) and free services for mothers and children under 5 years of age (free MCH program), and community-based voluntary health insurance. Since 2019, the health benefits of the National Social Security Fund, and the Social Security Organization (SSO) have been merged into the NHI, aiming for the full integration. Currently, the NHI has been implemented in 17 provinces, except Vientiane Capital and is covering 94 percent of total population.

1.1.1 Health Sector Structure

The MOH consists of twelve departments at the central level, ten divisions at the provincial level and ten units at the district level. An organogram of MOH is provided in Annex 5.3 for reference.

A minor restructure of MOH administration is underway, with a recent approval to merge the Department of Finance (DoF) with the Department of Planning and Cooperation (DPC). The new department will be named the Department of Planning and Finance (DPF). The Department of Health Personnel (DHP) also merged with the Department of Health Professional and Education or Training and Research.

Figure 1.1: Health facility classification and available services



Note: IPD (Inpatient Department)
OPD (Outpatient Department)
Source: DHIS2, March 22 (2023)

There are four strata of health facilities in Lao PDR. The lowest level of public health facility are the health centers (sometimes referred to as small hospitals), followed by the district or community hospitals, provincial hospitals and then central hospitals which are all located in the capital Vientiane. Figure 1.1 provides an overview of the inpatient and outpatient utilization at different public health facilities.

Health Centers are administered by District Health Offices (DHO) and provide a range of primary health care interventions. These include examination, diagnosis, treatment, rehabilitation, hygiene promotion, disease prevention and vaccination. Health centers are divided into two types, type A are more than an hour from the nearest hospital, cover a population of more than 7,000 people and have at least five in-patient beds, type B are less than an hour from the nearest hospital, cover a population of up to 7,000 people, with no more than five in-patient beds. In 2022, health centers were responsible for 45 percent of all outpatient visits and 14 percent of all inpatient visits. There is a total of 1,075 health centers in Lao PDR.[1]

District hospitals come under the administration of the DHO. These hospitals receive referrals from health centers and offer intermediate care including diagnostic services, treatment, and rehabilitative services. These hospitals are also subdivided into type A, which can perform minor surgeries such as caesarean section deliveries and type B which cannot perform surgeries. In 2022, district hospitals were responsible

[1] Health Facility Master list Online (Lao PDR), https://hfml.la/index.html, March 22 (2023)

for 31 percent of all outpatient visits and 34 percent of all inpatient visits. There are a total of 135 district hospitals in Lao PDR.

Provincial hospitals are administered by a hospital director with supervision by Provincial Health Office (PHO). These hospitals offer a higher level of care than district hospitals and deliver research and capacity building services. In 2022, provincial hospitals were responsible for 16 percent of all outpatient visits and 36 percent of all inpatient visits. Each province has one provincial hospital giving a total of 17, Vientiane capital does not have a provincial hospital.

Ten central hospitals include one police hospital, one army hospital, five general hospitals, two specialized hospitals and three centers for eye, dermatology, and rehabilitation.[2] In 2022, central hospitals were responsible for 8 percent of all outpatient visits and 16 percent of all inpatient visits.

The Health Sector Reform Strategy (HSRS) outlines the main objectives of sector reform strategies achieve universal health care coverage (UHC) by 2025 and Sustainable Development Goals (SDG) by 2023 and anchors health financing as one of the five reform pillars to increase and sustain public financing of health to achieve UHC and SDG targets. The Health Financing Strategy (2021-2025) and Vision (2030) further specify the key objectives to enhance '(a) transparent public financial management, connected to health information, for accountable payers and providers at all levels; (b) adequate and predictable public financing, including transition to domestic financing, primarily through general taxes; (c) efficiency in allocation of resources across provinces and districts, particularly for primary health care (PHC); (d) compliance of all providers with policies aiming to remove financial barriers for the most vulnerable, including the poor, pregnant women, and children under five; (e) efficiency in health service delivery; (f) strengthen NHI function to purchase quality of services. To contribute to the HSR and health financing strategy implementation, the National Health Insurance Strategy (2021-2025) was adopted to strengthen the overall NHI functions for delivery and financing of quality health services and improving financial protection to achieve UHC.

1.2 Health Funding Sources

Overall, total health expenditure (THE) in Lao PDR is low by international comparison, at an estimated 2.7 percent of GDP in 2019.[3] OOP health expenditures were estimated to make up 40 percent of THE, while domestic government expenditure on health made up 36 percent and donors contributed 20 percent in 2019 as shown in table 1.1. Government health expenditure relies heavily on external financing, which raises concerns regarding the long-term sustainability of some programmes.

Table 1.1: Health expenditure by funding source

	USD Per Capita	GDP% Per Capita	Value (Million LAK)	% of THE
Total Health Expenditure (THE)	71.59	2.7%	4,440,338	100.0%
Domestic Government Expenditure on Health	26.09	1.0%	1,618,053	36.4%
Social Health Insurance	0.74	0.0%	45,736	1.0%
Donors	14.62	0.6%	906,463	20.4%
NGOs	1.52	0.1%	94,227	2.1%
Out-of-pocket	28.63	1.1%	1,775,857	40.0%
General Government Health Expenditure	47.58	1.8%	2,951,189	66.5%

Source: National Health Accounts 2021

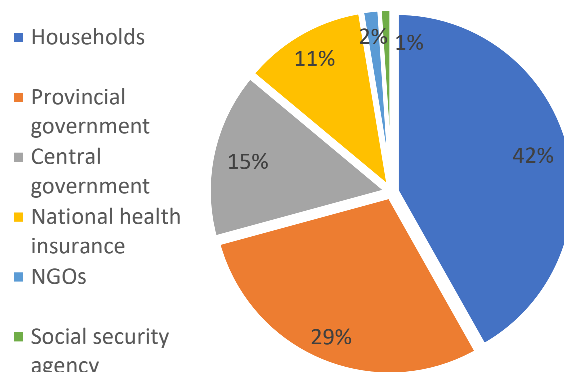
[2] Health Facility Master list Online (Lao PDR), https://hfml.la/index.html, March 22 (2023)

[3] National Health Accounts, MOH, September 2021.

THE has been increasing in nominal terms but makes up a stable proportion of GDP, as have donor contributions to the health sector. Domestic government health expenditure has been increasing in both nominal terms and as a proportion of GDP. OOP's have stabilized at around US$28 per capita and are declining as a percent of GDP.

A sharp currency depreciation and unfavorable external conditions are undermining the economic recovery. While the COVID-19 continue impacting the economy, emerging challenges including rising fuel and higher food prices can impact the steady recovery path. Inflation increases from 3.75 percent in 2021 to 22.96 percent in 2022. Most importantly, increased prices of medicines becoming as barriers to access to care for patients leading to higher out-of-pocket payments by patients. Government budgets in deficit and fiscal consolidation efforts getting worse due to the economic impact of the pandemic and increase in inflation rate.

Figure 1.2: Health sector by financing agent



Source: National Health Accounts 2021

MOH manages the largest proportion of total health spending with 29 percent managed by MOH central and 15 percent managed by MOH provincial, making a total of 44 percent. The National Health Insurance Bureau manages a total of 11 percent of total expenditure on health as shown in figure 1.2. The private sector is limited, representing only 7.7 percent of THE.[4]

1.2.1 Donor Financing

Donor financing is the third biggest source for financing health expenditures in Lao PDR after OOP and the government budget. In 2019, donor financing on health accounted for LAK 910 billion (equivalent to 20.4 percent of THE), increasing from LAK555 billion (17.7 percent of THE) in 2016.[5] Approximately half of the amount was allocated to the MOH central and the rest at MOH provincial.

Figure 1.3: Donor financing for health during 2011-19

Source: National Health Accounts, 2021

Donor financed health expenditure has had an upward trend over the last decade as shown in figure 1.3. Between the years 2011-2019, donor-funded expenditure for health increased 13.5 percent, per year on average. As a proportion of THE, donor financing increased from 17.7 percent in 2016 to 21.0 percent in 2018, before slightly decreasing to 20.4 percent. Donor financing is expected to further decline or stagnate as Lao PDR nears exceeding income related eligibility thresholds for both GAVI and the Global Fund.[6] The Institute for Health Metrics and Evaluation (2022) projects that the share of donor financing for health in THE will decline by 3.1 percentage points over the years 2019-2025.[7]

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[4] Calculated from National Health Accounts 2019. The private sector accounted for a total of LAK 342 billion.

[5] National Health Accounts, MOH, September 2021.

[6] Transition policy of GAVI https://www.gavi.org/sites/default/files/document/gavi-eligibility-and-transition-policypdf.pdf, eligibility policy of the Global Fund https://www.theglobalfund.org/media/4227/bm35_06-eligibility_policy_en.pdf.

[7] Global Burden of Disease 2020 Health Financing Collaborator Network, Tracking development assistance for health and for COVID-19: a review of development assistance, government, out-of-pocket, and other private spending on health for 204 countries and territories, 1990–2050, The Lancet, October 2021.

1.2.2 National Health Insurance Fund

The National Health Insurance Fund (NHIF) has integrated fragmented public insurance schemes into one fund. The major health insurance schemes under the NHIF are: (i) the National Health Insurance scheme (NHI); (ii) State Authority for Social Security (SASS); and (iii) Social Security Organization (SSO).

The NHI scheme is a Social Health Protection scheme designed to cover those people in the informal sector who were not otherwise covered by health insurance. The objective of the NHI is to accelerate the achievement of universal health coverage in Lao PDR. The scheme was rolled out to six of 17 provinces by the end of 2016 then expanded to 17 provinces in 2017. Vientiane capital remains outside of NHI coverage, although the NHI Strategy 2021-2025 specifically mentions expanding coverage to all provinces by 2025 as a strategic objective.[8] In 2016 and 2017 the government moved to fund the premiums for NHI directly, and to automatically enroll the eligible population, leading to a large expansion in coverage. Under the NHI scheme, a fixed co-payment is payable to the provider by the patient at the time care is sought, the remainder of the cost is reimbursed by the NHI scheme through a pre-payment based on expected demand and the estimated cost of services.

The State Authority for Social Security (SASS) is a public health insurance scheme for civil servants and their families, established in 1995. Premiums for SASS, the Military and the Police are sourced from an 8.5 percent contribution paid on top of staff salaries by the Government of Lao PDR and an 8 percent deduction from staff salaries, totaling 16.5 percent of staff salaries.

Like the SASS, the Social Security Organization (SSO), is a health insurance scheme for those in private, formal sector employment, established in 2001. All businesses with more than one employee are required to enroll their employees. Premium payments are set at 11.5 percent of an employee’s total salary, with 6 percent to be paid by the employee and 5.5 percent to be paid by the employer.

NHIB also receives a significant portion of funding from the National Social Security Fund (NSSF). The NSSF is responsible for managing pensions of civil servants and individuals who have chosen to opt into the government pension system.

The NSSF is responsible for the registration of policy holders and for the collection of premiums for SASS and SSO. However, NSSF transfers funds to the National Health Insurance Bureau (NHIB), under the MOH, which is responsible for managing health insurance for members of the NSSF.[9] Health insurance for army retirees (Social Security Fund of Ministry of Public Security) and forestry was brought under NHIF in 2022.[10] Health insurance for members of the military in service is the only public health insurance fund which remains outside of NHIB management. These formal sector schemes were once managed by the National Social Security Fund (NSSF) under the Ministry of Labour and Social Welfare (MLSW).

The NHIB is equivalent to a department under MOH. Department level revenues planned expenditure and actual expenditure are not reported on separately in the budget. The largest expense, the NHI premium payment, is included in chapter 63 subsidies and contributions of the MOH central budget.

NHIB produces an annual report titled *Previous year Implementation Report and Forward Year Plan*. This report provides excellent analysis and narrative of NHIB budget implementation and plans. The report also provides an overview of the Bureau’s objectives, administrative structure, completed activities, outputs and outcomes. However, the annual report lacks detail about budget versus actual outturns, the administrative budget, linkages between the budget, outputs, and objectives and other government financial reports.

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[8] National health Insurance Bureau, National Health Insurance Strategy 2021-2025, p.16.
[9] Health Financing Strategy 2021-2025, MOH, World Health Organisation, 2021. pp.3
[10] Report of the Implementation of Health Insurance for 2020 and plan for 2021, National Health Insurance Bureau, 2020.

The implementation of NHI has increased social health protection coverage from 32 percent in 2015 to 94.5 percent in 2023. The utilization rate at public hospitals has increased from 11 percent in 2007/08 to 33 percent in 2018/19; and decreased OOP in public health facilities from 10.1 percent to 8.4 percent (Household expenditure on health as a share of total household expenditure greater than 10%.[11]

1.2.3 Fiscal Decentralization

The management of both revenues and expenditure is heavily decentralized in Lao PDR. In the FY2020 State Budget Plan, provinces were estimated to raise 20 percent of total government revenues. Provinces are responsible for 27 percent of expenditure, rising to 34 percent if externally financed capital expenditure is excluded.

As expenditure by provincial governments is higher than the revenues they generate, provincial governments are reliant on central government transfers to fund their operations. The *Law on State Budget (2006)* makes provisions for the central government to support the provincial government where approved revenues are insufficient to cover approved expenditures. Both estimates and actual intergovernmental transfers are not publicly reported.

Most health facilities and funding for health services is managed at the provincial and district levels. Provincial governors have total authority to allocate funding within the responsibilities of the provincial government.[12] However, some factors that limit governors fully exercising that authority, are the single civil service (all civil servants are employed by the MOH, rather than by central MOH or provincial MOH) and the single party-political system. Under a single civil service, those working for the provincial government are reluctant to deviate from practice set at the central level. A civil servant can expect to rotate through many positions at different levels of government in their career. Though MOH central does not have formal authority over MOH provincial, civil servants at the provincial level prefer to adhere to procedures and policies set by more senior officials at the central level.

Though provincial governors are not formally required to follow the position of central ministers, the single party government also limits the autonomy of provincial governors. Provincial governors often transition to central party-political roles. As members of the same party, governors are expected to follow the policies endorsed by the central national assembly.

1.2.4 Provincial Government Revenues

Provincial government expenditure is mostly funded from their own revenues. Funding from the central government is considered as support rather than the foundation of provincial government activities. The source of financing does not impinge on the provincial governments' freedom to manage and allocate funding. Transfers or support from the central government do not carry restrictions on how they are managed. Funding from the central government and provincial sources of revenue are held in the same account and are treated equally.

Exceptions to this include targeted budget support under article 44 of the State Budget Law, technical or own-sourced revenues and donor support. Targeted budget support is funding to support projects handed over by the central government to the provincial government to implement.

According to the State Budget Law, targeted budget support must be used:

[11] National Health Insurance Strategy 2021-2025 (May, 2022) and report on Monitoring financial protection and utilization of health services in Lao PDR 2007/2008-2018/2019, May 2022.

[12] Article 65, *Amended Law on State Budget,* 2006, The Prime Minister has the authority to transfer funds between provinces.

- to enable the execution of investment programmes and projects in the annual master plan that the government additionally assigns; or
- to deal with emergencies and urgent situations not included in the annual budget plan of the localities, based on the decision of the government.

The MOH is exploring linking central government financing to policy objectives. The Health Financing Strategy 2021-2025 and Vision 2030 flag potential pilot block grants for chapter 62, Operation and Maintenance.[13] The management of technical or own sourced revenue is discussed in greater detail in section 3.8.3.

1.3 Financing of Health Facilities

1.3.1 Treasury Financing

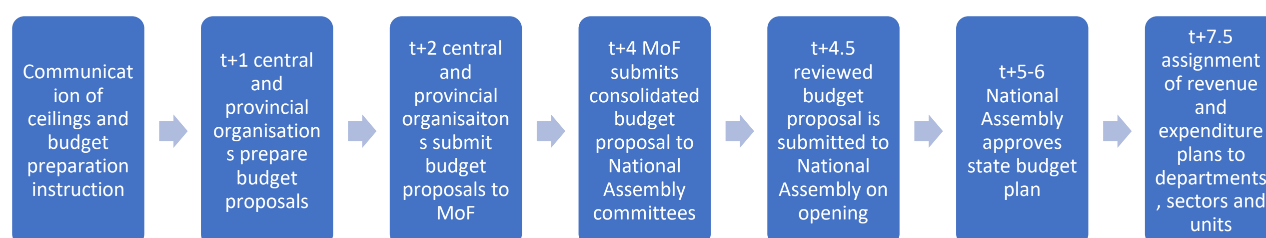
Budget preparation, execution and reporting processes are set by the *Amended Law on the State Budget 2006*. The law details the sources of revenue available to the central government and the 17 provinces and the capital city municipality prefecture as well as the revenues to be apportioned between the two levels of government.

Lao PDR's fiscal budget year changed from October-September to the calendar year in 2017.[14] Though both the budget for the national government and the 18 provincial governments are presented in one document, the budget preparation process for the two levels of government is sequential due to uncertainty around the total budget available for provinces.

National and Provincial treasuries disburse cash on a quarterly basis. Each budget unit maintains a bank account operated by the Bank of Lao (BoL). The BoL also operates sub-accounts, based on chapters from the chart of accounts. Cash is disbursed to central budget units following approval of the National Treasury, while cash is disbursed to provincial and district budget units following approval of the provincial or district treasury. Chapters 60, Wages and Salaries and 61, Compensations and Benefits are almost entirely funded (99 percent)[15] by funds appropriated through the treasury system.

The government budgets are prepared and endorsed sequentially. The National Assembly endorses the budget for the central government and provinces followed by the assignment of revenue and expenditure plans to departments, sectors, and units within one and a half months. The main phases in budget preparation are outlined in the Law on State Budget and represented in figure 1.6 below.

Figure 1.4: Lao PDR budget preparation and approval process



Source: Article 51 of Amended Law on the State Budget 2006

Following the endorsement of the state budget plan and the assignment of revenue and expenditure plans to departments, sectors and units, expenditure is allowed if it follows the conditions outlined under article 57 of the budget law below:

[13] Health Financing Strategy 2021-2025 and Vision 2030, MOH, p.14.
[14] World Bank, Lao PDR Economic Monitor, January 2019, p.23.
[15] 2021 Revised budget MOH budget plan, MOH supplied data.

All expenditures must:

- Be provided for in the annual budget plan;
- Approval must be obtained;
- Be in line with expenditure targets;
- Be accurately calculated in accordance with the spending norms;
- Be authorized by the ordonators or persons assigned [by them].[16]

The legislative basis for general verification and oversight is detailed below.

- State Budget Law (2016) part VI (amended in 2021) details the management, inspection and reporting of the state budget.
- Law on Public Procurement (2017) Part V- Tender Committees and Evaluation of Bids, Section 3- Inspection and Certification Committees, and Part IX Public Procurement management and inspection.
- Decree No.470 on National Health Insurance, article 41 gives authority to the Department of Inspection (MOH) to carry out internal inspections and the State Inspection Authority (MOF) to carry out external inspection. Both internal and external inspections are empowered to investigate the management, transparency, and efficiency in the utilization of health insurance funds.
- The Law on National Health Insurance establishes verification and oversight committees in articles 44 to 50. It also outlines their oversight responsibilities of national, provincial and district health insurance fund management committees. This includes prices of medicines and medical services, health services contracts, revenue and expenditure reports.

1.3.2 National Health Insurance Funding

NHIB manages financing of health services for insurance members. NHI funding is expected to make up 14 percent of the health budget in FY2022.[17] Health facilities are required to estimate their expected demand for services, based on population covered and historical data. Health facilities also estimate the costs of inputs for health services. These data are then reviewed and consolidated to form the annual service contract. The service contract stipulates an agreement between the health contractor (NHIB) to pay health providers for a range of services to health insurance members. Funding for health services is paid to health facilities quarterly from NHIB accounts, following approval from the relevant district, provincial or national NHIB office. Funding is transferred to health facilities sub-accounts for chapter 63, Subsides and Contributions. NHI funding is considered a prepayment for services and is deposited to health facilities bank accounts based on up-to-date reporting. NHIB withholds 20 percent of funds to health facilities until verification or audit procedures have been completed.

1.3.3 Donor Government Funding and Donated Funds

Outside of the usual government cash flows, specialized government bank accounts can be established to receive funding. Usually established by government decree, these accounts give additional accountability to ensure that funds raised are only used for their intended purpose. Where donor governments require additional procurement, accounting, or audit practices, the government may establish a separate account for receiving and disbursing the funding. Alternatively, the government may establish an account by decree to receive donations from businesses and individuals. The government decree will outline the objective of the fund, the administration and management of the fund, and the controls over the use of the funding.

[16] Article 57, Amended Law on State Budget, 2006, p. 23.

[17] Ministry of Health, Budget Plan, MOH supplied data. Ordinators are typically heads of departments while primary ordonators are heads of ministries.

1.3.4 Cash in Account

Health facilities can maintain positive cash balances and carry these balances between fiscal years. Only a minority of units under MOH are required to return the entirety of their budget to central or local state accumulation funds. Large cash balances mean most MOH units are not entirely dependent on treasury disbursements to carry out their planned activities.

The Amended Law on the State Budget, and the Instructions on Revenue and Expenditure Management of Financially Self-Sufficient Administrative and Technical Units, are designed to encourage provincial governments and health facilities to work toward becoming financially self-sufficient. The MOH is currently piloting an initiative to make some central hospitals self-sufficient. The long-term aim of NHI is to allow health facilities to be financially self-sufficient and to manage their resources as they see fit including personnel, operational and capital expenditures.

The Ministry of Finance (MOF) does not produce a public document detailing intergovernmental fiscal transfers, obscuring the exact flow of funding between levels of government and government organizations. A breakdown of expenditure by level of government is provided in table 1.2. This table includes expenditure from revenues received from the national treasury, provincial treasury, district treasury as well as technical revenues.

Table 1.2: Budget by level of organization

Health unit	Value (Million LAK)	% of Public Expenditure on Health
Central hospitals	244,640	6%
Provincial hospitals	964,760	25%
District hospitals	586,624	15%
Specialized hospitals	169,759	4%
Health centers	317,416	8%
Providers of preventive care	326,547	8%
Government health administration agencies	1,293,838	33%
Public sector	3,903,584	100%

Source: National Health Accounts 2019

Figure 1.5: Domestic health funding and reporting flows

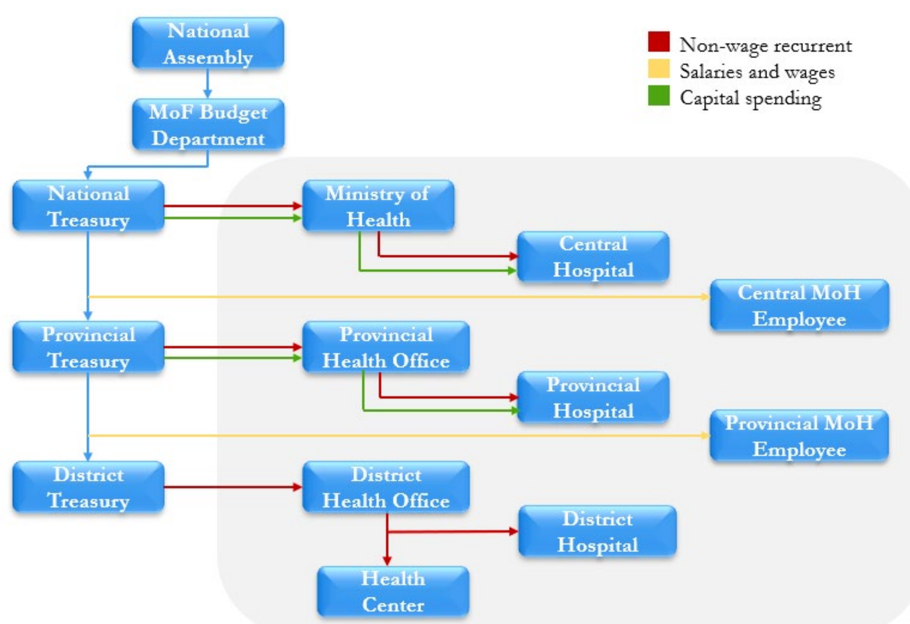


Figure 1.7 shows government financing flows in the public health system. The budget law, once approved, allows the national treasury to release cash from to the MOH and provincial treasuries. Following the approval of the provincial budget, the provincial and district finance offices assign revenue and expenditure plans for departments and units. Provincial governments' main source of revenue comes from revenues generated at the provincial level.

Capital expenditure is only managed at the central and provincial levels. Financing for approved capital projects (chapter 67), under MOH central flows from central MOH to central hospitals while funding for provincial hospitals flows from the PHOs to provincial hospitals.

Funding for wages and salaries (chapters 60 and 61) are directly transferred from either the national treasury or the provincial treasury to the employee. MOH employees working at district facilities are managed and paid through provincial level systems. Due to increasing instances of delays and uncertainty of payments the MOF transitioned to the direct payment of staff. Since 2013, salary payments have been directly deposited into civil servants' government bank accounts by the national or provincial treasury on a monthly rather than quarterly basis.

Funding for non-wage recurrent spending (chapters 62, 63, 64 and 66) are directed through the central, provincial and district level treasury systems. Central, provincial and district units are funded by their respective treasuries. Funding for district health facilities is transferred from district treasuries to DHOs and then to health facilities. Provincial health facilities are also funded through PHOs.

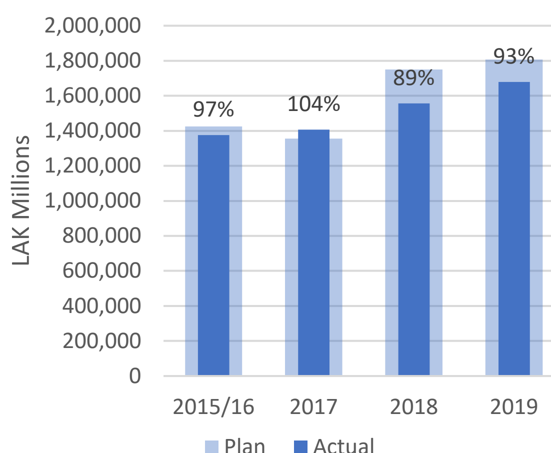
Quarterly cash requests are submitted to the provincial treasury by Provincial Finance Offices (PFO). Quarterly cash tranches are based on budget proposals for the forthcoming quarter. PHOs submit a quarterly budget request to PFO and once approved, receive the budget amount credited to their dedicated account at the provincial treasury office. DHOs in turn request their quarterly budget tranche of non-salary budget from PHO, and have their budget remitted to their respective account with the treasury office at district level.

Budget Execution Rates

1.4 Total Health Budget

Overall budget credibility and reliability of the Lao PDR health budget is good. Over the past four years, from fiscal year 2015/16 to 2019, the aggregate execution rate has been 97 percent, 104 percent, 89 percent and 93 percent, as shown in figure 2.1. Using the PEFA framework on aggregate expenditure outturn, the health sector receives a rating of 'B' and very nearly an 'A'.[18] It should be noted that this sample excludes externally financed capital expenditure. This category of expenditure was only included in the FY2018 budget plan with outturns achieving only 44 percent of budget plan. Including externally financed capital expenditure in budget plan would lead to much worse variations between the budget plan and actual expenditure outturns.

Figure 2.1: Total domestic government health expenditure



Source: Budget Law and Official Gazette 2016-2019

[18] PEFA Secretariat, *PEFA Framework for The Assessment of Public Financial Management,* February 2016, p.14 https://www.pefa.org/node/119

Table 2.1: Budget execution in the health sector by economic classification (LAK millions)

Fiscal Year	Classification	Plan	Actual	Execution Rate
2015/16	Ch. 60, 61: Salary, allowances, and compensation	130,025	116,629	90%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	376,576	360,384	96%
	Ch. 67 Locally funded capital expenditure	64,500	55,861	87%
2017	Ch. 60, 61: Salary, allowances, and compensation	127,731	126,406	99%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	377,765	370,605	98%
	Ch. 67 Locally funded capital expenditure	62,299	58,447	94%
2018	Ch. 60, 61: Salary, allowances, and compensation	128,981	133,116	103%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	520,759	408,194	78%
	Ch. 67 Locally funded capital expenditure	52,789	50,848	96%
2019	Ch. 60, 61: Salary, allowances, and compensation	132,153	130,046	98%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	579,373	596,504	103%
	Ch. 67 Locally funded capital expenditure	35,108	35,105	100%

Source: Budget Law and Official Gazette 2016-2019

1.5 Decentralized Budget Execution

A summary of MOH central and provincial budget execution rates in presented in table 2.2. A comparison of central and provincial execution rates shows that much better budget execution rates are achieved at the central level. A comparison of the absolute deviations in budget execution rates shows that the provincial level outperformed the central level in only one instance. In 2018, the MOH provincial level executed 89 percent of its budget compared to the central level which only executed 78 percent of its budget for non-wage recurrent expenditure. The poor budget execution for the MOH level central was due to the delayed scale up of the national health insurance fund discussed in section 3.5.

Table 2.2 Budget execution rates for Ministry of Health central and provincial

Administration	Budget Classification	2015/16	2017	2018	2019
Ministry of Health Central	Ch. 60, 61: Salary, allowances, and compensation	90%	99%	103%	98%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	96%	98%	78%	103%
	Ch. 67 Locally funded Capital	87%	93%	96%	100%
Ministry of Health Provincial	Ch. 60, 61: Salary, allowances, and compensation	91%	104%	93%	92%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	110%	106%	89%	78%
	Ch. 67 Locally funded Capital	115%	153%	115%	120%

Source: Budget Law and Official Gazette 2016-2019

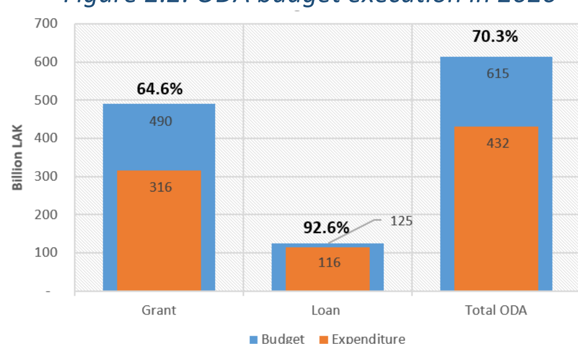
1.6 Donor Financing

In the period analyzed, externally financed capital expenditure was included for the first time in the budget law for FY2018. In prior years, no externally financed capital expenditure was reported in the budget law. In the official gazette, budget estimate figures were the same as actual expenditure outturn. It is assumed that the budget estimate figures were placeholders and were not true budget estimate figures. In FY2019, budget execution figures were presented in the official gazette for MOH central but were absent in the budget law publication. According to the official gazette, the MOH central level achieved a budget execution rate of 110 percent. These figures were excluded from the analysis as they were not present in the budget law.

The World Bank health team were able to analyze donor financing budget execution data from Department of Planning and Cooperation (MOH) for FY2020 and the first six months of FY2021. These do not reflect official figures, which were not available at the time of publication but offer some insight into the budget credibility of donor financing.

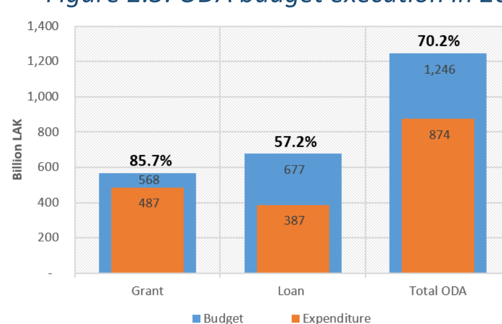
Based on recent MOH budget data represented in figure 2.2, the FY 2020 ODA budget execution rate for health sector was poor in FY2020, achieving only 70.3 percent, worse than any other budget categories analyzed for the period from FY2015/16 to FY2019. The COVID-19 pandemic and related government restrictions make comparison to earlier years difficult, however MOH officials believe this would consistently be the worst performing budget category. In FY2020, Lao PDR received LAK615 billion in health sector ODA (of which LAK490 billion was grants, equivalent to 79.7 percent of total health sector ODA). Throughout the year, 70.3 percent of the total ODA budget was spent (LAK432 billion), of which 64.6 percent of total grant financing and 92.6 percent of total loan financing were executed. This performance is worse than all other budget categories examined in the period FY2015/16 to FY2019. The worst performance in this period was non-wage recurrent spending in FY2018 which achieved a budget execution rate of 78 percent. Figure 2.3 shows that LAK1,246 billion flowed into the country as ODA in 2021. Over 2021, 70.2 percent of the total ODA budget was executed.

Figure 2.2: ODA budget execution in 2020



Source: The author, based on the data from Department of Planning and Cooperation (MOH), March 2021

Figure 2.3: ODA budget execution in 2021



Source: The author, based on the data from Department of Planning and Cooperation (MOH), August 2022

1.7 Revised Budget

The practice of preparing a revised budget is provided for in article 54 of the *Amended Law on the State Budget 2006* but is not a statutory requirement. A revised budget is only permitted once a year, after the first six months of implementation. A revised budget is recommended when major variations to revenue or expenditures are expected. Revised budgets are typically prepared once a year, although due to COVID-19 restrictions and a major downgrading of revenue projections, a second revised budget was prepared in FY2020. Revised budgets have only been publicly reported by the central government. Provincial governments have not presented revised budgets due to the shortened timeframe they face for budget implementation.

Table 2.3: Ministry domestic government health spending (LAK millions)

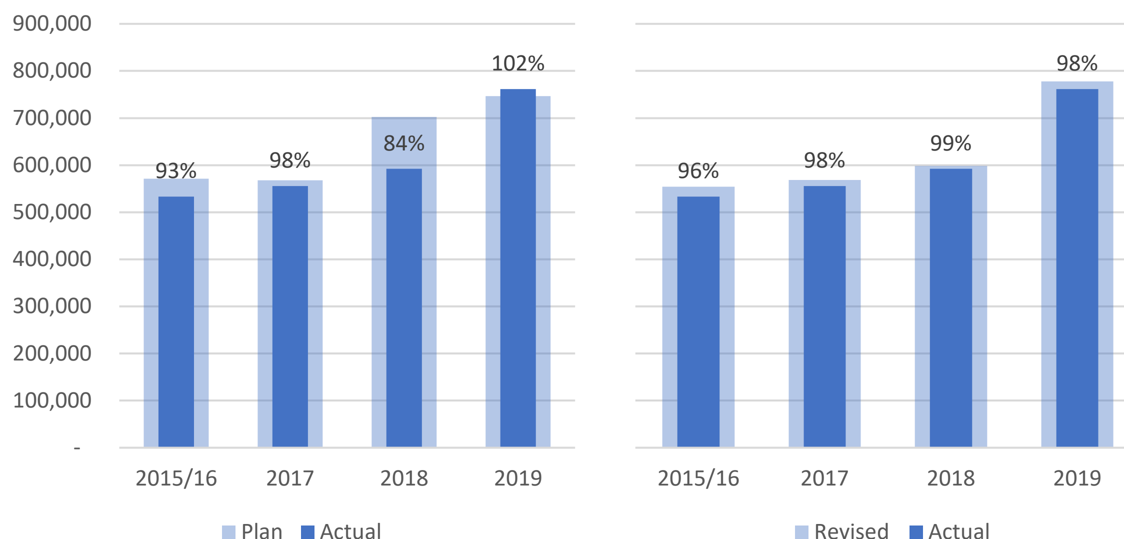
	(1)	(2)	(3)	(4)	(5)
Fiscal Year	Plan	Revised	Actual	Execution Rate (3/1)	Execution Rate (3/2)
2015/16	571,101	554,219	532,874	93%	96%
2017	567,795	568,470	555,458	98%	98%
2018	702,529	598,124	592,158	84%	99%
2019	746,634	777,777	761,655	102%	98%

Source: Budget Law and Official Gazette 2016-2019

Revised budgets for the MOH central level are more accurate than the original planned budgets. Over the period of analysis, the MOH central level executed between -16 percent to +2 percent compared to the

planned budget. This compares to a range of -4 percent to -1 percent when comparing the revised budget to actual expenditure outturns, as shown in figure 2.4. The main cause of the large variations in expenditure was due to in-year budget cuts stemming from Ministry of Finance instruction rather than any systemic budget execution issues within the MOH central level. MOH central level has revised its budget and therefore has nearly achieved full aggregate budget execution.

Figure 2.4: Planned and revised execution rates compared (LAK millions)



Source: Budget Law and Official Gazette 2016-2019

1.8 Budget Execution Across Programs

It is difficult to find a consistent definition of eight programs in 9th Five-year National Social-Economic Development Plan (2021-2025) and The Health Sector Reform Strategy and Framework until 2030, developed a costed program structure based on the Millennium Development Goals and the Sustainable Development Goals. In this exercise 49 sub-programs and 133 projects were defined and costed. The document also lists eight priority areas for the period 2021-2025 and These are:

- Program 1: Hygiene and health promotion
- Program 2: Communicable disease prevention and control
- Program 3: Health Care Services
- Program 4: Consumer protection for food, drugs, and medical products
- Program 5: Health personnel management, development, and health sciences research
- Program 6: Health financing
- Program 7: Planning, health information and cooperation
- Program 8: Governance and inspection

The MOH has also devised a functional budget classification by mapping departments to health priorities. This reporting system was developed to report against the National Health Accounts (NHA). Under the NHA the health programs are:

- Curative care
- Rehabilitative care
- Ancillary services
- Medical goods
- Preventive care
- Governance, health systems and financing administration

- Other

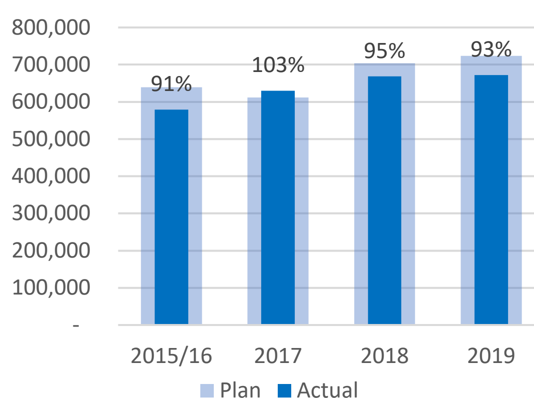
The strategic plans costing exercise does not follow the reporting under the NHA or the Official Gazette, making it impossible to compare actual expenditure to the costing estimates. To make up for the lack of a functional or program classifier in the GFIS, the MOH has developed its own programmatic classifier addendum to the Chart of Accounts (CoA). Forward budget estimates are not yet prepared according to programs, so it is not possible to calculate a budget execution rate.

A fully implemented program-based budget would enable program managers to reallocate expenditure between economic classifications within a program. By preparing a budget plan MOH would improve transparency and help inform virement limits.

1.9 Wages and Salaries

Health sector expenditure on salaries and wages can be tallied by adding chapter 60, Civil Servant Salaries and Subsidies and chapter 61, Compensation and Allowances from the CoA.[19]

Figure 2.5: Budget execution for salaries, allowances, and compensation (LAK millions)



Source: Budget Law and Official Gazette 2016-2019

In many countries, salaries and wages are the best performing budget execution categories. This expenditure is highly predictable, easy to calculate and a very difficult budget to cut. Surprisingly, MOH salaries and wages do not perform much better than other budget categories.

Most expenditure on salaries and wages are managed by the provincial governments because most of the health facilities are located at the sub-national level. According to the FY2019 Official Gazette, only 19 percent of the expenditure was managed by the MOH central level and 81 percent was managed by the MOH provincial level.

The provincial governments are the main driver of variation between budget plan and actual expenditure outturn as shown in table 2.3. Over the fiscal years analyzed there are relatively large deviations from the budget plan in both salaries, allowances, and compensation.

Table 2.4: Variance between budget and actual expenditure outturn for MOH central and provincial salaries and wages (LAK millions)

Administration	Fiscal Year	Plan	Actual	Variance	Execution
Central	2015/16	130,025	116,629	-13,396	90%
	2017	127,731	126,406	-1,325	99%
	2018	128,981	133,116	4,135	103%
	2019	132,153	130,046	-2,107	98%
Provincial	2015/16	509,648	462,744	-46,904	91%
	2017	484,384	503,369	18,985	104%
	2018	574,739	535,233	-39,506	93%
	2019	591,097	542,312	-48,785	92%

Source: Budget Law and Official Gazette 2016-2019

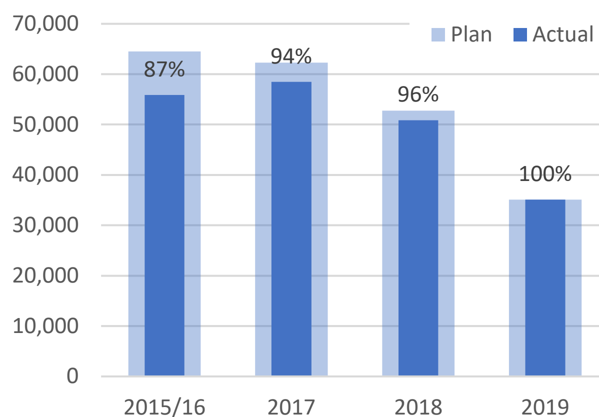
[19] See Annex 5.1 for an overview of the chart of accounts.

The absolute variation between budget law and actual expenditure outturn was worse for the MOH provincial level than the MOH central level, both in terms of magnitude and as a percentage. The average absolute deviation from the budget plan was four percent for MOH central level and seven percent for the MOH provincial level.

1.10 Capital Expenditure

The budget execution for capital expenditure is surprisingly good. Total actual domestically funded capital expenditure was within six percent of the budget plan for three of the four years analyzed, with the largest underspend being 13 percent in FY2015/16 as shown in figure 2.6. Responsibility for domestic capital expenditure is split relatively evenly between the central and provincial governments. MOH central level performed better than the provincial governments with a slight underspend each year. However, provincial governments overspent their capital expenditure budgets each year.

Figure 2.6: Domestic capital expenditure (LAK millions)



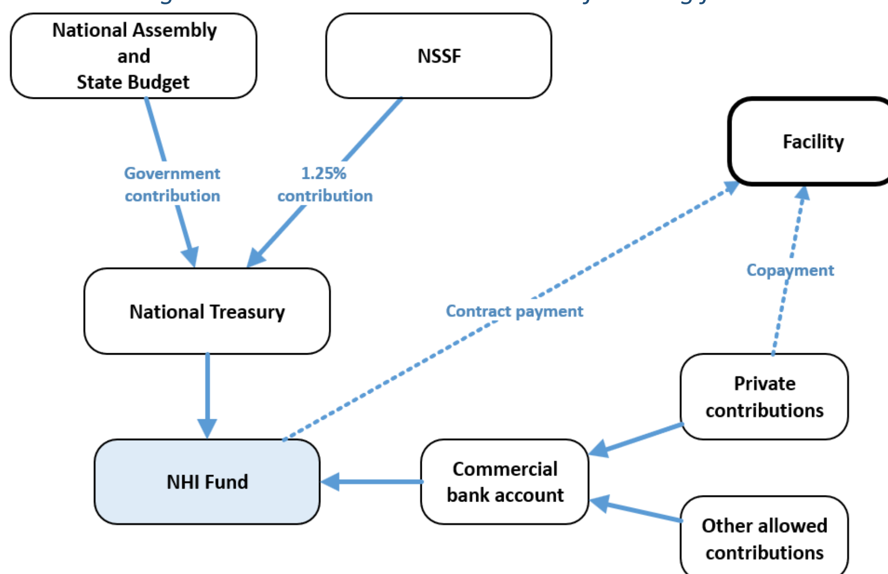
Source: Budget Law and Official Gazette 2016-2019

1.11 Health Insurance Transfers

Current reporting in the official gazette does not include information on budget execution figures below the ministry level. As a department under the MOH, information on budget execution related to NHIB can be obtained from different division under NHIB.

The NHIF has complex revenue flows. Revenues to the NHIF accrue from both premium payments and co-payments. Premium payments for formal sector insurance schemes (Defense, SSO, SASS) are drawn from contributions from both the employer and employee.

Figure 2.7: National health insurance financing flows



Source: the author, based on an original diagram by Taavi Lai and Agris Koppel

Total revenues to the NHIF were 180 billion LAK from the premium payments for the NHI scheme, LAK 90 billion from the NSSP which makes premium payments for the SSAS, Military and Police. The payment of premiums for retirees under the NSSF is not linked to the number of members or the health services provided. NSSF transfers 1.25 percent of revenue to the NHIB to pay for members' health insurance premiums. In 2022, this equated to LAK 90 billion or 31 percent of premium payments to NHIF.

Table 2.5: NHI revenue by source (LAK billions)

Premium Type	2022 Budget	% of budget	Members (2018)
NHI Premium	180.0	62%	5,039,239
National Social Security Fund	90.0	31%	472,940
NSSF Co-payments	21.6	7%	N/A
Total	291.6	100%	

Source: Implementation and plan of National Health Insurance Fund 2020

Like the NSSF, the premium payments for the largest insurance scheme, the NHI, is not linked to the number of members or the health services provided. In 2022 the NHI premium totaled LAK 180 billion as shown in Table 2.5. This funding is used to prepay agreed service charges for members at contracted health facilities based on expected utilization. The premium amount has been frozen at LAK 180 billion since 2018.

Table 2.5 shows the value of insurance premiums to the NHIF. The publicly funded NHI premium accounts for 62 percent of funding. The transfer from the NSSF makes up a total of 31 percent of NHI revenue. Health facilities also collect revenue on behalf of NHI from co-payments from members. The value of co-payments is expected to be LAK 24.6 billion in 2022, 7.4 percent of funding to the NHI.

The NHI Strategy 2021-2025 includes a detailed plan on amendments required to the enabling legislation of the NHI, the National Health Insurance Law. The strategy expresses the need for greater institutional independence of the NHIB and the possibility of transitioning from a government department to a semi-autonomous government agency.

The strategy also calls for potential changes to health insurance financing. The strategy proposes that a statutorily independent health insurance reserve fund be established which would sit outside of consolidated revenue. There are several justifications for an independent fund:

- An independent fund is required to maintain financial sustainability as required by the NHI law.
- Treasury instructions, government financial and accounting systems are not suitable for a health contracting facility.
- A statutory fund, outside of consolidated revenue would ensure continued health services even in the case of cash shortages or delays to the passing of state budgets.

NHIB is investigating the possibility of moving to direct transfers to health facilities.[20] This would circumvent provincial and district treasuries and would undoubtably speed up payment processing. This has been implemented through the World Bank project which support direct facility transfer based on the The benefits of faster transfers will have to be weighed against creating a misalignment between reporting and financing. Typically, budget discipline is enforced through financing agencies withholding payment until receipt of the required financial and performance reports by spending agencies. Under the current financing arrangements, health facilities report to their relevant MOH department, at either the central, provincial or district levels. Health facilities also receive most of their funding from the same organization responsible for receiving and approving reports. Direct funding would complicate the accountability lines.

1.12 Drugs and Medical Supplies

[20] National Health Insurance: An assessment of progress in 2016-2019 and priorities for 2021-2025, MOH, 2020.

At the most disaggregated level, it is possible to find a budget classifier for the purchase of medical drugs and a classifier for the purchase of medical equipment. However, it is not possible to disambiguate the budget execution data for MOH from the entire government. According to the official gazette MOH was responsible for 96 percent of the expenditure on the purchase of medical drugs and 90 percent of expenditure on medical equipment during FY2019. The MOH central level accounted for 79 percent of the expenditure on medical equipment, being responsible for central and specialist hospitals, while the MOH provincial level was responsible for 65 percent of the expenditure on drugs due to its greater responsibility for managing health facilities.[21]

Figure 2.8 shows that budget execution for medical equipment performed well in FY2016, 2017 and 2018. However, a planned increase in spending in FY2019, from LAK 80 to 116 billion was not fully achieved, partially due to the GoL's fiscal consolidation since FY2019 and insufficiently valid budget plans. Budget execution for medical drugs also performed well although actual expenditure outturns failed to fully execute a large, planned budget increase in FY2016 and a large, planned budget decrease in FY2017 as shown in figure 2.9.

Figure 2.8: Total government budget execution for medical equipment (LAK millions)

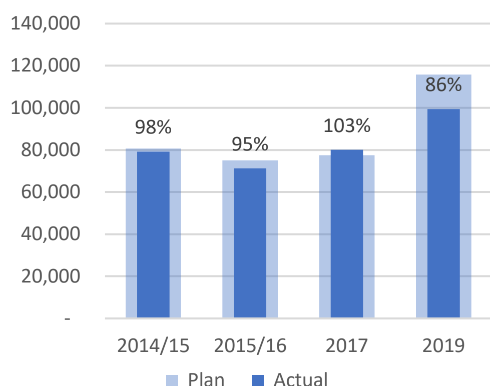
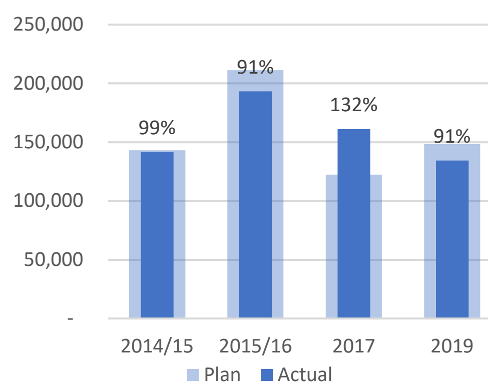


Figure 2.9: Total government budget execution for medical drugs (LAK millions)



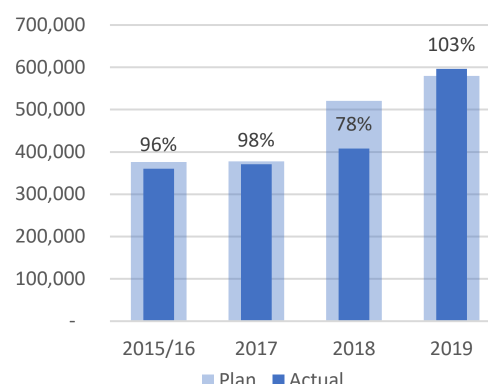
Source: Budget Law and Official Gazette 2014/15-2019, 2018 data not available because published 2018 State Budget Plan does not include detailed information of planned budget on medical equipment and medical drugs. As a result, it is unable to calculate the budget execution without the planned figures.

1.13 Non-wage Recurrent Expenditure

Non-wage recurrent spending consists of chapters 62, Operation and Maintenances, 63, Subsidies and Contributions, 64, Financial Expenditure, 65, Other Expenditures, and 66, Fixed Assets for Administration, with almost all spending coming under chapters 62 and 63. More operational expenditure is allocated to the MOH central level compared to the MOH provincial level, especially for preventive and treatment healthcare, and health insurance.

Figure 2.10 shows this budget category is normally well executed. For the years FY2015/16, 2017 and 2019 budget execution were within ±4 percent. The planned large expansion of non-wage recurrent spending to support the

Figure 2.10: Non-wage recurrent budget execution (LAK millions)



Source: Budget Law and Official Gazette 2016-2019

[21] Ministry of Finance, *Official Gazette 2019*, FY2019 budget actuals.

expansion of NHI in FY2018 was ultimately delayed leading to a one-off budget execution rate of 78 percent. Further discussion is included in section 3.5.

Budget Execution Challenges

1.14 Wages and Salaries

Of the years analyzed, total spending of MOH on wages, salaries, and subsidies, was underspent in every year except 2017 (as shown in figure 2.5). Breaking down spending on personnel emoluments by MOH central and provincial levels showed that underspending at the MOH provincial level was worse (table 2.3).

For the MOH central level there was a 10 percent underspend on wages and salaries in FY2015/16, and for the three following years spending was within three percent of the budget plan. Closer investigation shows large underspends by provincial governments in both salaries and subsidies and compensation and allowances as shown in table 3.1. Over the period examined, provincial governments budgets for personnel emoluments were underspent by 5 percent on average.

Table 3.1: Provincial budget execution of personnel emoluments (LAK millions)

Actual - Plan	Difference	%	Difference	%	Difference	%	Difference	%
Year	2015/16	2017	2018	2019				
Civil servant salaries and subsidies	-45,315	-13%	-1,805	-1%	-82,440	-8%	-35,374	-9%
Compensation and allowances	-1,588	-1%	20,790	13%	-29,257	-8%	-13,411	-6%
Total salary, allowances, and compensation	-46,904	-9%	18,985	4%	-111,697	-8%	-48,785	-8%

Source: Budget Law and Official Gazette 2016-2019

The budget preparation process for wages and salaries is not very precise, with the budgeting process being significantly worse at the MOH provincial level. Spending units under MOH prepare budgets for wages and salaries based on historical information. Budget submissions use the total spend from the previous year plus a percentage increment. The total budget is reviewed and amended by both the Departments of Finance at MOH and MOF, during the budget consolidation process before it is submitted to the National Assembly. The budget submission for wages and salaries is not linked to the number or type of positions, promotions, or allowances that it is intended to support. It also does not include details on the positions or even chapters it is expected to be allocated against.

According to international best practice, budget preparation instructions should provide comprehensive guidance on how to prepare a budget submission for wages and salaries. The total wage bill will be a function of the number of civil servants, their pay grade, newly established positions, and expected attrition. Allowances may be based on historical averages or expected activities such as travel or study. In most countries, expenditure on wages and salaries is highly predictable. Actual expenditure outturn would typically be within one or two percent of budget plan.

High quality staff records, including vacant and occupied positions and grade, are kept by both the Department of Health Personnel and the Ministry of Home Affairs. Revised costing guidance issued by MOF, alongside budget instructions and strict enforcement by the MOH Department of Finance, would see budget execution of wages and salaries brought within one to two percent of planned expenditure. This alone would see a large improvement in overall budget execution.

1.15 Capital Expenditure

Capital expenditure administered by MOH central level was underspent in FY2015/16 and slightly underspent in FY2017 and FY2018. Capital expenditure by the provincial health authorities was overspent each year in the period of examination.

Table 3.2: Capital expenditure budget execution for MOH central and provincial levels (LAK millions)

	Difference	%	Difference	%	Difference	%	Difference	%
	2015/16		2017		2018		2019	
Central	-8,639	-13%	-3,852	-6%	-1,941	-4%	-3	0%
Provincial	6,021	15%	24,409	105%	5,618	15%	5,047	17%

Source: Budget Law and Official Gazette 2016-2019

The planning and approval processes for capital projects are extensive. MOH as the sponsoring line ministry, develops a proposal and submits it to the MOH Department of Finance to be assessed against competing proposals and the budget ceiling. If selected by the MOH Department of Finance, the project will then be sent to the Ministry of Planning and Investment for technical review. After clearing these stages of review and assessment the proposal may be submitted in the budget proposal for approval of the provincial governor or Minister of Health.

Following approval, line ministries have little role in the implementation of sponsored capital projects. Projects are managed and implemented by the Ministry of Planning and Investment including contract drafting, procurement, inspection, and release of funding.

The MOH was unable to explain both one-off deviations in capital expenditure execution and the systemic overspending of the provincial capital expenditure budget. MOH suggested that the budget execution rate of 87 percent in FY2015/16 for MOH central capital expenditure may be due to lower-than-expected national revenues. The systemic overspending of the provincial capital expenditures may be explained by increases in material costs. However, no explanation of the 105 percent overspend of the provincial capital expenditure budget was provided. The lack of explanation for variations in the capital expenditure budget is concerning and raises further issues regarding the management of capital expenditure.

According to good practice for year-end reports, there should be detailed explanations for any major variations between the budget plan and how the budget was implemented. This report would usually be made public and released within six months to one year after the end of the fiscal year.[22] The public release of this information ensures that records are not lost and would allow for analysis to be undertaken to understand and address any systemic issues with capital budget implementation.

MOH's low level of involvement during the implementation of capital projects is another area of concern. It is not uncommon for the Ministry of Planning and Investment to lead the implementation of capital works. The staff are well versed in procurement policies, contract management and have technical expertise, such as qualified engineers on staff. However, sponsoring line ministries are typically heavily involved at every step of the project cycle. MOH involvement is essential to ensure that projects are aligned to their strategic plans and that projects meet the needs of the health sector.

The low level of involvement by MOH in the implementation of the capital budget may also create a disconnect between recurrent and capital expenditure. Capital investments must be linked to the recurrent budget. For instance, the construction of a health facility requires investments in maintenance and staffing to be effective.

A possible explanation for the consistent over-execution of the capital expenditure budget at the local level can be found in the *Amended Law on the State Budget 2006*. Article 6 paragraph 4 and 5 and article 32, paragraph 9 allows provincial authorities to allocate any revenues beyond approved plans to capital expenditures. This preferencing of capital expenditure often seems to lead to over execution of the capital expenditure budget where revenue exceeds expectations. A detailed review of revenue performance would

[22] Vivek Ramkumar and Isaac Shapiro, *Guide to Transparency in Government Budget Reports: Why are Budget Reports Important, and What Should They Include?*, International Budget Partnership, https://internationalbudget.org/wp-content/uploads/Guide-to-Transparency-in-Government-Budget-Reports-Why-are-Budget-Reports-Important-and-What-Should-They-Include-English.pdf, pp.37-38.

assist in determining how relevant this policy is in explaining provincial governments to exceed their capital expenditure budgets.

1.16 Externally Financed Capital Expenditure

Typical externally financed capital expenditure in the health sector, sees MOH accounts directly paid by donors to suppliers. The direct financing of the health sector complicates monitoring and reporting by MOF as reporting is entirely based on submissions from line ministries.

The lack of public reporting against externally financed capital expenditure is not unique to the health sector. Credible externally financed capital expenditure is absent from the entire budget law. MOH and other line ministries have good records of planned and actual donor spending, but these are not always public documents. It is unclear why MOF does not publish externally financed capital expenditure estimates, but it could relate to the completeness, timeliness, and accuracy of reporting from line ministries.

1.17 Non-wage Recurrent Expenditure

The MOH provincial level faced large underspends under chapter 62, Operation and Maintenance in FY2018 and FY2019 achieving budget execution rates of 87% and 65% respectively as shown in table 3.3. The explanation for the low budget execution rate offered by DOF, MOF, was demand for medicines and medical equipment was lower than expected.

Table 3.3: Operational and maintenance budget execution rates in MOH central and provincial (LAK millions)

	Variance	%	Variance	%	Variance	%	Variance	%
	2015/16		2017		2018		2019	
MOH Central	-12,160	-5%	-2,513	-1%	37,676	16%	-10,345	-4%
MOH Provincial	31,131	13%	15,744	7%	-48,855	-13%	-98,590	-35%

Source: Budget Law and Official Gazette 2016-2019

Equipment, medical equipment, and medicines make up most of the budget for chapter 62, Operations and Maintenance at MOH provincial level. In FY2019 these categories made up 80 percent of the total chapter. Service utilization has been very unpredictable in Lao PDR. Between the year 2017 and 2019 outpatient visits increased from 0.6 to 0.84 per capita. A very large increase in OPD visits occurred in 2018. OPD utilization increased from 0.68 to 0.78. It is difficult to reconcile this with the underutilization of the budget for medicines. Public records only show the actual expenditure for State Budget MOH expenditures on medicines and medical equipment, making it impossible to verify the explanation provided by DOF, MOH.

1.18 Health Insurance Expenditure

At the time analyzed, the single largest underspend was the LAK 150 billion underspend in FY2018 in chapter 63, Subsidies and Contributions. The cause of this large underspend was a delay in the implementation of NHI. A large increase in the NHI payment was budgeted in FY2018, increasing the budget for chapter 63 from LAK 140 billion to 290 billion. Actual expenditure for FY 2018 followed the previous year with an outturn of LAK 140 billion. The budget execution rate for chapter 63 was only 48 percent for the MOH central level. In FY2018 the government faced an unexpected revenue shortfall that led MOF to cut any additional spending resulting in the very low budget execution rate for this chapter. Chapter 63 is typically well performing for both the MOH central and provincial levels. Excluding the result from the MOH central level in FY2018 chapter 63 averages a four percent absolute variation from the budget plan.

Table 3.4: Chapter 63-Subsidies and contribution, MOH central (LAK millions)

	Variance	%	Variance	%	Variance	%	Variance	%

	2015/16		2017		2018		2019	
Subsidies and contributions	-3,144	-2%	-4,578	-3%	-150,284	-52%	28,825	8%

Source: Budget Law and Official Gazette 2016-2019

1.19 Expenditure Arrears

The government does not make any report on expenditure arrears publicly available. The *Public Finance Development Strategy 2025*[23] discusses the existence of arrears and the efforts to prevent the accumulation of arrears in the future but mostly in the context of on-lending by SOE's and capital expenditure. The joint World Bank IMF, Debt Sustainability Analysis 2019, found the known stock of domestic payment arrears was three percent of GDP. Contractor's pre-financing of capital projects has been mentioned by MOH officials and does represent a risk of arrears accumulation in the health sector. Overall, the level of capital investment in the health sector is low and MOH has no responsibilities for SOE's, reducing the risk of arrears accumulation in MOH.

The NHIF 2020 implementation report, mentions that two provincial hospitals had negative cash balances. Reports of delayed NHI payments to health facilities creates a risk of dwindling cash reserves at health facilities. This could cause health facilities to delay paying invoices to private sector suppliers. Some health facility staff believe wait times for the settlement of invoices with suppliers has been increasing. The NHIF annual report closely monitors cash balances at health facilities and opines that overall cash balances are stable, although higher demand hospitals have lower cash balances. Private sector suppliers are known to charge an additional 30 percent above market prices for government contracts due to the complicated procurement processes and the likelihood of delayed payment.

1.20 Facility Level Budget Execution

Facilities prepare a revenue and expenditure plan based on the ceiling communicated to them by central or provincial DoF (health). The most senior person at the health facility is usually appointed by the Ordinator to take responsibility for managing and approving all expenditures within a health facility. Appointed persons have a good deal of autonomy in how they manage the budget, though their ability to revise and reallocate the budget between chapters and within the fiscal year is limited. Central and provincial hospitals prepare a budget that can include all chapters under the CoA. Health centers prepare a more limited revenue and expenditure budget plan which only includes expenditure under chapters 62, Operation and Maintenance and chapter 63, Subsidies, and Contributions.

1.20.1 Operational Expenditure

Health facilities have access to operational funding. Chapter 62 Operation and Maintenance made up 30 percent of Attapeu Provincial Hospital's approved budget in FY2020. Health facilities are instructed to use their own sourced revenues for operational expenditures while pedagogical equipment and medicines, which is also categorized under operational spending, is specifically budgeted and funded by transfers to the hospital from the provincial treasury.

1.20.2 Transfers From Treasury

Treasury provides broad based funding to support the activities of health facilities. DoF (health) does require the appointed persons to provide a breakdown by paragraph and sub-paragraph of expenditures under chapter 62, Operation and Maintenance, usually pedagogical equipment, and medicines.

1.20.3 Technical Revenues and Out-Of-Pocket Payments

[23] Government of Lao PDR, Vision to 2030 and Public Finance Development Strategy to 2025, 2018, pp. 66, 70.

The management, use and reporting of technical revenues is governed by *Instructions on Revenue and Expenditure Management of Financially Self-Sufficient Administrative and Technical Units.* Health facilities are expected to estimate technical revenues when preparing their annual revenue and expenditure budget plan which is submitted to and approved by the DoF (health). Health facilities can maintain a cash reserve up to 20 percent of their monthly revenue. Health facilities are required to reconcile revenue and expenditure with the treasury accounts on a monthly, quarterly and annual basis. People utilizing government health services are expected to contribute to covering the cost of the service. The regulation on OOP charges is set in the *National Health Insurance Funds Implementation Guideline 2016*. The payment schedule is included in annex 5.2. Health facilities are directed to use fees collected for expenditures under chapter 62, Operation and Maintenance and chapter 63, Subsidies and Contributions.

1.20.4 National Health Insurance Transfers

Health facilities receive a prepayment for health services expected to be delivered throughout the year. The prepayment is estimated by NHIB based on membership and expected utilization. NHI capitation payments are made through quarterly transfers. In submitted cash-flow estimates, the health facilities evenly spread the annual NHI transfer throughout the year. However, health facilities reportedly do not receive even cash disbursements throughout the year, rather most of the budget transfers are received late in the fiscal year. Health facilities have reported that NHI payments are increasingly unpredictable and delayed, even being received in the next fiscal year. NHI funds cannot be used for staff expenses but can be used to support expenditures under chapter 62, Operation and Maintenance and chapter 63, Subsidies and Contributions.

1.20.5 Donor Funding

Donor funds from multilateral development banks such as ADB and World Bank in the health sector have been channeled through the treasury system. Donor funds are also directed to supporting chapter 62 and 63 and are typically received by health facilities at the beginning of the fiscal year.

1.21 Facility Level Accounting and Reporting

Accounting practices are based on the Amended Accounting Law 2013. The law requires double entry bookkeeping, chronological transaction records, daily updates of the general ledger with validation by a trial balance, monthly financial reports, and a comprehensive annual financial report.

Facility level accounting follows the CoA which is input based. The MOH can add on to the CoA if procedures are documented in the MOH accounting procedure manual. Records are excel based and/or the Government Financial Information System (GFIS).[24] Table 3.5 shows the information systems in use by MOH.

Table 3.5: MOH Information Systems[25]

Information System	Purpose
Government Financial Information System (GFIS)	Recording of financial transactions within the government
National Health Insurance Bureau Administer Transfer Discharge (NHIB-ATD) System	Recording and reconciliation of patient records with health insurance records and health services
Hospital Management Information System (HMIS)	Admission Patient ID Staff ID Staffing schedule Health records

[24] Alain Perras, *Laos PDR Health Insurance Information System Master Plan*, International Labour Organization and Ministry of Health, 2021, p.21.
[25] Alain Perras, *Laos PDR Health Insurance Information System Master Plan*, International Labour Organization and Ministry of Health, 2021, p.20.

	Diagnosis Prescription Nursing plan Lab results Imaging report
mSupply	Drug supply and logistics information

Source: Lao PDR Health Insurance Information System Master Plan

1.21.1 Positive Cash Balances and Carry Overs

Health facilities can maintain substantial cash balances, allowing for more independence from cash disbursements through the treasury system. Table 3.6 compares cash balances carried over from FY2018 to total approved expenditure in FY2019 for all health facilities managed by the MOH provincial level. In sum, provincial health facilities carried over LAK 64 billion from FY2018 against a total of almost LAK 92 billion of expenditure in FY2019. These funds are only permitted to be used for non-wage recurrent expenditure. The large cash balances held by health facilities may partly explain the relatively good budget execution performance of non-wage recurrent expenditure.

Table 3.6: 2019 Cash balances at health facilities (LAK)[26]

	Cash Balance	Expenditure	Balance/Expenditures
Provincial Hospitals	22,716,703,046	45,334,023,256	50%
District	23,808,114,782	35,023,164,538	68%
Small Hospitals/ Health Centers	17,565,645,836	11,480,385,128	153%
Total	64,090,463,664	91,837,572,922	70%

Source: Implementation and plan of National Health Insurance Fund 2020

1.21.2 Invoice Management

Health facilities have been able to smooth spending by delaying payments to private sector suppliers. In most cases, public procurement in Laos PDR requires goods to be delivered before payment. In such instances, health facilities can report expenditure against their approved budget before payment has been received by the supplier. This helps health facilities achieve high rates of budget execution even in the face of delayed treasury disbursements or low cash balances.

This practice may even result in health facilities operating negative cash balances. In FY2020 two provincial hospitals had payable invoices totaling more than the available cash balance and receivables combined. The provincial hospitals of Bolikhamxay and Xaysomboun maintained negative balances of 26 percent and 3 percent of revenue respectively.

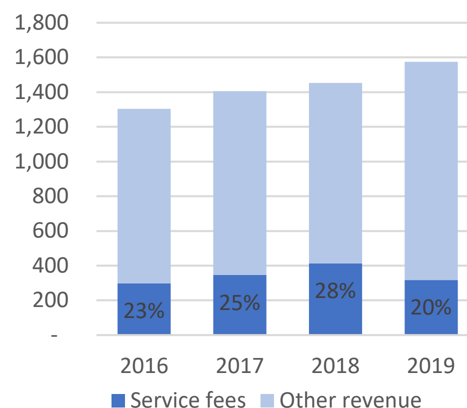
Though delaying payment to suppliers may assist hospitals to achieve a high rate of budget execution it creates a risk of suppliers raising prices due to expected delays in payment which are costed into procurement.

1.21.3 Revenue Management

Figure 3.1: Ministry of Health Own Revenue, % of total revenue (LAK billions)

[26] National Health Insurance Bureau, Implementation Report for the Health Insurance Scheme 2020 and 2021 Plan. 2020.

Provincial governments and health facilities can raise and retain revenue. Provincial governments prepare an expected revenue plan for the review and approval of the provincial governor or municipal mayor. Health facilities prepare revenue and expenditure budget plans for the review and approval of the relevant DoF. Total own-sourced revenue was a significant proportion of expenditure, between 2016 and 2019 own-sourced revenue was equivalent to 20-28 percent of total MOH expenditure.



Source: MOH supplied budget data

Health facilities can utilize revenues as they are collected and have greater flexibility in the use of own-sourced revenues compared to funding received from central or provincial transfers. While quarterly requests for funding must be submitted, approved, and funded by DoF, the appointed head of the department or unit is able to authorize expenditure from the technical revenues.

In 2021, Treasury issued instructions to update revenue and expenditure management for financially self-sufficient administrative and technical units, which includes health facilities. This included some major changes to financial management.

- They can keep up to 20 percent of monthly revenue in cash or a cash account. The remainder should be held in provincial or national treasury deposit accounts.
- Second level budget units can manage procurement up to a value of 300 million LAK or 500 million LAK for repairs and maintenance.[27]

Central hospitals are considered first level budget units while provincial hospitals, district hospitals and health centers are considered second level budget units. Almost all own sourced revenue is held in the sub account for chapter 62, Operation and Maintenance. Own source revenue is an important source of funds for chapter 62, Operations and Maintenance, accounting for 68 percent of expenditure.[28]

Causes of Poor Budget Execution and Policy Options

1.22 Overview

Budget execution by MOH compares well against general government expenditure. A comparison across economic classifications at the central level, MOH outperformed general government expenditure in all categories across four years other than wages and salaries in FY2015/16 and non-wage recurrent in FY2018. A comparison of budget execution rates for MOH and the rest of government at the provincial level gives a mixed result. The rest of government expenditure also failed to reach planned budget for wages and salaries. MOH and the rest of government show similar budget execution performance at the provincial level.

This section will explore the causes of poor budget execution in the health sector. It will also explore the factors that enable the health sector to out-perform general government expenditure and achieve actual outturns which are very near the planned budget levels despite the known PFM challenges.

Table 4.1: General budget execution rates compared to Ministry of Health

Administration	Budget Classification	2015/16	2017	2018	2019
	Ch. 60, 61: Salary, allowances and compensation	99%	88%	93%	106%

[27] Ministry of Finance, Instructions on Revenue and Expenditure Management of Financially Self-Sufficient Administrative and Technical Units, May 2021.

[28] 2021 Revised Budget, Ministry of Health Budget Plan, Ministry of Health supplied data.

General Government Central	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	211%	146%	89%	132%
	Ch. 67 Locally funded Capital	86%	81%	92%	122%
Ministry of Health Central	Ch. 60, 61: Salary, allowances and compensation	90%	99%	103%	98%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	96%	98%	78%	103%
	Ch. 67 Locally funded Capital	87%	93%	96%	100%
General Government Provincial	Ch. 60, 61: Salary, allowances and compensation	96%	95%	95%	92%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	126%	97%	125%	110%
	Ch. 67 Locally funded Capital	88%	127%	100%	104%
Ministry of Health Provincial	Ch. 60, 61: Salary, allowances and compensation	91%	104%	93%	92%
	Ch. 62, 63, 64, 65, 66: Non-wage Recurrent Exp.	110%	106%	89%	78%
	Ch. 67 Locally funded Capital	115%	153%	115%	120%

Source: Budget Law and Official Gazette 2016-2019

1.23 Health Specific Budget Execution Challenges

1.23.1 Complex Revenue Management

In comparison with other social sectors, the MOH manages large and complex revenue flows. Revenue from service fees made up between 20 and 28 percent of total revenue for the years 2016 to 2019. Revenues are collected by decentralized units (health centers, district, provincial and central hospitals) which have special privileges in how these funds can be managed and used.

The monitoring of revenue collection is complicated by the highly decentralized structure of MOH. Revenue forecasts and reports are consolidated at the district, provincial and then the central level. The lengthy consolidation process means revenue monitoring is delayed and this impacts the accuracy of forecasts. Own sourced revenue makes up a large and volatile proportion of the health sector budget which introduces a degree of uncertainty to the budget and impacts on budget execution.

The current Government Financial Information System (GFIS) only allows for the classification of four types of revenue (see table 4.2) and cannot accommodate the complex accounting needs of NHIB and the broader health sector. As a stop gap measure, NHIB has requested the Bank of Lao to create sub-accounts for each insurance type to better manage the revenue streams. As the GFIS and treasury system do not accommodate the requirements of NHIB this has pushed additional accounting responsibilities onto NHIB and health facilities. Without useful computer software, much of this accounting work is paper based which is both time consuming and prone to errors.

Table 4.2: Fund source categories in the current GFIS classification

1	Own source funding, including
Detail under the code 1	Annual budget, emergency funds
	Road maintenance and poverty reduction funds, reforestation, and social welfare funds, social security fund
	SMEs development and protection fund, NT2 fund
	Other special funds (English description not provided)
3	Domestic borrowing
5	Foreign borrowing
7	Donor funding (grants)

Source: Technical note on the Improvement of the CoA. No.64, World Bank

Inaccurate revenue estimates reduce the certainty over the total estimated health sector budget and complicate the work of planners. As technical revenues are a major source of funding for operations and maintenance there is also a risk regarding the timing of the receipt of funding. Delayed operational revenues can delay the implementation of activities and lead to poor budget execution.

Budget managers are instructed to contain expenditures within revenues. In the case of revenue shortfalls, expenditure should be reduced, thereby reducing budget execution.

Revenue forecasts and outturns are not published. Reporting and publishing revenue forecasts and outturns requires discipline and enforces strict dates for the submission and consolidation of reports. The greater level of oversight which comes with public review would likely improve revenue performance.

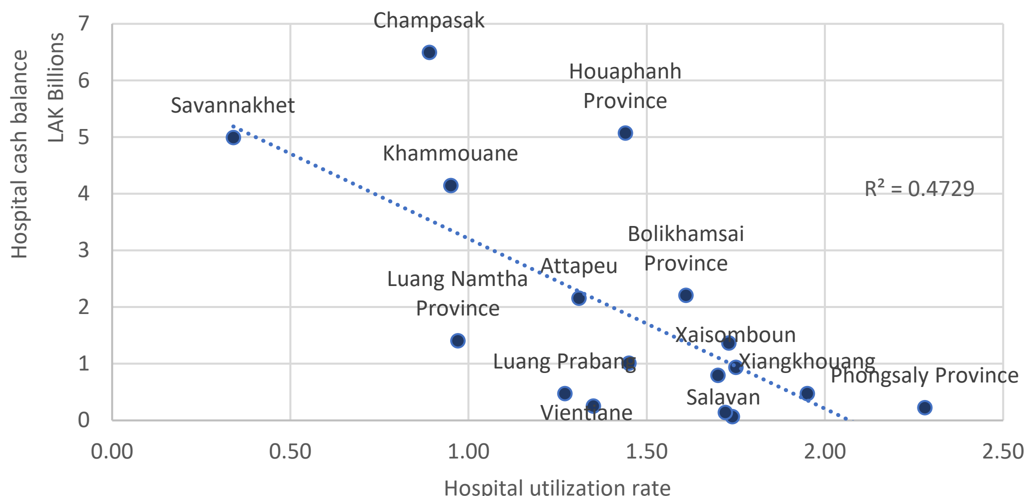
1.23.2 National Health Insurance Implementation

The implementation of NHI has changed the budgeting processes for health facilities and impacted on budget execution. Originally, the budget for provincial hospitals was managed by PHOs and the budget for district hospitals was managed by DHOs. Budget allocations were based on historical trends. The introduction of NHI resulted in provincial hospitals operations budget (chapters 62-66) being consolidated by the provincial health insurance bureau and district hospitals budget being prepared by the district health insurance bureau.

This change in budgeting practice has resulted in a poor allocation of funding. Figure 4.1 shows there is a strong relationship between high SASS utilization rates and low cash balances. This means that hospitals with high demand had low cash balances, while hospitals with low demand had high cash balances. Ideally, there should not be a strong relationship between cash balances and utilization rates. NHIB prepares its anticipated demand and budgets based on population estimates of members within a catchment area rather than using historical data. Many people near the Thai border choose to seek healthcare in Thailand which reduces the utilization rate of some provincial hospitals. This appears to be a key factor neglected in NHIB estimates of utilization rates.

The implementation of NHI has also fragmented the budgeting process. For decentralized health facilities, the budget for personnel emoluments and capital spending is managed by DHOs or PHOs. The budget for chapter 62, Operations and Maintenance, is now mostly managed by NHIB. The fragmenting of the budgeting process has introduced a risk of a misalignment of the budget, where wages and capital expenditure has become disconnected from operational expenditure.

Figure 4.1: SASS utilization rate and provincial hospitals cash balance



Source: Implementation and plan of National Health Insurance Fund 2020 and National Health Statistics Report 2020

1.23.3 Financial and Performance Reporting

Financial and health performance information is tied to budget allocation. Inaccuracies, underreporting, and incomplete reporting are acknowledged in the *National Health Statistics Report*.[29] Long processes and inaccuracies can lead to poor budget allocation and delayed cash disbursements which can adversely impact on budget execution.

Currently, a minority of health budget units are using a financial management system approved by the Ministry of Finance. A survey of four provinces in 2018 found that 40 percent of provincial hospitals and half of health centers were not using the standard financial reporting forms required of all budget units.[30]

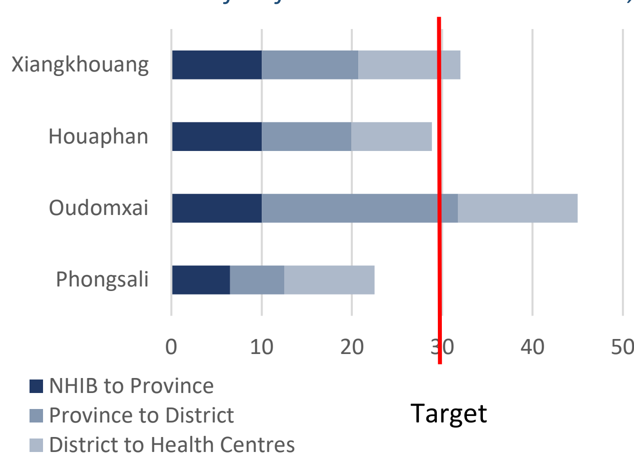
Health facilities and many MOH departments do not have access to the GFIS financial management system. Health facilities, divisions and departments maintain offline paper based financial records. Records must be consolidated at the district, provincial and the central levels. The record keeping system is prone to errors and the many layers of consolidation lead to reporting delays.

MOH has access to GFIS at the central and provincial level; departmental access is being considered. In the meantime, duplicate paper and digital financial reports are produced by health facilities, DHOs and district hospitals and PHOs and provincial hospitals.

1.23.4 Lengthy Treasury Processes

Cash disbursement tracking revealed that there is an extensive procedure required for cash disbursements to be released from the central NHIB department to health facilities. Figure 4.2 shows the average number of days required for cash to be released from NHIB to the provincial treasury, then from the provincial treasury to the district treasury and finally, from the district treasury to the health facilities bank account. A target was set of 30 days, linked to the HANSA program's disbursement linked indicator. Based on information from four provinces, transfers of funds from NHIB central took an average of 32 days to reach health centers. The long delays in receiving funding transfers can shorten the timeframe for budget implementation.

Figure 4.2: Cash transfers from NHIB to Health Facilities, days



Source: Data from payment tacking system DLIX HANSA, MOH

[29] *National health Statistics Report 2019*, Ministry of Health, Department of Planning and Cooperation. p.2.

[30] National Health Insurance: An assessment of progress in 2016-2019 and priorities for 2021-2025, Ministry of Health, 2020.

1.23.5 Poor Alignment of Budget, Administration, and Strategic Plans

The administrative structure itself, cannot be easily aligned to strategic goals. The disconnect between strategic policy goals and the existing administrative structure complicates the task of budgeting and oversight. For instance, it is difficult to determine which departments or divisions should receive additional funds to implement a strategic decision to increase the proportion of the health budget dedicated to preventative health care.

This misalignment increases the chance of in-year budget changes as the civil service finds it difficult to interpret instructions from Ministers and the National Assembly is not able to effectively oversee the implementation of policy.

1.23.6 Year on Year Budget Changes

MOH has faced difficulty in implementing large budget increases and cuts. In FY2017 the budget for provincial capital expenditure was cut from LAK 46.4 to 23.2 billion. Actual provincial capital expenditure incurred was LAK 47.7 billion. In FY2018, MOH central subsidies and contributions was increased from LAK140.6 to 290.6 billion while the actual expenditure outturn was LAK 140.3 billion. MOH did eventually manage a large increase in FY2019.

1.24 Budget Execution Enablers

The study of budget execution in the health sector has provided some surprising results. At the MOH central level budget execution outperforms the rest of government while the MOH provincial level had very similar performance to the rest of government. Some aspects of public financial management help to enable good budget execution though they may be at odds with the PFM principles of transparency, strategic focus, and accountability.

Table 4.3: Budget execution enablers and good PFM practices

Improve budget execution	Improve cash management and PFM
Allow spending units to hold cash and retain revenue	Consolidate balances and reduce idle cash, reduce banking costs and appropriate spending controls
Allow carry over of unspent funds	Enforce good planning and budget discipline
Delay payment of invoices	Reduce procurement costs and minimize arrears
Relax performance management	Link cash disbursement to submission of financial and performance reports

1.24.1 Positive Cash Balances

Health facilities are afforded greater flexibility in how they manage their budget compared to other government entities. As health facilities make up 67 percent of the health budget, this has an impact on the overall budget execution by the health sector.[31]

Though these features assist health facilities to execute their budget, they do not strictly follow treasury instructions and good public financial management practices. Good cash management in government aims to consolidate cash balances, minimize idle cash and reduce the cost of banking by reducing the number of bank accounts. The MOF has been working to reduce the number of bank accounts operated by the BoL and to consolidate cash balances. If MOH were to strictly adhere to treasury instructions and consolidate a greater share of health facilities' cash balances, this would most likely, negatively impact on budget execution.

[31] National Health Accounts, Ministry of Health, September 2021.

Where governments delay payment of invoices they often face increasing costs from the private sector suppliers as the risk of delayed payment is priced into government procurement. The accumulation of arrears is an acknowledged issue in the Public Financial Development Strategy 2025. Better procurement management would make it difficult for health facilities to delay or bring forward payments to suppliers. This would likely lead to lower budget execution figures for capital and operational expenditure.

Health facilities can utilize revenues generated and hold up to 20 percent of revenues in cash or in operational bank accounts. These revenues, often referred to as service fees, have become an important source of funding for health facilities' operational budgets. Good PFM practice tries to align cash disbursement with reporting responsibilities. Spending units must complete both financial and performance reporting before payments is authorized. With large sources of revenue coming from outside the treasury system, health facilities may be less incentivized to fulfil their reporting responsibilities. Discussions with DoF (health) have confirmed difficulties regarding the completeness and accuracy of financial reports submitted by the health facilities.

1.24.2 Ringfenced Health Budget

The ring-fencing of the health budget is another factor that explains the good budget execution rates in the health sector. While the Lao PDR is being forced to cut government spending due to increasing debt service costs, the government has committed to protecting the health budget. This assurance has helped MOH budgeting and has reduced the chance of in-year budget cuts.

Across the government strategic focus is vague and links between budgets and outputs are weak. This can lead to reduced efficiency of spending, a lack of results and little accountability. However, it reduces pressure on spending units and can make budget execution easier. Spending units submit activity plans along with their proposed budget to MOF at the beginning of the year. Completed activity reports are submitted along with actual expenditure outturn figures to MOF at the end of the financial year. Neither the activity plans nor the completed activity reports are available to the public. In addition, they are not linked to budget and are not subject to audit. This enables budget managers to veer expenditures between activities with little oversight, offering a great deal of budget flexibility.

1.25 Non-Health Specific Challenges

1.25.1 Poor Budget Transparency

The lack of transparency regarding public finances in Lao PDR is concerning. Of the few public documents that are produced by MOF, many are published late and lack sufficient detail.

Table 4.4: Publicly available reports on health spending

Key health financing information	Plan	In-year	End of year
Total health expenditure	✔	×	✔
Central and provincial health spending	✔	×	✔
Individual provinces health spending	✔	×	✔
Health spending by administrative unit	×	×	×
Department level health spending	×	×	×
Health spending by economic classification*	✔	×	✔
Health spending by function or program	×	×	×
Total health revenue	✔	×	×
Revenue by administrative unit	×	×	×
Intergovernmental transfers	×	×	×
Audit report			×

*Budget law excludes information on externally financed capital expenditure

Analysis presented in this research paper is largely based on the *Budget Law* and the *Official Gazette*. The publication of these documents is regularly delayed, for example the Official Gazette 2020 had not been published as of mid-2022. This severely impacts on the usefulness of public review.

The inadequate quality of the documents that are published also limits their usefulness. The *Budget Law* provides no comparison to the previous year. Neither the *Budget Law* nor the *Official Gazette* have accompanying narrative or explanation for changes to the budget or deviations between planned and actual expenditure outturn.

The *Budget Law* and the *Official Gazette* often cannot be reconciled. In FY2017 for example, the budget plan for MOH central was reported to be LAK 505.5 billion in the *Budget Law* but was then reported as LAK 1,271 billion in the *Official Gazette*. In several instances, figures within these documents were not internally consistent. There are also discrepancies comparing financial records from MOF to records held by MOH.

Lao PDR has limited or poor budget transparency. A recent government by government assessment has highlighted a few of the pressing weaknesses in transparency. In FY2020 the government did not publish an executive budget proposal or an end of year report. The enacted budget proposal was published but very late into the year.[32] The budget execution data produced was consolidated at the ministry level. This could potentially mask poor budget execution at the department level. It is also very difficult to assess if the approved and actual expenditure supported the stated policy objectives. The last PEFA assessed public access to fiscal information as a "D", the lowest possible score.[33] Fiscal transparency would benefit from a comprehensive assessment and stand-alone reform plan.

There are no publicly available estimates of revenue collected by ministries. This is especially relevant for the MOH which sources between 20 and 28 percent of revenues from service fees. MOH is responsible for publishing anticipated technical revenues. Having a clear picture of the total expected funding envelope is key to formulating and implementing a quality budget.

The poor state of fiscal transparency requires Ministries and Departments to prioritize improvements in reporting. The NHIB Implementation and Forward Plan annual report, is an excellent example of the type of information that is of interest to the public. The addition of financial details such as budget actuals, would satisfy the transparency requirements under the *Budget Law 2006* and international norms.

1.25.2 Wages and Salaries

Wages and salaries are frequently underspent. This budget execution issue is not limited to MOH but can been seen across the entire government sector. In enquiries of the DOF, MOF, the budget planning process was identified as the main cause of systemic poor budget execution of the budget plan.

The budget preparation process for this category is not aligned to the positions and estimated costs. Typically, the budget planning process involves planners adding a percentage increment to chapters 60, Salaries and Subsidies and 61, Compensation and Allowances. In the consolidation process, these budget submissions may be trimmed by the department of finance at the district and provincial finance office. Only

[32] United States Department of State, *2021 Fiscal Transparency Report: Laos*, https://www.state.gov/reports/2021-fiscal-transparency-report/laos/.

[33] *Lao Peoples's Democratic Republic, Public Expenditure and Financial Accountability (PEFA) Assessment 2018,* PEFA 2019. https://www.pefa.org/sites/pefa/files/2020-01/LA-Mar19-PFMPR-Public%20with%20PEFA%20Check.pdf pp. 49-51.

when health facilities are assigned their final budget for chapters 60 and 61 are they able to prepare an input-based budget plan for the fiscal year.

Tight controls and pressure to contain budgets prevents many health facilities from fully executing their approved budget for wages and salaries. Recruitment and personnel management is jointly managed by the Ministry of Home Affairs and the Department of Health Personnel (MOH). There is a lengthy, centrally controlled, process to establish a new position or recruit to fill a vacancy and approval is rare.

While the approval process for expenditure under chapter 61, Compensation and Allowances is not as complicated as for chapter 60, this budget category has been identified by auditors as a target for wasteful spending. Ordinators, fearing negative audit findings, are reluctant to approve expenditure under this chapter, leading to frequent underspends.

1.25.3 MOH Provincial/MOH Capital Expenditure Overspending

The consistent overspending of the provincial capital expenditure budget is likely due to a combination of factors. The budget law encourages spending units to preference capital expenditure in the event of revenue overperformance and in the event of cost overruns or revenue underperformance cuts should come from recurrent spending rather than capital expenditure.

Links between internal reporting on capital expenditure projects and accounting is weak and creates possibilities for cost overruns, fraud and corruption. MOH may report a project has been completed while payments for the project are still outstanding. If a project faces cost overruns, these may only be reported in subsequent years which can lead the MOH provincial level to exceed its total capital expenditure budget. More transparent project reporting and tighter links between project reporting and expenditure would improve budget execution.

Financial management at the MOH provincial level appears to be much weaker than at the central level. MOH has reported staff shortages, underqualified and untrained staff as persistent problems at the provincial level. Decentralization is an ongoing reform in Lao PDR.[34] In efforts to support decentralization, an audit of finance and accounting staff and training programs would make a good first step toward ensuring there is an appropriate level of financial and accounting expertise at the provincial level.

1.25.4 Uncertain and Late Cash Disbursements

Lao PDR has one of the largest stocks of public and publicly guaranteed debt in the region. Lao PDR is currently experiencing difficulties meeting its debt obligations. Fiscal space is highly constrained with debt servicing costs accounting for 52 percent of public revenues in 2021.[35] Though not covered in the period of analysis, MOH officials have reported increasing uncertainty regarding cash flows. Cash shortages have pushed treasury to ration quarterly cash allocations, meaning that line ministries, such as MOH have little certainty about their quarterly cash-flows. With growing demands on revenues, MOH have reported quarterly cash disbursements are often delayed. Payments were once made at the beginning of the quarter but now are not received until the end of the quarter. Unpredictable and delayed disbursements reduce the time available and complicate the work of budget implementation. Budget implementation can be greatly assisted by negotiated and reliable cash-flow estimates. Cash-flow estimates can be submitted with budget submissions from line ministries. The MOF will then review, and revise cash-flow estimates to ensure they meet quarterly expenditure ceilings and treasury instructions.

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[34] Zubair K. Bhatti, Lachlan McDonald, Deepening Decentralization within Centrally Led States: The Direction of Local Governance Reforms in Southeast Asia, p.5. https://openknowledge.worldbank.org/bitstream/handle/10986/35005/Deepening-Decentralization-within-Centrally-Led-States-The-Direction-of-Local-Governance-Reforms-in-Southeast-Asia.txt?sequence=2&isAllowed=y

[35] World Bank, *Lao PDR Economic Monitor*, August 2021, p.2.

No budget execution records were available for recent years, but it is expected that budget execution figures will worsen following the emergence of cash shortages and cash rationing.

1.25.5 No Forward Budget Estimates

Lao PDR has not fully implemented a Medium-Term Expenditure Framework (MTEF). This reform provides forward year estimates (usually three to five years) for government revenue and expenditure. It helps to demonstrate the feasibility of government plans and gives line ministries a forward plan of budget estimates. For line ministries this budgeting reform assists planning and ensuring that difficult trade-offs and negotiations occur well in advance of budget implementation.

1.26 Budget Execution Challenges Unaddressed

The government of Lao PDR pursues ambitious reform plans. While the government is aware of many of the issues discussed in this paper, some reform objectives do not have convincing implementation plans and some issues are left unaddressed.

1.26.1 Poor Execution of Wages and Salaries

The low execution rates for wages and salaries are seen across government. As such, the MOF, budget department would be best placed to lead action to improve budgeting for wages and salaries. However, the DOF, MOF, would also need to take the initiative to improve the budgeting process.

The budget preparation process could be managed at the MOH central and provincial levels rather than collating submissions from each health facility. Records of staff, grade, assigned workplace, leave balances as well as vacancies are available at the Department of Health Personnel and the Public Administration and Civil Service Authority (PACSA). Alternatively, the budget preparation process for wages and salaries could continue to follow the bottom-up approach with detailed budget preparation instructions and ensuring budget planners have access to all the information on staffing required to prepare a detailed budget. The involvement of decentralized health units will help improve the accuracy of budget estimates. Health facilities may be the best places to collect information on expected leave, training, promotions, and travel.

Adding detail such as, the number of staff, grade, recruitment, leave and allowances to budget submissions would greatly improve the accuracy of budget estimates. It is acknowledged that this would complicate the budget preparation process and increase the time required to prepare budget submissions. The Department of Health Personnel would need to ensure decisions regarding placement, recruitment and establishment of new positions were planned well ahead of the communication of budget ceilings. The timeframe for budget preparation would be even more pressing for the MOH provincial level.

1.26.2 Lack of Hard Ceilings

The negative impact of delayed release of budget ceilings is compounded by the heavily decentralized health system and the squeeze on the time available for budget preparation and implementation. Introducing both a Medium-Term Fiscal Framework (MTFF) and a Medium-Term Expenditure Framework (MTEF) are priority PFM reforms primarily to better maintain fiscal discipline and manage public investment. The MTEF will give MOH stronger and earlier indications of expected budget allocations. MOH should then ensure that these ceilings are utilized to give soft forward ceilings to departments and provinces. This will allow additional time for budget preparation and a more strategic focus to be taken when preparing the MOH budget.

The Public Financial Development Strategy also acknowledges that the MOF has not adhered to the budget calendar included in the Budget Law. The strategy calls for strict adherence but does not have an accompanying plan as to how this will be achieved.

1.26.3 Sequential Budgeting

The Lao PDR budget is prepared sequentially. Provinces are only given a ceiling alongside all central ministries. The preparation, passing and publication of the budget plan is then delayed as provincial ministries allocate ceilings to divisions and districts. The continuing Sam Sang reform will delegate additional responsibilities to provincial MOF departments. This reform will have to be coupled with the publication of intergovernmental transfers in the MTEF and the provision of early ceilings to provinces as part of the budget preparation process to empower provinces to prepare their budgets alongside the central government.

1.26.4 Poor Revenue Management and Reporting

Though poor reporting and management of revenue is acknowledged as a broad PFM issue, revenue reform is focused on increasing revenue collection and mobilizing and preventing leakages. There is an ambition to centralize accounts for technical revenues and integrate revenue, banking, and expenditure management systems though there are no detailed implementation plans on when or how this might be achieved. MOH should collect and publish revenue estimates and actuals as a stop gap measure while broader revenue reforms are underway.

1.26.5 Cash Management

The harmonization of the CoA will enable further cash management reforms. The Public Financial Development Strategy includes an objective to link budgeting and banking systems. Full integration may have to wait for the modernization of the CoA and the adoption and roll out of the IFMIS. Further roll out of the GFIS and closer reporting linkages to the BoL systems may be a useful reform to improve the timeliness and accuracy of financial reports.

1.26.6 Poor Transparency

The recent government to government assessment of fiscal transparency reported that key budget documents were delayed, absent and/or missing key information.[36] The budget is missing both an administrative breakdown and a functional or programmatic presentation. No budget document has accompanying narrative to explain the links to policy objectives or to describe and explain changes.

The health sector has developed a programmatic presentation of the budget based on mapping administrative budget divisions to their functions. MOH often prepares insightful annual reports and presentations to donors. While wider improvements to budget transparency may be a few years away, MOH should investigate the possibility of preparing and presenting its budget by both functional and administrative classifications. Both budget plans and actual expenditure outturns should be prepared and publicly released, including in machine readable format, as per international budget transparency norms.

1.26.7 Long Intergovernmental Transfer Processes

Figure 4.2 showed that it can take 32 days for funds to reach health centers after being disbursed from the central treasury. NHIB have an ambition to trial direct disbursements from the central treasury to health facilities. This will only impact on expenditure under chapter 62 Operations and Maintenance. While this will be a worthwhile trial and a good stop gap measure, increasing the independence of MOF provincial will provide a durable long-term solution.

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[36] United States Department of State, *2021 Fiscal Transparency Report: Laos*, https://www.state.gov/reports/2021-fiscal-transparency-report/laos/.

Relevant reform objectives are documented in Vision to 2030 and Public Finance Development Strategy to 2025, Health Financing Strategy 2021-2025 and Vision 2030 and NHI Strategy 2021-2025.

Table 4.5: Identified budget execution weaknesses and suggested measures identified to address them

Issue	Suggested Measures to address the issues
Low budget execution of budget for wages and salaries	Yet to be acknowledged by personnel department and provincial administration as an issue and there are no plans in place to address this issue.
Poor transparency	Efforts to improve the quality of fiscal reporting (PFM strategy, 3.14). Ambition to prepare monthly, quarterly, and annual budget execution reports and to release reports to the public. (3.2.9) Further and more immediate measures are required to bring budget transparency closer to international norms
Lack of hard ceilings	MTFF and MTEF are under development, greater emphasis on complying with budget calendar defined by the Law on State Budget article 57 is required
Sequential budgeting	Sam Sang pilot to delegate additional responsibilities to MOF provincial departments Greater investment in provincial departments of finance is required
GFIS and CoA weaknesses	Extending some MOH provincial connections, unification of the CoA, manual on public sector accounting. Update CoA (6.2.2)
Poor expenditure controls	Simplify expenditure manuals, assigning responsibilities for ex-ante spending controls to budgetary units, increasing audit coverage. No commitment to publishing audit findings. (3.2.5)
Performance reporting and DHIS2 weaknesses	NHIB management information system (3.4), Health Insurance Information Systems Master Plan (5.1.3)[37]
Disconnect between budget and outputs	Not addressed in reform plans.
Disconnect between outputs and strategy	Acknowledged in PFM strategy 3.2.2
Donor funding is off budget	Proposed merger of Planning and International Cooperation Department and Department of Finance
Poor revenue management and reporting	Strong focus on increasing revenue collection and mobilization and preventing leakages. Little attention to estimates, reporting and transparency. Ambition to integrate revenue, banking, and expenditure management systems (3.2.6) Centralise accounts for technical revenues (6.2.2)
Poor cash management	Linking budget systems to central bank systems (7.2.2)
Lack of provincial government revised budget	This is not addressed in any reform plans.
Long intergovernmental transfer processes	NHIB investigation of direct financing to health facilities (3.3)
Unsustainable funding to health centers	Increase autonomy of NHIB, benefit package and policies to be determined by NHIB dependent on budget allocation. NHIB to be an off-budget financing vehicle (strategic objective 1,2)

[37] Alain Perras, *Laos PDR Health Insurance Information System Master Plan*, International Labour Organization and Ministry of Health, 2021, p.21.

Policy Recommendations

1) Full alignment of strategic planning, budgeting, and financial reporting

Medium term

- MOH should focus its efforts on putting the basic building blocks in place by:
  - i) Improving the medium-term planning process by:
    - monitoring expenditure on health sector priority programs and measuring the results achieved,
    - more accurately reflecting the level of external financing into the health sector and identifying the extent of any gaps in health sector financing requirements.
  - ii) Strengthening budget preparation and improving the monitoring of budget execution by:
    - ensuring all external and/or other financing sources are brought on-budget,
    - completing budget versus actual analysis for all significant variances.
  - iii) Improving the comprehensiveness and timeliness financial reporting for MOH management and external users.

Longer term

- Once this has been achieved, the linkages between the desired outcomes/priorities, intermediate outcomes, outputs, and inputs can be fully established. [38]

2) Strengthen Budget Preparation and Budget Execution

PFM Manual

Short term

- A nationwide training program should be implemented as soon as possible.
- A Train the Trainer program should be implemented to ensure internal capacity is built to conduct refresher training when required.

Medium term

- Annual update of the PFM Manual for any procedural or system changes.
- Refresher training provided as needed, targeted at areas identified by the regular assessment process (see below) where implementation issues exist.

Monitoring and Compliance Regime

Experience shows that successful implementation of this type of manual is more likely if it is supported by an appropriate monitoring and compliance regime that:

- Provides regular assessments of the level of compliance at all levels across the health sector.
- Ensures any systemic implementation issues are identified and resolved in a timely manner.
- Ensures that actions are taken to promptly address issues of non-compliance.

Short term

- Develop a risk-based financial management focused internal audit (inspection) plan led by MOH Department of Inspection.

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[38] As this is a more advanced reform, this would require establishment of a performance management system that would use a combination of financial and non-financial performance indicators to measure progress. This type of reform is often done in conjunction with a transition to accrual-based accounting which allows the full costs of providing health services to be measured.

- Establish a revised Audit and Inspection Committee structure (perhaps as a subcommittee of the MOH Executive Committee).[39]

Medium Term

- Implement a risk-based financial management focused internal audit (inspection) plan progressively to the subnational levels and increase the scope to cover both the state budget and external financing.
- Implement the revised Audit and Inspection Committee across all levels of the health sector.

Longer Term

- Extend the scope of the internal audit (inspection) mandate to cover non-financial management areas.

3) Improve the quality and comprehensiveness of MOH and health sector financial reporting

Short-term

- Enable full implementation of HSAS across the health sector:
  - i) Complete the credentialing of finance staff at the 40 percent of districts where this is not yet achieved.
  - ii) Strengthen security, password access controls and monitoring, virus protection.
  - iii) Complete preparations for piloting the roll-out to the health centres.

- Enable the full functionality of HSAS to be utilized by:
  - I) Reactivating the ability to report against the health sector priority programs and providing training and capacity building for subnational level staff.
  - II) Continue working on piloting the recording of budget and expenditure information for external financing.

Medium Term

- Progressively improve cash-basis financial reporting (with minor modifications for recognition of accounts receivable, accounts payable, and in-kind assistance):
  - i) Internal management reporting to assist MOH senior management decision making (Minister of Health, Ministry Executive Committee, Departments/Budget Units, Provinces and Districts and individual Health Facilities).
  - ii) External reporting that provides comprehensive and transparent information about MOH and the health sector's financial performance.

Longer Term

- Work with MOF on a phased transition to compliance with IPSAS accrual basis standard.

4) HSAS Interoperability with other IT Systems

HSAS currently has no interoperability with other relevant IT systems used in the health sector (Patient Management Systems, Supply Chain and Logistics Systems, Laboratory and Pharmacy Management Systems). This is also a relevant consideration for NHIB's planned implementation of a claims management system.

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[39] The primary function of the Audit and Inspection Committee would be to co-ordinate the internal audit (inspection) and the external audit processes and ensuring actions are taken to implement recommendations or resolve any issues identified.

Medium term

- In accordance with the Health Sector Digital Strategy work on interoperability of HSAS with other relevant health sector IT systems.

Longer term

Improving interoperability will assist with determining the detailed user specifications for a fully integrated IT system to be implemented at some stage in the future.

Annex 1: Lao PDR Chart of Accounts

The chart of accounts has four segments related to economic classifications. These are Division, Article, Paragraph and Sub-paragraph.

Chapter 60: Civil servant salaries and subsidies
Chapter 61: Compensation and Policy Allowances
Chapter 62: Operation and Maintenances
Chapter 63: Technical Activities, Subsidies and Contributions
Chapter 64: Financial Expenditure
Chapter 65: Other Expenditures
Chapter 66: New Purchase for operation
Chapter 67: Capital expenditure

Table 5.1: Chart of accounts

Account Code and National Accounts						Description
Account Code		Budget Code				
		Cha	Art	Para	Sub-Para	
						Category 6 - Budget expenditure
60	60000000	60	00	00	00	**Salary and employee allowance**
	60100000	60	10	00	00	**Basic saralies**
	60200000	60	20	00	00	**General alllowances**
61	61100000	61	10	00	00	**Compensation and Policy Allowances**
	61100100	61	10	01	00	**Specific Allowances by activity**
	61200000	61	20	00	00	**Family allowances**
62	62000000	62	00	00	00	**Operation expenditure**
	62100000	62	10	00	00	**Utilities and Purchase**
	62100402	62	10	04	02	Medical equipments and consumable materials
	62100404	62	10	04	04	Other pharmaceutical (Purchase of drugs)
63	6300000	63	00	00	00	**Technical activities, subsidies and contributions**
	63100000	63	10	00	00	**Political activities**
	63200000	63	20	00	00	**Economic Subsidy**
	63300000	63	30	00	00	**Cultural and social activities**
	63400000	63	40	00	00	**Other technical extension and subsidies**
64	64000000	64	00	00	00	**Financial expenditure**
	64200000	64	20	00	00	**Payment guarantees**
65	6500000	65	00	00	00	**Other expenditures**
	65100000	65	10	00	00	**Government accumulated saving funds**
66	66000000	66	00	00	00	**New purchase for operation**
67	67000000	67	00	00	00	**Capital expenditure**
	67100000	67	10	00	00	**Land development**
	67200000	67	20	00	00	**Land compensation**

Procedures for budget reallocation:

1. The transfer of budget expenditures from one line to another within the same chapter of the annual budget plan is decided by the Ordonators;
2. The transfer of budget expenditures from one chapter to another of the annual budget plan is decided by the Primary Ordonator;
3. The transfer of budget expenditures from one 46organization to another, or from one locality to another in the annual budget plan is decided by the Prime Minister.[40]

[40] Law on State Budget Article 65.

Annex 2: MOH Organogram