Public Financial Management in the Health Sector in Lao People's Democratic Republic - Service Delivery Challenges and Opportunities

December 2018

Contents

List of Tables

List of Figures

Acronyms and Abbreviations

ADB	Asian Development Bank
ANC	Antenatal Care
CF	Conceptual Framework
CoA	Chart of Accounts
DH	District Hospital
DHO	District Health Office
DoF	Department of Finance
DPC	Department of Planning and Cooperation
DRF	Drug Revolving Fund
DT	District Treasury
EU	European Union
FMIS	Financial Management Information System
GDP	Gross Domestic Product
GFIS	Government Finance Information System
GP	Global Practice
HANSA	Health and Nutrition Services Access
HC	Health Center
HEF	Health Equity Fund
HFSA	Health Financing System Assessment
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
ICT	Information and Communication Technology
IFMIS	Integrated Financial Management Information System
IMF	International Monetary Fund
IPD	Inpatient Department
IMCI	Integrated Management of Childhood Illness
LECS5	Fifth Lao PDR Expenditure & Consumption Survey
LEM	Lao Economic Monitor
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
MPI	Ministry of Planning and Investment
NA	National Assembly
NHI	National Health Insurance
NHIB	National Health Insurance Bureau
NT	National Treasury
OOP	Out-of-pocket
OPD	Outpatient Department

PEA	Public Expenditure Analysis
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PFS	Provincial Financial Services
PH	Provincial Hospital
PHO	Provincial Health Office
PPA	Provincial People's Assembly
PT	Provincial Treasury
SARA	Service Availability and Readiness Assessment
SBL	State Budget Law
SDG	Sustainable Development Goals
TA	Technical Assistance
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization

Acknowledgments

This report has been jointly prepared under the aegis of a Global Flagship ASA "PFM in health – Service Delivery Opportunities and Challenges" (P155193) and Lao PDR Health Sector Programmatic ASA - Bottleneck Analysis on PFM in Health (P164585).

The report was prepared under the overall coordination and supervision of Emiko Masaki (Senior Economist, Health and TTL) and Maxwell Bruku Dapaah (Senior Financial Management Specialist, GGP and Co-TTL) and Manoj Jain (Lead Financial Management Specialist and & TTL of the Global Flagship - PFM in health). The core team included Anthony Higgins (PFM Consultant) and Viriyasack Sisouphanthong (Consultant), Thongleck Xiong (Consultant), Mayuly Chamleunsab(Consultant). The team received insightful comments and inputs from following peer reviewers: Owen Smith, Sr. Economist; Fanny Weiner, Sr. Public Sector Management Specialist; Shomikho Raha, Sr Public Sector Specialist; and Nang Mo Kham, Sr Human Development Specialist. Administrative support was received from Boualamphan Phouthavisouk.

From the study design to report preparation, overall guidance was provided by a committee comprised of PFM health TA, and technical departments from various ministries. The team is grateful to the committee chair Dr. Somphone Phangmanixay, Director General, Department of Finance and the technical members including Dr. Suphab Panyakeo and Mr. Viengxay Viravong from the Ministry of Health; Mr. Soulivath Souvannachoumkham, Deputy Director, Department of Budget, Mr. Theutthoun Soukaloun, Tax Department, Mr Chanmina Pamanivong and Mr. Vialaythong Southavilay from the Ministry of Finance; and Mr. Kaluna Nanthavongdouangsy, Deputy Director, Planning Department, Mr. Nakhonexay Phimphachanh, Planning Department from the Ministry of Planning and Investment.

The report has been reviewed by Nicola Pontara (Country Manager, Lao PDR), Enis Barış (Practice Manager, HNP) and Serdar Yılmaz (Lead Public Sector Specialist, Governance).

1. Executive Summary

This report summarizes the finding of an assessment of Public Financial Management (PFM) in Health in Lao People's Democratic Republic undertaken jointly by the Governance and the Health, Nutrition and Population (HNP) Global Practices (GPs). The Government of Lao PDR is committed to achieving Universal Health Coverage (UHC) by 2025 and has embarked on major health financing reforms to expand population and service coverage and to improve financial protection. In this context, a focused analysis of the PFM constraints in health financing and service delivery will provide evidence to draw useful lessons that will help shape the implementation of on-going and future reforms. The goal of the assessment therefore was to identify and assess PFM bottlenecks in health service delivery and to identify actions or recommendations that are feasible, and provide a basis for collaboration among the Ministry of Health (MoH), the Ministry of Finance (MoF) and development partners going forward. The assessment built on the earlier health financing system assessment (HFSA) conducted by the World Bank where PFM was identified as one of the key systemic challenges for health sector performance in Lao PDR.

The approach to the PFM assessment was guided and informed by the PFM in Health - Conceptual Framework (CF, Draft 2016) and the accompanying PFM in Health - Assessment Toolkit (2016). The CF builds upon a body of research and literature that supports a link between achievement of improved results or outcomes in the health sector and the need to strengthen systems for fiscal sustainability, operational efficiency, fiscal transparency, and accountability. The questionnaire in the PFM in Health - Assessment Toolkit was modified to accommodate the Lao country context and was administered to managers in a sample of health facilities across five provinces to collect data to inform the analysis. A desk review of secondary reports was also used. The underlying assumption of the CF is that the country PFM and health financing arrangements are critical for effective and efficient health service delivery.

The Lao country context is quite unique. The health system operates within a complex but changing decentralized system of government. Provincial governments have historically enjoyed a high level of autonomy in terms of tax/revenue collections, budget allocation, treasury, and service delivery, but without the counterbalancing reporting and accountability mechanisms. More recently, the national government has strengthened oversight and control over the tax collection and treasury functions at sub national level. Also, the MoF has encouraged the health and education ministries to provide stronger leadership and policy direction in their sectors, while at the same time continuing to work with and through provincial governments and departments that are better informed about local needs and priorities.

In Lao PDR, the health financing and PFM systems are undergoing rapid change. Through the Lao PDR Public Finance Strategy (2017 to 2025), and with support from various development partners including European Union (EU), The World Bank (WB) and the Asian Development Bank (ADB), the MoF is leading the implementation of a range of PFM reforms that will impact all sectors across all levels of government. Reforms aimed at improving the efficiency of resources allocation through 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 at an early stage. The proposed PFM reforms raise difficult change management challenges for provincial governments and departments at central ministries. That there will be significant impacts on the health sector is certain, but the timing is unclear, particularly at the subnational level where health service delivery improvements are needed the most.

Financing for the health sector in Lao PDR has long been challenged by the low level of government investment in health and the correspondingly high reliance on OOP health expenditure and external assistance for health. Total health spending from all sources in 2016 was US$59 per capita or about 2.4 percent of GDP, lower than in neighboring countries like Cambodia (US$72 per capita) and Vietnam (US$123 per capita). Underfinancing of the sector has led to supply-side readiness shortfalls, especially in rural and poorer parts of the country, and to inefficient and inequitable financing through an overreliance on OOP spending sources. The reforms to health financing arrangements through the national health insurance (NHI) scheme are directing funds to facilities on a per capita and case basis with less reliance on out-of-pocket (OOP) spending from households, and with more transparency around the use of technical revenues from fees and charges. National-level macro fiscal and cash management reforms should in time result in greater reliability of cash flows to provincial treasuries (PTs) and district treasuries (DTs).

The PFM in Health Assessment acknowledges the challenging macro-fiscal environment for Lao PDR and the impact this continues to have on the domestic financing of human resources for health and health operations at the subnational level. Against competing demands from other sectors and macro-fiscal constraints, the ambition to increase public expenditure from the 2017 level of 7.2% to 9% of total of government expenditure in the medium term is ambitious, if there are no fundamental positive changes in the Laos fiscal outlook. Although all sectors are impacted by the limited fiscal space, in the case of health the situation is dire because achieving UHC through expanding health coverage and access, and through lowering the level of out-of-pocket spending by the year 2025, is unlikely without an increase in domestic financing for health.

The assessment also underscored weaknesses in planning and budgeting systems in the health sector that reflect the broader macro level planning and budgeting systems weaknesses, but are also derived from structural health-specific disease programing constraints, weak coordination of decentralized provincial planning and non-existent facility planning and budgeting. Addressing inefficiencies s in the allocation of resources at both central and decentralized levels of the health system against increasing healthcare demands of Lao PDR is urgent, since the sector will have to do more with less resources given current macro fiscal conditions. Furthermore, scaling up and sustaining the National Insurance scheme will in large part depend on the adequacy and reliability of planning and budgeting systems that can pool resources and share risks. Improved planning and budgeting efficiency can save resources to address inadequate equipment and drugs, and skilled health work force shortages at facilities.

The assessment also identified that major weaknesses in budget execution processes have contributed negatively to service readiness of facilities. Some of the weaknesses include low financial management (FM) skills capacity, poor financial record-keeping, lack of transparency and accountability on technical revenue collection and use, weak internal controls, and compressed budgeting execution cycle at provincial and district levels, resulting in delayed procurements for healthcare delivery. The demand on service facilities to adhere to parallel implementation arrangements for different donor funding sources has also stretched prevailing low implementation capacity.

The PFM in Health Assessment used a 'fishbone' framework to summarize the various constraints and issues affecting the service delivery identified in the assessment. The summary level fishbone diagram is shown in Figure 1 below. Based on the identified bottlenecks, the report made sets of recommendations that MoH are able to lead and implement in the short to medium term, (which will be complementary to the macro-level reforms that MoF will continue to implement in the medium to long term). These recommendations for MoH led actions are summarized in Table 1 below.

Table 1: Summary of Recommended Actions for MoH in Short to Medium Term

Policy Recommendation 1: Develop a framework for internal MoH ceilings early in the budget cycle to guide preparation of baseline budget proposals to the MoF (and to guide activity plan preparation), with separately costed, targeted, and prioritized new policy proposals or budget briefs (short term). At the central level MoF is planning to implement a new baseline approach to annual budget submissions to avoid annual ambit bids or wish-lists from line ministries and provinces. This

would involve early notification of ceilings to MoH and other ministries by MoF. To take advantage of this MoF initiative and to ensure it can prepare the health sector at sub national level, MoH could take several early actions, including:

- MoH should build internal capacity for sectoral analysis, policy development, budget brief preparation, and negotiation with MoF;
- MoH work to strengthen its relationship with the MoF Budget Department officials to improve the MoF's understanding of health sector financing and the MoH medium-term budget strategy, and to allow the MoF to participate in the MoH's process of developing new policy proposals and budget submissions;
- The MoH could consider establishing a planning and budget committee to ensure recurrent and capital budgets strategies are consistent and prioritize the same goals, programs, and activities, consistent with the Health Sector Reform Strategy & Framework;
- The MoH should develop guidelines for and build capacity in PHOs on how to prepare and align their budget proposals with national priorities within internal MoH ceilings agreed early in the budget preparation process and not at the end;
- The MoH, led by the DPC, could establish a health worker allocation committee that would develop a workforce strategy that favors the districts and HCs most affected by the current uneven workforce distributions;
- With early knowledge of PHO level ceilings, MoH could encourage PHOs and DHOs to also consult with facilities and HCs early in the budget cycle, allowing those facilities and HCs to adjust their planned use of other sources of funding such as technical revenues, NHI, and private sector contributions.

MoH would require technical support to provide advice on and help coordinate these reforms with MoF. Such assistance can be aligned with the World Bank PFM TA support to the MoF on budget reforms that includes developing and implementing ministerial ceilings in the budget preparation process. At the health sector level, complementary support can be provided under the Health Governance and Nutrition Development Project (HGNDP) and the PASA TA to help strengthen MoH capacity on prioritization and resource allocation within ceilings.

Policy Recommendation 2: Improve MoH activity planning tools to provide greater flexibility and responsiveness to changes in ceiling or limitations to cash available through treasury (short to medium term).

Current MoH activity planning tools using Excel worksheets have significant limitations, and are not able to be quickly adapted to ceiling changes during budget preparation, or to cash flow limitations during budget execution. Until MoF are able to provide a longer term government wide solution to improve linkages between plans and budgets, MoH should consider the possibility of using a database planning tool, similar to that currently being tested by the DPC with ADB support. A centralized database tool with distributed access to MoH departments and PHOs will provide greater flexibility, and allow budget plans to be changed more easily and consolidated quickly at central level.

The World Bank PFM TA makes provision for development of tools for determining ceilings at the MoF Budget Department level. The ceilings will give more predictability to sectors for planning and allocating resources.

MoH needs to further divide the ministerial ceilings received from the MoF among its second-tier spending units that, among others, include PHOs. PHOs need significant capacity strengthening to develop detailed and reliable proposals on time. The new Health and Nutrition Services Access (HANSA) project and PASA TA could support such efforts at PHO level.

Policy Recommendation 3: It is recommended that MoH engage early with MoF on the specifications and requirements for a new FMIS and Chart of Accounts to ensure that health sector needs are accommodated (short term).

As and when the MoF develop and implement a World Bank financed FMIS, MoH Excel based recording and reporting systems will be replaced. The MoH will need to transition from the use of various Excel systems to an automated system of record keeping and reporting. In preparation, it is essential for the MoH to proactively engage the MoF on its financial information needs so that this will be considered as the FMIS specifications and chart of accounts requirements are developed. The need for disaggregated expenditure reports and ease of consolidation of such reports by disease, geography, or program from provinces and district health facilities should be part of this discussion

Policy Recommendation 4: It is recommended that the MoH explore which donors have the flexibility to front-load their annual financing so that when cash shortages emerge at provincial treasuries, activity plans could be adjusted to bring forward the implementation of the donor-funded activities (short term).

Currently, when cash shortages arise at provincial treasuries, PHOs and DHOs have little alternative than to defer their outreach and other activity plans until later in the financial year. This can leave PHO and DHO resources idle early in the year, and overcommitted in the last two quarters of the year. By bringing forward some donor financed activities, this may give PHOs and DHOs more flexibility in the deployment of their resources between government financed and donor financed activities. This would require the revisions of activity plans, and so would be dependent on the implementation of a more flexible activity planning tool as per the previous recommendation.

Policy Recommendation 5: Strengthen financial management capacity at health facility level and quantify the impact of NHI implementation on OOP and technical revenue collection (medium term).

The lack of financial management capacity at health facility level and the failure to properly account for and manage receipt and use of technical revenues (including OOP amounts) and other revenues, contributes to a lack of trust between health facilities and DHOs on the one hand, and provincial and district treasuries on the other, as to the true level of resources available to DHOs and health facilities. The NHI scheme may progressively impact on the level of OOP spending at health facility level. The MoH should also work with NHIB to regularly monitor the NHI implementation as well as the impact of NHI on OOP spending, and whether this in turn has any impact on technical revenue collection.

Technical assistance will be required to develop financial record keeping and reporting templates, and to provide financial management training of staff at relevant facilities. Some advisory

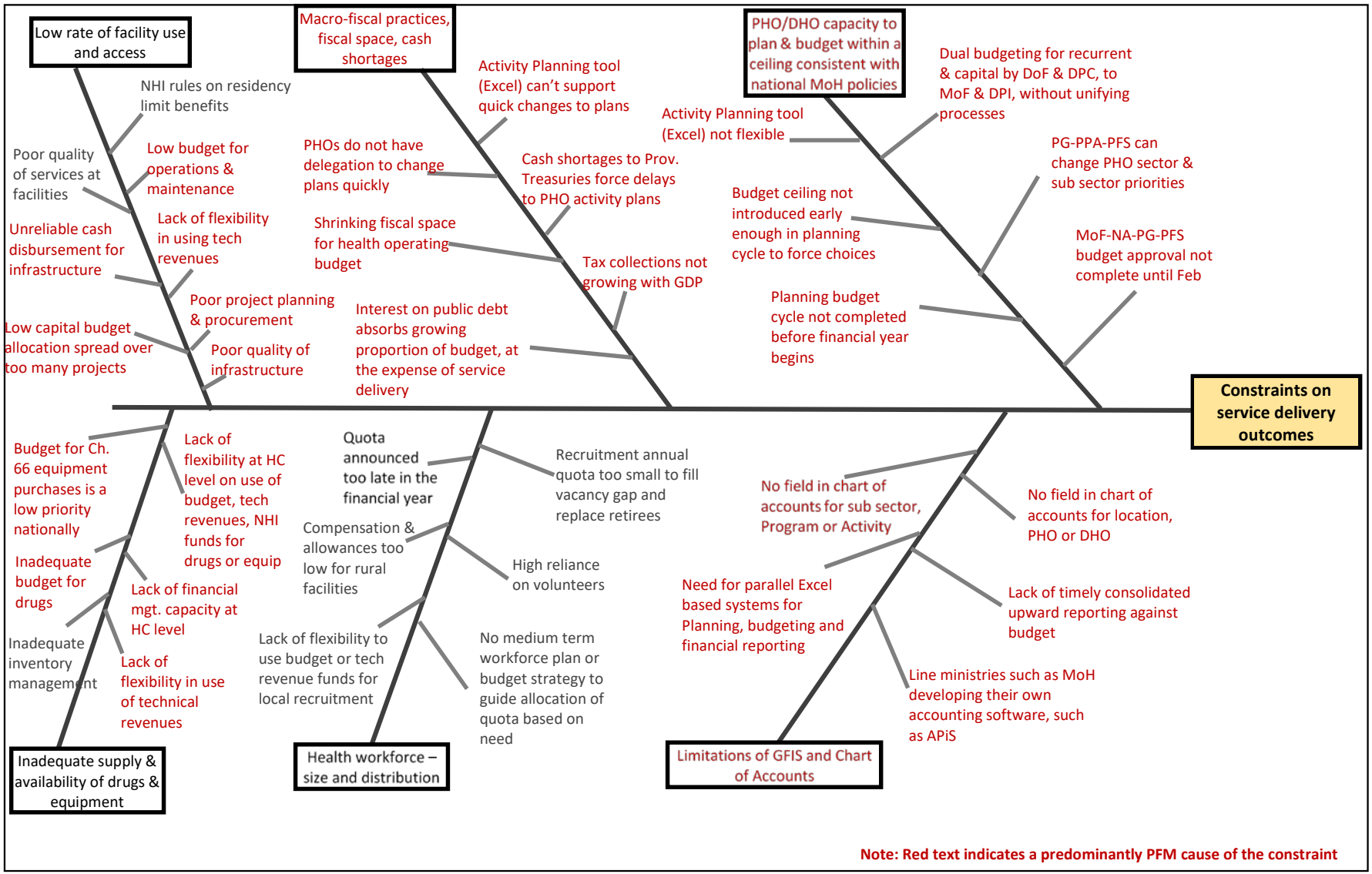
assistance may also be required to work with the MoH DoF. This can be supported through the new health operation, i.e. the HANSA project that is under preparation.

Policy Recommendation 6: MoH could work with the MoF, MPI and Government leaders to ensure that the MoH has greater influence and control over policy and program prioritization at the sub-national level (short term).

The MoH should take steps to identify the nature of the protected status enjoyed by the education sector and further explore whether health could operate within the same framework. This would allow the MoH and PHOs to finalize their detailed activity plans as soon as the NA approves the budget in November or December, and not have to wait until the provincial government approval in February, i.e. two months after the commencement of the financial year.

The MoH DPC and DoF should consult directly with the MoF and MPI at first instance, but the nature of this reform may also require consultations by Minister of Health with other Government leaders. Advisory support can be provided through ongoing TA and capacity-building support for Health Financing Reforms under the Lao Health PASA.

Figure 1. PFM-related constraints on service delivery at the subnational level



2. Objective and Background to this PFM Assessment in the Health Sector

2.1 Objective

This assessment aims to assess PFM bottlenecks in health service delivery and to identify actions or recommendations for the Ministry of Health (MoH) and its partners to take forward. The World Bank is also supporting the Ministry of Finance (MoF) to carry out assessments of national PFM systems and to implement a range of sequenced reforms across all PFM components that will affect all sectors and all levels of government over the medium term. This PFM assessment in the health sector will therefore focus on identifying bottlenecks and recommending actions that the MoH and provincial health offices (PHOs) can address in the short term. It will also feed into the technical assistance (TA) and capacity-building activities that aim to address immediate PFM challenges under the Health Governance and Nutrition Development Project as well as to inform the design of the new health operation and the governance/PFM operation of the World Bank.

2.2 Background and Approach

The assessment builds on the earlier health financing system assessment (HFSA)[1] conducted by the World Bank to identify critical constraints and opportunities to building health financing systems in a country aiming to accelerate and sustain progress toward universal health coverage (UHC). The key finding from the HFSA identified PFM in health service delivery as one of the key systemic bottlenecks for health sector performance in Lao PDR, which requires further analysis in the second phase of the assessment using a PFM in Health Assessment Toolkit. The joint team of Health, Nutrition and Population (HNP) and Governance Global Practices (GPs) was formed to lead this assessment to understand PFM issues and challenges within and outside of the health sector and formulate relevant policy recommendations of both the MoH and MoF.

The approach to this assessment has been guided and informed by the PFM in Health - Conceptual Framework (CF, Draft 2016) and the accompanying PFM in Health - Assessment Toolkit (2016). The CF employs a problem-driven approach to analyze PFM and health finance bottlenecks or enablers that constrain or support service delivery results at the provider level. The CF and the supporting toolkit are being used to inform pilot studies or assessments in various countries including Lao PDR, and the findings from these assessments will be used to further refine the CF.

The CF builds upon a body of research and literature that supports a link between the achievement of improved results or outcomes in the health sector and the need to strengthen systems for fiscal sustainability, operational efficiency, fiscal transparency, and accountability. The evidence supports the proposition that governance matters for the effective use of public resources in health service delivery. However, progress in integrating PFM into the agenda for strengthening health systems has

[1] The HFSA provides a standardized, systematic, and comprehensive approach to health financing applied across countries and has a common 'core' module with flexible modular design to adapt to country context, paying attention to institutions and the interface between service delivery and health financing. The specific objective of the HFSA is to identify critical constraints and opportunities to building health financing systems in a country aiming to accelerate and sustain progress toward UHC.

been slow. The pilot studies, and this assessment in Lao PDR, aim to analyze key challenges and opportunities associated with PFM arrangements in the health sector to propose ways to strengthen PFM arrangements for better service delivery.

This PFM assessment in the health sector aims to provide Lao PDR health sector decision makers and stakeholders with meaningful analysis and recommended actions and at the same time help inform and further develop the CF. Analyzing key bottlenecks at critical stages in budget formulation and execution can also provide a strong basis for dialogue between the MoH and its partners in the MoF. The broader MoF-led approach to PFM reforms will likely place additional demands on the MoH to support its budget proposals with evidence-based and quality analysis of the needs of the sector, costed and prioritized new policies or programs, and credible implementation arrangements.

Recognizing the tight medium-term fiscal outlook for Lao PDR, assessments such as this one should not be seen as one-off. It should be followed by regular updates to build the capacity of the MoH to better engage in dialogue with the MoF and to ensure that the MoF itself is better informed about the structure of the health sector and of the challenges to improved health service delivery outcomes. To ensure that MoF-led PFM reforms and MoH led reforms are consistent and harmonized, it will be important for MoH to improve its capacity to engage with MoF, and to develop budget policy briefs that are consistent with an affordable medium-term expenditure framework for the sector.

3. The Health Sector in Lao PDR

3.1 Overview

Lao PDR has made consistent and substantial progress regarding key population health outcomes. Life expectancy at birth increased from 49 years in 1980 to 66 years in 2015, while infant mortality decreased from 135 per 1,000 live births to 50 per 1,000 live births during the same period. The maternal mortality ratio reduced from 546 per 100,000 live births in 2000 to 197 in 2015. Despite the measurable improvement, challenges still remain including geographic disparities in coverage of health services as well as health outcomes; inequalities relating to wealth and ethnicity are especially pronounced.

3.2 Access and Service Utilization

Utilization of health services, and in particular maternal health services including institutional delivery suffer from accessibility and low acceptance due to traditional beliefs and practices. While costs and accessibility are the key barriers for not utilizing health services at public facilities, non-financial barriers such as cultural barriers, language issues, poor education are also understood as reasons for not seeking health services among the poor households.

Numbers of patients seeking treatment at public health facilities. As per the table below, LECS5 data show that although 10 percent of those surveyed (40,000 individuals across 8,000 households) indicated a health problem in the past four weeks, only 3.4 percent sought treatment from a health facility or provider, that is, only 31 percent of those with a health problem sought treatment.

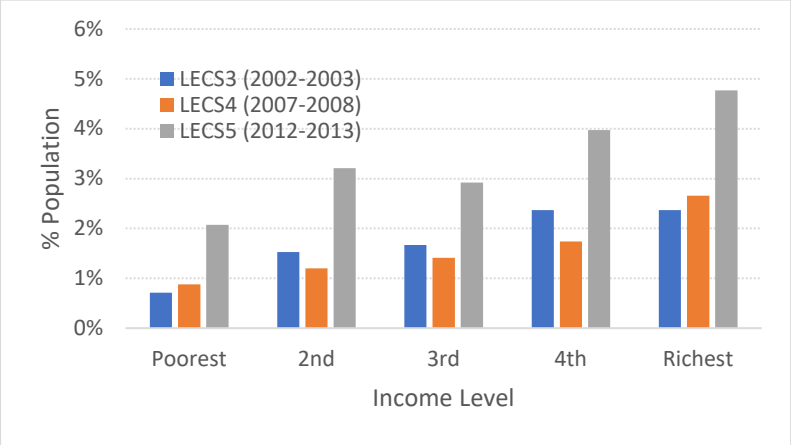
Table 2. Outpatient utilization of health services in the past four weeks by economic quintile (2012–13) (%)

Reason for attendance	All	Poorest	Q2	Q3	Q4	Richest
Any illness or injury	10.0	9.2	9.5	9.1	10.5	11.6
Seeking care when ill	31	24	27	29	33	39
Seeking care in public facilities when ill	25	20	23	25	27	28
Seeking care in private facilities when ill	10	5	8	8	10	18

Source: World Bank staff calculations, based on LECS5 (Lao Statistics Bureau, 2014).

Figure 19 below summarizes the main reasons given for not seeking treatment. Excluding where respondents believed their complaint was not serious enough, 55 percent indicated that difficulty of travel prevented them from seeking treatment, 33 percent did not seek treatment because they believed no cure was possible, 9 percent did not seek treatment because it was too expensive, and 3 percent believed they would not get quality treatment or care from the facility. The chart below shows that, over the past 10 years, a greater proportion of Lao of all income levels has been seeking treatment.

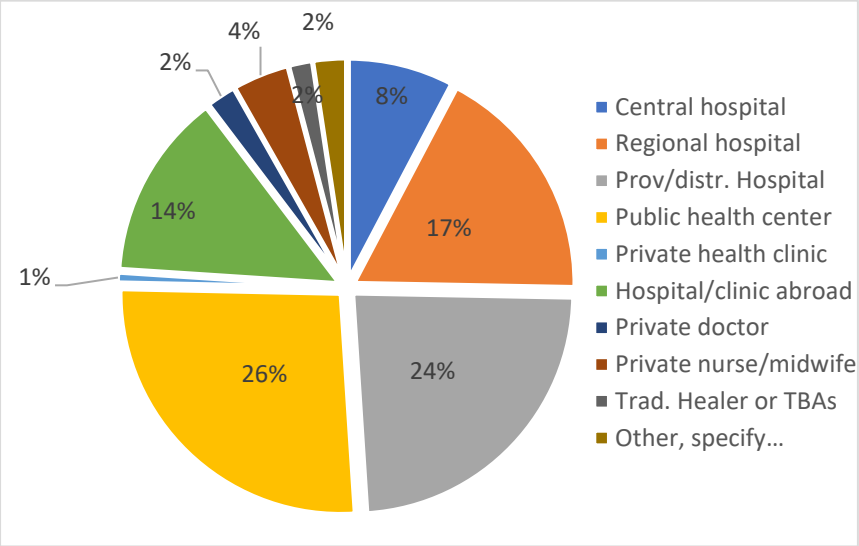
Figure 2. Percentage of individuals who sought outpatient care (any type) in the past four weeks (by income quintile) (2012–13)



Source: World Bank staff calculations, based on LECS3–5 (Lao Statistics Bureau, 2014).

Even where patients do decide to seek treatment, they have choices between private and public facilities, or other types of treatment. The pie-chart below shows for those patients that did seek treatment the type of facility they chose to use. Some 75 percent of patients chose to use a public facility of some kind, that is, central, regional, or PH/DH or public HC. The remaining 25 percent used other options, that is, private clinics, treatment abroad, private doctors/nurses, and so on, or traditional healers. For those who did not seek treatment through a public provider in Lao PDR, 56 percent chose treatment abroad. In Lao PDR, treatment 'abroad' need not be a challenge, as a large part of the Mekong River borders with Thailand, and villagers are able to cross over easily, where language also allows them to communicate easily with Thai doctors.

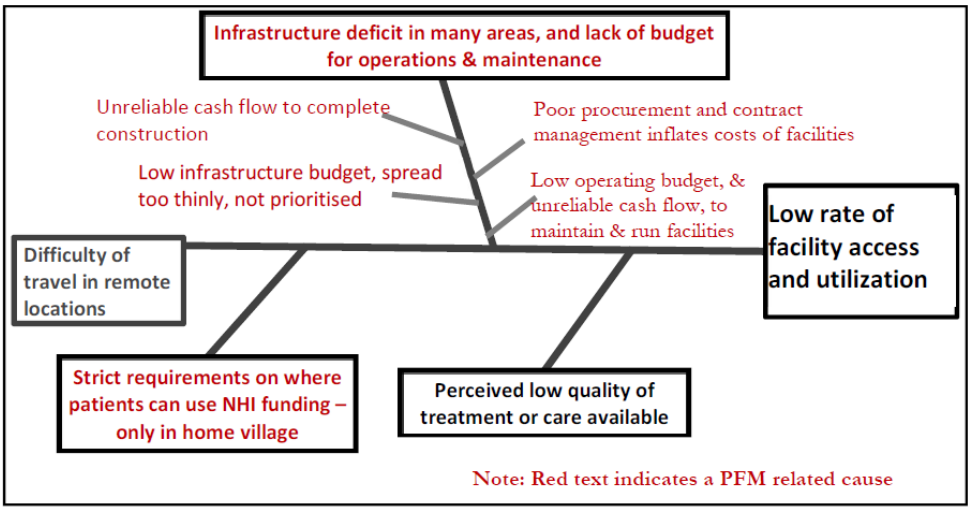
Figure 3. Proportion of patients using facilities by type of facility



Source: Authors.

Possible factors affecting the low rate of utilization. There are several factors that may contribute to the low rate of utilization of facilities, that is, in addition to travel difficulties. These include (a) low quality of health services, (b) low budget allocation for operation of facilities, (c) low and unreliable budget for health facility infrastructure, and (d) application of strict rules on residency for patients to benefit from NHI. The cause-effect diagram below summarizes these factors.

Figure 4. Cause-effect diagram on low rates of facility access and utilization



Source: Authors.

3.3 Health Service Delivery

Service availability and readiness of the health providers are the major service delivery bottlenecks. According to the findings from the 2014 Service Availability and Readiness Assessment (SARA), the overall general service readiness index for Lao PDR was 59 percent in 2014—meaning that, on average, 59 percent of facilities had the required tracer items and amenities to provide basic health services to the population. The survey specifically demonstrated low readiness scores on the availability of essential medicines as well as diagnostics at health centers (HCs). Service readiness was

generally found to be higher in the central region than in the north or south regions. The problem was most acute in the northern region, where only 43 percent and 37 percent of HCs had one or more staff with training in Integrated Management of Childhood Illness (IMCI) and growth monitoring, respectively, in the two years before the survey. In all, two-thirds (67 percent) of individual health workers reported never having received training in nutrition; yet, 87 percent of staff had provided these services in the three months before the survey.

Poor and remote populations rely on outreach services. A large part of the population—primarily the poorest population groups, ethnic minorities, and those who live in the difficult-to-reach areas—depend on outreach services for both preventive and basic curative care. A number of studies, including the rapid field assessment carried out by the World Bank in 2016, found that there were great variations in the services offered during such outreach between and within the two provinces surveyed and that only a few HCs could provide the prescribed integrated outreach services on a regular basis. Lack of appropriate medical tools and equipment to carry out outreach services as well as lack of clear guidelines and supervision were found to be affecting the quality of outreach services. It was also found that the areas with the most effective outreach were those in which regular supportive supervision and monitoring were provided. Such findings indicate that a share of the population, particularly the most disadvantaged, in fact does not have access to even basic services and that, in addition to provision of financial protection for the poor, the delivery of basic preventive and curative services needs to be streamlined and strengthened.

Frontline health workers lack relevant skills and training. The 2014 World Bank study on health workforce found substantial gaps in the clinical abilities of frontline health workers in the management of basic clinical care and preventive services for pregnant women, mothers and children. It highlights a significant gap in the quality of health education, beginning at the preservice stage (including entry regulations or requirements for health workers) and continuing throughout the professional life of the health worker. The study also suggests that there are opportunities to address the significant inefficiencies related to underutilization of frontline human resources in health service delivery. The study suggests investments to reduce demand-side barriers such as physical access barriers and ethno-linguistic and gender barriers are needed to increase the utilization of essential health services. Finally, the study also notes the need for investment in improving service readiness of public health facilities to ensure the availability of essential health commodities, equipment and infrastructure.

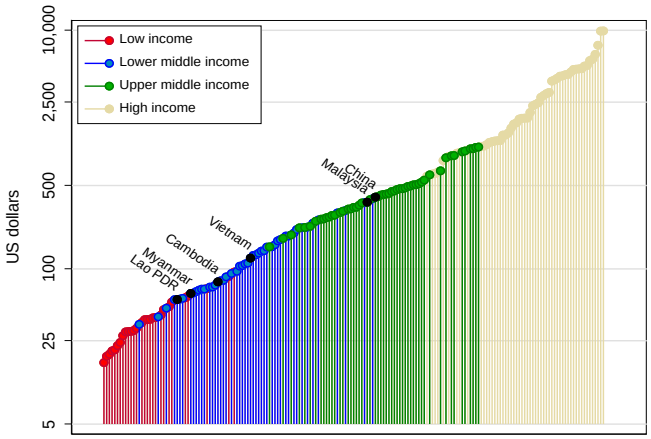
Shortage of qualified manpower is further compounded by an uneven distribution of health workers across provinces. The density of doctors to population in Vientiane is four times that of the rural areas. Similar but less-pronounced differences exist for high-level nurses and midwives. However, the 2014 study found a maldistribution of staff (by geography, level, and type), substantial gaps in clinical knowledge, and a mismatch between the type of in-service training provided and the knowledge needed to perform the service required.

3.4 Health Financing

Compared to neighboring countries there is a low level of government financing of the health sector and a high reliance on OOP. As in many other countries in the region, the Lao health system faces a number of key health financing challenges including underfinancing of the sector leading to supply-side readiness shortfalls, especially in rural and poorer parts of the country; inefficient and inequitable financing through an overreliance on OOP spending sources; and the need to increase domestic financing to replace declining development assistance for health.

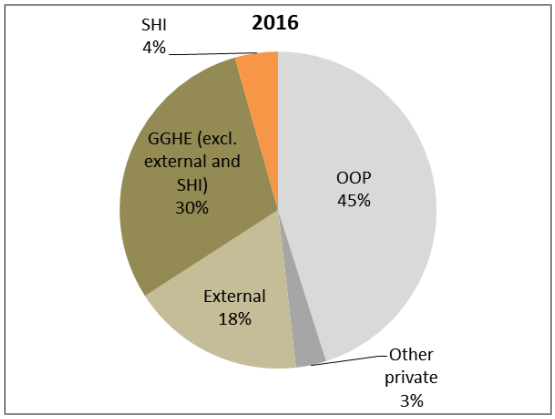
Financing for the health sector in Lao PDR has long been challenged by the low level of government investment in health and the correspondingly high reliance on OOP health expenditure and external assistance for health. Total health spending from all sources in 2016 was US$59 per capita (Figure 5), or about 2.4 percent of GDP, lower than in neighboring countries like Cambodia (US$72 per capita) and Vietnam (US$123 per capita).

Figure 5 Total Health Expenditure per capita, 2016



Source: WHO Global Health Expenditure database

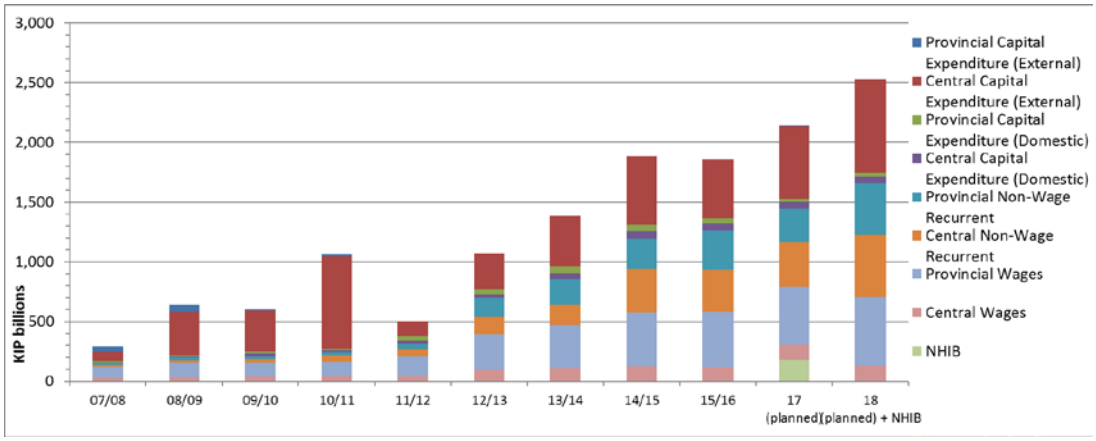
Figure 6 Composition of Health Expenditures



Source: MOH, 2017. NHA 2013-2016 report

The government budgetary expenditure on health was only 1.3 percent of GDP in 2016, though it has increased from US$11 per capita in 2011 to US$30 per capita in 2016. Although there is a government target of 9 percent of government expenditure for the health sector, there is some confusion about whether the denominator is both recurrent and capital, and whether it includes donor funding, and whether it should include debt servicing. In any event, the target is ambitious and has never been achieved. Government health spending as a percentage of total government spending increased from 3.3 percent in 2011/12 to 7.5 percent in 2015/16, before dropping back to 7.2 percent in 2017. As discussed in section 5.3.1.1 below, current macro fiscal conditions suggest it is unlikely to increase again in the short to medium term. The chart below shows that only a small percentage of public spending on health (domestic and external) is available for non-wage and/or capital spending by provincial-level facilities.

Figure 7. Public health spending including donor support (in LAK, billions)



Sources: Official Gazette and State Budget Plan, various years.
Note: The 2018 plan includes the NHIB budget under chapter 63 (subsidies and maintenance).

OOP spending remains the single largest source of financing for health, persistently high at around 45 percent for the past five years (Figure 6 above). The high levels of OOP spending deter health service utilization by the poor and reduce the potential redistributive capacity of the health financing system. Further, the poor and the near poor are frequently impoverished or pushed deeper into poverty because of high OOP spending on health. The introduction of NHI and phasing out of the Revolving Drug Funds (DRF) aim to address this challenge of high OOP and the low level of financial protection, in particular for the poor and vulnerable populations.

External funding is another large source of financing for health services in Lao PDR. The country has substantial dependence on external finance—in particular, in priority health programs including tuberculosis (TB), malaria, and immunization programs. With the country's income levels increasing, Lao PDR will increasingly find itself not eligible to receive grant funds from transitional donors. This could potentially have a disproportionate impact on key health services, such as immunization, human immunodeficiency virus (HIV), and TB programs. Already some of the key development partners have initiated a process of transition and are reducing or even withdrawing their support to procuring commodities including family planning and vaccines and to financing the operating costs for the provision of these services. The reduced availability and unpredictability of the funding for priority health programs may potentially cause a challenge in sustaining and expanding coverage of critical services. Importantly, this transition of financing is taking place while there is still a large pending agenda on access and quality.

The table below shows other health financing indicators for Lao PDR and its near neighbor or comparator countries. Total health expenditure as a share of GDP is the lowest in the region. Similarly, public spending on health as a share of total government spending is also the lowest in the region.

Table 3: Health financing indicators – Lao PDR and comparator countries, 2015

Country	Total health expenditure per capita (current US$)	Total health expenditure as a share of GDP (percent)	Government health as a share of total government spending (percent)	Government share of total health expenditure (percent)
Lao PDR*	59	3.0	7.4	33.6
Myanmar	65	5.4	5.1	21.5
Cambodia	72	6.2	6.6	21.7
Thailand	232	4.0	15.3	71.6
Vietnam	127	6.1	8.2	40.0

Source: World Development Indicators, MOH, 2017. NHA report for the Lao data

3.5 Health Sector Reforms

Implementation of a Health Sector Reform Strategy will contribute to the achievement of UHC. The health sector policy and spending priorities are guided by the Health Sector Reform Strategy and Framework to 2025 and the 8th National Health Sector Development Plan (2016–2020). The 8th National Health Sector Development Plan strives for an acceleration of the health sector reform, particularly, the development of human resources, the improvement of governance and financing, and the completion of the comprehensive health information system. Phase 2 (2016–2020) of the Health Sector Reform Strategy aims to ensure essential health services of reasonably good quality are

accessible for the majority of the population. In the medium term, the Government of Lao PDR aims to cover 80 percent of the population with an essential package of health services and appropriate financial protection by 2020 and to achieve Universal Health Coverage (UHC) by 2025. It is envisioned that over 95 percent of the population will be covered by the social health protection scheme, and that out-of-pocket (OOP) payment will be reduced to less than 30 percent of health expenditure.

To achieve the policy objectives, the Government of Lao PDR has introduced targeted programs for the poor, that is, health equity funds (HEFs) and free care for maternal and child health (MCH) to improve service coverage and financial protection for the targeted groups, i.e., the poor and the pregnant women, mothers, and children under age of 5 years in the past years. While coverage of social protection schemes has steady increased over time, the development of targeted schemes with different funding sources resulted in a fragmented system for financing for health services. Under the recent health sector reform, the Government has introduced the National Health Insurance (NHI) Scheme that covers the entire informal sector population to accelerate the progress toward UHC. More recently, political decisions have been made to progressively expand coverage to the whole population through a unified scheme of NHI by integrating the HEFs, the free MCH program, and the community-based health insurance schemes and reducing fragmentation in the system. While the NHI has been rapidly expanded since its introduction in 2007, challenges still remain in ensuring availability of quality health services to meet increasing demands for services at all level.

3.6 National Health Insurance

The integration of multiple social protection schemes under the NHI scheme has significantly increased coverage. By the end of 2017, the NHI scheme covered 4,996,070 citizens equivalent to 74 percent of the total population. Despite the short period of implementation, the effect of the NHI expansion has already seen increased utilization of services for both inpatient department (IPD) and outpatient department (OPD) services, for example, from 41.7 percent in 2016 to 53.9 percent for OPD in 2017 (Annual NHI Report 2017). However, in spite of the clear policy direction and a rapid expansion of the NHI scheme, the implementation of the scheme still requires extensive efforts in building the operating capacity of the National Health Insurance Bureau (NHIB) and of the MoH and close monitoring of its implementation.

The NHI is primarily funded through the government general budget with limited contributions as co-payments from the users. The NHI scheme uses capitation and case-based payments with low co-payment at a point of service delivery in public health facilities. Capitation covers outpatient services at district hospitals (DHs) and provincial hospitals (PHs), and outpatient and inpatient services at a HC. Case-based payment is used for inpatient services in DHs and PHs, and for both outpatient and inpatient services in referral hospitals.

Patients themselves pay a small co-payment at HCs. Currently, co-payment at HCs is set for 5,000 kip per visit for both OPD and IPD, 10,000 kip for OPD at DHs, and 15,000 kip at PHs. The copayment rate for IPD cases for both DHs and PHs is 30,000 kip per visit. Co-payments are exempted for patients in the list of poor households, pregnant women, and children under 5 years. However, these small co-payment amounts and the exemptions are only available to patients who present for care and treatment within their own village or residential area. When they work, travel, or live outside of their residential villages, they must pay the full amount for services. In addition, patients who do not carry

the required identification documents cannot use the NHI scheme. In many cases, patients from remote locations including ethnic minorities may not have the required documents. These strict requirements deter some patients from making use of public health facilities.

With the integration of social protection schemes under the NHI scheme, the funding for social health protection schemes is now being streamlined under NHI. The fund flow mechanism for NHI was developed to ensure adequate and timely funding for delivering health services at public facilities. Through a rapid nationwide expansion of NHI, the government budget allocation for health has increased even further. However, there is not yet sufficient evidence to confirm whether this increase has translated into improved availability and delivery of health services. The NHI implementation assessment is currently under way, and further facility surveys will make this clearer.

4. The PFM system in Lao PDR

4.1 Overview

National level budget reforms will soon impact on MoH, and force important choices to improve efficiency. Budgeting is heavily influenced by politics, and rightly so. To budget is to choose, and choices are inherently political (Schiavo-Campo 2017). The choices involve questions of where to spend (which provinces, districts, and so on), which sectors or subsectors, which programs, whether to invest in capital improvements or recurrent operations, when to spend, and how to finance the spending (increased taxes, borrowings, cuts to other spending, development partners, and so on). The effectiveness of the budgeting process depends in large part on how well the process and the budgetary institutions facilitate those choices. Any lack of capacity or willingness to make such choices will give rise to some of the PFM bottlenecks in health service delivery discussed in the following paragraphs.

Budgetary systems and PFM systems more broadly are generally analyzed and assessed around the major components of the PFM cycle, that is, national- and sector-level strategic planning, budget preparation and approval, budget execution including payroll and procurement systems, recording (accounting), financial reporting and accountability, and independent audit. Inefficiencies and bottlenecks can and do arise at every level, and governments of all persuasions constantly seek to improve these systems. Bottlenecks and opportunities for improvement can arise within any component, and especially in the links between the components, for example, are sector strategic plans realistically costed, and how well can they be translated into annual and medium-term budget proposals?

In 2010, the World Bank supported the MoF to carry out an assessment of each of these components using an internationally recognized tool known as the Public Expenditure and Financial Accountability (PEFA) assessment. The scores from this assessment are attached as annex 5. In 2018, the World Bank is supporting the MoF to carry out an updated PEFA assessment. The findings from this PEFA should be available late in 2018 or early in 2019. The PEFA scores and supporting analysis provide a useful baseline against which to assess the need for reforms, to prioritize and sequence those reforms, and to measure progress over the medium term. The MoH will cooperate with the MoF and benefit from national-level reforms to PFM systems. However, this PFM assessment of the health sector in Lao PDR has more immediate objectives. Which bottlenecks in PFM systems in the health sector can the MoH

and its partners realistically action in the short to medium term, at the same time ensuring that any actions will be complementary with and not in conflict with current or planned reforms to national systems?

4.2 Constraints of the national level PFM systems

Debt servicing absorbs an increasing proportion of the budget. The Lao Economic Monitor (LEM) of June 2018 confirmed that persistently high fiscal deficits have resulted in a high level of public debt, putting Lao PDR at a high risk of debt distress. The annual interest on this debt continues to absorb a growing percentage of government revenues (forecast at 11 percent in 2018, which is more than total health expenditure) and a growing percentage of recurrent spending. This leaves less room or fiscal space each year for the recurrent costs of financing Lao's health and expenditure programs.

The budget is not benefitting from strong economic growth. Lao PDR continues to benefit from a high rate of economic growth (6.9 percent in 2017). However, the benefits of that growth have not been evenly shared across the population, and inequality has widened.[2] In addition, the strong growth in gross domestic product (GDP) has not been translated into increased revenue collections by government, that is, tax collections have not been buoyant relative to growth in national income. Domestic revenues as a percentage of GDP have declined from 16.1 percent in 2014 to 14.5 percent in 2017.

Compensation of employees (salaries and allowances) also absorbs a growing proportion of government expenditure, up from less than 20 percent in 2012 to around one-third in 2017. This leaves less room for nonwage recurrent spending, important for health service delivery and outreach activities.

Hard budget ceilings are not announced early in the budget cycle. On the expenditure side of the budget process, while the revised budget cycle in the new State Budget Law (SBL) 2015 fits better with the National Assembly (NA) schedule, there is recognition by the MoF that hard ceilings need to be set earlier in the budget cycle and that budget users need to adhere to the revised budget preparation timetable. Without preannounced budget ceilings, sector agencies including PHOs have no incentive to make the hard choices about priorities by districts, programs, and activities. Instead, sector agencies have an incentive to outbid each other with unrealistic budget submissions, particularly on the capital budget side where it would be better for sector agencies to submit well-costed multiyear investment proposals.

Deficit transfers to Provincial Treasuries (PTs). Since the recentralization of oversight of provincial revenue collection through the new SBL, only one province is now in 'surplus' (that is, cash inflows from revenue exceed cash outflows from spending through the PT), compared to seven in 2002. PTs and the PHOs and other agencies that use the PTs are now reliant on the timely flow of cash into the PT from the National Treasury (NT). Any shortfall in tax or revenue collections at the national level results in delayed transfers to PTs and therefore in delayed activity plan and budget implementation by PHOs and other agencies. This has the effect of pushing provincial-level spending into the last two quarters of the financial year. Combined with the late approval by Provincial Financial Services (PFS)

[2] World Bank, Public Expenditure Analysis Synthesis Note, May 2018.

of PHO and other agency detailed activity plans in January or February, this compresses the time available to sector agencies for procurement, outreach programs, and so on. The lack of banking and information and communication technology (ICT) infrastructure at the subnational level also increases the logistical challenge to spending for district officials who must carry documents to the province and then later return for the cash.

In addition, the amount of these cash transfers to provinces is not formula based and is not based on national strategic priorities or need (for example, population, poverty incidence, and remoteness). The lack of a transparent approach to provincial cash transfers encourages overbidding and deal-making from sector agencies.

Current accounting and reporting arrangements are not reliable or timely. Limitations in the MoF chart of accounts (CoA) and the lack of a central and integrated financial management information system (IFMIS) with remote access mean that there is no reliable mechanism whereby district or provincial spending plans, or actual spending against those plans, can be reported back up to the central agencies such as the MoH. In addition, although the new Law on Accounting (2013) proposes the adoption of international financial reporting standards, based initially on the Cash Based International Public Sector Accounting Standard, MoF CoA, and GFIS limitations do not currently facilitate this.

4.3 PFM Reform Plan in Lao PDR

MoH will need to improve internal efficiency, and at the same time work within the broader MoF led PFM reform strategy. The World Bank, European Union (EU), International Monetary Fund (IMF) and other partners are supporting the Government of Lao PDR to address many of these weaknesses, including through support for the implementation of the Public Finance Development Strategy to 2025, led by the MoF. Technical support is being provided through a World Bank-EU Single Donor Trust Fund to support implementation of the PFM Program in Lao PDR. Many of these centrally driven national reforms will ultimately improve PFM in the health sector, including in the provinces and districts.

Areas of PFM reform currently being explored or led by the MoF at the national level include

- Further improvements to the SBL, including the development of secondary regulations;
- Implementation of a requirement for presentation by the MoF of a draft Fiscal and Budget Policy document to the Government early in the budget cycle (March) to provide an informed basis for sector ceilings to line ministries and provincial governments;
- Based on these hard ceilings early in the budget cycle, introduction of a requirement for submission of budget proposals to the MoF from budget entities in a standard format, limited to their current level of funding (that is, the baseline, adjusted for inflation and Government-approved pay rises) and new policy proposals, costed and prioritized (with financing dependent on the MoF forecast of fiscal space available)
- Related development of sector ministry capacity to develop and maintain medium-term budget plans;

- Consideration of options for formula- or indicator-based approach to subnational budget transfers for health and education;
- Improvement of treasury and budget information systems, including arrangements to support a transition from current GFIS to FMIS;
- Expansion and improvement of CoA to make use of dynamic reporting options available from improved treasury and budget information systems and enable compliance with international accounting standards; and
- Strengthening of cash management, forecasting, reporting, and treasury operations at the national and subnational levels (which will improve reliability of cash flows for budget implementation).

However, in the short to medium term, the MoH and health partners will need to make better use of existing resources and target or prioritize allocations to optimize health outcomes (see section 5). It is important that the MoH and its health partners work closely with the MoF on the design and implementation of these reforms to ensure that they take into account service delivery objectives, as well as financial efficiency objectives.

5. How PFM Bottlenecks Affect Service Delivery

5.1 Overview

Section 3 provided a summary of current health financing arrangements and section 4 discussed some of the limitations or constraints of national-level PFM systems. It also discussed current and likely areas of PFM reform in the medium term. Some of these constraints have a greater impact on the health sector than they do on other sectors, especially at the provincial and district levels. This section of the assessment looks more closely at their impact on the health sector at the national and subnational levels. The discussion of these impacts and issues is summarized below by PFM component, that is, Planning & Budgeting, Budget Execution & Treasury, and Accounting & Reporting. The discussion is further categorized by impacts at the central/national level and at the subnational level.

5.2 Data Collection

To support this PFM in health assessment, a survey was carried out on a sample of health facilities in five of the provinces of Lao PDR. Data for the study were collected by a World Bank health team including a PFM specialist and an economist. Data were collected at the central, provincial, district, and health facility levels. Findings from the surveys by province are summarized in annex 2.

Using the PFM in health toolkit, survey questionnaires were developed for health facilities and health offices (annex 3), which covered background and training of interviewee; organization and operations of health facility; the process of planning and budgeting; revenue sources; expenditures; management of revenues and expenditures; results, report writing, and data; communication with different levels of the health systems (central, provincial, and district); and user fees at health facilities. The interviewee was either the Provincial or District Health Officers, Hospital Director, or Health Facility Staff. In larger facilities, more than one person was interviewed at the same time. Interviews were

undertaken at the health facility in the manager's office or in a consultation room. Each interviewee filled out a participant form and signed a consent form. The interviews lasted on average four hours (with interruptions) with follow-up calls and were qualitative in nature. Regarding secondary data, the bibliography in annex 1 shows the sources used.

5.3 Planning and Budgeting

5.3.1 National Systems

5.3.1.1 Fiscal Space for Health

A challenging fiscal environment means that Government health spending targets alone will not increase resources available for health. As discussed briefly above, the link between growth in national income (GDP) and increased revenue collections is not automatic (Barroy et al. 2018), and in Lao PDR, revenues as a percentage of GDP have actually declined in recent years. Setting health spending targets (such as 9 percent of government expenditure for Lao PDR) without recognizing the macro-fiscal realities faced by the government will ultimately have little traction with the MoF or government leaders. It is important to situate health financing within the broader macroeconomic context for identifying opportunities and constraints to fiscal space (Tandon and Cashin 2010). Even if the target could be achieved, it will not guarantee progress toward UHC. The MoH and other partners with a stake in improved health outcomes must engage with the MoF and the government on all possible sources of revenue, including reform of the tax system and tax administration, and including NHI. Progress toward UHC and better outcomes can also be made through efficiency gains, prioritized programs and activities, and better geographic targeting, including through workforce planning. Improving PFM in the health sector could help achieve many of these objectives.

The MoF is less likely to respond to ambit bids for percentage increases across the sector (the historic approach of the MoH) than it is to evidence-based new policy proposals for funding of targeted initiatives, programs, or disadvantage populations. As discussed previously, the MoF will soon be requiring all sectors and ministries to submit budget proposals using baseline ceilings provided early in the budget preparation process. The implications for the MoH and PHOs are discussed in 5.3.2.

5.3.1.2 Budget Preparation Cannot Be Finalized before Start of Financial Year

A long budget preparation cycle reduces the time available for budget implementation at subnational level. Under current national arrangements, at province and district levels, the budget preparation and approval process is not complete until up to two months into the new budget year, leaving around 10 months for budget execution through PTs and district treasuries (DTs), which have their own delays (see the following paragraphs). Under SBL 2015, ministries and provincial government are Level 1 budget entities, and the NA approves the budget by ministry, provincial government, and chapter. After approval of the national budget by the NA in December, the MoF advises both the MoH and the provincial governments of the allocations for each PHO. However, the PHOs cannot act on this advice until the provincial government further reviews and approves the sector and subsector allocations. This is done through the relevant provincial Party Standing Committee, the Provincial People's Assemblies (PPAs), and then the PFS is able to advise the PHO of their final allocation. There is a possibility that the provincial government can vary the subsector

allocations within the PHO, and even the sector allocations between other provincial departments such as Education and Transport. The PHOs are therefore not in a position to finalize their activity plans by district, program, chapter, article, and so on, until they receive this final approval and advice from the PFS, usually in February.

It is understood that in 2015 the national-level government considered granting both health and education sectors special status, whereby their sector and subsector approved allocations from the NA could not be changed by the provincial governments. The rationale was to ensure that national policies on health and education could be implemented down to the subnational level without variation by provincial governments. Ultimately, only the education sector was granted this protected status. It is not clear why the health sector was not granted this status, or what the legal basis for this special status is. However, it is accepted politically at all levels.

The MoH should take steps to identify the nature of this protected status and further explore whether the health sector could operate within the same framework. The benefits are clear - once the NA has approved the national budget in November or December, the MoH and each PHO can finalize their detailed activity plans immediately and not have to wait until February for provincial government approval. Each PHO would be in a position to submit its quarterly spending plan to the PT as soon the PFS releases the budget authority.

5.3.1.3 National Priority Programs

New SBL 2015 targeting provisions have potential to ring fence or protect government and donor financing of priority programs. SBL 2015 makes provision in Article 48 for the identification of 'national priority programs' and financing them through specific purpose transfers to provincial governments. To date, this provision has not been used. For the health sector, specific purpose transfers could be used to ring-fence or protect the NA approved funding of national priority programs so that those funds could not be reprioritized by the provincial government or used for other purposes. In Vietnam, a similar mechanism for National Target Programs allows both government funds and donor funds to be channeled to the provincial level, and the funds are protected from being reallocated by provincial governments or provincial assemblies. This has provided a level of assurance to multilateral or bilateral donors who wish to support specific programs and/or specific needy provinces, but who fear that those funds may be redirected to other political priorities.

There are various provisions of SBL 2015 that have not been implemented and that are not yet supported by subsidiary regulations. The MoH and its partners should explore this provision in Article 48 further with the MoF Budget Department and if possible become an early user of that provision. If successful, the MoH would need to incorporate this financing into its proposed medium-term budget strategy (see section 4.3.2).

5.3.2 MoH

5.3.2.1 MoH Annual Budget Submissions

MoH can benefit from early adoption of the MoF led implementation of a new baseline ceiling approach to sector allocations. As discussed previously, the MoF will soon be requiring all sectors and ministries to prepare budget submissions using baseline ceilings provided by MoF early in the budget

cycle. The MoH and its partners should ensure that the health sector is well prepared to take advantage of this MoF change of direction, that is, by building internal capacity for sectoral analysis, policy development, budget brief preparation, and negotiation. This will require a united approach across national health programs and PHOs as choices are made to finance the programs and activities that best achieve the goals of the Health Sector Reform Strategy and Framework, especially as they affect rural and remote areas. The MoH will need to lead the development and communication of a medium-term budget strategy that will direct funding to those programs and activities that optimize service delivery outcomes for target populations. The medium-term budget strategy will also need to accommodate the Health Sector Development Plan, that is, to work with the MoF to improve fiscal space available for priority health programs, to extract improved efficiencies from health insurance arrangements, bring more transparency to technical revenue collections and disbursements, and minimize OOP expenses for those least able to pay.

The MoH should not underestimate the political challenge of developing such a medium-term budget strategy. It will require agreement on policy targets and minimum standards of service delivery to guide choices about where to target new spending. The MoH will need to take the lead to establish a permanent planning and budget committee, led by the MoH Department of Planning and Cooperation (DPC) and Department of Finance (DoF), and with both national program and PHO members. The planning and budget committee would accept ongoing responsibility for translating the goals of the Health Sector Reform Strategy & Framework and the specific targets set out in the five-year Health Sector Development Plan into a well-integrated medium-term budget strategy, and annual budget submissions to the MoF and Ministry of Planning and Investment (MPI) supported by budget briefs and targeted new policy proposals. It is important that such a committee has broad representation so that it is able to submit a consistent and integrated strategy to the MoF and MPI on behalf of the MoH and its partners.

The recent World Bank Public Expenditure Analysis (PEA) - Education and Health Sectors (2018) suggests that there are significant variations in per capita spending across provinces and districts (pages 46–48). There are similar mismatches when budget allocations are compared with service delivery outputs as well as health outcomes, again suggesting some inequities in resource allocation. Similarly, there is an uneven distribution of skilled health workers across provinces (see section 5.3.5 on workforce allocations). A medium-term budget strategy could attempt to address these resource allocation issues over the medium term, at the same time providing evidence-based analysis to support new policy proposals to the MoF for additional targeted funding and workforce quotas.

In the short term, the MoH will require TA to support the transition to a more targeted and prioritized approach to budget preparation. This TA can be made available through current or proposed World Bank operations in Lao PDR.

5.3.2.2 MoF Capacity to Understand and Support the Health Sector

MoH should strengthen its relationship with MoF to improve MoF's ability to engage with the sector. The MoF Budget Department does not have dedicated sector specialists or desk officers responsible for analysis, monitoring, and evaluation of specific sectors. This limits MoH's ability to work cooperatively with MoF to ensure they fully understand and are also committed to jointly working with MoH to implement the health sector strategy, including the necessary PFM and health

financing reforms. MoF has its own medium term PFM reforms in the Public Finance Development Strategy 2025, and many of these will require close working relationships between MoF Budget Department officials and MoH DPC and DoF officials.

5.3.2.3 Separate Recurrent and Capital Budgeting Processes

Separate institutional arrangements for recurrent and capital budgeting can contribute to inefficiencies in resource allocation. There is a recognized need for the MoH, PHOs, and health partners to better integrate the processes currently used to prepare the recurrent budget proposal and the capital budget proposal (see 2010 PEFA indicator PI-12(iv)). Institutional arrangements at the national level currently allow the two budgets to be developed quite separately, that is, by the MoH DPC to MPI, and by the MoH DoF to the MoF (World Bank, Public Expenditure Analysis - Education and Health Sectors, June 2018). Separate institutional arrangements for recurrent and capital budgets are not uncommon, but they need to be complemented by other arrangements to ensure that both budget processes are supporting the same priority programs, activities, and populations. Dual recurrent and capital budgeting processes can mean that recurrent budget implications may not be considered in capital investment decisions or that capital investments are spread too thinly across all programs and all districts, with insufficient regard to priority or need.

5.3.2.4 Program, Activity, and Location Coding in the Chart of Accounts

Until national level reforms to the chart of accounts are available, MoH activity and budget planning tools will need to be made more dynamic. The limitations of the MoF maintained CoA are well known and have been covered extensively in other reports (World Bank, Action Plan for Expansion of the Chart of Accounts, October 2018). The most significant gap in the CoA is the lack of any field for programs/activities or for location (province or district). Both of these fields are critical for linking strategic plans and activity plans to annual budget submissions and for aggregating subnational plans into a consolidated MoH budget submission, prioritized by program and location. Under current arrangements, cuts imposed to budget submissions by the MoF, NA, or the provincial government are made at the chapter level only, which then means that the MoH and PHOs need to make the detailed changes to their activity-level plans and resubmit them to the PFS, MoH, and MoF. Actual spending against budget plans is similarly recorded and reported, that is, GFIS only supports reporting by chapter subheadings and not by program, activity, or location. PHOs need to maintain parallel Excel-based records for these dimensions of spending, which cannot be consolidated easily by the MoH.

As mentioned previously, the proposed World Bank-financed financial management information system (FMIS) project under preparation will upgrade the accounting systems and also expand the CoA. These reforms are unlikely to be available to the MoH or PHOs in the short to medium term. On the other hand, it will be difficult for the MoH to accommodate the MoF's planned introduction of a baseline approach to budget submissions without using these program and location fields. With Asian Development Bank (ADB) support, the MoH DPC has developed a planning and budgeting database tool that does include fields for programs, activities, and locations, using the MoH standard coding for each. However, this tool has only reached the beta-testing phase and has not yet been piloted in any MoH department or any PHO. It is also not clear what level of involvement and ownership the DPC has of this tool. The DPC should explore the feasibility of using this tool to facilitate budget preparation

at the subnational and national levels, particularly its capacity to support the MoH's adoption of the MoF's proposed baseline approach to annual budget ceilings.

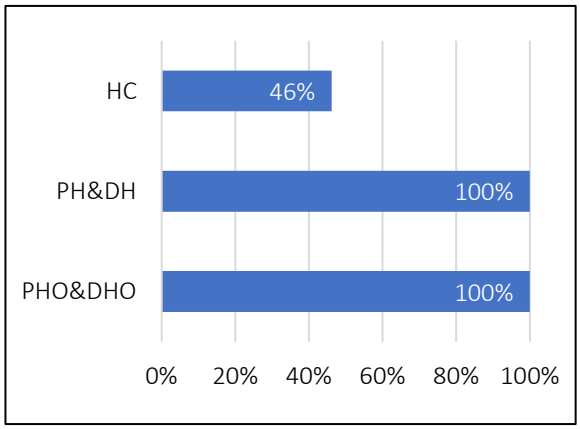
It does appear that this database tool has fields for program/activity and for location. Nevertheless, it is important to ensure that any activity planning or budget preparation tools used by the DPC or DoF are using coding and fields that will be consistent with the MoF-led revisions to the national CoA. The MoH DPC and DoF should consult with the MoF Budget Department and PFM Reform Program to ensure coding systems will be compatible. Coordination between the MoH DPC/DoF and the MoF Budget Department will be critical here, as the MoF is still considering the scope of changes to the national CoA.

5.3.3 PHO Planning and Budgeting

5.3.3.1 Involvement and Capacity of Facility Health Officials in Budget Process

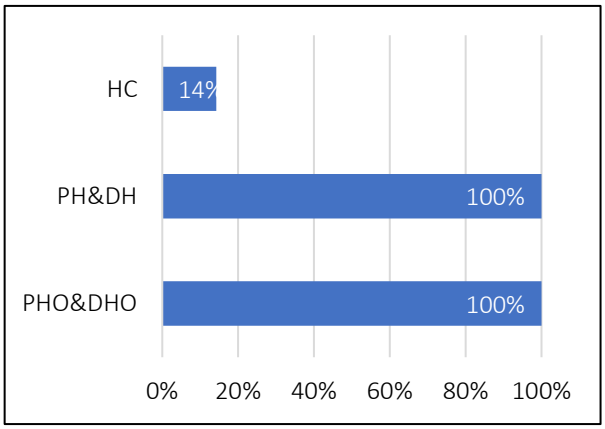
Health officials are normally not consulted on budget preparation and allocations. In theory, health facilities should be consulted on budget priorities and needs and on chapter allocations. In practice, PHOs prepare budgets in consultation with DHOs and with hospitals but would rarely consult with lower-level HCs. Based on the field survey discussed earlier, Figure 8 shows that less than half of HCs were consulted on budget priorities. Given that HC staff actually deliver the services and have a more accurate knowledge of the levels of finance and the different eligibility requirements for spending financed from their technical revenues, government funds, and private sector sources, PHOs and DHOs could improve the efficiency of spending by consulting HCs early in the budget cycle (especially if ceilings are imposed earlier as suggested previously).

Figure 8. Proportion of facilities and offices involved in budget preparation by type of facility



Source: Field survey of five provinces in 2018.

Figure 9. Proportion of facilities with skilled financial specialist by type of facility



Source: Field survey of five provinces in 2018.

HCs do not have the financial management skills for budget management and financial accountability. Figure 9 shows that only 14 percent of HCs have a staff member capable of maintaining financial records and preparing financial reports to account for funds used. This may explain why most of them are not consulted during budget preparation but may also go some way in explaining the lack of trust between HCs and DTs who believe that HCs significantly underreport receipts from technical revenues and how they are spent.

5.3.3.2 Capacity at PHO for Budget Preparation Consistent with National Policy Priorities

To work within the new MoF baseline ceilings framework, PHOs will need guidance on how to operationalize MoH policy priorities within ceilings. The World Bank PEA identified two related problems with budget preparation by PHOs (World Bank, Public Expenditure Analysis, Education and Health Sectors, June 2018). First, without preannounced budget ceilings, PHOs have no incentive to make choices about the priority programs and activities that will improve service delivery, especially for rural and remote areas. In fact, PHOs have an incentive to outbid each other with unrealistic budget submissions, particularly on the capital budget side where it would be better for sector agencies to submit well-costed multiyear investment proposals. Second, there is a lack of guidance to PHOs and district health offices (DHOs) on how to operationalize national MoH policies and priorities when preparing budget proposals or detailed spending plans, for both recurrent and capital budget.

If the MoH decides to adopt its own ceilings early in the budget cycle and communicate these early to PHOs so that PHO first-round submissions to the MoH and PFS are consistent with these ceilings, then the MoH will also need to provide guidelines to and build capacity in the PHOs on how to prepare and align their budget proposals with national priorities and within the agreed ceilings. Given the dual reporting obligations of PHOs to both provincial government PFS offices and to the MoH at the center and that sector budgets at the provincial level also need to be approved by PPAs, these guidelines and the associated capacity building will need to ensure that the PFS and other provincial authorities are included. If national MoH new policy proposals are to target priority programs and populations, while maintaining existing funding baselines for lower priorities, then the PFS will need to be fully aware of and supportive of the approach.

5.3.3.3 Need for Flexibility in PHO Activity Plans

Activity planning and budgeting tools will need to be made more flexible and responsive to changed ceilings and cash availability. As mentioned previously, PHOs currently build their annual detailed activity plans using a complex set of Excel spreadsheets. In consultation with health sector partners and with DHOs, these spreadsheets cost each of the activities, identifying various sources of finance, including health sector donors. The costings are then translated into chapter headings using the MoF CoA. It is a logical process but demanding on PHO and DHO time and capacity. However, the major drawback of an Excel-based approach to activity planning and budgeting is for the MoH at the center, where plans and budgets need to be consolidated from multiple PHOs and other health institutions. A centralized database with remote access by PHOs and so on through entry forms or screens provides a faster, better-structured, and more secure approach to data entry for plans and budgets. Within preapproved parameters or ceilings, PHOs and so on could quickly change the timing or location of spending, for example, in response to delays at treasury in cash availability, and the centralized and consolidated database at the MoH will be automatically updated. At any time, PHOs can still extract data from the central database to analyze locally using Excel.

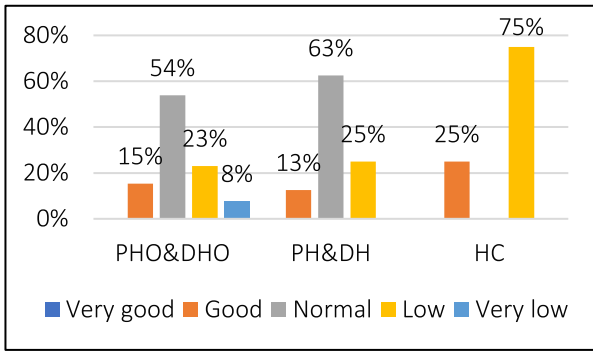
5.3.4 Inadequate Supplies of Drugs and Equipment

Many health facilities do not have sufficient supplies of drugs and basic medical equipment. Hospitals at the subnational level and HCs lack essential equipment for basic treatment. Based on the

field survey carried out as part of this assessment, many HCs lack modern birth delivery equipment and patient beds and generally do not have the equipment considered essential for that level of facility. Many HCs rely on used or secondhand equipment and beds donated from hospitals or more advanced HCs.

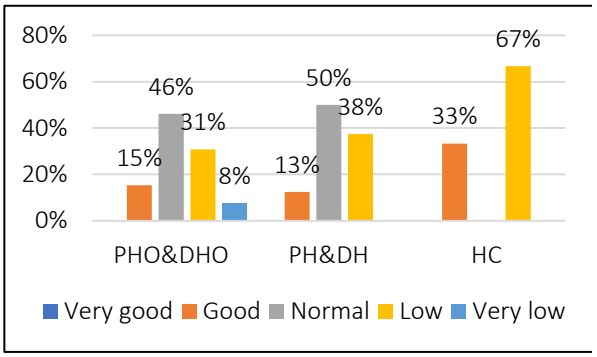
HCs report a lower level of satisfaction on budgets for purchases and repairs than hospitals and health offices. The field survey also recorded significantly lower levels of satisfaction at the HC level with the budget available for purchases of drugs and equipment and for repairs. Figure 10 and Figure 11 show the level of satisfaction with purchases and repair budgets, respectively. The majority of health offices and hospitals recorded normal or higher levels of satisfaction with their budgets for purchases and repairs, whereas a significant majority of HCs reported low levels of satisfaction. In fact, several facilities reported that they are rarely allocated any budget at all for maintenance. Many facilities rely on their technical revenues and support from the local private sector to finance equipment and building maintenance.

Figure 10. Level of satisfaction with budget for operational purchases by facility type - 2018



Source: Field survey of five provinces in 2018.

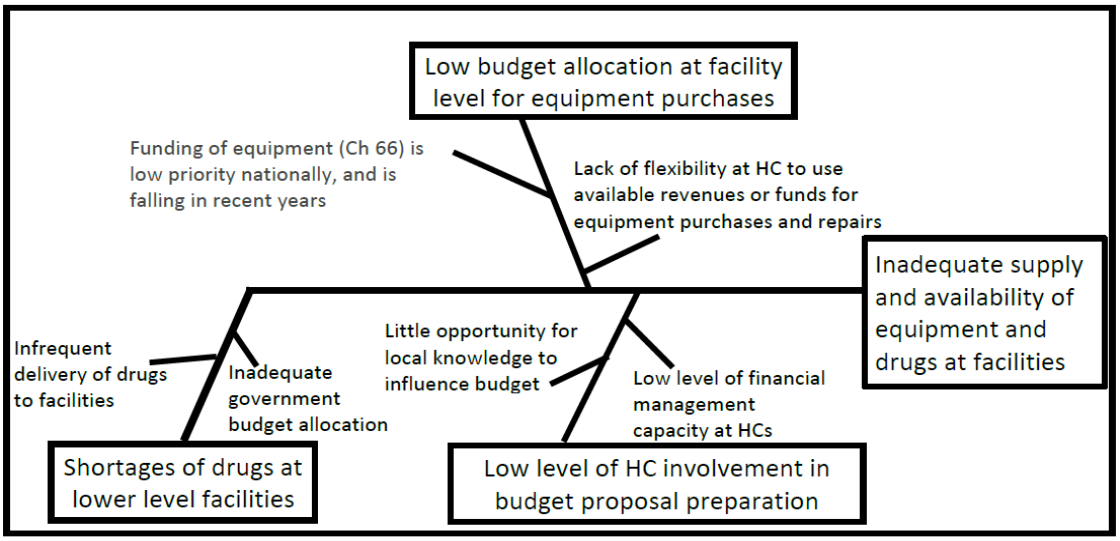
Figure 11. Level of satisfaction with budget for repairs by facility type - 2018



Source: Field survey of five provinces in 2018.

Various factors contribute to the problem of inadequate supply of equipment and drugs at the health facility level. The fishbone diagram below summarizes several constraints. These include inadequate budget and budget arrangements to finance drug purchases and deliveries to health facilities; a similar low level of budget allocation for purchase and maintenance of medical equipment; and a lack of flexibility at the facility level on use of revenues from the provincial budget, from technical revenues, from NHI, and from DRF for drugs.

Figure 12. Cause-effect diagram on inadequate supply of equipment and drugs

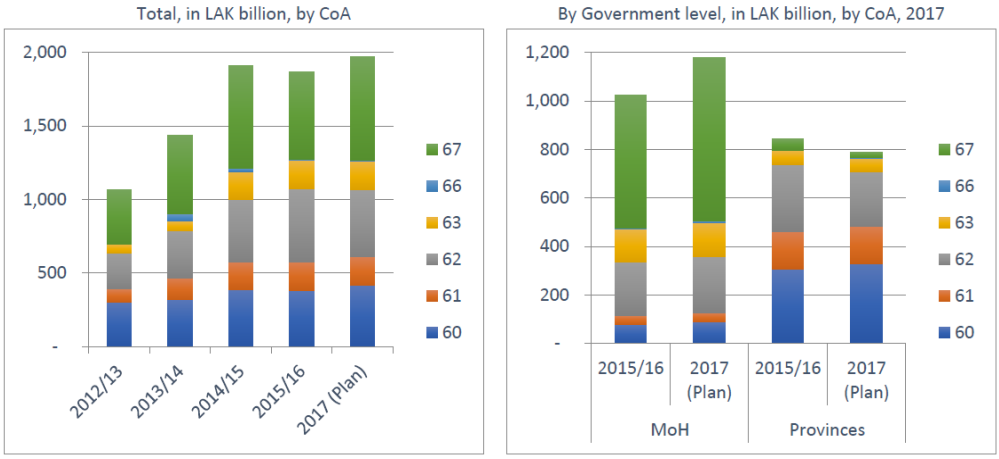


Source: Authors.

Government recurrent budget funds cover about one-third of the cost of drugs at the facility level, with the rest financed through OOP from patients, including for drugs. There are a variety of financing mechanisms for procurement of medicines, with some procured nationally and some procured at the provincial level through PHO budgets. These result in bulk delivery of drugs to facilities once per year, with shortages or stockouts arising, as well as expiry of use-by dates for some drugs. By charging patients for some drugs dispensed at the facility level, facilities are able to use a drug revolving fund (DRF) to finance procurement of replacement drugs through the MoH at the center. The PEA - Education and Health 2018 noted that the DRF has some limitations. The DRF provides (perverse) incentives for suppliers to overprescribe medicines to increase their revenues (that is, supplier-induced demand) and contribute to high reliance on OOP payment by households. This results in overprescribing with potential consequences in terms of drug resistance and risks to patients' health as well as an overall increase in health expenditure without corresponding health benefits. While the DRF is set to be phased out and fully replaced by NHI, whether facilities continue to use DRF or not will largely depends on the successful implementation of NHI with timely transfer of the funds to facilities.

Purchase of equipment is considered a low priority by MoF. The MoF gives low priority to financing of purchase and maintenance of equipment, and the allocation available at the facility level is therefore very low. At the center, when fiscal space is limited, equipment purchases of all kinds under chapter 66 are given low priority behind other operating expenditure budgets. As can be seen from the charts below (taken from PEA - Education & Health 2018) the percentage of the government health budget available for equipment dropped from around 5.5 percent in 2013/14 to less than 1 percent in 2017. Many PHOs have no government budget for purchase of equipment.

Figure 13. Public health spending by chapter by year, and by level of government



Source: Gazetted Budget Plan, several years. Actuals up to FY2015/16, plan for FY2017.

5.3.5 Fragmented and Poorly Executed Infrastructure Budget

Fragmentation of infrastructure budget, poor project planning, and unreliable cash flow delay completion of health facility infrastructure. There remains an ongoing problem for health infrastructure projects dragging on over several years, with likely inflation of costs by construction firms to compensate for the uncertainties they face. The field survey team for this assessment observed first hand many of these delayed construction projects for health facilities. As noted in the PEA - Education and Health 2018, there are a range of contributing factors:

- As with recurrent budgets, there is no capital budget ceiling applied early in the budget cycle (as well as no multiyear ceiling for capital), which means that districts submit long wish lists of unprioritized proposals.
- There are no clear criteria applied consistently by the MoH or by PHOs in the selection of which infrastructure projects will be funded either through the national-level MoH capital allocation or through the PHO allocations. It is not clear that relative costs and benefits are compared, or that any priority is given to underserved geographic areas.
- Limited capital budget and limited capacity to appraise, cost, and compare proposals results in the capital budget being spread too thinly over too many proposals.
- Priority is in fact given to existing or ongoing projects, which were either poorly costed originally or were planned to be implemented over several years.
- Projects for construction of facilities can be further delayed by cash shortages through the PT or DT.
- Off-budget projects—where unsolicited project proposals are received from private construction firms on a build-now-pay-later basis, and where there is no competitive tendering and prices—are therefore higher than through more transparent procurement arrangements

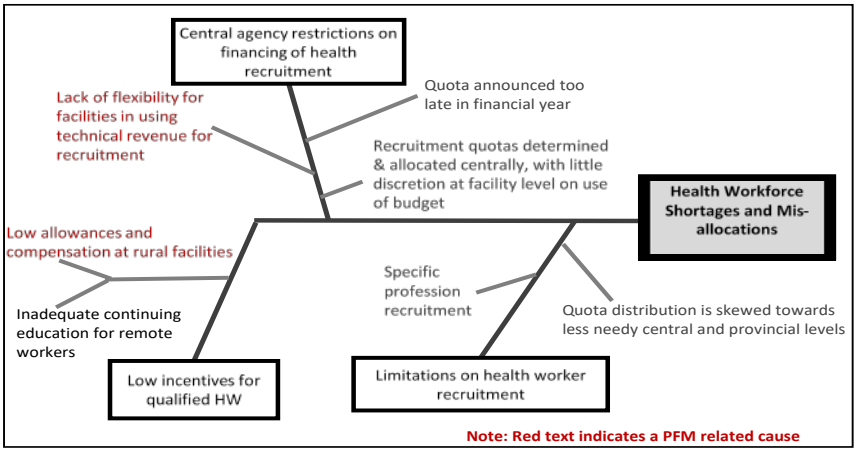
5.3.6 Health Workforce – Resource and financing issues

Payroll costs and workforce misallocations both impact on service delivery. The focus of this assessment is on PFM bottlenecks to service delivery, and the analysis has focused predominantly on

non-payroll spending. However, given that payroll and allowances comprise around 60% of spending in the health sector, some discussion of health workforce issues, particularly as they affect allocations at sub-national level, is warranted.

Payroll-related spending is difficult to vary in the short term and is largely determined by national government policies on approved pay increases and on the Ministry of Home Affairs (MoHA) and MoF approved annual quota allocations for new appointments (including to replace retirees). In the health sector in Lao PDR, it is recognized that there are both overall workforce shortages and misallocations of workers (with shortages in rural or remote locations)[3]. The workforce studies cited identify a range of supply and demand issues that contribute to the overall shortages of health workers and the allocation that favors urban facilities. The following fishbone or cause-and-effect diagram summarizes possible causes.

Figure 14. Cause-and-effect diagram on health workforce shortages and misallocations



Source: Authors.

More health workers, especially medical health workers, are required to meet the World Health Organization (WHO) workforce density threshold and to fill vacancies. Although there is no universal norm or standard for a minimum health worker density in any given country or region, the WHO estimates that a threshold density of 2.3 physicians, nurses, and midwives per 1,000 population is required to achieve a targeted 80 percent coverage rate for skilled birth attendance and child immunization, and a threshold density of 4.45 per 1,000 is needed to achieve a median level of performance for a broader range of 15 Sustainable Development Goals (SDG)-based indicators. In Lao PDR, the number of medical health workers was 1.96 per 1,000 people in 2016. One of the reasons for the low health worker density is the large number of vacant positions. The table below shows the number of health workers and vacancies in 2016, that is, a vacancy rate of over 30 percent.

Table 4. Number of health workers and vacancies in 2016

	Number of health workers	%
Qualified health worker positions	29,515	100
Heath workers	20,484	69.4
Qualified health workers vacancies	9,031	30.6

Source: Department of Personnel, MoH, 2017.

[3] Qian et al. 2016; World Bank, Lao PDR Health Centre Workforce Survey, May 2016.

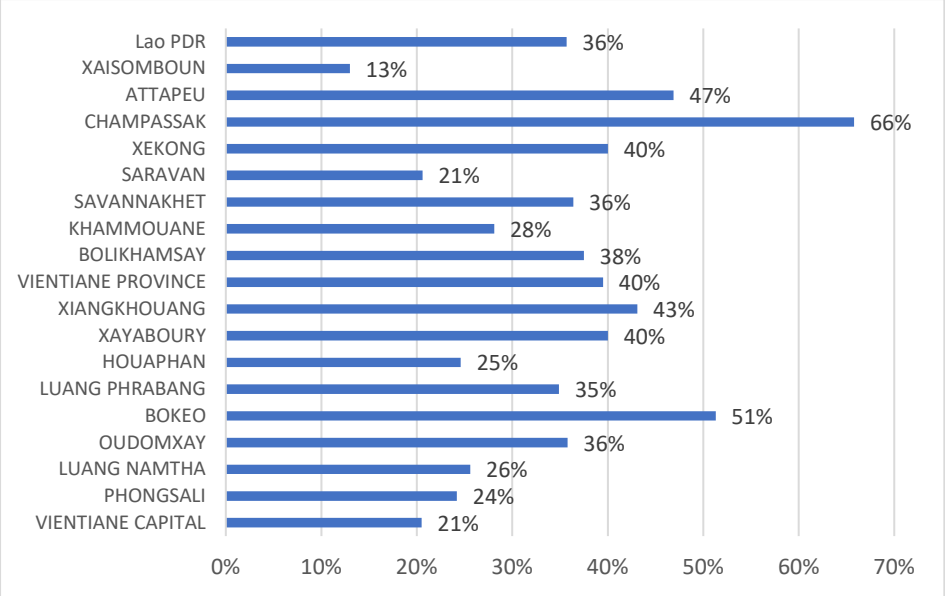
Most of the vacancies are in rural and remote areas. Table 5 shows that a disproportionate number of the vacancies are at the district and HC levels, that is, 30 percent and 33 percent, respectively. This reflects the difficulty of attracting and retaining staff at this level, particularly females. A consequence of this difficulty is that there is a substantial number of unpaid volunteers who work in government institutions, with majority of them working in the education and health sectors at the subnational level.[4]

Table 5. Number of vacancies by level or location in 2016

	# of positions	% of total	# of health workers	% of total	# of vacancies	% of total
Health Centers	6,788	23.0	3,777	18.4	3,011	33.3
District	7,420	25.1	4,681	22.9	2,739	30.3
Provincial	8,428	28.6	7,332	35.8	1,096	12.1
Central	6,879	23.3	4,694	22.9	2,185	24.2
Total	**29,515**	**100.0**	**20,484**	**100.0**	**9,031**	**100.0**

Many HCs lack a sufficient number of health workers. The MoH has a standard or target of one medical doctor for every HC. However, Figure 15 shows that nationally only 36 percent of HCs meet this requirement, with a significant variation across provinces. Note that Xaisomboun Province was only established in 2013; thus, it has a lack of public workers in general. HCs in the capital, Vientiane, have a low number of HCs with a medical doctor because of their close proximity to central hospitals. Figure 16 shows that at the district and HC levels, fewer than 34 percent of medical staff have a bachelor's degree or higher level of qualification. Table 6 shows a higher rate of vacancies for health workers requiring a higher level of qualification, that is, medical associates and pharmacists.

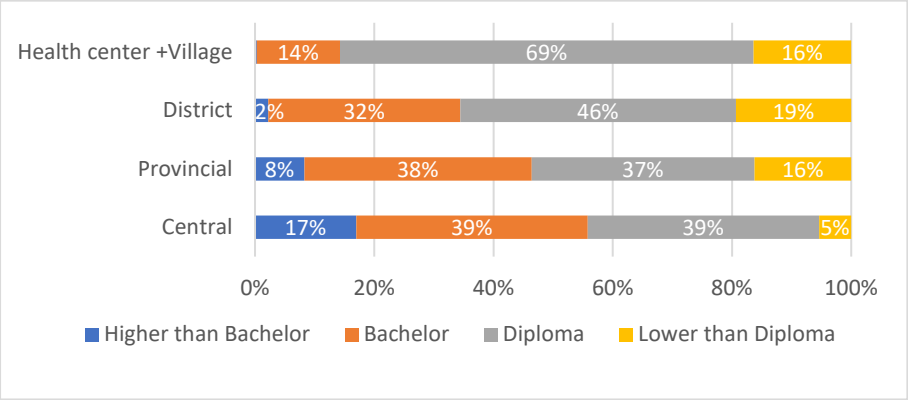
Figure 15. Percentage of health facilities with doctor by province (2016)



Source: Department of Personnel, MoH, 2017.

[4] Lao Public Expenditure Analysis (PEA), May 2018.

Figure 16. Proportion of qualified health workers by qualification and level of facility, 2016



Source: Department of Personnel, MoH, 2017.

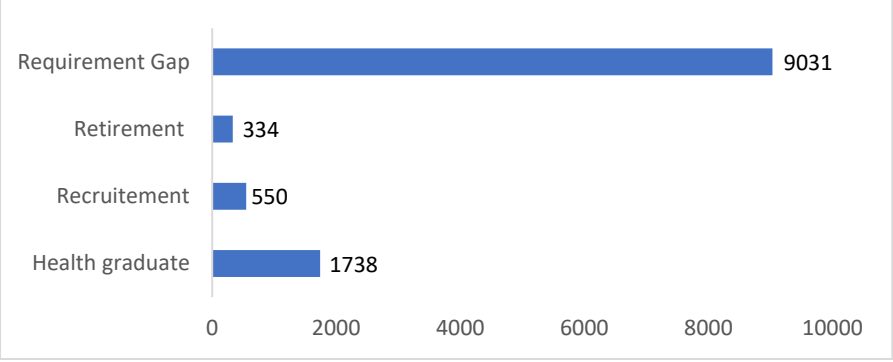
Table 6. Vacancies by type of health worker, 2016

Type of Health Worker	Vacancy rate for this type of health worker (%)	Number of Vacancies for this type of worker
Technical nurse	11	1,031
Lab technician	12	1,061
Pharmacist	15	1,310
Medical associate	17	1,515
Hygienist	11	1,001

Source: Department of Personnel, MoH, 2017.

Recruitment of health workers is not sufficient to fill the current vacancy gap. As shown in Figure 17, despite there being 1,738 graduates available, the MoH was limited to a total recruitment quota of 550 in 2016. After covering retirements, this left 216 to fill vacancies, which numbered at 9,031 in 2016. In addition, the government limits the number of volunteers in each facility.

Figure 17. Recruitment, retirement, and vacancy gap in 2016 (# of positions)



Source: Department of Personnel, MoH, 2017.

Recruitment quotas favor central and provincial levels. Given the current national-level fiscal situation that makes it unlikely the health sector will receive additional allocations in the short term, an efficient and equitable workforce allocation is important. Yet, as shown in Table 7, despite having the highest vacancy rates at over 30 percent and 33 percent, districts and HCs receive only 25 percent

and 12 percent of recruitment quota. Even though there is only a 23 percent vacancy rate at the central level, it received almost 50 percent of the recruitment quota.

Table 7. Filled and vacant positions by facility type 2016

	Number of Positions			%		
	Current	**Vacancy**	**Recruitment**	**Current**	**Vacancy**	**Recruitment**
HC	3,664	3,011	64	17.9	33.3	11.6
District	4,681	2,739	136	22.9	30.3	24.7
Provincial	7,332	1,096	77	35.8	12.1	14
Central	4,694	2,185	273	22.9	24.2	49.6
Total	20,484	9,031	550	100.0	100.0	100.0

Source: Department of Personnel, MoH, 2017.

Restrictions on use of budget for particular types of expenditure. Government budget allocations are approved by the MoF and NA at the chapter level, to the MoH and to provincial governments. Once allocated to DHOs and health facilities, these health entities have no flexibility to shift funds between chapter headings. This includes prohibitions on using operating funds to finance salaries or allowances of health workers. Even for technical revenues collected by facilities, these are not allowed to be used to finance salaries or allowances, or to otherwise compensate volunteers.

Civil service compensation is not attractive for health workers, especially in rural areas. Civil service pay structures do not reward health qualifications, which take many years to obtain. In addition, in remote areas where living conditions are difficult, there are no additional incentives to attract graduates to apply for positions in these locations. Instead, rural health workers rely on travel allowances, per diems, and so on available through outreach programs. Rarely, some villages may provide housing or other fringe benefits to attract health workers to a HC. There is also evidence that there are inadequate continuing education or training opportunities for the rural health workforce and that the training that is provided is not related to demand (Qian et al. 2016).

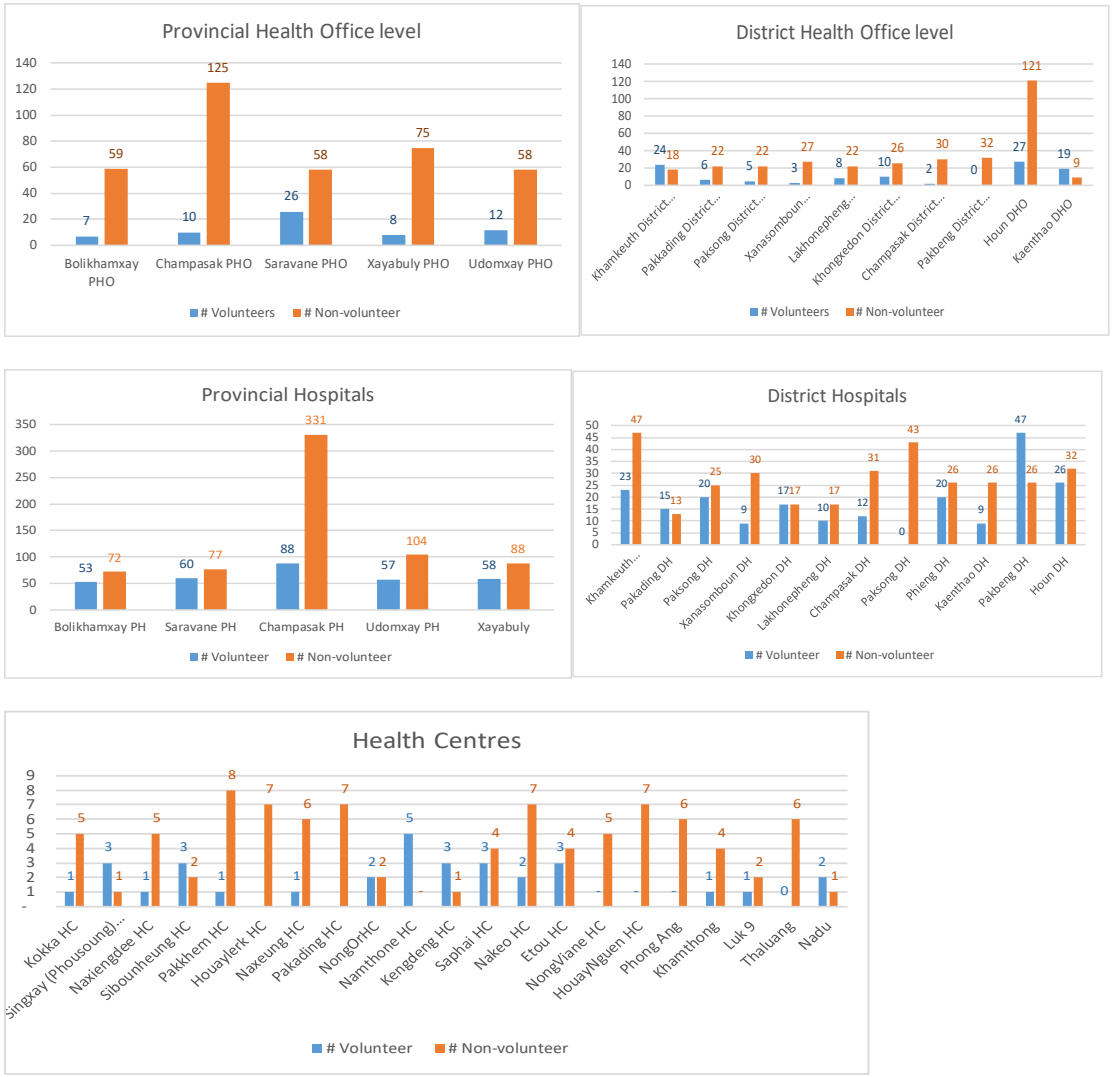
5.3.7 Volunteer Health Workers

There are large numbers of volunteer health workers, but further research is required to quantify their impact. The shortage of paid health workers has also given rise to the 'employment' of large numbers of volunteer health workers. Although these volunteers do not occupy government positions, they can benefit from the payment of per diems when they are involved in outreach activities or if they are working on-call hours (Qian et al. 2016). These volunteers (also known as 'contract' workers) can work for several years in their voluntary status until they are successful in securing one of the few quota paid positions, which might be allocated from the MoH to the PHO or DHO. This can lead to perverse incentives for retaining or contracting volunteers. Volunteers are not peculiar to the health sector, and it is well known that volunteers or the families may make informal payments to other government officials to secure a volunteer position. The potential this practice has for distorting allocation of quota away from the most needy districts or populations is clear.

There has been no formal study of the number of volunteer workers in the health sector, but the data from the survey of health facilities in five provinces suggests the numbers are significant. The survey data summarized in annex 2 show that up to 50 percent or more of the staff in some facilities may be

volunteers. Based purely on the survey data, the following charts show the number of volunteers compared to non-volunteers for each level of health office or facility in the survey.

Figure 18. Numbers of volunteers and non-volunteers by type of health office or facility



Source: Authors' survey data.

5.3.8 Health Workforce Issues

Addressing uneven workforce distribution requires early action on a medium-term strategy. It will be difficult in the short term to vary civil service salary and compensation levels in the health sector or to increase the civil service quota numbers given the difficult fiscal situation discussed previously. However, it may be possible to make better use of the existing level of resources and of annual quotas. The education sector in Lao PDR has faced an equally if not more challenging workforce allocation problem, that is, teacher vacancies are the highest in remote areas, but there are surpluses of teachers in urban areas. In addition to creating a Planning and Budgeting Committee, the Ministry of Education (MoE) Department of Planning has also led the creation of a Teacher Allocation Committee in a bid to achieve a more equitable allocation of teachers over the medium to long term, making use of natural attrition and targeted appointments.

It is not possible in the short term to relocate health workers from one location to another, given the family and other commitments that the existing health workers have. The best timing for intervention in the allocation of the health workforce is at retirement, resignation, and new appointments. It is very difficult to relocate staff once they are in position. At the sub-national level, decisions on appointments are made at PHO level, in consultation with DHOs and with the provincial government. However, decisions on quotas for each PHO are made centrally. Sector level quota allocations for the health sector as a whole are decided by MoHA and MOF, and advised to MoH. MoH, in consultation with PHOs then decides on the quota allocation available to each PHO.

5.4 Budget Execution and Treasury

5.4.1 MoH

Rates of budget execution in health are lower at the subnational level than at the central level. The rates of budget execution for the central MoH are quite high when compared to original budgets (World Bank, Public Expenditure Analysis, Education and Health Sectors, June 2018), often exceeding 100 percent. This is made possible in part by the savings from poor rates of budget execution at the subnational level, particularly for chapters 60, 62, and 67 (domestic financed), where in 2014/15, provincial spending was closer to only 70 percent of the original budget available. For chapter 60, this may be related to the fact that annual quotas are not announced by Ministry of Home Affairs until well into the financial year, that is, around May. This also demonstrates the correcting role played by the midyear budget revision process, which allows PHOs to adjust their activity plans to make them more realistic. Budget execution constraints for PHOs and DHOs are discussed further in the following paragraphs.

5.4.2 Subnational Budget Execution

5.4.2.1 Compressed Budget Execution Period for PHO and DHO

Cash available for health through PTs is sometimes rationed. Section 5.3.1.2 discussed the causes for the delays in notifying PHOs of their final approved budget and then the finalization of their detailed activity plans, as well as the preparation of their quarterly spending plans for submission to the PT. This loss of the first 1–2 months of the year compresses the financial year available to PHOs and DHOs to actually implement their budget. However, after budget and plan finalization, there are additional delays and inefficiencies at the provincial level that further compress the time available to health officials for service delivery and outreach activities.

Cash transfers to PTs and DTs to finance provincial and district-level activities are weighted to the last two quarters of the financial year. At the national level, there is considerable uncertainty as to the level of revenue/tax collections flowing into the NT (that is, whether collections will achieve budget targets) and also as to the timing of those collections. Any shortfall in collections or uncertainty about the timing of collections at the national level results in restrictions on cash transfers to PTs, that is, below the level required to finance PHO and other provincial departments' payroll and activity plans. PHOs are not made aware of these cash restrictions until after they submit their quarterly spending plans to the PTs. The PT prioritizes payment of salaries and allowances (chapters 60 and 61) and then

makes cuts to PHO spending plans (for chapters 62, 63, 64, and 67), usually without consulting the PHO.

These cuts to the quarterly disbursements to PHOs at the chapter level must then be translated into cuts in activity plans of the PHO for that quarter. In some cases, the PT itself decides which activities of the PHO will be cut, that is, for which districts, which activities, how many health workers will conduct outreach visits for how many days, and so on. This reflects a lack of trust between the PT and the PHO about what resources are required to complete certain outreach activities. In other cases, the PHOs will have to make these changes to their activity plans. However, the default position for the PHO is to delay the activity or purchase until later in the financial year, but not to change the detailed activity plan.

As explained previously, the Excel-based detailed activity plans are difficult to change given the amount of consultation work that has gone into their preparation and the multiple levels of approval required from the PHO, PFS, and MoH. In practice, those activity plans are not changed, but simply delayed until later in the financial year. The PT has no authority to change budgets of PHOs and can only delay the transfer of cash until later in the financial year. In practice, there is also a midyear revision of the national budget by the MoF and PFSs to reflect lower-than-expected revenue forecasts, as well as delayed implementation of activities and projects (chapter 67), and PHOs also have the opportunity to revise (reduce) the level of their activities or project spending.

There are other delays caused by approval processes and logistics. When PHOs submit their quarterly spending plan to the PT, it can take up to six weeks for the PT to make the cash or other form of payment available. For DHOs where their DT is not able to process payments, there can be further delays caused by the logistics of the DHO having to carry their payment request to the PHO and PT and then making a second trip when the cash becomes available.

Toward the end of the financial year, when cash from the PT is received late in November or December, some of the PHO spending or outreach activities can actually be carried out in the first few months of the next financial year. Where the payment request to the PT is for a specific procurement or contract payment (for chapters 66 or 67), there are also complex procurement and approval processes to follow, which can further delay budget execution or project implementation.

5.4.2.2 Technical Revenues

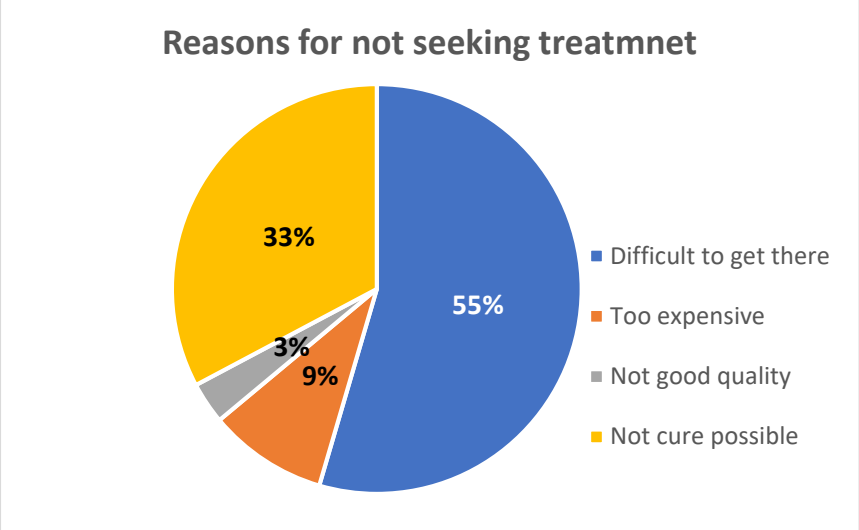
Accountability and transparency around collection and use of technical revenues needs to be improved, but care should be taken not to increase the burden of OOP on poorer populations. Technical revenues (fees and charges collected by health facilities that are allowed to be retained by the same facility and used for service delivery by that facility) provide an additional source of financing for provincial and district-level facilities. The MoF places restrictions and controls on both the amounts that can be collected and how those revenues can be spent. The lack of transparency around formally recording and reporting these revenues through PTs and DTs makes it difficult to quantify the amounts collected and how they are used at the facility level. PTs and DTs believe that the true level of technical revenues collected and used at the facility or HC level is several times higher than the amounts formally deposited and recorded with the PTs and DTs.

The first requirement under SBL 2015 is that the technical revenues must first be deposited intact into that facility's technical revenue subaccount at the nearest DT or PT, that is, the health facility cannot make payments from those cash receipts before depositing them with DT or PT. Second, the amount of technical revenue that can be collected from service users is limited to 12 percent of the approved budget. Unused technical revenues in one financial year can be carried over to the next financial year, provided they are deposited with and reported to the PT or DT in the correct financial year and budgeted for in the next financial year.

Based on revenues reported through DTs and PTs, technical revenues comprise only 3 percent of sources of finance available to HCs (World Bank, LEM, April 2017). However, it is widely accepted that health facilities and HCs formally report to treasury only a fraction of the true level of these revenues and retain the rest in cash to finance other expenses of the facility or HC. This would mean that health spending financed by technical revenues comprise a high proportion of discretionary spending at the facility or HC level (that is, excluding payroll costs).

Of course, it is the patients who present to the facilities or HCs who pay these fees as OOP expenditure; so, care needs to be taken before encouraging greater use of technical revenues. Even so, in terms of reasons given by patients for not seeking treatment (see chart below) according to the Fifth Lao Expenditure & Consumption Survey (LECS5) of 2014, only 9 percent said that they could not afford the treatment.

Figure 19. Reasons given for not seeking treatment when illness warranted treatment



Source: LECS5.

It is likely that the 9 percent would comprise the poorest segment of the population. The lack of transparency and accountability around technical revenues means that it is difficult to draw conclusions. There is also a lack of trust between PTs/DTs and the PHOs/DHOs about the scale and use of these revenues. As the coverage of the NHI expands and its impact on OOP becomes clearer, the MoH may be able to cooperate with the MoF Budget Department and Treasury Department to further refine their policies on technical revenues collected by health facilities and raise community awareness around NHI and rules surrounding fees charged by facilities.

The MoH should regularly monitor the impact of NHI on OOP spending and whether this in turn has any impact on technical revenue collection.

5.4.2.3 Reprioritizing Budgets at Facility Level Is Difficult

MoF and PFS rules limit the flexibility of facilities for purchasing and maintenance. Health facilities are not able to reprioritize their budgets to purchase or repair medical equipment because of MoF and PFS restrictions. This limits their ability to respond flexibly to local circumstances, including to the different levels of financing at different facilities from technical revenues, NHI, DRF, and private sector contributions. Even if facilities have a sufficient level of personnel and supply of drugs, they cannot provide the services to the level required without the necessary equipment. The NHI scheme also has its own set of restrictions on eligible expenditures that can be financed from NHI capitation-based payments.

5.5 Accounting and Reporting

5.5.1 National Level and MoH

Limitations of the Chart of Accounts (CoA) and the MoF GFIS will continue to impact on MoH in the short term. The current MoF-owned GFIS and associated CoA has significant limitations, including the following:

- The CoA does not support financial reporting by subsector, program, activity, or district-level reporting entities such as DHOs—limiting the MoH's ability to monitor budget execution for the health sector.
- The GFIS is not networked to PHOs or other sector agencies at the provincial level and is only networked to PTs and not DTs.
- The GFIS does not provide timely consolidated reporting for the MoH for in-year expenditure reporting against budget allocations.
- The GFIS does not provide annual financial statements consistent with international accounting or financial reporting standards.

As with other sectors (for example, education), the MoH is forced to maintain parallel but relatively inflexible Excel-based financial reporting systems to capture and report on spending by subsector, program, activity, or district. In addition, to meet MoF requirements for the introduction of double entry accounting and compliance with the journal and cash book requirements of the Handbook on Accounting, reliable and consistent record keeping is needed at the MoH central level and at health facilities in the provinces. As and when the MoF develop and implement a World Bank financed FMIS, MoH Excel based recording and reporting systems will be replaced.

5.5.2 Subnational Systems

The impacts CoA and GFIS limitations are greater at subnational level where financial management skills are lower. The limitations of accounting and financial reporting systems discussed previously for the MoH are the same for PHOs and DHOs. However, the financial management skills are lower at the subnational level, and even more so at facility or HC level, where technical revenues are first received

and recorded. All expenditure is recorded using either paper-based cash books, or Excel-based records, and often both. For audit or inspection purposes, many transactions must be recorded first in paper-based cash books where alterations are easier to detect. To allow reporting by subsector, program, or district, multiple versions of cash books are maintained, with the same data entered several times. This is a time-consuming and error-prone process. Excel does not facilitate upward consolidation of data from facilities and HCs to DHOs, and then to PHOs, and then to the MoH; so, the same data have to be entered multiple times by the small number of finance staff in each DHO or PHO.

6. Options for Consideration

This PFM in health assessment has identified a wide range of bottlenecks, constraints and issues that impact on service delivery in the health sector, particularly at health facility level. Some of these constraints are common across all sectors, and will require national level or whole of government actions led by central agencies such as MoF, MoHA or MPI. National, whole of government or macro level reforms are being supported by WB and ADB through other programs, including support for the Lao PFM Modernisation Program. Where these are relevant to the health sector and to addressing some of the bottlenecks or constraints discussed above, these have been summarised separately in Annex 6.

There have been two other recent and significant pieces of analysis of the health financing and public expenditure arrangements in the health sector. These are a) The Health Financing System Assessment (HFSA, December 2017), and b) The Education and Health Sectors - Public Expenditure Arrangements (PEA, June 2018). The recommendations from these two analyses are relevant to this PFM assessment, and to the policy options discussed below. Annex 7 summarizes the findings from the HFSA and the PEA, with cross references to those documents.

Other constraints discussed directly in this PFM in Health Assessment Report lend themselves more feasibly to actions or reforms that can be led by MoH and implemented in the health sector in the short to medium term, but will still require close cooperation with MoF and other central agencies. These are discussed immediately below.

Policy Recommendation 1: Develop a framework for internal MoH ceilings early in the budget cycle to guide preparation of baseline budget proposals to the MoF (and to guide activity plan preparation), with separately costed, targeted, and prioritized new policy proposals or budget briefs (short term).

At the central level MoF is planning to implement a new baseline approach to annual budget submissions to avoid annual ambit bids or wish-lists from line ministries and provinces. This would involve early notification of ceilings to MoH and other ministries by MoF. To take advantage of this MoF initiative and to ensure it can prepare the health sector at sub national level, MoH could take several early actions, including:

- MoH should build internal capacity for sectoral analysis, policy development, budget brief preparation, and negotiation with MoF;
- MoH work to strengthen its relationship with the MoF Budget Department officials to improve the MoF's understanding of health sector financing and the MoH medium-term budget strategy, and to allow the MoF to participate in the MoH's process of developing new policy proposals and budget submissions;
- The MoH could consider establishing a planning and budget committee to ensure recurrent and capital budgets strategies are consistent and prioritize the same goals, programs, and activities, consistent with the Health Sector Reform Strategy & Framework;

- The MoH should develop guidelines for and build capacity in PHOs on how to prepare and align their budget proposals with national priorities within internal MoH ceilings agreed early in the budget preparation process and not at the end;
- The MoH, led by the DPC, could establish a health worker allocation committee that would develop a workforce strategy that favors the districts and HCs most affected by the current uneven workforce distributions;
- With early knowledge of PHO level ceilings, MoH could encourage PHOs and DHOs to also consult with facilities and HCs early in the budget cycle, allowing those facilities and HCs to adjust their planned use of other sources of funding such as technical revenues, NHI, and private sector contributions.

MoH would require technical support to provide advice on and help coordinate these reforms with MoF. The World Bank PFM TA support to the MoF on budget reforms includes developing and implementing ministerial ceilings in the budget preparation process. At the health sector level, complementary support can be provided under the Health Governance and Nutrition Development Project (HGNDP) and the PASA TA to help strengthen MoH capacity on prioritization and resource allocation within ceilings.

Policy Recommendation 2: Improve MoH activity planning tools to provide greater flexibility and responsiveness to changes in ceiling or limitations to cash available through treasury (short to medium term).

Current MoH activity planning tools using Excel worksheets have significant limitations, and are not able to be quickly adapted to ceiling changes during budget preparation, or to cash flow limitations during budget execution. Until MoF are able to provide a longer term government wide solution to improve linkages between plans and budgets, MoH should consider the possibility of using a database planning tool, similar to that currently being tested by the DPC with ADB support. A centralized database tool with distributed access to MoH departments and PHOs will provide greater flexibility, and allow budget plans to be changed more easily and consolidated quickly at central level.

The World Bank PFM TA makes provision for development of tools for determining ceilings at the MoF Budget Department level. The ceilings will give more predictability to sectors for planning and allocating resources.

MoH needs to further divide the ministerial ceilings received from the MoF among its second-tier spending units that, among others, include PHO. PHOs need significant capacity strengthening to develop detailed and reliable proposals on time. The new Health and Nutrition Services Access (HANSA) project and PASA TA could support such efforts at PHO level.

Policy Recommendation 3: It is recommended that MoH engage early with MoF on the specifications and requirements for a new FMIS and Chart of Accounts to ensure that health sector needs are accommodated (short term).

As and when the MoF develop and implement a World Bank financed FMIS, MoH Excel based recording and reporting systems will be replaced. The MoH will need to transition from the use of various Excel systems to an automated system of record keeping and reporting. In preparation, it is essential for the MoH to proactively engage the MoF on its financial information needs so that this

will be considered as the FMIS specifications and chart of accounts requirements are developed. The need for disaggregated expenditure reports and ease of consolidation of such reports by disease, geography, or program from provinces and district health facilities should be part of this discussion.

Policy Recommendation 4: It is recommended that the MoH explores which donors have the flexibility to front-load their annual financing so that when cash shortages emerge at provincial treasuries, activity plans could be adjusted to bring forward the implementation of the donor-funded activities (short term).

Currently, when cash shortages arise at provincial treasuries, PHOs and DHOs have little alternative than to defer their outreach and other activity plans until later in the financial year. This can leave PHO and DHO resources idle early in the year, and overcommitted in the last two quarters of the year. Even though PHOs cannot vary the overall budget by chapter heading, they do have flexibility at the activity level, provided they are delegated the authority by the MoH, and provided they can quickly reschedule and re-cost the activity plan. By bringing forward some donor financed activities, this may give PHOs and DHOs more flexibility in the deployment of their resources between government financed and donor financed activities. This would require the revisions of activity plans, and so would be dependent on the implementation of a more flexible activity planning tool as per the previous recommendation.

Policy Recommendation 5: Strengthen financial management capacity at health facility level and quantify the impact of NHI implementation on OOP and technical revenue collection (medium term).

The lack of financial management capacity at health facility level and the failure to properly account for and manage receipt and use of technical revenues (including OOP amounts) and other revenues, contributes to a lack of trust between health facilities and DHOs on the one hand, and provincial and district treasuries on the other, as to the true level of resources available to DHOs and health facilities. The NHI scheme may progressively impact on the level of OOP spending at health facility level. The MoH should also work with NHIB to regularly monitor the NHI implementation as well as the impact of NHI on OOP spending, and whether this in turn has any impact on technical revenue collection.

Technical assistance will be required to develop financial record keeping and reporting templates, and to provide financial management training of staff at relevant facilities. Some advisory assistance may also be required to work with the MoH DoF. This can be supported through the new health operation: HANSA project that is under preparation.

Policy Recommendation 6: MoH could work with the MoF, MPI and Government leaders to ensure that the MoH has greater influence and control over policy and program prioritization at the sub-national level (short term).

The MoH should take steps to identify the nature of the protected status enjoyed by the education sector and further explore whether health could operate within the same framework. This would allow the MoH and PHOs to finalize their detailed activity plans as soon as the NA approves the budget in November or December, and not have to wait until the provincial government approval in February, i.e. two months after the commencement of the financial year.

The MoH DPC and DoF should consult directly with the MoF and MPI at first instance, but the nature of this reform may also require consultations by Minister of Health with other Government leaders. Advisory support can be provided through ongoing TA and capacity-building support for Health Financing Reforms under the Lao Health PASA.

7. Annexes

Annex 1 – Bibliography

Barroy, Hélène, Joseph Kutzin, Ajay Tandon, Christoph Kurowski, Geir Lie, Michael Borowitz, Susan Sparkes, and Elina Dale. 2018. "Assessing Fiscal Space for Health in the SDG Era: A Different Story." *Health Systems & Reform* 4:1, 4-7. DOI:10.1080/23288604.2017.1395503.

Lao PDR Health Systems Review, Asia Pacific Observatory on Health Systems and Policies, Health Systems in Transition, Vol. 4 No. 1, 2014.

Ministry of Health, Annual Report on the Implementation of Health Insurance 2017 and Workplan for 2018, MoH, June 2018.

Ministry of Health, Health Sector Reform – Strategy and Framework Till 2025, 2016.

Ministry of Health, National Insurance Strategy 2017-2020, September 2017.

Qian, Yi, Fei Yan, Wei Wang, Shayna Clancy, Kongsap Akkhavong, Manitrhon Vonglokham, Somphou Outhensackda, and Trus Ostbye 2016. *Challenges for Strengthening the Health Workforce in Lao PDR.* Human Resources for Health.

Schiavo-Campo, S. 2017. *Government Budgeting and Expenditure Management.* Routledge, New York.

Tandon, A, and C. Cashin. 2010. "Assessing Public Expenditures on Health from a Fiscal Space Perspective." HNP Discussion Paper, World Bank, Washington, DC.

Welham B., T. Hart, S. Mustapha, S. Hadley. 2017. *Public Financial Management and Health Service Delivery.* ODI.

World Bank, Action Plan for Expansion of the Chart of Accounts, October 2018.

World Bank, Lao Economic Monitor, April 2017.

World Bank, Lao Economic Monitor, June 2018.

World Bank, Lao PDR Health Centre Workforce Survey, May 2016.

World Bank, The Lao PDR Public Expenditure and Financial Accountability Assessment, June 2010.

World Bank, Managing Transition, Reaching the Vulnerable While Pursuing UHC, December 2017.

World Bank, PFM in Health, Assessment Toolkit.

World Bank, PFM in Health, Conceptual Framework, Draft, November 2016.

World Bank, Public Expenditure Analysis, Education and Health Sectors, June 2018.

World Bank, Public Expenditure Analysis Synthesis Note, May 2018.

World Bank, Transition Planning for Upgrade and COTS FMIS Acquisition, October 2017.

World Health Organization, Global Strategy on Human Resources for Health, Workforce 2030, 2016.

Annex 2 – Summary Findings from the PFM Health Assessments

UDOMXAY Province

Summary Findings from the PFM Health Assessment Survey

Key indicators:

	2015	2016	2017
Population	307,622	312,236	316,920
Provincial government expenditure (LAK, millions)	442,119	449,774	488,357
Per capita health expenditure per capita (LAK)	110,150	113,033	90,518

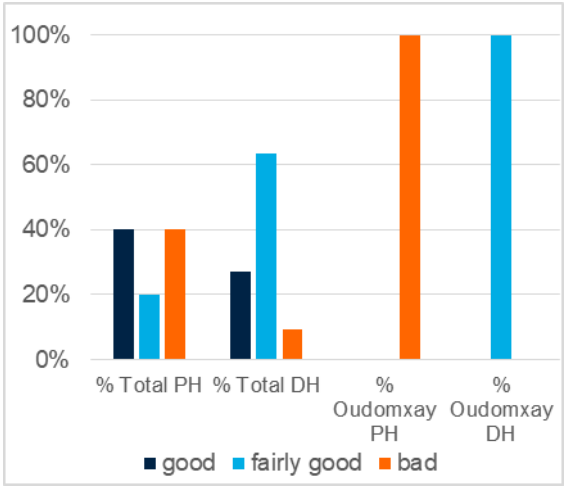
Health Outcomes	2017	Service Delivery	2017
Infant mortality rate	68	Antenatal care (ANC) (1–3 visits)	26.4
Under-5 mortality rate	71	Skilled birth attendance	56.1
Stunting rate (below -2SD)	42.7	Immunization coverage	23.9

List of Facilities Surveyed:

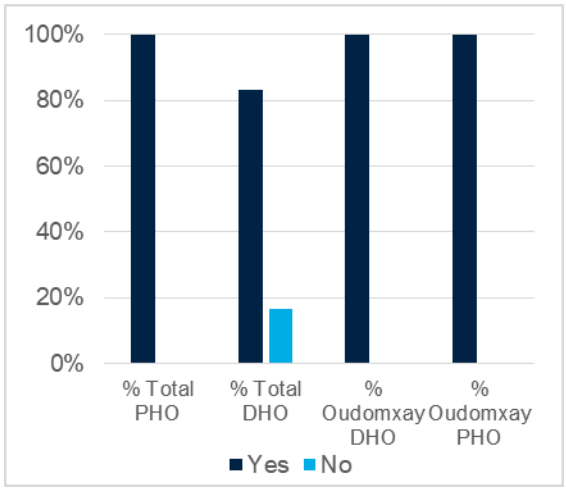
1. Udomxay Provincial Health Office
2. Udomxay Provincial Hospital
3. Houn District Health Office
4. Houn District Hospital
5. Pakbeng District Health Office
6. Pakbeng District Hospital
7. Kokka Health Center
8. Sinxay Health Center
9. Naxiengdee Health Center
10. Sibounheuang Health Center

Summary Data and Key Findings:

A. Is the PH and DH's budget for maintenance objects/equipment enough?

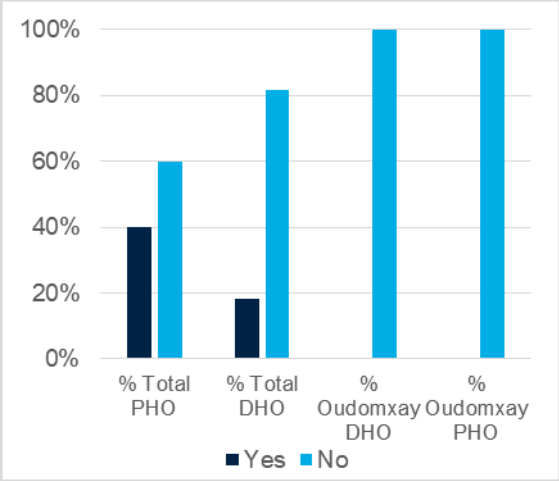


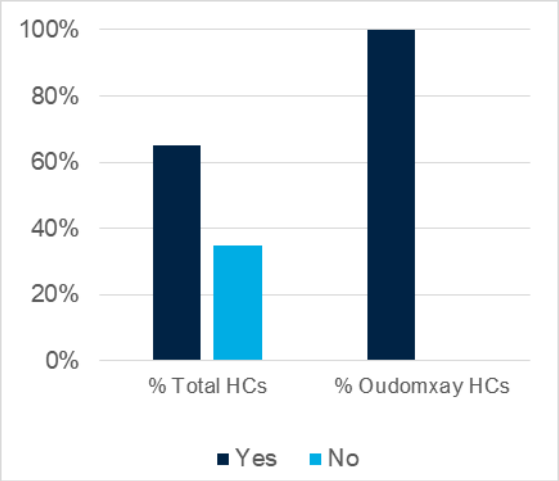
B. Do the PHO/DHOs receive the financial reports from the PH/DHs?



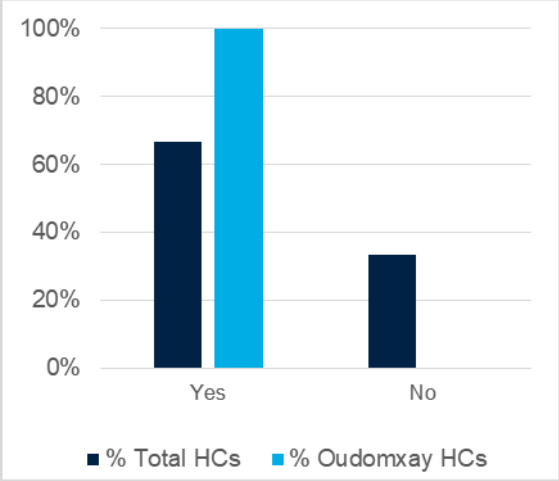
C. Do the PHO and DHOs have any revenues from service fees?

D. Does your HC have any consultative meeting on budget plan negotiation/defense?

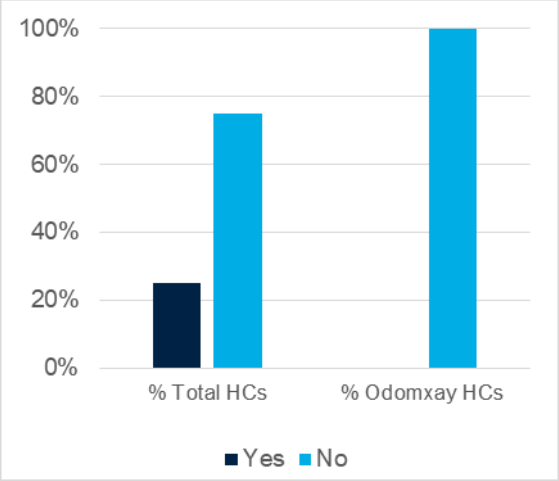




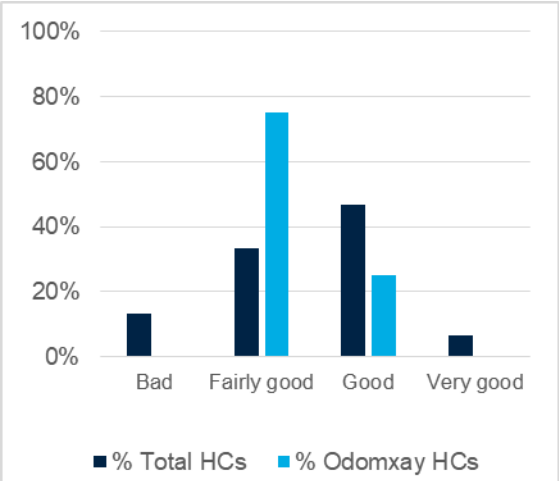
E. Is your facility involved in state budget planning?



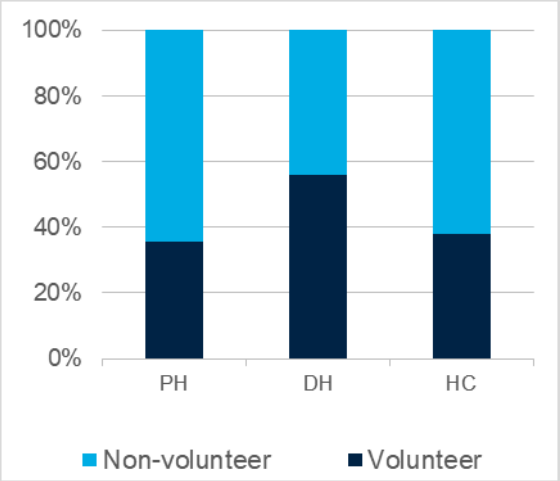
F. Does your HC have a treasury account?



G. Is the budget for maintenance objects/equipment enough?



H. Volunteer versus non-volunteer staff



Key Qualitative Findings:

- Since there is no specified financial worker and no financial training available to HCs, when the district health officials carry out visits or follow up visits, they not only provide technical advice but also provide advice, support, and checks on accounting and reporting.
- No road, electric, water system, and Internet connection are available to some HCs. Some roads cannot be used during the rainy season, therefore the number of the third and fourth ANC visits, and delivery at a facility are very low compared with number of registered pregnant women and the 1–2 ANC.
- Many volunteers remain as unpaid volunteers for many years because they do not obtain a paid position through the annual quota for paid government positions.
- Revenue collected is a very small amount because people qualify for exemption when they are attending for delivery or when they are children under 5 and so on.
- Facilities are not involved in annual plan formulation. They just unofficially submit their needs to the DHO for chapter 63.
- HCs receive cash and materials for their regular program as planned
- No health activities are carried out in quarter 1 and 2 because there is no budget. The activities planned are postponed to quarter 3 and 4.
- The PPA session can convene after the NA, around January to February; therefore, after that all provincial sectors, including at the district level, need to visit and revise their plan. The sectors and districts need to discuss and work closely; normally the PHO calls DHOs for a financial and planning meeting, and at district level it conducts the same kind of meeting, calling facilities to revise their activity plan after they got a figure from the provincial-level meeting. this is the reason the local plan implementation is delayed.
- There is no procurement or purchasing at HCs. In hospitals, a purchase system is operational with a limited amount based on the decision of the local government and its committee and a process under health office advices. Hospitals prepare purchase proposals and logistic arrangements and the health office is the key member in the committee and takes the lead during the process. Rules of purchase referring to the decree on government procurement of goods, works, maintenance, and services no. 03/PM dated January 9, 2004; implementing rules and regulations on decree of government procurement of goods, works, maintenance and services no. 063/MoF, dated March 12, 2004 and no. 0861/MoF, dated May 5, 2009 (amended version).
- Commonly the PHO plans to visit districts in each quarter to monitor the plan and budget implementation. However, in fact, it could make visits only one or twice per year due to limitation of budget and workers.
- The reports from facilities are written in different formats.

Further Comments

- Since both provincial and district levels use the same national accounting system, but recording in Excel files for vertical (health) and horizontal (finance) lines are different, this involves double the work. It will be better if the Excel files are revised and can be used as one pattern for both lines (MoH and MoF);

- More trainings are needed on the financial management system at both district level and provincial level;
- The NHIB budget is late, and calculation/payment by case is not so appropriated.

Xayabuly Province

Summary Findings from the PFM Health Assessment Survey

Key indicators:

	2015	2016	2017
Population	381,376	385,954	390,584
Provincial government expenditure (LAK, millions)	464,060	4 79,182	534,343
Per capita health expenditure (LAK)	161,819	141,061	185,046

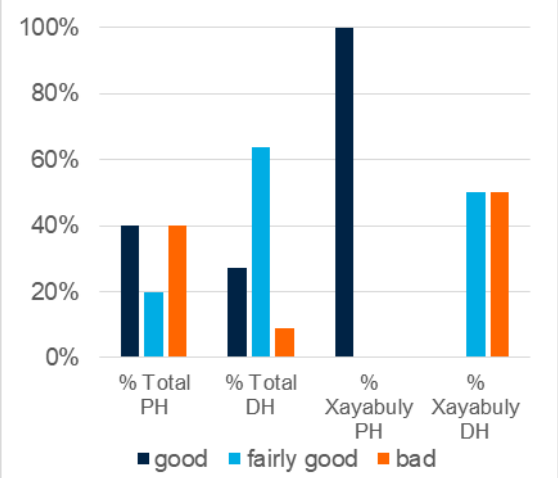
Health Outcomes	**2017**	**Service Delivery**	**2017**
Infant mortality rate	9	ANC (1–3 visits)	6.8
Under-5 mortality rate	11	Skilled birth attendance	81.5
Stunting rate (below -2SD)	25.1	Immunization coverage	68.1

List of Facilities Visited:

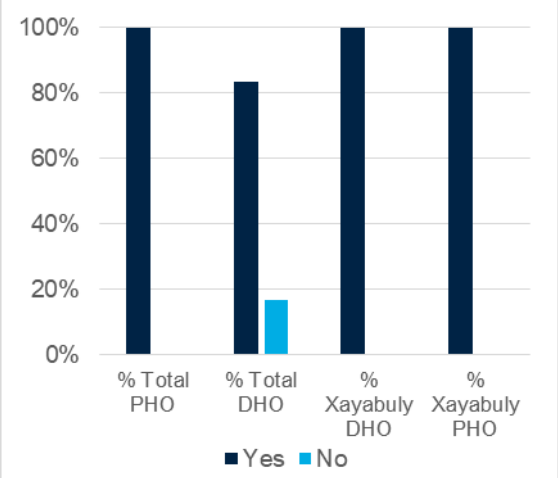
1. Xayabuly Provincial Health Office
2. Xayabuly Provincial Hospital
3. Kaenthao District Health Office
4. Kaenthao District Hospital
5. Phieng District Health Office
6. Phieng District Hospital
7. Pakkhem Health Center
8. Houylerk Health Center
9. Naxeuang Health Center
10. Phong Ang Health Center

Summary Data and Key Findings:

A. Is the PH and DH's budget for maintenance objects/equipment enough?

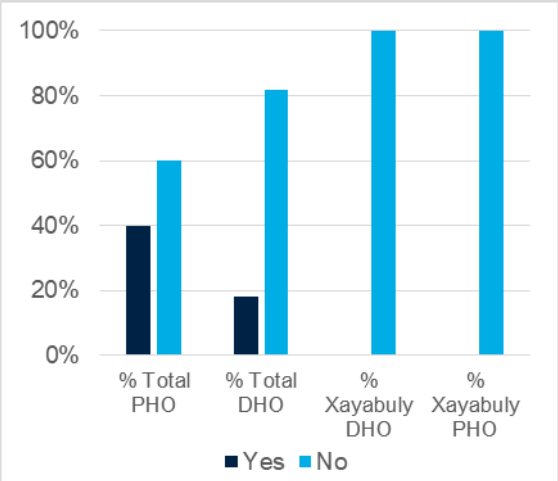


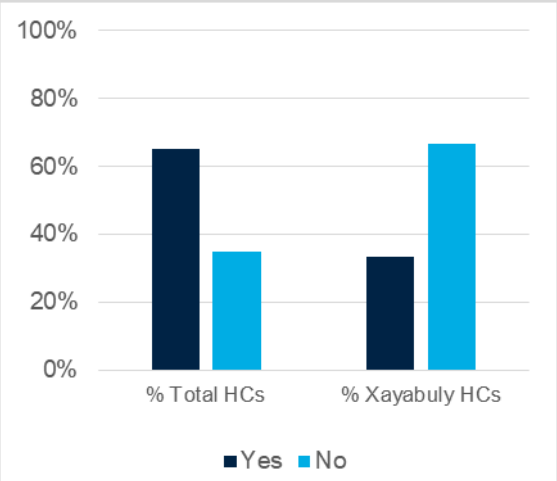
B. Do the PHO/DHOs receive the financial reports from the PH/DH?



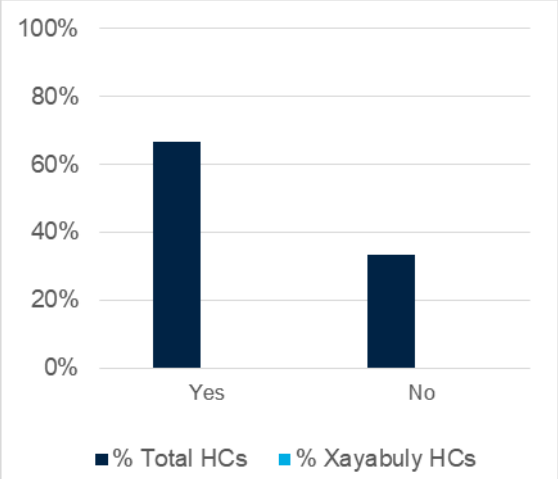
C. Do the PHO and DHOs have any revenues from service fees?

D. Does your HC have any consultative meeting on budget plan negotiation/defense?

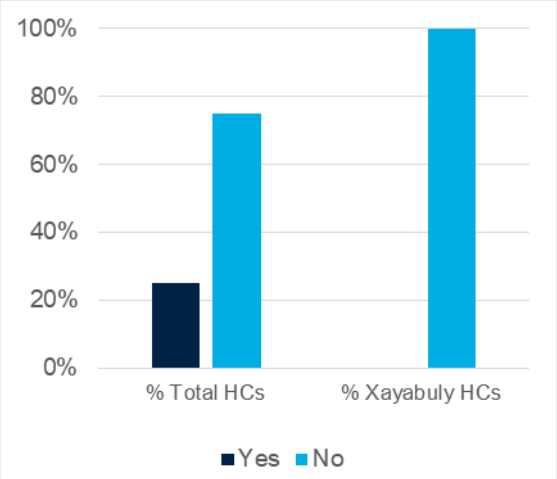




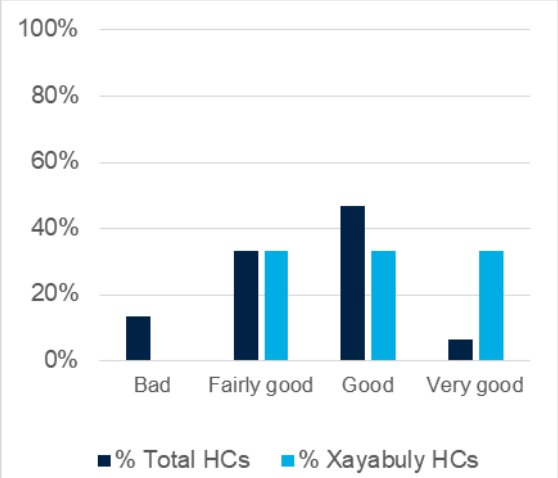
E. Is your facility involved in state budget planning?



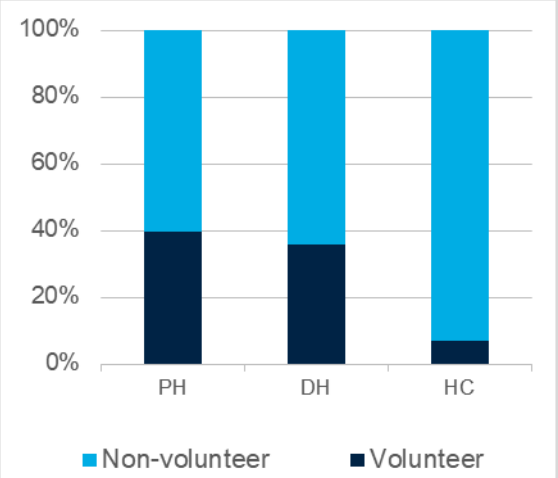
F. Does your HC have a treasury account?



G. Is the budget for maintenance objects/equipment enough?



H. Volunteer versus non-volunteer staff



Key Qualitative Findings:

- Some new buildings were constructed for HCs.
- Technical revenue is a small amount in HCs.
- The PHO and DHOs commonly manage and do accounting for DHs and PHs.
- Common transactions are processed through the NT account.
- Regulation on actual budget spending is not regularly conducted.
- The PHO proceeds with the procurement of drugs.
- The provincial planning and investment office must try hard to negotiate with the governor to maintain 9 percent of the total government budget.
- No financial staff are trained at HC.
- Because of the long distance from HCs to DHs and PHs, patients are treated as outpatients.
- Technical revenue is a small amount.
- HCs and hospitals are not involved in annual plan formulation. They unofficially make a request for their needs to health district office for chapter 63.
- Some program funds are transferred via commercial bank.
- No procurement or purchasing is done at HCs.
- Some HCs proceed with birth delivery and operations which are supposed to be done at hospitals.
- Sometimes donor's support is received off budget.
- There are few staffs compared to the workload at each level.
- There are no volunteers because there is insufficient revenue to hire extra staff.
- Water and electricity bills are paid by the DHO.
- Medical doctors are lacking, and there is high potential for reallocating the existing doctor.
- The data system sometimes does not work; thus they must wait for district staff to come and fix it.

Further comments

- Cleaning and hygiene cost is from technical revenue, which sometimes is off budget.
- Monthly income is standard but different location have different living standards.
- No exact accounting book is available at different facilities.
- Facilities strongly need accounting training and a simplified reporting system.

Bolikhamxay Province

Summary Findings from the PFM Health Assessment Survey

Key indicators:

	2015	2016	2017
Population	273,691	279,165	284,749
Provincial government expenditure (LAK, millions)	442,119	449,774	488,357
Per capita health expenditure (LAK)	137,077	173,048	184,380

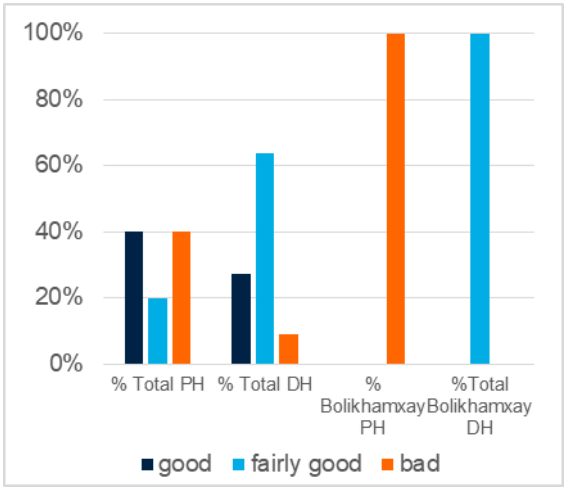
Health Outcomes	2017	Service Delivery	2017
Infant mortality rate	40	ANC (1–3 visits)	21.7
Under-5 mortality rate	42	Skilled birth attendance	78.4
Stunting rate (below -2SD)	29.9	Immunization coverage	74.9

List of Facilities Visited:

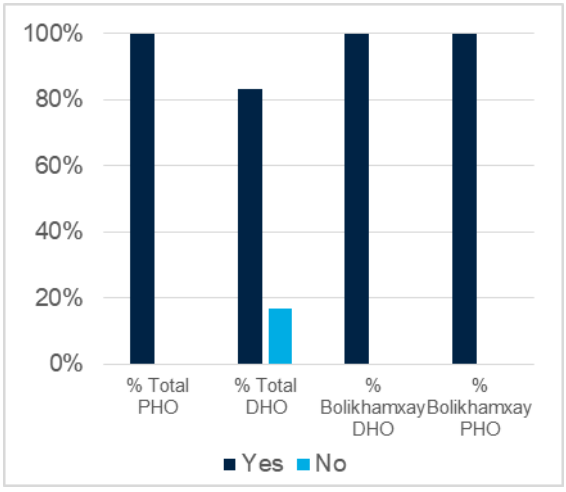
1. Bolikhamxay Provincial Health Office
2. Bolikhamxay Provincial Hospital
3. Pakkading District Health Office
4. Pakkading District Hospital
5. Khamkeuth District Health Office
6. Khamkeuth District Hospital
7. Pakkading Health Center
8. Nong Or Health Center
9. Namthone Health Center
10. Kengdeng Health Center

Summary Data and Key Findings:

A. Is the PH and DH's budget for maintenance objects/equipment enough?

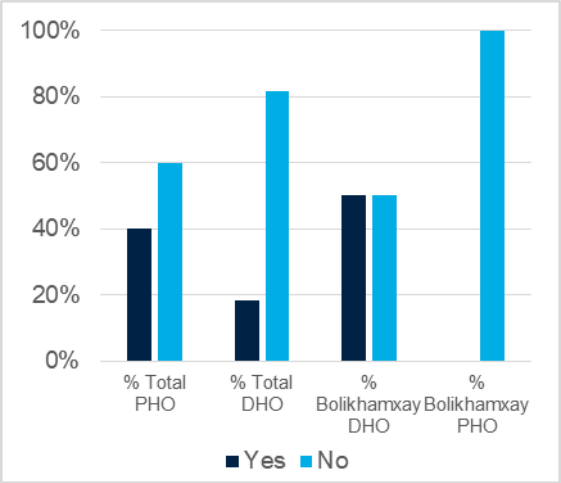


B. Do the PHO/DHOs receive the financial reports from PH/DH?

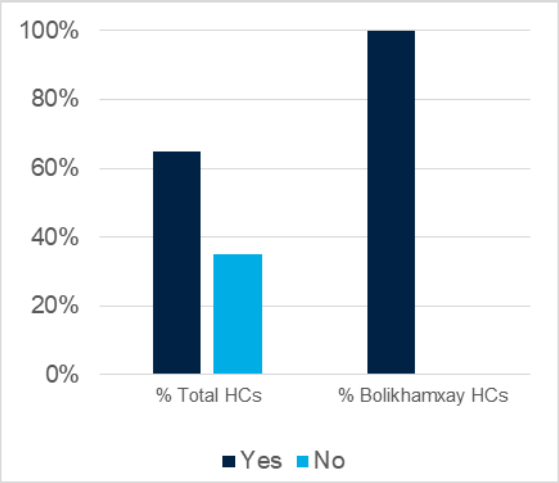


C. Do the PHO and DHOs have any revenues from service fees?

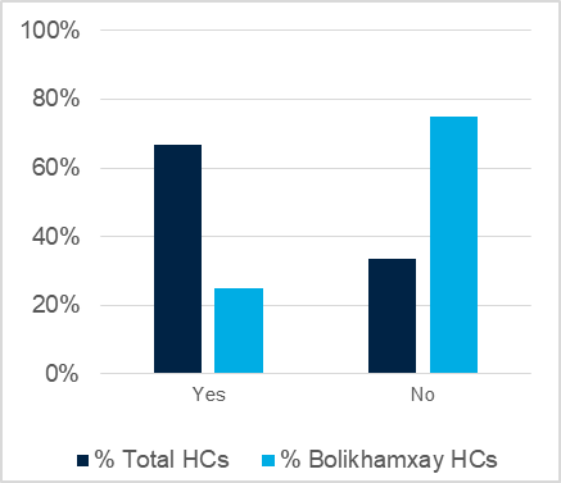
D. Does your HC have any consultative meeting on budget plan negotiation/defense?



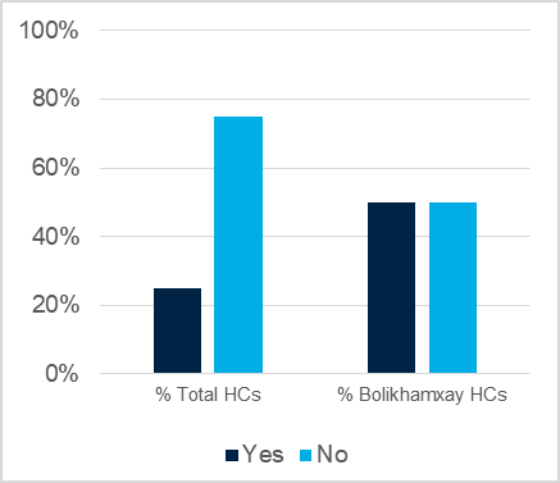
E. Is your facility involved in state budget planning?



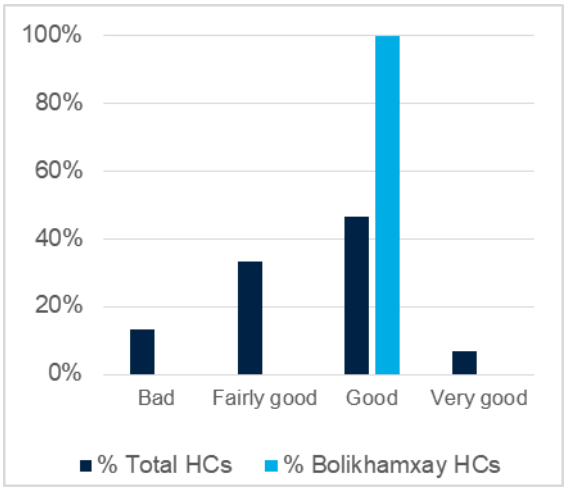
F. Does your HC have a treasury account?

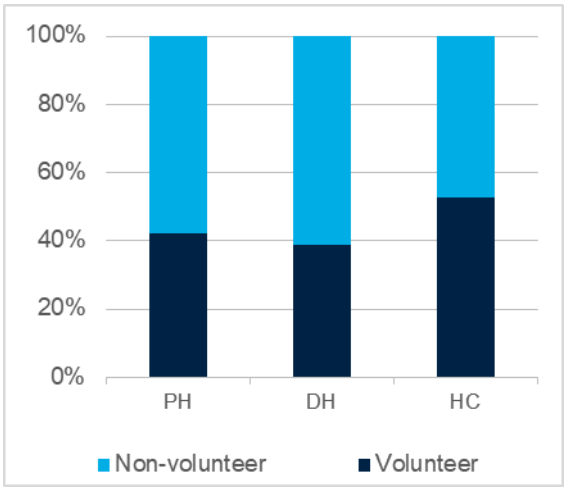


G. Is the budget for maintenance objects/equipment enough?



H. Volunteer versus non-volunteer staff


100%
80%
60%
40%
20%
0%
Bad
Fairly good
Good
Very good
% Total HCs
% Bolikhamxay HCs


100%
80%
60%
40%
20%
0%
PH
DH
HC
Non-volunteer
Volunteer

Key Qualitative Findings:

- HCs have no staff who are qualified in finance/accounting and no financial training or very limited training is provided to those in charge of accounting.
- Many volunteers, especially at hospitals, have been volunteers for many years and have not yet got a quota position to be government officials.
- Revenues collected are very small amounts from health service fees because all areas are covered by free services, and the little revenue collected is from full charge for people who have no evidence or proof that they are living within the service area.
- Facilities are not involved in annual plan formulation. They unofficially propose their needs to a health office such as for maintenance, small repair, and office items.
- Budgets come to facilities very late; so they cannot implement activities on time.
- HCs have no account with the NT. Although hospitals have their NT account those accounts are used for deposit of revenues. To withdraw money, they have to present many documents through the health office to the finance office and then end at the NT.
- No procurement or purchasing is done at HCs. In hospitals, a purchase system is operational with a limited amount based on the decision of the local government and its committee and processed under health office advices.
- No specific monitoring and evaluation of budget implementation is done at the district level.
- Visits are regularly planned from the health office to facilities. They are planned monthly or depend on budget availability.
- Rules of purchase referring to the decree on government procurement of goods, works, maintenance and services no. 03/PM dated January 9, 2004; and implementing rules and regulations on decree of government procurement of goods, works, maintenance and services no. 063/MoF, dated March 12, 2004 and no. 0861/MoF, dated May 5, 2009 (amended version). The health office is the key member of the committee and for decision making.
- Regional inspection and central state audit organizations conduct monitoring and evaluating with the PHO regularly, once or twice per year (after 6 months and 12 months of implementation).
- Facilities at the district level cannot write reports; so the health office helps with writing monthly reports.

Further Comments

- HCs have difficulty in finance tasks because the limited number of accounting staff have difficulty in claiming budget from the NHI and SSO, always with a delay.
- A comprehensive PFM system covering documentation, including reporting, is needed.
- A financial management program and Excel system, including accounting tools, are needed.

Saravane Province

Summary Findings from the PFM Health Assessment Survey

Key indicators:

	2015	2016	2017
Population	396,942	404,880	412,979
Provincial government expenditure (LAK, millions)	435,807	4 26,597	435,526
Per capita health expenditure (LAK)	125,691	115,372	127,222

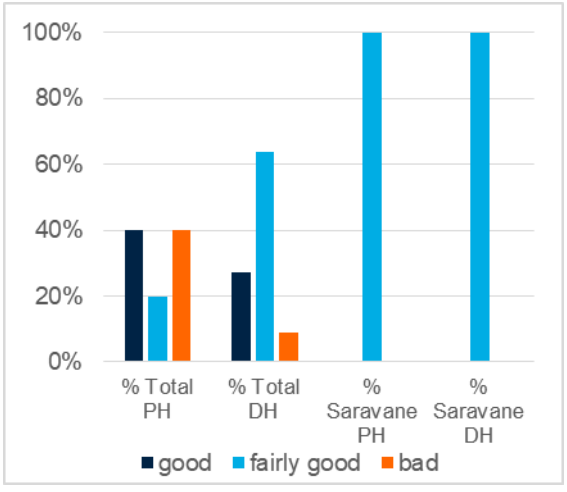
Health Outcomes	2017	Service Delivery	2017
Infant mortality rate	50	ANC (13 visits)	30.7
Under-5 mortality rate	54	Skilled birth attendance	53.9
Stunting rate (below -2SD)	42.9	Immunization coverage	48.9

List of Facilities Visited:

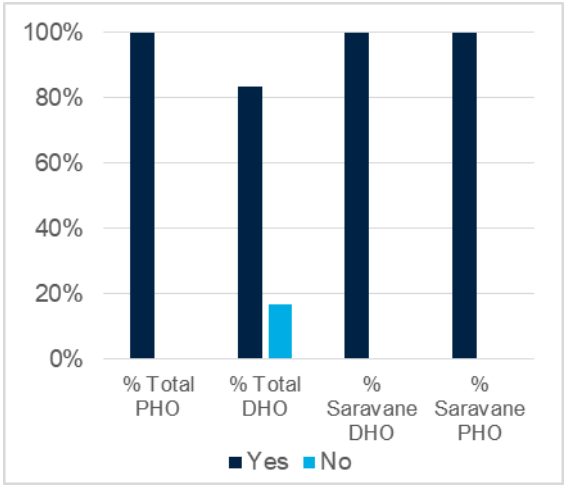
1. Saravane Provincial Health Office
2. Saravane Provincial Hospital
3. Lakhonepheng District Health Office
4. Lakhonepheng District Hospital
5. Khongxedon District Health Office
6. Khongxedon District Hospital
7. Khamthong Health Center
8. Luk 9 Health Center
9. Thaluang Health Center
10. Nadu Health Center

Summary Data and Key Findings:

A. Is the PH and DH's budget for maintenance objects/equipment enough?

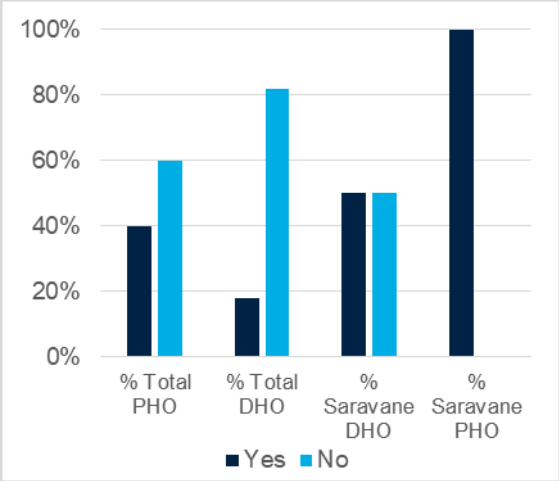


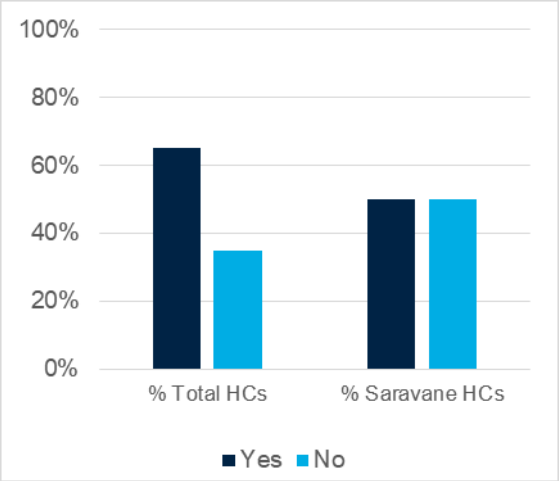
B. Do the PHO/DHOs receive the financial reports from PH/DH?



C. Do the PHO and DHOs have any revenues from service fees?

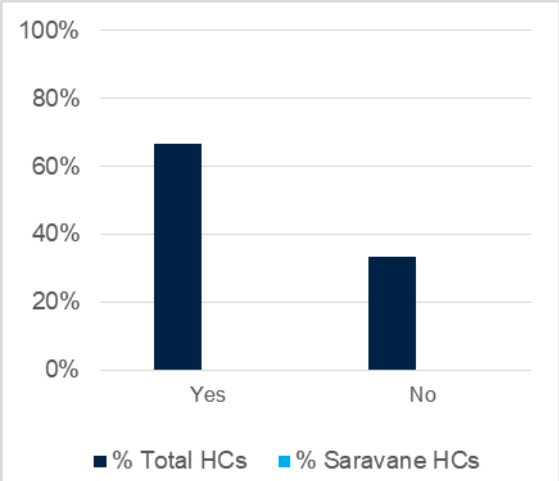
D. Does your HC have any consultative meeting on budget plan negotiation/defense?

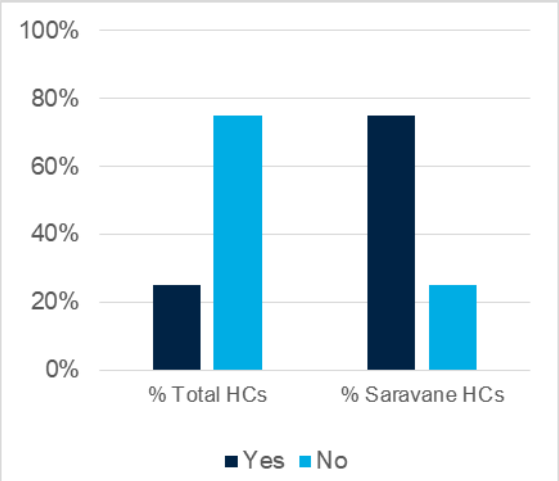




E. Is your HC involved in state budget planning?

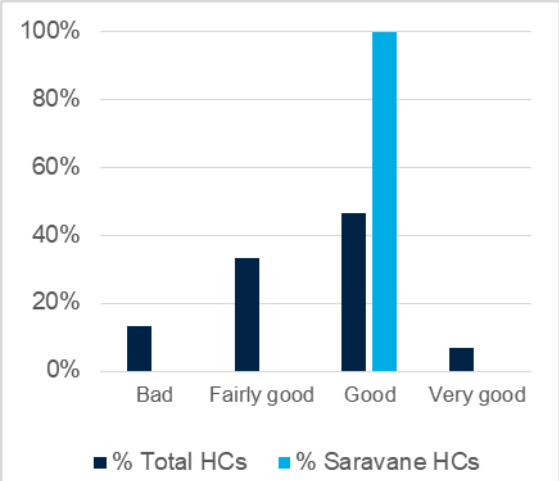
F. Does your HC have a treasury account?

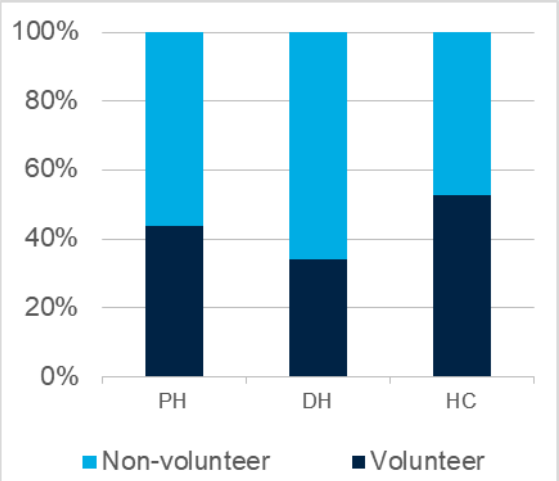




G. Is the budget for maintenance objects/equipment enough?

H. Volunteer versus non-volunteer staff





Key Qualitative Findings:

- There are no staffs who are qualified or skilled in finance/accounting and no financial training or very limited training is provided to those in charge of accounting.
- Many volunteers, especially at hospitals, have been volunteers for many years and have not yet got a quota position to be government officials.
- Since no specific finance staff are available at HC level, when district health officials follow up/visit HCs, they perform not only technical works but also tasks that are needed to support the accounting and reporting teams. DHOs have follow-up plans as monthly-basic plans, but many facilities are very difficult to access during the rainy season due to the road conditions.
- Revenues collected are very small amounts from health service fees and some charges are full charged to people who have no evidence or proof that they are living within the service area.
- Facilities are not involved in the annual plan process. They unofficially propose their needs to a health office for the activities under budget chapters 62 and 63.
- Almost no health service activities are implemented during the first half of the year because their action plan could be revised after the convening of the provincial assembly in March.
- The final approved budget by province is very low compared with the proposed plan. Therefore, big revisions need to be made for all districts while the financial process also takes too much time.
- HCs have no account with the NT and although hospitals have an NT account those accounts are used for deposit of revenues. The withdrawal has to proceed through the health office. Facilities would prepare a financial proposal and its plan which they would submit to the health office for endorsement and then the approved documents would be submitted to the finance sector for final processing.
- No procurement or purchasing is done at HCs. In hospitals, a purchase system is operational with a limited amount based on the decision of the local government and its committee and processed under health office advices. Hospitals shall prepare the purchase proposal and logistic arrangement while the health office is the key member in the committee and takes the lead during the process.
- No specific monitoring and evaluation of budget implementation is done at facilities. Regular follow-up programs are planned to facilities as monthly-basic or depending on budget. Similarly, the PHO plans to visit districts in each quarter to monitor the plan and budget implementation. However, in reality, it could visit one or twice per year due to limitation of budget and workers.
- Financial report formats (Excel files) from the health line and finance sector line are different so it results in double the work for facilities.
- Facilities at the district level cannot write reports; so the health office helps with writing monthly reports.

Further comments

- Facilities strongly need training on finance and accounting, computer skills, and a simplified financial management system.

- The NHIB budget is late and calculation/payment by case is not appropriate, and the NHI budget transfer from the central to provincial levels is very late;
- The budget to implement health service activities are late and it makes many activities to be implemented at the end of the year.

Champasak Province

Summary Findings from the PFM Health Assessment Survey

Key indicators:

	2015	2016	2017
Population	694,023	703,045	712,187
Provincial government expenditure (LAK, millions)	664,044	7 02,571	767,307
Per capita health expenditure (LAK)	120,688	109,893	62,963

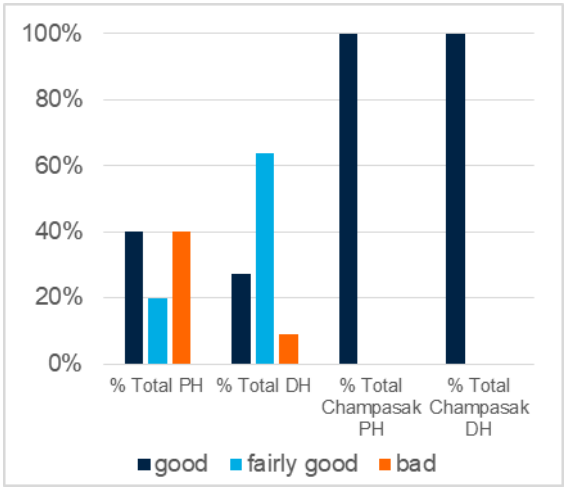
Health Outcomes	2017	Service Delivery	2017
Infant mortality rate	40	ANC (1–3 visits)	16.1
Under-5 mortality rate	45	Skilled birth attendance	52.6
Stunting rate (below -2SD)	24.6	Immunization coverage	50.6

List of Facilities Visited:

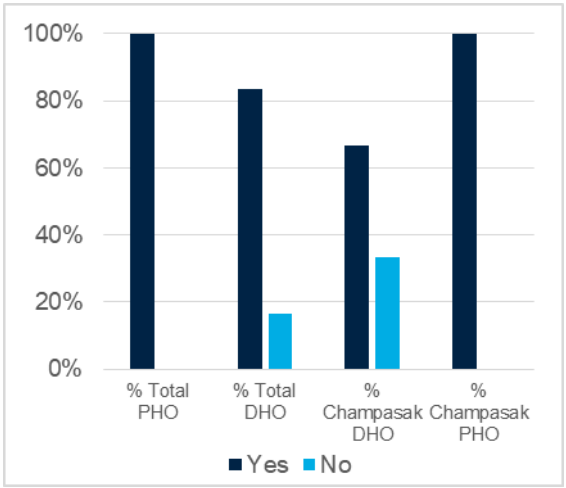
1. Champasak Provincial Health Office
2. Champasak Provincial Hospital
3. Paksong District Health Office
4. Paksong District Hospital
5. Xanasomboun District Health Office
6. Xanasomboun District Hospital
7. Champasak District Hospital
8. Champasak District Health Office
9. Nakeo Health Center
10. Sapphai Health Center
11. Etou Health Center
12. Nongvieng Health Center
13. Houyngern Health Center

Summary Data and Key Findings:

A. Is the PH and DH's budget for maintenance objects/equipment enough?

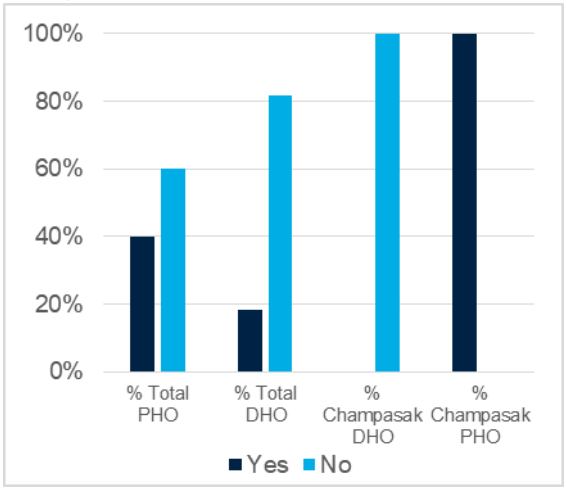


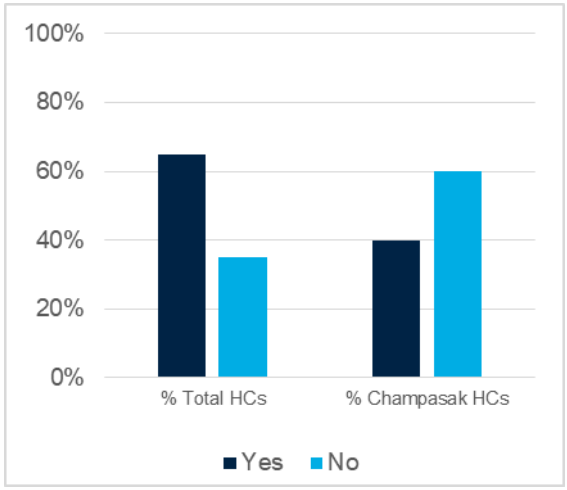
B. Do the PHO/DHOs receive the financial reports from PH/DH?



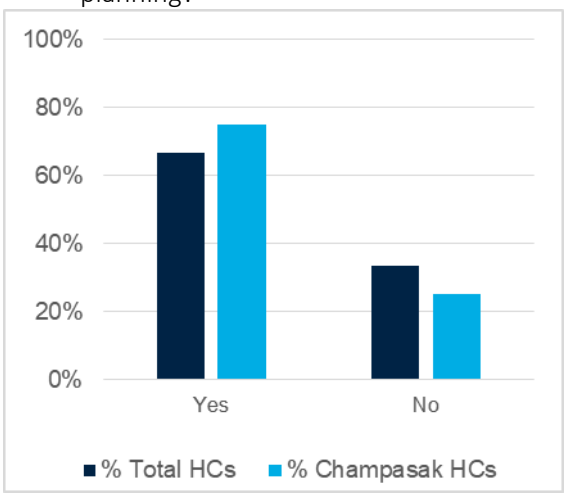
C. Do the PHO and DHOs have any revenues from service fees?

D. Does your HC have any consultative meeting on budget plan negotiation/defense?

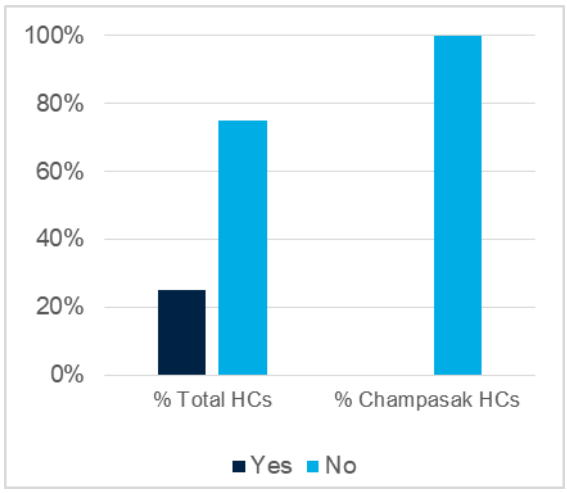




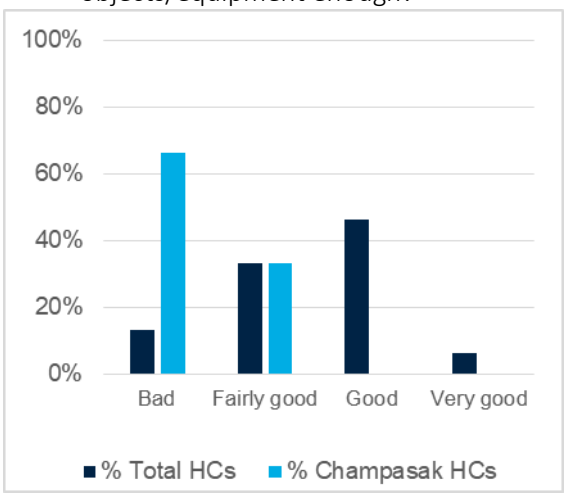
E. Is your facility involved in state budget planning?



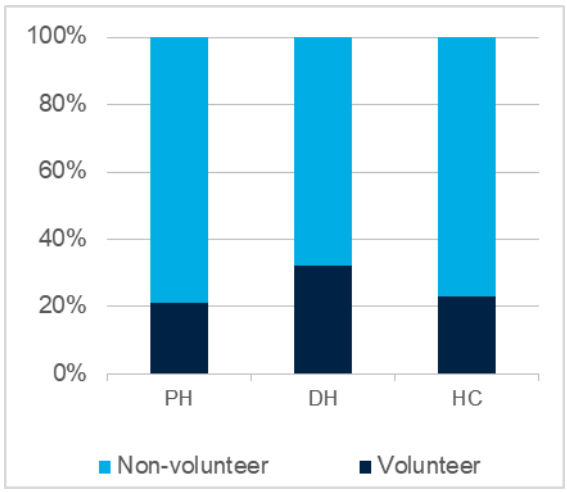
F. Does your HC have a treasury account?



G. Is the budget for maintenance objects/equipment enough?



H. Volunteer versus non-volunteer staff?



Key Qualitative Findings:

- There are no staff who are qualified or skilled in finance/accounting and no financial training, and many volunteers for many years have not got a quota position to be government officials.
- Revenue collected is a very small amount and recorded between the HC and DHO, and cash is deposited into an NT account through DHO-finance.
- Facilities are in not involved in annual plan formulation. They unofficially request for their needs to a health office for activities under the budget chapter 62 and 63.
- There is no budget to implement activities in quarter 1 and 2. Those activities are postponed to quarter 3 and 4 because the budget comes late;
- Facilities' financial process is tight and strictly with the health office.
- Champak district uses one single account; it cannot secure the budget for the health sector.
- No procurement or purchasing is done at HCs and some limited amount procurement can be done in hospitals; its process must be worked through the health office only.
- Monthly reports, including financial aspects, among facilities are in different formats, and financial report formats (Excel files) from the health line and finance sector are different; so it is double the work for facilities.
- Since they handle the financial performance of facilities, health offices take on the task of planning, budgeting, and reporting for facilities under them, through their monthly/quarterly monitoring.
- Based on the new fiscal year (year calendar), the NA approves the overall figures and the provincial assembly needs to work on the provincial plan and budget allocation to provincial sectors and districts based on the provincial direction and policies. The provincial assembly session can do this after the NA, around January to February; therefore, subsequently all provincial sectors, including at the district level, need to revisit and revise their action plans. The sectors and districts need to discuss and work closely and normally the PHO calls DHOs for financial and plan meetings, and then at the district level also does the same thing, calling facilities to revise their activity plan, including their budget after they get actual figures from the provincial level. This is the reason the local plan implementation is delayed.
- The health sector gets a very limited budget (the health budget was cut by half by a provincial decision), which the sector has tried to allocate into salaries (chapter 60 and 61).
- Commonly, the PHO plans to visit districts each quarter to monitor the plan and budget implementation. However, in fact, it could make these visits only one or twice per year due to limitation of budget and staff.
- The quarterly, 6-month, and annual reports are also prepared by the DHOs and submitted to the PHO for consolidating and submitting to the central level.

Further Comments

- At facilities, especially the HCs, there are many books that need to be completed, at the same time the health workers have to fulfil their health care job.
- Financial records also require filling up into many different files/formats.

- At HC level, health workers have no computer skill including the accounting team; so it has strongly requested training.
- The NHIB budget is late and calculation/payment by case is not so appropriate, and the NHI budget transfer from central to province levels is very late.
- Payment for overtime work at facilities is also late.

Annex 3 – Survey Questionnaires

PFM Assessment Questionnaire

For HCs

Name of health center: ..... District: ……..; Province: ……..

Name of respondent: ……., Position: ……..

Contact number:…….. Email: ……

Interview start time: ……

Part A: General information

Questions	Answers
1. How many officials and volunteers are there in your facility?	Officials: …….. persons. Volunteers: …….. persons. Number of physicians:……., number of nurses: …….. Number of primary care:……., number of midwives: …… Number of village care (if there is): ……., other: ……..
2. What is the estimated number of trained staff required? (this depends on the area of staffing shortage indicated)	……persons
3. What are the incentives to attract skilled staff to positions in difficult-to-reach locations? - What is the level of morale among staff in difficult-to-reach locations? Any records on staff turnover in the health sector?	Please explain: …… …… Please explain: …… ……
4. Are there any records on staff absenteeism?	☐ Yes ☐ No

<table>
<tr><td>- What are the most common reasons cited for absenteeism?</td><td>Please explain:
……
……</td></tr>
<tr><td>5. Are different persons responsible for finance, planning, and accounting?</td><td>☐ Yes ☐ No
Please explain:
……
……</td></tr>
<tr><td>6. Does the person in charge of finance have a degree in finance/accounting?

- If not, how much training has he/she received in finance/accounting?</td><td>☐ Yes ☐ No

- Number of received trainings: ……
Number of days of the received trainings:<table><tr><td>Training</td><td>Number of days</td></tr><tr><td>Training 1</td><td></td></tr><tr><td>Training 2</td><td></td></tr><tr><td>Training 3</td><td></td></tr></table></td></tr>
<tr><td>7. How many villages are covered by this facility? How many villages are in Zone2 and Zone3?</td><td>Number of villages covered: ……
Zone2: …… and Zone3: ……</td></tr>
<tr><td>8. What percent of the population has physical access/proximity to this facility?
(% of patients out of total population in catchment area used this facility during the most recent year).
(Please provide copies of 2017 report)</td><td>Information of 2017:
Total population in catchment area: …….
Total patients used services during the most recent year: ……
OPD: ……. (total amount of contribution:……..kip)
IPD: ……. (total amount of contribution:……..kip)
NHI: ……. (total amount of contribution:……..kip)
SASS: ……. (total amount of contribution:……..kip)
SSO: ……. (total amount of contribution:……..kip)
100% paid by patient: ……. (total amount of contribution:……..kip)</td></tr>
</table>

9. Are there service delivery indicators that are periodically monitored and published? - If any, please explain?	☐ Yes ☐ No Please explain: …… ……
10. Is there any cooperation with private sector in health service delivery? - If any, what are they?	☐ Yes ☐ No Please explain: …… ……

Part B: Public Financial Management

Questions	Answers
I. Fund Sources	
1. What sources of fund does your facility receive? *[multiple answers are applied]*	☐ Salary and employee allowance (60) ☐ Compensation and policy allowances (61) ☐ Operation expenditure (62) ☐ Technical activities, subsidies and contributions (63) ☐ Financial expenditure (64) ☐ Other expenditures (65) ☐ New purchase for operation (66) ☐ Capital expenditure (67) ☐ Technical Revenue or Drug Revolving Fund: …… ☐ NHI

<table>
<tr><td></td><td>☐ SASS
☐ SASS
☐ Vertical program (HIV/EPI/TB....)
☐ Grant Aid (not included in chapter 67) (name of donor): ……
☐ Others (specify): ……</td></tr>
<tr><td>2. How does your facility receive these funds? Who does the disbursement?</td><td>
<table>
<tr><td>Type</td><td>Source</td><td colspan="2">Disbursement unit</td></tr>
<tr><td>Cash</td><td>Ex: 62, 63, ….</td><td colspan="2"></td></tr>
<tr><td>Transfer through NT</td><td>NHI, …….</td><td colspan="2"></td></tr>
<tr><td>Transfer through commercial bank</td><td>60, 61, …..</td><td colspan="2"></td></tr>
<tr><td>Other:……</td><td></td><td colspan="2"></td></tr>
</table>
</td></tr>
<tr><td>3. How often does your facility receive the funds?</td><td>
<table>
<tr><td>Period</td><td>Source</td><td colspan="2">Receive on time?</td></tr>
<tr><td>Monthly</td><td>60, 61, ….</td><td>Yes</td><td>No</td></tr>
<tr><td>Quarterly</td><td>62, 63, ….</td><td></td><td></td></tr>
<tr><td>Every 6 months</td><td></td><td></td><td></td></tr>
<tr><td>Yearly</td><td></td><td></td><td></td></tr>
<tr><td>Activity based</td><td></td><td></td><td></td></tr>
<tr><td>Other: ……..</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td><<Technical revenue>></td><td></td></tr>
</table>

4. What revenues are generated by your health facility? *[multiple answers are applied]*	☐ Service fee ☐ Drug and medical equipment ☐ Others (specify)……
5. Does your facility submit the financial report (collected service fee and its spending) to DHO?	☐ Yes ☐ No
6. Are those revenues recorded on-budget? – if no, why?	☐ Yes ☐ No Explain: …… ……
7. How do you record your facility revenues? *[multiple answers are applied]* (Please provide copies, if any)	☐ Paper-based ☐ Excel ☐ Accounting software (specify): …… ☐ Other (specify): ……
8. Where does your facility keep the revenue? *[multiple answers are applied]*	☐ DHO ☐ District-NT (DFO) ☐ Bank ☐ Other (specify): ……
9. What type of expenditure is your facility's revenue earmarked for?	Explain: …… ……
10. Who is the final approver for this revenue spending?	
11. What is the rule to manage this revenue?	Explain: …… ……
12. Are there written procedures for petty cash management?	☐ Yes ☐ No Explain: …… ……

- if yes, how adequate are these procedures in ensuring that cash and check assets are safeguarded and appropriate records maintained?	
II. Annual budget plan formulating and executing	
13. Is your facility involved in state budget planning? – if yes, what is your facility's involvement?	☒ Yes ☐ No (If no, skip number 14 – 20) Explain: …… ……
14. Is technical revenue included in the annual budget plan? - How do you calculate/estimate the revenue? And what chapter is it included into?	☐ Yes ☐ No Please explain: …… ……
15. Are there any guidelines or norms on budget planning? - If Yes, who provided the guideline? *[multiple answers are applied]*	☐Yes ☐ No ☐ MoF ☐ MoH ☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): ……
16. When does your facility start the annual budget planning?	Date/Month: ……
17. Does your facility have any consultative meeting on budget plan negotiation/defense? - If yes, when is it? How do you conduct it? Who participated?	☐ Yes ☐ No Please explain: …… ……

18. Is your facility's budget plan reviewed by other offices before official submission?

– if yes, who reviews the budget plan?

[multiple answers are applied]

☐ Yes ☐ No

☐ PFO ☐ PHO ☐ PGO

☐ DFO ☐ DHO ☐ DGO

☐ Others (specify): ……

Please explain how to review the plan:

……

……

19. To whom does your facility officially submit the budget plan to?

[multiple answers are applied]

☐ PFO ☐ PHO ☐ PGO

☐ DFO ☐ DHO ☐ DGO

☐ Others (specify): ……

20. When does your facility officially submit the budget plan?

Date/Month: ……

21. When does your facility get the announcement of the approved annual budget plan?

Date/Month: ……

22. What is the approval budget for current year (2018) by chart of account?

Chpt.	Amount (kip)	Service fee	Chpt.	Amount (kip)	Service fee
60			64		
61			65		
62			66		
63			67	Domestic:	
				External:	

23. What is the proposal amount for the current year (2018) by chart of account?

Chpt.	Amount (kip)	Service fee	Chpt.	Amount (kip)	Service fee
60			64		
61			65		
62			66		
63			67	Domestic:	

<table>
<tr><td></td><td>
<table>
<tr><td></td><td></td><td></td><td>External:</td><td></td></tr>
</table>
</td></tr>
<tr><td>24. What is the approval budget for last year (2017) by chart of account?</td><td>
<table>
<tr><th>Chpt.</th><th>Amount (kip)</th><th>Service fee</th><th>Chpt.</th><th>Amount (kip)</th><th>Service fee</th></tr>
<tr><td>60</td><td></td><td></td><td>64</td><td></td><td></td></tr>
<tr><td>61</td><td></td><td></td><td>65</td><td></td><td></td></tr>
<tr><td>62</td><td></td><td></td><td>66</td><td></td><td></td></tr>
<tr><td>63</td><td></td><td></td><td rowspan="2">67</td><td>Domestic:</td><td></td></tr>
<tr><td colspan="2"></td><td>External:</td><td></td></tr>
</table>
</td></tr>
<tr><td>25. Is there any expenditure excluded in the annual plan?
- If yes, what amount is it for 2017?</td><td>☐ Yes ☐ No
Amount: ……</td></tr>
<tr><td>26. Is your facility’s expenditure over the plan?
- If yes, what amount is it for 2017?</td><td>☐ Yes ☐ No
Amount: ……</td></tr>
<tr><td colspan="2">III. Treasury arrangement</td></tr>
<tr><td>27. Does your facility have a treasury account?

- if yes, what statements deal with this account?

- if no, why?</td><td>☐ Yes ☐ No (Skip question number 28–29)

Please explain:
……
……
Please explain:
……
……</td></tr>
<tr><td>28. What are required documents for fund deposit?</td><td>Please explain:
……
……

Please explain:
……</td></tr>
</table>

<table>
<tr><td>- What are difficulties in this deposit procedure?</td><td>……</td></tr>
<tr><td>29. What is the procedure and required documents for fund withdrawal?

- What are difficulties in this withdrawal procedure?</td><td><table><tr><td>Withdrawal procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table>Explain:
……
……</td></tr>
<tr><td colspan="2">IV. Commercial Bank Accounts</td></tr>
<tr><td>30. Does your facility have a commercial bank account?

- if yes, what statements deal with this account?

if no, why?</td><td>☐ Yes ☐ No (Skip question number 31–32)

Please explain:
……
……
Please explain:
……
……</td></tr>
<tr><td>31. What is the procedure and required documents of fund deposit?

- What are difficulties in this deposit procedure?</td><td><table><tr><td>Deposit procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table>Explain:
……</td></tr>
</table>

	…….
32. What is the procedure and required documents of fund withdrawal? - What are difficulties in this withdraw procedure?	<table><tr><td>Withdrawal procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table> Explain: …… …….
V. Procurement management and Maintenance	
33. Did you do any procurement at your facility in the last years? – if yes, what types of goods and services does your facility procure? *[multiple answers are applied]*	☐ Yes ☐ No ☐ Drugs ☐ consumables and medical equipment ☐ Ambulance services ☐ Cleaning and laundry services ☐ Others (specify): …… If you have undertaken the procurement of a drug, please explain its procedure: (what regulations are referred?)

<table>
<tr><td>34. Does your facility have a procurement committee?

– if yes, who comprise the committee?</td><td>☐ Yes ☐ No

Please explain:

……
……</td></tr>
<tr><td>35. What value of purchase requires committee approval?</td><td>Amount:…….Kips</td></tr>
<tr><td>36. What is the procedure and required documents for purchase requisition?</td><td><table><tr><td>Procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>37. Who issues the rules and regulations for purchasing?

[multiple answers are applied]

(Copy of the documents is needed)</td><td>☐ MoF ☐ MoH ☐ PGO

☐ PFO ☐ PHO ☐ DGO

☐ DFO ☐ DHO

☐ Others (specify): ……</td></tr>
<tr><td>38. Who has highest level of authorization of your purchase requisition?

[multiple answers are applied]</td><td>☐ District governor ☐ Director of DHO

☐ Director of District Finance Offices ☐ Director of DH/PH

☐ Others (specify): ……</td></tr>
<tr><td>39. What budget chapter is used for maintaining? If other sources, please specify?</td><td>☐ Operation expenditure (62)

☐ Technical activities, subsidies and contributions (63)

☐ revenues (from service fee)</td></tr>
</table>

- What is the operation procedure?	☐ Other (not government budget): …… Explain: …… ……
40. Is the budget for maintenance objects/equipment enough? - If the budget is lower than planned, please explain what status it would be in?	☐ Very good ☐ Good ☐ Normal ☐ Bad ☐ Very bad Please explain: …… ……
41. Is the budget for general objects/equipment supplying enough?	☐ Very good ☐ Good ☐ Normal ☐ Bad ☐ Very bad
VI. Monitoring and Evaluation	
42. Is there any budget monitoring and evaluation of budget execution in your facility? - If no, why?	☐ Yes ☐ No (Skip number 43–44) Please explain: …… ……
43. Who carries out the monitoring and evaluation? *[multiple answers are applied]*	☐ MoF ☐ MoH ☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): ……
44. How frequently does the monitoring and evaluation happen? *[multiple answers are applied]*	☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: ……

45. Is there any external financial audit/inspection that has happened at your facility?	☐ Yes ☐ No (Skip number 46–47)
46. Who carried out the external financial audit/inspection? *[multiple answers are applied]*	☐ Provincial SIA ☐ Regional SIA ☐ Regional SAO ☐ Others (specify): ……
47. How frequently does the audit/inspection happen? *[multiple answers are applied]*	☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: ……..
VII. Expenditure report	
48. To whom does your facility submit the state budget expenditure report? *[multiple answers are applied]* - When does your facility submit the state budget expenditure report? *[multiple answers are applied]* - How is your expenditure report submitted? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): …… ☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Others (specify): …… ☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): …… ☐ Other (specify): ……

49. To whom does your facility submit the NT2/NHI/Vertical Program expenditure report? *[multiple answers are applied]* - When does your facility submit the NT2/NHI/Vertical Program expenditure report? *[multiple answers are applied]* - How is your expenditure report submitted? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): …… ☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Others (specify): …… ☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): …… ☐ Other (specify): ……
50. To whom does your facility submit the expenditure report directly to? *[multiple answers are applied]* (Please provide a copy of your report) - When does your facility submit the NGOs/Donors expenditure report? *[multiple answers are applied]* - How is your expenditure report submitted? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Directly to donors/NGOs ☐ Others (specify): …… ☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: …….. ☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): ……

	☒ Other (specify): ……

Part C: Other questions/comments

1. What are the problems related to finance that affect your service delivery?
   ……
   ……
   ……

2. What is your expectation on a financial management system at your facility level? Do you expect to have any software/database for your PFM? What are there?
   ……
   ……
   ……

3. Do you have any other comments/feedbacks that you need to share?
   ……
   ……
   ……

Interview end time: ……..

At:……..; Date:……..

Interviewer [Name and signature]

PFM Assessment Questionnaire

For PHO and DHO

Name of PHO/DHO: .....; Province: ……
Name of respondent: ……., Position: ……..
Contact Number: …… Email: ……

Interview start time: ……

Part A: General information

Questions	Answers
1. How many officials and volunteers are there in your office?	Officials: ……. persons. Volunteers: …….. persons.
2. What is the estimated number of trained staff required? (This depends on the area of staffing shortage indicated)	……. persons
3. What are the incentives to attract skilled staff to positions in difficult-to-reach locations? - What is the level of morale among staff in difficult-to-reach locations? Any records on staff turnover in the health sector?	Please explain: …… …… Please explain: …… ……
4. Are any records on staff absenteeism? - What are the most common reasons cited for absenteeism?	☐ Yes ☐ No Please explain: …… ……
5. Are different persons responsible for finance, planning, and accounting?	☐ Yes ☐ No Please explain:

<table>
<tr><td></td><td>……
……</td></tr>
<tr><td>6. Does the person in charge of finance have a degree in finance/accounting?
- If not, how much training has he/she received in Finance/Accounting?</td><td>☐ Yes ☐ No
- Number of received trainings: ……
Number of days of the received trainings:<table><tr><td>Training</td><td>Number of days</td></tr><tr><td>Training 1</td><td></td></tr><tr><td>Training 2</td><td></td></tr><tr><td>Training 3</td><td></td></tr></table></td></tr>
<tr><td>7. Are there service delivery indicators that are periodically monitored and published?
- If any, please explain?</td><td>□Yes □No
Please explain:
……
……</td></tr>
<tr><td>8. Is there any cooperation with private sector in health service delivery?
- If any, what are they?</td><td>□Yes □No
Please explain:
……
……</td></tr>
</table>

Part B: Public Financial Management

Questions	Answers
I. Fund Sources	
1. What sources of fund does your office receive? *[multiple answers are applied]*	☐ Salary and employee allowance (60) ☐ Compensation and policy allowances (61) ☐ Operation expenditure (62) ☐ Technical activities, subsidies and contributions (63) ☐ Financial expenditure (64) ☐ Other expenditures (65) ☐ New purchase for operation (66) ☐ Capital expenditure (67)

☐ Technical Revenue or Drug Revolving Fund: ……
☐ NHI
☐ SASS
☐ SASS
☐ Vertical program (HIV/EPI/TB....)
☐ Grant Aid (not included in chapter 67) (name of donor): …… ☐ Others (specify): ……

2. How does your office receive these funds? Who does the disbursement?

Type	Source	Disbursement unit
Cash	Ex: 62, 63, ….	
Transfer through NT	NHI, …….	
Transfer through commercial bank	60, 61, …..	
Other:……		

3. How often does your office receive the funds?

Period	Source	Receive on time?		
Monthly	60, 61, ….	Yes	No	
Quarterly	62, 63, ….			
Every 6-month				
Yearly				
Activity based				
Other: ……..				

<<Technical revenue>>

4. Does your office have any revenues from service fees?
   - If yes, what are they?

☐ Yes ☐ No

Explain:
……
……

5. Does your office receive the financial report (collected service fee and its spending) from PHO/DHO?

☐ Yes ☐ No

6. Are those revenues recorded on-budget? - if no, why?	☐ Yes ☐ No Explain: …… ……
7. How do you record your office revenues? *[multiple answers are applied]* (Please provide copies, if any)	☐ Paper-based ☐ Excel ☐ Accounting software (specify): …… ☐ Other (specify): ……
8. Where does your office keep the revenue? *[multiple answers are applied]*	☐ PHO/DHO-DoF ☐ Provincial/District-NT (PFO/DFO) ☐ Bank ☐ Other (specify): ……
9. What type of expenditure is your office's revenue earmarked for?	Explain: …… ……
10. Who is the final approver for this revenue spending?	Final approval by……..
11. What is the rule to manage this revenue?	Explain: …… ……
II. Annual budget plan formulating and executing	
12. Does your office involve in state budget planning?	☐ Yes ☐ No
13. Is technical revenue included in the annual budget plan? - How do you calculate/estimate the revenue? And what chapter is it included into?	☐ Yes ☐ No Please explain: …… ……
14. Are there any guidelines or norms on budget planning?	☐Yes ☐ No

- If Yes, who provided the guideline? *[multiple answers are applied]*	☐ MoF ☐ MoH ☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): ……
15. When does your office start the annual budget planning?	Date/Month: ……
16. Does your office have any consultative meeting on budget plan negotiation/defense? - If Yes, when is it? How do you conduct it? Who participated?	☐ Yes ☐ No Please explain: …… ……
17. Is your office's budget plan reviewed by other offices before official submission? – if yes, who reviews the budget plan? *[multiple answers are applied]*	☐ Yes ☐ No ☐ PFO ☐ PHO ☐ PGO ☐ DFO ☐ DHO ☐ DGO ☐ Others (specify): …… Please explain how to review the plan: …… ……
18. To whom does your office officially submit the budget plan to? *[multiple answers are applied]*	☐ PFO ☐ PHO ☐ PGO ☐ DFO ☐ DHO ☐ DGO ☐ Others (specify): ……
19. When does your office officially submit the budget plan?	Date/Month: ……
20. When does your office get the announcement of the approved annual budget plan?	Date/Month: ……

21. What is the approval budget for current year (2018) by chart of account?

Chpt.	Amount (kip)	Service fee	Chpt.	Amount (kip)	Service fee
60			64		
61			65		
62			66		
63			67	Domestic:	
				External:	

22. What is the proposal amount for the current year (2018) by chart of account?

Chpt.	Amount (kip)	Service fee	Chpt.	Amount (kip)	Service fee
60			64		
61			65		
62			66		
63			67	Domestic:	
				External:	

23. What is the approval budget for last year (2017) by chart of account?

Chpt.	Amount (kip)	Service fee	Chpt.	Amount (kip)	Service fee
60			64		
61			65		
62			66		
63			67	Domestic:	
				External:	

24. Is there any expenditure excluded in the annual plan?
    - If yes, what amount is it for 2017?

☐ Yes ☐ No
With amount: ……

25. Is your office's expenditure over the plan?
    - If yes, what amount is it for 2017?

☐ Yes ☐ No
With amount: ……

26. What are the alternatives to building new infrastructure/facilities to help increase service coverage? What government sources are used for those infrastructures?

Please explain:
……
……
☐ Domestic capital (67)
☐ External capital (67)
☐ Grant aid of private sector
☐ Others (specify): ……

<table>
<tr><td colspan="2">III. Treasury arrangement</td></tr>
<tr><td>27. Does your office have treasury account?

- if yes, what statements deal with this account?

- if no, why?</td><td>☐ Yes ☐ No (Skip question number 28–29)

Please explain:
……
……
Please explain:
……
……</td></tr>
<tr><td>28. What are required documents for fund deposit?

- What are difficulties in this deposit procedure?</td><td>Please explain:
……
……

Please explain:
……
……</td></tr>
<tr><td>29. What is the procedure and required documents for fund withdrawal?

- What are difficulties in this withdrawal procedure?</td><td><table><tr><td>Withdraw procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table>
Explain:
……
……</td></tr>
<tr><td colspan="2">IV. Commercial Bank accounts</td></tr>
<tr><td>30. Does your office have a commercial bank account?

- if yes, what statements deal with this account?</td><td>☐ Yes ☐ No (Skip question number 31–32)

Please explain:
……
……</td></tr>
</table>

<table>
<tr><td>- if no, why?</td><td>Please explain:
……
……</td></tr>
<tr><td>31. What is the procedure and required documents of fund deposit?

- What are difficulties in this deposit procedure?</td><td><table><tr><td>Deposit procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table>Explain:
……
……</td></tr>
<tr><td>32. What is the procedure and required documents of fund withdrawal?

- What are difficulties in this withdrawal procedure?</td><td><table><tr><td>Withdraw procedure</td><td>Required documents</td></tr><tr><td></td><td></td></tr></table>Explain:
……
……</td></tr>
<tr><td colspan="2">V. Procurement management and Maintenance</td></tr>
<tr><td>33. Did you do any procurement at your office in the last years?
– If yes, what types of goods and services does your office procure?
[multiple answers are applied]</td><td>☐ Yes ☐ No

☐ Drugs ☐ consumables and medical equipment
☐ Ambulance services ☐ Cleaning and laundry services
☐ Others (specify): ……
<table><tr><td>If you have the undertaken the procurement of a drug, please explain its procedure:
(what regulation referred?)</td></tr></table></td></tr>
</table>

34. Does your office have a procurement committee? – If yes, who comprise the committee?	☐ Yes ☐ No Please explain: …… ……
35. What value of purchase requires committee approval?	Amount:……..Kips
36. What is the procedure and required documents for purchase requisition?	Procedure | Required documents |
37. Who issues the rules and regulations for purchasing? *[multiple answers are applied]* (Copy of the documents is needed)	☐ MoF ☐ MoH ☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): ……
38. Who has highest level of authorization of your purchase requisition? *[multiple answers are applied]*	☐ Provincial governor ☐ District governor ☐ Director of PHO ☐ Director of DHO ☐ Director of Provincial Finance Offices ☐ Director of District Finance Offices ☐ Director of PH ☐ Director of DH ☐ Others (specify): ……
39. What budget chapter is used for maintaining? If other sources, please specify? - What is the operation procedure?	☐ Operation expenditure (62) ☐ Technical activities, subsidies and contributions (63) ☐ Revenues (from service fee) ☐ Other (not government budget): …….. Explain: …… ……

40. Is the budget for maintenance objects/equipment enough? - If the budget is lower than planned, please explain what status it would be in?	☐ Very good ☐ Good ☐ Normal ☐ Bad ☐ Very bad Please explain: …… ……
41. Is the budget for general objects/equipment supplying enough?	☐ Very good ☐ Good ☐ Normal ☐ Bad ☐ Very bad
VI. Monitoring and Evaluation	
42. Is there any budget monitoring and evaluation of budget execution in your office? - If no, why?	☐ Yes ☐ No (Skip number 43-44) Please explain: …… ……
43. Who carries out the monitoring and evaluation? *[multiple answers are applied]*	☐ MoF ☐ MoH ☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): ……
44. How frequently does the monitoring and evaluation happen? *[multiple answers are applied]*	☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: ……..
45. Is there any external financial audit/inspection that has happened at your office?	☐ Yes ☐ No (Skip number 46–47)
46. Who carries out the external financial audit/inspection? *[multiple answers are applied]*	☐ Provincial SIA ☐ Regional SIA ☐ Regional SAO ☐ Others (specify): ……

47. How frequently does the audit/inspection happen? *[multiple answers are applied]*	☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: ……..
VII. Expenditure report	
48. To whom does your office submit the state budget expenditure report? *[multiple answers are applied]* - When does your office submit the state budget expenditure report? *[multiple answers are applied]* - How is your expenditure report submitted? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): …… ☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Others (specify): …… ☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): …… ☐ Other (specify): ……
49. To whom does your office submit the NT2/NHI/Vertical Program expenditure report? *[multiple answers are applied]* - When does your office submit the NT2/NHI/Vertical Program expenditure report? *[multiple answers are applied]* - How is your expenditure report submitted? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Others (specify): …… ☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Others (specify): …… ☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): …… ☐ Other (specify): ……
50. To whom does your office submit the expenditure report directly to? *[multiple answers are applied]*	☐ PGO ☐ PFO ☐ PHO ☐ DGO ☐ DFO ☐ DHO ☐ Directly to donors/NGOs

(Please provide a copy of your report)	☐ Others (specify): ……
- When does your office submit the NGOs/Donors expenditure report? *[multiple answers are applied]*	☐ After fund executed ☐ Monthly ☐ Quarterly ☐ After 6 months ☐ Annually ☐ Other: ……..
- How is your expenditure report submitted? *[multiple answers are applied]*	☐ Hard copy (by mail or hand transfer) ☐ Electronic version ☐ Web-based system (specify): …… ☐ Other (specify): ……

Part C: Other questions/comments

1. What are the problems related to finance that affect your service delivery?
   ……
   ……
   ……

2. What is your expectation on a financial management system at your office level? Do you expect to have any software/database for your PFM? What are there?
   ……
   ……
   ……

3. Do you have any other comments/feedbacks that you need to share?
   ……
   ……
   ……

Interview end time: ……..

At:……..; Date:…….

Interviewer [Name and signature]

Annex 4 – List of Survey Respondents

Name of respondent	Position	Name of office/facility
PHOs and DHOs		
Mr. Keobounphanh Phonchaleunxay	Finance staff	Khamkeuth DHO
Ms Vieng Keo Vankhamdy	Finance staff	Pakkading DHO
Ms Chansamay Thammavong	Technical officer	Bolikhamxay PHO
Dr. Ketkeo	Deputy Director	Paksong DHO
Dr. Wat Kongkeo	Deputy Director of PHO	Champasak PHO
Dr. Bouangern	Director of DHO	Xanasomboun DHO
Ms Somvang Nanthaphet	Vice-director of DHO	Lakhonepheng DHO
Ms Bounnath Inthalad	Planning and Finance Section Chief	Khongxedon DHO
Mr. Somphan	Planning and Finance Unit Chief	Saravane PHO
Mr. Phetsamone	Finance head	Champasak DHO
Ms Soutladda Suphatphon	Technical officer	Pakbeng DHO
PHs and DHs		
Mr. Khamdeng Luangxay	Finance staff	Khamkeuth community hospital
Ms Thongphoud Siharath	Finance Chief	Bolikhamxay PH
Deunephen Payathong	Finance staff	Pakkading DH
Mr. Khamphanh	Deputy director of DH	Paksong DH
Dr. Sone Phounmavong	Finance staff	Champasak hospital
Dr. Viengxay Feuangvilay	Vice-director of Hospital	Xanasomboun DH
Dr. Kongsith Unchit	Director	Saravane PH
Dr. Chanthavy Sengsulivong	Vice-Director of DH	Khongxedon DH
Dr. Saly Vongkhampheng	Director of Hospital	Lakhonephen DH
Dr. Somphone	Vice-Director	Pakbeng DH
Sengdala Taysavath	Technical officer	Udomxay PH
Kheuavanh Khanthavong	Finance	Kenthao DH
Mr. Thongdeng Sasopha	Finance Chief	Xayabuly PH
Dr. Somlith Sithichanh	Director	Houn DH
Mr. Khamdeng Luangxay	Finance staff	Khamkeuth community hospital
Ms Thongphoud Siharath	Finance Chief	Bolikhamxay PH
Deunephen Payathong	Finance staff	Pakkading DH
Dr. Manisone	Finance staff	Champasak hospital
Dr. Viengxay Feuangvilay	Vice-director of Hospital	Xanasomboun DH
Dr. Kongsith Unchit	Director	Saravane PH
Dr. Chanthavy Sengsulivong	Vice-Director of DH	Khongxedon DH
Dr. Saly Vongkhampheng	Director of Hospital	Lakhonephen DH
HCs		
Noulath Kounphavong	Technical officer	Pakading HC
Phouthong Louangsouvannavong	Head of HC	NongOrHC
Phoukham Bolivan	Head of HC	Namthone HC
Litsamay	Head of HC	Kengdeng HC

Name of respondent	Position	Name of office/facility
Phoumy, Viengphout, Chaykham, Sengkham, Souksavanh and Noimany	Head, deputy head of HC, and staff respectively.	Saphai HC
Khonsavanh and Phonpaserth	Technical staff	Nakeo HC
Nathana	Deputy Head	Etou HC
Khanti Xaysongkham	Head of HC	NongViane HC
Sengchan, Douamkeo and Phonphet	Technical	HouayNguen HC
Dongvay Fasathanh	Head of HC	Kokka HC
Phounsavath	Head of HC	Singxay (Phousoung) HC
Khampheng	Head of HC	Naxiengdee HC
Xiengthong	Head of HC	Sibounheung HC
Sombounthan Sisouk	Head of HC	Pakkhem HC
Somphat Inthavong	Head of HC	Houaylerk HC
Somvang	Head of HC	Naxeung HC
Dr. Bouaphanh	Head of HC	PhongAng HC
Dr. Oudomsack Saysana	Head of HC	Khamthong HC
Dr. Chansamay Bounavong	Head of HC	Luk 9 HC
Mr. Khamhou	Head of HC	Thaluang HC
Dr. Chanpheng	Head of HC	Nadu HC

Annex 5 – Summary of Performance Measurement Scores – 2010 PEFA

		Score
A. PFM outturns: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	**B**
PI-2	Composition of expenditure out-turn to original approved budget	**NR**
PI-3	Aggregate revenue out-turn compared to original approved budget	**A**
PI-4	Stock and monitoring of expenditure payment arrears	**C+**
B. Key cross-cutting issues: Comprehensiveness and transparency		
PI-5	Classification of the budget	**C**
PI-6	Comprehensiveness of information included in budget documentation	**B**
PI-7	Extent of unreported government operations	**D+**
PI-8	Transparency of intergovernmental fiscal relations	**D**
PI-9	Oversight of aggregate fiscal risk from other public sector entities	**D+**
PI-10	Public access to key fiscal information	**C**
C. Budget execution		
C. (i) Policy-based budgeting		
PI-11	Orderliness and participation in the annual budget process	**C+**
PI-12	Multiyear perspective in fiscal planning, expenditure policy, and budgeting	**D+**
C. (ii) Predictability and control in budget execution		
PI-13	Transparency of taxpayer obligations and liabilities	**D+**
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	**C**
PI-15	Effectiveness in collection of tax payments	**NR**
PI-16	Predictability in the availability of funds for commitment of expenditures	**B+**
PI-17	Recording and management of cash balances, debt, and guarantees	**D+**
PI-18	Effectiveness of payroll controls	**C+**
PI-19	Competition, value for money, and procurement controls	**D+**
PI-20	Effectiveness of internal controls for nonsalary expenditure	**D+**
PI-21	Effectiveness of internal audit	**D**
C. (iii) Accounting, recording, and reporting		
PI-22	Timeliness and regularity of accounts reconciliation	**C**
PI-23	Availability of information on resources received by service delivery units	**D**
PI-24	Quality and timeliness of in-year budget reports	**C+**
PI-25	Quality and timeliness of annual financial statements	**D+**
C. (iv) External scrutiny and audit		
PI-26	Scope, nature, and follow-up of external audit	**D+**
PI-27	Legislative scrutiny of the annual Budget Law	**C+**
PI-28	Legislative scrutiny of external audit reports	**C+**
D. Donor practices		
D-1	Predictability of Direct budget Support	**D+**
D-2	Donor information for budgeting and reporting on project/program aid	**C+**
D-3	Proportion of aid managed by national procedures	**D**

Source: World Bank, The Lao PDR Public Expenditure & Financial Accountability assessment, June 2010

Annex 6 - Other Macro Level Reforms That Will Impact On The Health Sector

Area of national reform	Relevance to health sector	Reference or recent status
Chart of accounts and budget classification	Improved linkages between strategic plans (by program objectives, activities) and annual budgets by departments; currently no location field for sub national budget plans or source of funds field; compliance with IPSAS accounting standards needed	Lao PFM Modernisation Program (LPFMMP) 2018 Component 2.b: TA to improve budget execution, including cash management, forecasting and reporting, and the monthly reporting on all cash flows by provincial treasuries
Shift from incremental to baseline budgeting	Health and education will be pilot sectors for this reform	LPFMMP Component 2: – support for strengthening budget preparation and execution processes
Implementation of a financial management information system (FMIS) across whole of government	MoH, PHOs and DHOs can work within an integrated whole of government financial management system rather than rely on stand alone Excel or database solutions	LPFMMP Component 1.a: Building blocks for a core PFM system in Lao. See also the report on GFIS Transition and FMIS Implementation Sequencing of November 2017 LPFMMP Component 2: Support draft fiscal policy implementation by assisting the Government to strengthen its budget execution processes
ICT infrastructure and wide area network	PHOs and DHOs need capacity to access centralised budget preparation, execution, reporting and accounting systems	LPFMMP Component 1.C – Cyber Security and ICT Strategy
Strengthening of cash management, forecasting, reporting, and treasury operations at the	Need to improve reliability of cash flows for budget implementation at sub national level	LPFMMP Component 2.B – Improved budget execution including cash management, forecasting and reporting

national and subnational levels		LPFMMP Component 2.C Review and improvement of the treasury and budget information systems
Targeted national programs (SBL 2015 Section 48)	Potential to protect sub national allocations to priority programs, including for donor funding	Section 48 of State Budget Law 2015 – MoF yet to initiate implementation of this provisions
Consideration of options for formula- or indicator-based approach to subnational budget transfers for health and education	Improved reliability and equity of financing for health units at sub national level, to address horizontal imbalances	ADB supported program of Fiscal Decentralisation Options paper to Government of Lao PDR in August 2018
Taxation compliance and administration	Improved linkages between economic growth and tax collections, increasing domestic resources available for service delivery in health and education	LPFMMP Component 3: Support revenue policy and management, including the institutional strengthening of the large taxpayer unit, and support for VAT implementation
Further improvements to the SBL, including the development of secondary regulations	Improved capacity within MoH, PHOs and DHOs for budget management	LPFMMP Component 2 – support for strengthening budget preparation and execution processes
New procurement regulatory framework	Improved efficiencies in purchasing and procurement at all levels of the health sector	LPFMMP Component 4: Technical Note: Finalisation of Procurement Law and drafting of secondary legislation

Annex 7 – Recommendations from Other Assessments

The table below summarizes recommendations from other assessment, i.e. the Health Financing System Assessment (December 2017), and the Education and Health Sectors - Public Expenditure Arrangements (June 2018).

Reference	Health Financing System Assessment (December 2017)
Section 5, p.136	**To make greater progress toward attainment of UHC by 2025 in Lao PDR, an increase in government spending for health services, particularly from domestic revenue sources, is inevitable. This will reduce the financial burden on households and the vulnerability associated with the uncertainty of external financing**
Section 5, p.136	**Considerable challenges remain in ensuring not just an increase in the quantum of spending, but to target this increase to reduce OOP spending and reach those who have limited or no access to essential services.** At the macro level, this requires a clear government commitment to meet the 9 percent budgetary target both at the central and the provincial level.
Section 5, p.136	**At the sectoral level, this includes an increase in the efficiency and effectiveness of spending to ensure that additional health spending achieves the desirable population health outputs and outcomes while ensuring sustainability of financing for health.** One essential budgeting and planning exercise for the country would be to undertake systematic priority setting to help decide where limited sectoral resources should be invested
Section 5, p.136	**A key focus here would need to be on the defragmentation of financing, implementation and budget execution, and mainstreaming of multiple, often parallel, implementation modalities and social health protection schemes.** Addressing fragmentation of financing and implementation of multiple schemes such as the CBHI, HEF and the free MCH program would be an important step in improving efficiency of the system. While the expansion of integrated NHI is a good starting point, a process of gradual merger and functional integration of these various schemes is imperative for effective implementation.
Section 5, p.136	**Effectiveness of spending would be further strengthened through the introduction of results-based planning and, in the longer term, through a transition to results-based budgeting.** The latter requires, however, a much-improved financial management and expenditure tracking system than is presently in place
Section 5, p.137	**From an external financing perspective, one of the major challenges for Lao PDR is to continue expanding the service coverage for the key health programs that have been traditionally financed by donors, and accelerate and sustain the progress toward UHC while effectively managing the transition from external financing**
Section 5, p.137	**Integration of externally funded programs into a well-functioning health system and reduced fragmentation in financing and service delivery is key to ensuring sustainability and enhancing health outcomes.**

Section 5, p.137	**The UHC package needs to be defined and costed to ensure and sustain financing:** • **Completing the definition of the essential package of services that will be provided to the entire population to achieve UHC** • **Costing the delivery of these services:** Costing (staff, drugs, supplies, operations) should reflect the mainstreaming of vertical programs such as immunization, HIV, TB, Malaria into one comprehensive health system to ensure efficiencies of health spending. • **Evidence-based and systematic priority setting** • **Balancing supply-side and demand-side investments**
Section 5, p.137	**Gradual and functional integration of financing, planning and program execution is imperative for successful transition and sustainability** • **Planning and budgeting to align and integrate all the funding streams and programs at national and subnational level** • **Mainstreaming of information systems and focus on improved data quality and end-use for policymaking** • **Similarly, other duplications and overlaps in program execution should be identified and a single entity with responsibility for each program function designated within the overall health system**– such as procurement, supervision and supply chain management. • **Specifically, for ensuring that essential services reach the poor and vulnerable, the delivery of integrated outreach services needs to be streamlined and strengthened.** • **Strengthening the institutional capacity is necessary for managing the integrated scheme and steering purchasing functions for improved health system performance.**
Section 5, p.138	**Making the health system ready and able to take on the changing burden of disease is another critical policy focus area**
Section 5, p.138	**Mainstreaming services, strengthening front line service delivery and ensuring coverage for the poor is a critical need during the transition period, and requires:** • **a uniform system to identify the poor and the vulnerable** • **ensuring adequate funding through both demand- and supply-side funding mechanisms** • **leveraging the information systems, monitoring and purchasing capacity in an integrated system to improve the quality of service delivery.**
Reference	**Education and Health Sectors - Public Expenditure Arrangements (June 2018)**
Section 9, p.49	***Policy recommendation 1: Keep tight control on employment in the sector and devise a strategy to retain staff in underserved areas and deal with excess staff (including volunteers).***
Section 9, p.50	***Policy recommendation 2: Sector allocations should be based on the actual needs in the two sectors to achieve the development objectives***

Section 9, p.50, 51	***Policy recommendation 3: Advance the introduction of budget ceilings and reform the fiscal transfers system.*** ***Such transfers would need to be:*** • ***Specific to sub-sectors (ECE, primary, and so on) and possibly to economic expenditure categories (staff, non-staff and capital)***. • ***Allocated by formulae which reflect relative spending needs (based on populations to be serviced and service delivery costs)***. • ***Based on costed, stable national sub-sector transfer pools***. • ***Announced to provinces – at least in indicative manner – early enough in the budget cycle***.
Section 9, p.51	***Policy recommendation 4: Consider further delegation of budgeting authority to improve efficiency of spending and more clearly defining responsibilities for capital spending***
Section 9, p.53	***Policy recommendation 5: Provide additional guidance to budget users on assessment of spending options and prioritization in line with sector policy.***
Section 9, p.54	***Policy recommendation 6: Improve reporting and monitoring.*** **Lack of data availability and transparency is a key problem for sector policy-making and sector budgeting and monitoring of delivery**. Several recommendations flow from this, which could be implemented over a period of 6-12 months: • **Central-level guidance is needed to province authorities to ensure that finalized province recurrent and capital budget spending plans are submitted up to line ministries by a specified date at the start of the budget year.** • **It would also be extremely helpful if the CoA framework could be amended as part of the ongoing reform in financial management systems to provide more detail**. • **Finally, the procedures and timetable for preparation and issuance of execution reports for the state budget needs to be accelerated, to allow policymakers and others access to much more recent actual expenditure data.** • **Strengthening the PFM systems in the education and health sectors through the reforms mentioned above can go a long way in facilitating the use of country systems by development partners.**