The Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

HEALTH SECTOR REFORM STRATEGY 2021-2030

August 2022

World Health Organization
Lao PDR

JICA

Foreword

From the implementation of the Health Sector Reform Strategy (HSRS) in Phase I (2014–2016) and Phase II (2016–2020) at the central and local levels, the health sector has been strengthened in many areas. Health infrastructure in central and district hospitals and health centers across the country has been improved and built with better quality. Health personnel receive quality training and are distributed to be in line with health needs in communities. Working methods and management have been improved with better quality. Health financing has made progress and the national health insurance scheme expanded population coverage in 17 provinces (all provinces except Vientiane Capital). As a result, the majority of the population have benefited from the scheme. The Three-Builds Policy for primary health care (PHC) has been extended to reach the community level. The number of model healthy villages that have been certified and declared throughout the country has increased by more than more than 80%. Health information has been improved and used to formulate effective health policy decision-making and development plans in each phase.

It is my honor to represent the Ministry of Health and Secretariat of the National Commission for Health Sector Reform in presenting the updated HSRS Phases III (2021–2025) and IV (2026–2030) to the representatives of the party, the government, all sectors, civil servants, defense forces, security forces, social organizations, development partners, financial institutions and the multi-ethnic Lao people throughout the country.

The purpose of HSRS Phases III and Phase IV is to improve the capacity and quality of health services in line with national social and economic development as well as regional and international situations, in order to meet the needs of the Lao people and to achieve development targets related to the health sector including universal health coverage (UHC) by 2025 and Sustainable Development Goals (SDGs) by 2030.

From the mid-term review and assessment of the implementation of HSRS Phase II, it was revealed that many factors, both domestically and internationally, have impacted the health sector, such as, national disasters, public health emergencies including the COVID-19 pandemic, conflicts in international relations, and economic tensions in the country and elsewhere. The health sector faces many challenges. Many of the goals and indicators adopted by the National Assembly for the health sector are at risk of not being achieved if we do not have appropriate and strong measures. It is imperative that we continue to plan strategically and ensure HSRS Phase III and Phase IV have stronger and more appropriate mechanisms, procedures and measures with a clear focus on the five HSRS pillars: (1) Health Service Delivery; (2) Human Resources for Health; (3) Governance, Management, and Coordination; (4) Health Financing; and (5) Health Information, Planning, Monitoring and Evaluation.

The objectives of HSRS Phase III are to improve the quality of health services so that it is comparable to that of neighboring countries and regions, and to achieve the goals of UHC through strengthening PHC based on the Three-Builds Policy. The objectives of HSRS Phase IV is to ensure comprehensive development in the health sector, including hospital autonomy and encouragement of the private sector to contribute to public health services in the country, and to achieve the health-related SDGs.

I would like to take this opportunity to request party leaders and government, all sectors, social organizations, development partners, health personnel, and Lao people of all ethnic groups throughout the country to take ownership of, encourage, support, contribute to and accelerate the implementation of the HSRS.

I congratulate and thank all contributing organizations, departments, and development partners for their support and efforts in preparation of this HSRS. I wish the party and government, the National Assembly, party members, civil servants, soldiers, police and the multi-ethnic Lao people throughout the country good health and happiness, contributing to the preservation and development of our beloved nation. Thank you.

Vientiane Capital, Date:

. Minister of Health

Bounfeng PHOUMMALAYSITH MSc, MMA, Ph.D.

Lao People's Democratic Republic
Peace Independence Democracy Unity and Prosperity

Ministry of Health

No. 2645/MOH
Vientiane Capital, Date 13 Sep 2022

Decision

The appointment of Committee for Implementing the Health Sector Reform Strategy and Coordination in the Health Sector

- Pursuant to Decree on the Organization and Activities of Ministry of Health No. 570/PM dated 16 Sep 2021;
- Pursuant to Resolution of National Assembly on Health Sector Reform Strategy and Framework Till 2025 No. 044/NA dated 05 Apr 2012;
- Pursuant to Order of Prime Minister No. 34/PM dated 23 Aug 2016 on Direction, Target and Measures for establishing provinces as strategic units, districts as comprehensive and strong units, and villages as development units;
- Pursuant to proposed letter of Ministry of Health No. 2101/CAB dated 01 Aug 2022.

Minister has approved:

Article 1: approved the appointment of Steering Committee for Health Sector Reform Strategy and Coordination, and Secretariat.

I. Steering Committee

1. H.E. Dr. Bounfeng Phoummalaysith	Minister of Health
2. H.E. Dr. Sanong Thongsana,	Vice Minister of Health
3. H.E. Dr. Phayvanh Keopaseuth	Vice Minister of Health
4. Dr. Bounthom Samountry	President of University of Health Sciences

❖ **Roles and responsibilities of Steering Committee**

- Provide guidance on the implementation of the Health Sector Reform Strategy and coordination in the health sector, ensuring the Strategy is harmonized and centralized, can be implemented effectively and efficiently, and can achieve targets.
- Mobilize funding from government and private sources for the implementation of the Health Sector Reform Strategy and coordination in the health sector.
- Monitor, inspect, and evaluate the implementation and report to the National Committee on the relevant works regularly.

II. Committee for Sector Working Group (SWG) Policy Level Meeting – SWG (P)

1. H.E. Dr. Bounfeng Phoummalaysith	Minister of Health	Chair
2. Dr. Kobayashi Kenichi	Ambassador of Japan to Lao PDR	Co-chair
3. Dr. Ying-Ru Lo	WHO Representative to Lao PDR	Co-chair

❖ **Roles and responsibilities of Committee for SWG (P)**

- Provide guidance on the implementation of the Health Sector Reform Strategy and coordination in the health sector, ensuring the Strategy is harmonized and centralized, can be implemented effectively and efficiently, and can achieve targets.
- Mobilize funding from government and private sources for the implementation of the Health Sector Reform Strategy and coordination of the health sector.
- Approve legislation, reports, and meeting outcomes of the Health Sector Reform and Coordination Meeting of the Health Sector Committee in order to report to the State Government's Round Table Meeting (RTM).

III. Coordination Committee of SWG (P)

1. H.E. Dr. Sanong Thongsana	Vice Minister of Health	Chair
2. H.E. Dr. Phayvanh Keopaseuth	Vice Minister of Health	Vice Chair
3. Dr. Bounthom Samountry	President, University of Health Sciences	Vice Chair
4. Ms. Aphone Visathep	Director General, National Health Insurance Bureau	Member
5. Dr. Chanthanom Manithip.	Director General, MOH (Ministry of Health) Cabinet	Member
6. Dr. Rattanaxay Phetsouvanh	Director General, Department of Communicable Diseases Control (DCDC)	Member
7. Dr. Khamphoua Southisombath	Director General, Department of Healthcare and Rehabilitation (DHR)	Member
8. Dr. Khampasong Theppanya	Director General, Department of Organization and Personnel (DOP)	Member
9. Dr. Bounserth Keoprasith	Director General, Department of Planning and Cooperation (DPC)	Member
10. Dr. Bounsou Keohavong	Director General, Food and Drug Department (FDD)	Member
11. Dr. Phonepaseuth Ounaphom	Director General, Department of Hygiene and Health Promotion (DHHP)	Member
12. Dr. Phasouk Vongvichit	Special Advisor to Minister of Health	Member
13. Dr. Khamsay Dethleuxay	Director General, DHR	Member
14. Representatives from relevant international organizations		Member

❖ **Roles and responsibilities of Coordination Committee of SWG (P)**

- Act as Secretariat in providing overall guidance on review/analysis, setting the national targets, planning for the health sector in each period to improve service delivery, achieve the 11 national health indicators, Universal Health Coverage by 2025, Sustainable Development Goals by 2030, and Health Sector Reform Till 2030, including strengthening coordination in the health sector and ensuring activities are aligned with the country's context and situation.
- Coordinate with domestic departments and relevant parties at central and sub-national level, including international organizations, development partners (DPs) and donors.
- Take ownership in providing guidance and leadership, and facilitate Technical Working Groups (TWGs) and Health Sector Reform Secretariat, including coordination for smooth implementation.
- Supervise, monitor, and inspect content of the health sector reports and HSDP direction, and present health sector reform plan in the SWG (P) meetings.
- Prepare health contents for government RTM.
- Provide support to the government and embassies or DPs in health development dialogue, and supervision, decision-making and policies in the health sector through SWG (P) Committee.
- Monitor and report progress in a timely manner on the results of the Vientiane Declaration on Aid Effectiveness.
- Promote the use of sector-wide coordination (SWC) to ensure understanding and support across multi-stakeholders.
- Monitor and inspect progress of SWG Operational Level Meeting – SWG (O) – and TWGs with support from the Secretariat.

IV. Coordination Committee of SWG (O)

1. H.E. Dr. Sanong Thongsana	Vice Minister of Health	Chair
2. H.E. Dr. Phayvanh Keopaseuth	Vice Minister of Health	Vice Chair
3. Dr. Chanthanom Manithip	Director General, MOH Cabinet	Member
4. Dr. Mayfong Mayxay	Vice President, University of Health Sciences	Member
5. Dr. Souphaphone Sadettan	Deputy Director, MOH Cabinet	Member
6. Dr. Daodouangchanh Boulommavong	Deputy Director, MOH Cabinet	Member
7. Dr. Sengmany Khambounheuang	Deputy Director General, DOP	Member
8. Dr. Thongvanh Phetchaleun	Deputy Director, Department of Inspection (DOI)	Member
9. Dr. Souksomkouan Chanthamath	Deputy Director, FDD	Member
10. Dr. Sommana Rattana	Deputy General, DHR	Member
11. Dr. Bouakeo Souvanthong	Deputy General, DHHP	Member
12. Dr. Souphab Keopanya	Deputy General, Department of Finance (DOF)	Member
13. Dr. Chansaly Phommavong	Deputy Director General, Department of Planning and Finance (DPF)	Member
14. Dr. Viengmany Bounkham	Deputy Director General, DPF	Member
15. Dr. Phonpaseuth Sayamoungkhoun	Director General, DCDC	Member
16. Mr. Viengxay Viravong	Deputy Director General, National Health Insurance Bureau	Member

❖ **Roles and responsibilities of Coordination Committee of SWG (O)**

- Implement outcomes of SWG (P).
- Assess and report on the progress of past implementation and future direction.
- Coordinate, resolve, and avoid duplication of technical and financial activities under the same sectoral framework.
- Implement and enhance health concept and SWC mechanism in reference to supervision of SWG (P).
- Implement coordination between organizations and work implementation.

V. SWC Mechanism Secretariat (SWCMS)

1. Dr. Chanthanom Manithip	Director General, MOH Cabinet	Head of Secretariat
2. Dr. Souphaphone Sadettan	Deputy Director, MOH Cabinet	Coordinator
3. Dr. Daodouangchanh Boulommavong	Deputy Director, MOH Cabinet	Member
4. Dr. Viengmany Bounkham	Deputy Director General, DPF	Member
5. Dr. Viengsakhone Louangpradith	Deputy Director, DHR	Member
6. Dr. Bouakeo Souvanthong	Deputy General, DHHP	Member
7. Dr. Sengmany Khambounheuang	Deputy Director General, DOP	Member
8. Dr. Phonpaseuth Sayamoungkhoun	Director General, DCDC	Member
9. Dr. Souksomkhouan Chanthamath	Deputy Director, FDD	Member
10. Mr. Sengaloun Souliyanon	Chief, Administration Division, MOH Cabinet	Member
11. Ms. Dalouny Choulamany	Chief, Women and Child Advancement Promotion Division, MOH Cabinet	Member
12. Dr. Daovieng Duangvichit	Chief, Administration Division, MOH Cabinet	Member
13. Ms. Onsy Vilayseng	Deputy Chief, Administration Division, MOH Cabinet	Member
14. Dr. Phetvongsin Chivorakoun	Deputy Chief, Division of Planning and Investment, DPC	Member
15. Ms. Sony Sisomvong	Deputy Chief, Division of International Relations, MOH Cabinet	Member
16. Dr. Phongsavang Bounsavath	Deputy Chief, Administration Division, MOH Cabinet	Member
17. Dr. Sengtavanh Keokeanchanh	Technical Officer, Division of International Relations, MOH Cabinet	Member
18. Ms. Somdaovieng Sayathong	Technical Officer, Division of Administration and Finance, MOH Cabinet	Member
19. Mr. Vilakhone Kindalack	Technical Officer, Division of International Relations, MOH Cabinet	Member
20. Ms. Sotsay Khamsone	Technical Officer, Division of International Relations, MOH Cabinet	Member
21. WHO representative		Member
22. Japan International Cooperation Agency representative		Member

❖ **Roles and responsibilities of SWCMS**

- Implement technical coordination between internal line departments, relevant sectors at central and sub-national level, and international donors.
- Take ownership, facilitate the meetings and consolidate the meeting reports and key updates from TWGs to the Secretariat of SWG (P) and SWG (O), and Health Sector Reform to report in the meetings of SWG (P) and SWG (O).
- Support TWGs in monitoring, inspection, and evaluation of the implementation of projects, activities, and various works on quarterly, six-monthly, nine-monthly, and yearly basis, to ensure relevant works under its program are being implemented and achieving target indicators.
- Support TWGs in report-assessment, including outcomes, pros and cons, challenges, and lesson learned from the implementation, through the meeting, including coordination work prior to report to Steering Committee, and provide direction, methods, and measures for resolving the issues to achieve target indictors.
- Support coordination works under the guidance of the Overall Leading Committee, such as, coordinating meeting arrangements, line departments, interpretation and translation, publications/handouts, secretary tasks (select meeting date), agenda, invitations, memos, and others.
- Join with health coordination committee in the development of Program Management Matrixes, A Joint Monitoring and Evaluation Framework, system capacity development.
- Improve database for international aid and large projects in the health sector.
- Draft, print, and disseminate meeting minutes and key information of the health sector by email or by paper.
- Disseminate information of relevant sectors and DPs based on approval of coordination committee.

■ Governance Structure of SWCMS

- SWCMS is under MOH Cabinet which will coordinate with relevant departments, whereas relevant departments take ownership under the direct guidance of the Director General of MOH Cabinet.

VI. SWG Technical Level – SWG (T)

TWG 1: Human Resource for Health

1. Dr. Khampasong Theppanya	Deputy Director General, DOP
2. Dr. Bounthom Samountry	President, University of Health Sciences
3. Professor Dr. Mayfong Mayxay	Vice President, University of Health Sciences
4. Professor Dr. Akao Lyvongsa	Vice President, University of Health Sciences
5. Dr. Latsamy Siengsounthone	Director General, Lao Tropical&Public Health Institute
6. Dr. Sengmany Khambounheuang	Deputy Director General, DOP
7. Dr. Molina Choummanivong	Chief, Administration Office, University of Health Sciences
8. Dr. Visany Vongsavanh	Chief of Administrative Division, Department of Organization and Personnel
9. Dr. Viengsanh Phanmanivong	Chief, Health Financing Policy Division, DOF
10. Mr. Pattanaphong Patsamath	Chief, Hospital Management-IT Division, CMR

TWG 2: Health Financing

1. Dr. Bounserth Keoprasith	Director General, DPF
2. Ms. Aphone Visathep	Director General, National Health Insurance Bureau
3. Dr. Chansaly Phommavong	Deputy Director General, DPF
4. Mr. Southanou Nanthanontry	Deputy Director General, DPF
5. Dr. Viengmany Bounkham	Deputy Director General, DPF
6. Dr. Souphab Panyakeo	Deputy Director General, DPF
7. Mr. Mayphone Soukvisay	Chief, Division of Monitoring and Evaluation, DPF
8. Dr. Thepphouthone Sorsavanh	Chief, Division of Health Information, DPC
9. Dr. Viengsavanh Phanmanivong	Chief, Health Financing Policy Division, DOF
10. Mr. Pattanaphong Patsamath	Chief, Hospital Management-IT Division, CMR
11. Dr. Molina Choummanivong	Chief, Administration Office, University of Health Sciences
12. Ms. Manosone Phetsomphone	Chief, Division of Accounting, DOF
13. Dr. Phetvongsin Sivorakhoun	Deputy Chief, Division of Planning and Investment, DPF

TWG 3: Service Delivery

- **Healthcare and Rehabilitation**

1. Dr. Khamsay Dethleuxay	Director General, DHR
2. Dr. Sommana Rattana	Deputy Director General, DHR
3. Dr. Viengsakhone Louangpradith	Deputy Director, DHR
4. Dr. Sousath Vongphachanh	Director General, Mahosot Hospital
5. Dr. Sommanikhone Phangmanixay	Director General, Children Hospital
6. Dr. Sivanxay Chanthavongsack	Director General, Mother and Children Hospital
7. Dr. Bouakeo Souvanthong	Deputy General, DHHP
8. Dr. Thongphet Sitthivanh	Director, Centre of Medical Rehabilitation
9. Dr. Khamkhoune Holanouphap	Director, National Ophthalmology Center
10. Dr. Amala Philavanh	Director, National Dermatology Center
11. Dr. Phonesavanh Keonakhone	Director, National Nutrition Centre
12. Dr. Visany Vongsavanh	Chief of Administrative Division, Department of Organization and Personnel
13. Mr. Pattanaphong Patsamath	Chief, Hospital Management-IT Division, CMR
14. Dr. Phoumsavath Ounnavong	Technical Officer, Division of Healthcare and Rehabilitation, DHR

- **Hygiene and Health Promotion**

1. Dr. Phonepaseuth Ounaphom	Director General, DHHP
2. Dr. Bouakeo Souvanthong	Deputy General, DHHP
3. Dr. Dr. Khamkhoune Holanouphap	Director, National Ophthalmology Center
4. Dr. Kongkham Miboun	Director, National Center for Environmental Health and Water Supply (Nam Saat)
5. Mr. Visith Khamleusa	Director, Centre of Information and Education for Health
6. Dr. Viengkhan Phixay	Deputy Director, Mother Child Health Center
7. Dr. Phonethavy Khotsimeung	Chief, Division of Administration and Planning, DHHP

- **Communicable Diseases**

1. Dr. Rattanaxay Phetsouvanh	Director General, DCDC
2. Dr. Phonpaseuth Sayamoungkhoun	Deputy Director General, DCDC
3. Dr. Phonepadith Xangsayarath	Director, National Center for Laboratory and Epidemiology
4. Dr. Donekham Inthavongsa	Director, National TB Center
5. Dr. Phouthone Southalack	Director, Centre for HIV/AIDS and Sexually Transmitted Infections
6. Dr. Keobouphaphone Chindavongsa	Director, Center for Malaria Parasitology and Entomology of Lao PDR

- **Food and Drug**

1. Dr. Bounsou Keohavong	Director General, FDD
2. Dr. Souksomkouan Chanthamath	Deputy Director, FDD
3. Dr. Bounleune Duangdeaune	Director, Institute of Traditional Medicine
4. Dr. Chansapha Pamanivong	Director, National Center of Food & Drug Analysis
5. Dr. Mani Thammavong	Director, Medical Products Supply Centre
6. Dr. Bounleune Palathsagnotha	Director, Bureau of Food and Drug Inspection

TWG 4: Governance, Management, and Coordination

1. Dr. Chanthanom Manithip.	Director General, MOH Cabinet
2. Dr. Bounserth Keoprasith	Director General, DPF
3. Dr. Khampasong Theppanya	Director General, DHP
4. Dr. Khamphoua Southisombath	Director General, Department of Inspection
5. Ms. Aphone Visathep	Director General, National Health Insurance Bureau
6. Dr. Khamsay Dethleuxay	Director General, DHR
7. Dr. Somphaeng Sounvannmety	Deputy Director General, DOI
8. Dr. Daodouangchanh Boulommavong	Deputy Director, MOH Cabinet
9. Dr. Souphaphone Sadettan	Deputy Director, MOH Cabinet
10. Dr. Viengmany Bounkham	Deputy Director General, DPF
11. Dr. Chansaly Phommavong	Deputy Director General, DPF

TWG 5: Monitoring and Evaluation

1. Dr. Chanthanom Manithip.	Director General, MOH Cabinet
2. Dr. Khamphoua Southisombath	Director General, DOI
3. Dr. Daodouangchanh Boulommavong	Deputy Director, MOH Cabinet
4. Dr. Souphaphone Sadettan	Deputy Director, MOH Cabinet
5. Dr. Thongvanh Phetchaleun	Deputy Director, DOI
6. Dr. Chansaly Phommavong	Deputy Director General, DPF
7. Dr. Viengmany Bounkham	Deputy Director General, DPF
8. Dr. Molina Choummanivong	Chief, Administration Office, University of Health Sciences
9. Mr. Mayphone Soukvisay	Chief, Division of Monitoring and Evaluation, DPF
10. Thepphouthone Sorsavanh	Chief, Division of Health Information, DPF
11. Mr. Pasoumphone Thammarongsad	Chief, Division of Planning and Investment, DPF
12. Dr. Viengsavanh Phanmanivong	Chief, Health Financing Policy Division, DOF
13. Mr. Pattanaphong Patsamath	Chief, Hospital Management-IT Division, CMR

❖ **Roles and responsibilities of TWGs**

- Develop strategies under its scope of work.
- Develop annual and five-year implementation plan, and undertake regular monitoring and evaluation, to achieve target indicator.
- Report work progress to SWG (O) and SWG (P).
- Organize TWG meetings.
- Carry out other activities relating to health sector development under its program.

Article 2: assign committee for supervision, technical coordination, and implementation of the Health Sector Reform Strategy and coordination in the health sector at provincial level, comprising the following members:

1. Chief of Provincial Health Department
2. Director of Provincial Hospital
3. Director of Provincial Health Science College/Provincial Health School
4. Chief of Provincial Planning and Cooperation, Provincial Health Department
5. Chief of Finance Division, Provincial Health Department
6. Chief of Provincial Health Insurance, Provincial Health Department
7. Chief of Provincial Healthcare Division, Provincial Health Department
8. Chief of Hygiene and Health Promotion Division, Provincial Health Department
9. Chief of Provincial Communicable Disease Division, Provincial Health Department
10. Chief of Provincial Food and Drug Division, Provincial Health Department
11. Other division or sector as deemed necessary.

Article 3: leading technical committee, technical coordination committee, secretariat and provincial coordination committee can assign assisting team as deemed necessary.

Article 4: Cabinet, DPC, DHHP, DCDC, DHR, FDD, DOI, and DOP, Department of Education and Scientific Research, DOF, institutions, centers, provincial departments, provincial hospitals, health science colleges, provincial health schools, and other assigned individuals shall implement this Decision based on his/her role.

Article 5: this Decision is effective from the date of signature and to replace Decision No. 1825/MOH dated 25 Aug 2017.

Minister

Bounfeng PHOUMMALAYSITH MSc, MMA, Ph.D.

Cc:

1. MOH Cabinet 1 copy
2. Department 1 copy
3. Provincial Health Department, 1 copy/province
4. District Health Office, 1 copy/district
5. Provincial Hospital 1 copy
6. Health science college/school
7. Relevant individual 1 copy
8. Filing 1 copy

Table of content

Abbreviations

APSED	Asia-Pacific strategy for emerging diseases
ASEAN	Association of Southeast Asian Nations
CBHI	Community-Based Health Insurance
CDC	Centre for Disease Control
CHE	current health expenditure
CRVS	Civil Registration and Vital Statistics
DGHE	domestic government health expenditure
DH-A	district hospitals type A
DH-B	district hospitals type B
DHIS2	District Health Information Software
DP	development partner
FreeMNCH	Free Maternal, Newborn and Child Health
GDP	gross domestic product
GGE	general government expenditure
GGHE	general government health expenditure
HEF	Health Equity Fund
HSDP	Health Sector Development Plan
HSRS	Health Sector Reform Strategy
LDC	least developed countries
LPRP	Lao People's Revolutionary Party
LSIS2	2016 Lao Social Indicator Survey
MOH	Ministry of Health
NCD	non-communicable disease
NHI	national health insurance
NSEDP	National Socio-Economic Development Plan
ODA	official development assistance
OOP	out-of-pocket
PHC	primary health care
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SASS	State Authority for Social Security
SDG	sustainable development goal
SSO	Social Security Organization
SWC	Sector-Wide Coordination
TWG	technical working group
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Background

The Health Sector Reform Strategy (HSRS) and Framework Till 2025 was approved by the National Assembly (No. 044/NA.VII) on 19 December 2012 and has been implemented in three phases with different objectives since 2014. Phase I (2013–2015) focused on achieving the Millennium Development Goals related to health status and Phase II (2016–2020) focused on ensuring quality primary health care (PHC) services, accessible by a majority of the Lao people. Phase III (2021–2025) aims to achieve universal health coverage (UHC) and health system sustainability in order to contribute to reducing poverty. The HSRS has been widely disseminated throughout the country and has become an important reference for the health sector to plan health development, supported by the Government of Lao PDR as well as other countries and international and civil society organizations, to continuously build on advancements made in the health sector.

To ensure that the implementation of the HSRS is effective and efficient and achieve the targets set until 2025, in 2019, the Ministry of Health (MOH), in collaboration with relevant stakeholders, including other countries, the World Health Organization (WHO), and other international organizations, reviewed the implementation of Phase I and II of the HSRS to identify progresses, strengths, weaknesses and challenges. The review found that many of the targets set out in the HSRS have been achieved, especially in the areas of health promotion, disease prevention, treatment and rehabilitation (including for malaria, TB and HIV/AIDS), maternal and child health care, and UHC. At the same time, there are many challenges that need to be addressed, such as nutrition in children under 5 years old, maternal and child mortality, antenatal care in obstetrics and gynecology, immunization, access to clean water and latrines, quality and sustainability of the national health insurance (NHI) scheme, hospital autonomy, implementation of the Three-Builds Policy approach (province as the strategic unit, district as the integration unit and village as the development unit), and strengthening PHC.

Therefore, according to the resolutions of the 11th National Congress of the Lao People's Revolutionary Party (LPRP), the 9th National Socio-Economic Development Plan (NSEDP) and the 9th National Congress of the Ministry of Health, MOH together with relevant departments and international organizations has revised HSRS Phase III and launched HSRS Phase IV with a focus on 11 indicators approved by the National Assembly. The revised HSRS retains the five pillars given under Phase I and II, however, the name of the fifth pillar has been changed from Health Information System to Health Information, Planning, Monitoring and Evaluation. The five pillars of the revised HSRS are: (1) Health Service Delivery, (2) Human Resources for Health; (3) Governance, Management, and Coordination, (4) Health Financing, and (5) Health Information, Planning, Monitoring and Evaluation. The revised HSRS further sets out targets, measures and approaches for both central and sub-national levels to implement and monitor the pillars effectively.

2. Review of the Health Sector Reform Strategy (HSRS)

2.1. Sector Context

With the expansion of international relations and development of the country according to the market economy mechanism and in line with the new vision of the party, Lao PDR has made rapid and continuous progress with socio-economic development. Various projects have been developed to create job opportunities, market integration, and trade and investment mechanisms with neighboring countries and the region, resulting in a large number of people moving in and out of Lao PDR each year. The country's gross domestic product (GDP) has grown at an average rate of 7% per year.

However, there is inequity in the socio-economic development. The infrastructure such as road accessibility between urban and rural areas and the average per capita income between urban and rural people is very different. The Lao Social Indicator Survey 2017 (LSIS2)[1] found that the majority of the Lao population (72%) are children and adolescents, which is a condition and an important force for the development of the nation. At the same time, there are major challenges for public health, such as maternal, neonatal, infant and under-5 mortality, and malnutrition among children under 5; although rates have fallen sharply over the years and almost met the expected targets, Lao PDR still has higher rates than many countries in the Association of Southeast Asian Nations (ASEAN) region, as shown in Table 1 below.

Table 1. Maternal, neonatal, and infant mortality rates[2]

Country	Maternal mortality per 100,000 live births		Neonatal mortality per 100 live births		Infant mortality per 100 live births	
	2015	2017	2018	2019	2018	2019
Brunei	30	31	5	6	10	10
Cambodia	178	160	14	14	24	23
Indonesia	192	177	13	12	21	20
Lao PDR	**209**	**185**	**23**	**22**	**38**	**36**
Malaysia	30	29	4	5	7	7
Myanmar	246	250	23	22	37	36
Philippines	127	121	14	13	22	22
Singapore	9	8	1	1	2	2
Thailand	38	37	5	5	8	8
Vietnam	45	43	11	10	16	16

Further, each year vaccination rates in the target population have reached only 70%, far from the national target 95%, while there are still outbreaks of communicable diseases which can be prevented with vaccination. There are also other disease burdens such as the COVID-19 pandemic, seasonal outbreaks, HIV/AIDs, TB, antimicrobial resistance, injuries, road accidents, and non-communicable diseases.

The National Health Account data[3] show that even though Lao PDR has expanded population coverage of the NHI scheme in 17 provinces (all provinces except Vientiane Capital), with more than 74% of the population covered, out-of-pocket (OOP) expenditure as a share of total health expenditure is still high, accounting for about 40% of total health expenditure. At the same time, the proportion of the population using clean water and households using latrines is declining, due to the effects of floods combined with the unfamiliar habits of Lao people in remote rural areas.

All of the above are highly challenging and urgent issues. The health sector in collaboration with other relevant sectors must strive to raise the standard of management and quality of health services on par with other countries in the region.

In the future, the health sector will continue to focus on the 11 national health indicators approved by the National Assembly, as outlined in Table 2 below.

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[1] Lao Statistics Bureau, Lao Social Indicator Survey; 2017.

[2] Sources: WHO, Trends in maternal mortality 2000 to 2017 report; 2019: https://apps.who.int/iris/handle/10665/327596 ; UNICEF, Levels and trends in child mortality report; 2020: https://www.who.int/publications/m/item/levels-and-trends-in-child-mortality-report-2020

[3] Ministry of Health of Lao PDR, Lao National Health Account; 2021.

Table 2. 11 health sector indicators, achievements, and targets for 2025 and 2030

No.	Indicators	Progress					Targets	
		2016	2017	2018	2019	2020	2025	2030
1	Underweight children under 5 (%)	24.2	22	21	20.5	20	15	10
2	Stunting among children under 5 (height for age) (%)	35	34	33.2	32.5	32	27	23
3	Infant mortality rate (per 1,000 live births)	47	43	38	34	30	20	<12
4	Under-5 mortality rate (per 1,000 live births)	62	56	51	45	40	30	<25
5	Maternal mortality ratio (per 100,000 live births)	190	182	175	167	160	110	<70
6	Births attended by skilled health professionals (%)	67.2	70	74	77	80	85	>90
7	Pentavalent 3 vaccine coverage (%)	90	90	90	90	95	95	100
8	Households with access to rural water supply (%)	86.6	87	88	89	90	95	>95
9	Households using latrines (%)	70	72	73	74	80	85	>90
10	Universal health coverage (UHC) (%)	42	71	75	78	94	96	>96
11	Model health village certification (%)	67	74	78	79	80	85	>85

As demonstrated in Table 2, satisfactory progress has been made on many indicators including infant mortality rate, under-5 mortality rate, maternal mortality rate, UHC, and model health village certification. At the same time, other indicators show slow progress and high risk that targets will not be achieved if appropriate measures are not taken; in particular, the rates of births attended by skilled health attendants, Penta 3 vaccine coverage (for infants under 1), underweight children under 5, stunting among children under 5, households with access to rural water supply and households using latrines.

Based on the review of the achievements and challenges in the implementation of the HSRS, these indicators suggest that the health sector in Lao PDR is facing new opportunities and challenges. With geographical location of the country, demographic transition, lifestyle changes, and socio-cultural changes, our efforts to strengthen the national health care system gives us lessons in identifying future opportunities to move forward for the future and priorities for effective implementation of the HSRS to achieve UHC and SDG targets. It is noted that international environment, domestic socio-economic development and the national health system are correlated, and all these supports the achievement of the development targets of public health in our country. Strengthening the national health system is the priority. It covers infrastructure, coordination, management, health service delivery, human resources for health, relevant laws and regulations in the health sector, funding, budget for investment, and implementation of key interventions. Apart from these, the HSRS requires support and ownership by various stakeholders, relevant sectors, social organizations, development partners (DPs), communities, and all levels of society to ensure that health needs of population in Lao PDR in the new era are met. People in urban and rural areas should have equitable and fair access to quality health services to “Leave No One Behind.”

Another important issue in the development of health services is reducing the gap in the quality of services between urban and rural areas. More than half of the population of Lao PDR are farmers and live in the countryside. While making efforts to enhance the quality of health services in urban areas to the same level

of quality as other countries in the region, we must improve and build health service networks in rural areas for greater accessibility, quality and safety. Our party and government have taken this issue seriously and have a clear Three-Builds Policy focused on strengthening PHC, as well as a dedicated PHC Policy. Improving and strengthening health service networks at the local level includes: reviewing the system and improving and upgrading health infrastructure; ensuring adequate provision of medicines and medical supplies to meet basic service needs; managing and allocating health workers in remote rural areas to meet actual service conditions and build professionalism; improving health financing, especially the quality and sustainable universal health coverage; supporting appropriate policies and incentives provided by the legislature in accordance with regulations; encouraging people from all walks of life and all sectors of society to take ownership based on 'Health for All by All'.

2.2. Review of HSRS Phase I and Phase II

The mid-term review of HSRS implementation in 2019 indicated that priorities had been set and integrated at both central and sub-national levels. Many indicators approved by the National Assembly had shown satisfactory progress. Legislation, guidelines, and improved working methods developed more rapidly than in the past. There has been substantial progress in each of the five pillars of the HSRS:

- **Health Service Delivery**: MOH announced the Five Goods, One Satisfaction Policy as an important basis for health facilities to improve and upgrade the quality of health services and infrastructure at both central and sub-national levels, which have been repaired and rebuilt to a higher standard. The Health Care Professional Council was established to improve the quality of health personnel. The Essential Health Services Package was developed and the process of preparing to set service fees in line with the current socio-economic situation in the country is underway.
- **Human Resources for Health**: The government improved the organizational structure of selected health education institutions; improved selection criteria and the mechanism of selecting students to enroll in health education institutions; improved and defined the rights, roles and responsibilities of each department, division, and institution at the central, provincial and district levels; distributed staff based on the health needs of the communities in catchment areas; prioritized remote and rural areas in the distribution of human resources for health; and implemented the initial steps to introduce a licensing/registration system for health care professionals.
- **Governance, Management and Coordination**: The government issued decisions, guidelines, laws and regulations to provide a strong legal basis for effective management and implementation of the HSRS. The government also divided governance and management between the district health office and district hospital; piloted and rolled out the Three-Builds Policy approach for relevant health activities; strengthened monitoring and evaluation; and addressed challenges which occurred during the implementation of the HSRS.
- **Health Financing**: The government improved financial management mechanisms for the health sector, implemented official development assistance (ODA), integrated various health insurance schemes into the NHI scheme and expanded NHI coverage to 17 provinces (all provinces except Vientiane Capital). More than 74% of the population are now covered by the integrated NHI scheme.
- **Health Information, Planning, Monitoring and Evaluation**: The government improved the health information management system for data collection and reporting and assisted health service facilities (central, provincial, and district hospitals and health centers) in using IT and the District Health Information Software (DHIS2). Furthermore, great efforts were made to improve the collection of the Family Folder data (off-site health services data) to provide important information for monitoring and evaluation of health care services and health planning.

3. Vision, Mission and Objectives of the HSRS until 2030

3.1. Vision

The vision of MOH remains "health for all by all." According to this vision, all sectors and all of society must support, contribute to, and be responsible for health, so that Lao people as a whole have good health in accordance with the concept and principle of PHC agreed upon in the Astana Declaration in 2018.

3.2. Mission

The mission, in line with the resolution of the 11th Party Congress, is to "continue to develop and enhance strategies on human capital development through policies to achieve UHC, focusing on the promotion of healthy lifestyles, prevention of diseases, and equitable access to quality health services to all."

3.3. Objectives

3.3.1. Target

The target of HSRS Phase III and IV is to achieve UHC by 2025, contribute to least developed countries (LDC) graduation by 2026 and achieve SDGs by 2030.

3.3.2. Strategic direction

To achieve UHC by 2025, LDC graduation by 2026 and SDGs by 2030, the HSRS will focus on strengthening PHC as a critical foundation to implement health sector priorities across the five HSRS pillars in a more sustainable, equitable, efficient and effective way in the next decade. Further, building a resilient national health system will be critical in responding to and being well-prepared for any public health emergencies. For this we must ensure to:

(I) *Upgrade the standards of health care services in hospitals across all levels according to the national quality standards and with a strong focus on PHC to be comparable to other countries in the region and globally* by setting clear priorities for improvement each year and investing in infrastructure, medicines and medical products, medical equipment, and human resources for health. Further, by reviewing the current and future health needs of communities at the sub-national level (district hospitals and health centers) and restructuring health care facilities for efficient use of limited resources to improve the quality of health care services. Furthermore, efforts will be made to repurpose underutilized health centers to provide other forms of services such as health promotion and prevention and develop effective investment plans for financing human resources and services for better response preparedness to public health emergencies and outbreak diseases such as the COVID-19 pandemic.

(II) *Strengthen health care at the grassroots level through improved health care service capacity in accordance with the PHC and Three-Builds policies* by establishing systems and mechanisms to support health services across the continuum of care: from health promotion, disease prevention, treatment, and rehabilitation and palliative care at health facilities, specifically district hospitals and health centers, to outreach services (for families, communities and villages). This is achieved through empowered communities and mechanisms to coordinate between communities and health care facilities, and with other sectors, supported by comprehensive policies and regulations in alignment with the principles of the PHC and Three-Builds policies.

(III) *Improve the emergency referral system from PHC services to more suitable facilities* by establishing clear systems, mechanisms, and responsible persons, without barrier in terms of transportation and affordability, to ensure timely referral and safety of patients during emergencies

(IV) *Improve and expand the NHI scheme* by expanding coverage to include more treatments and services such as health promotion and prevention, while improving the sustainability of the scheme, in order to ensure equitable access to essential health services and financial protection and reduce OOP expenditure.

(V) *Strengthen governance of management, planning, financing, monitoring and evaluation* at all levels and in all areas of the health sector. Strengthen leadership and management roles of authorities, party management, and leaders at all levels to enable ownership, responsibility and accountability for party members and personnel across the health sector. This should be undertaken with the spirit of the Four Breakthroughs ideology (focusing on breakthroughs in creative and proactive mindset, human resources, administration reform, and socio-economic development) and Three-Builds Policy approach (province as the strategic unit, district as the integration unit and village as the development unit).

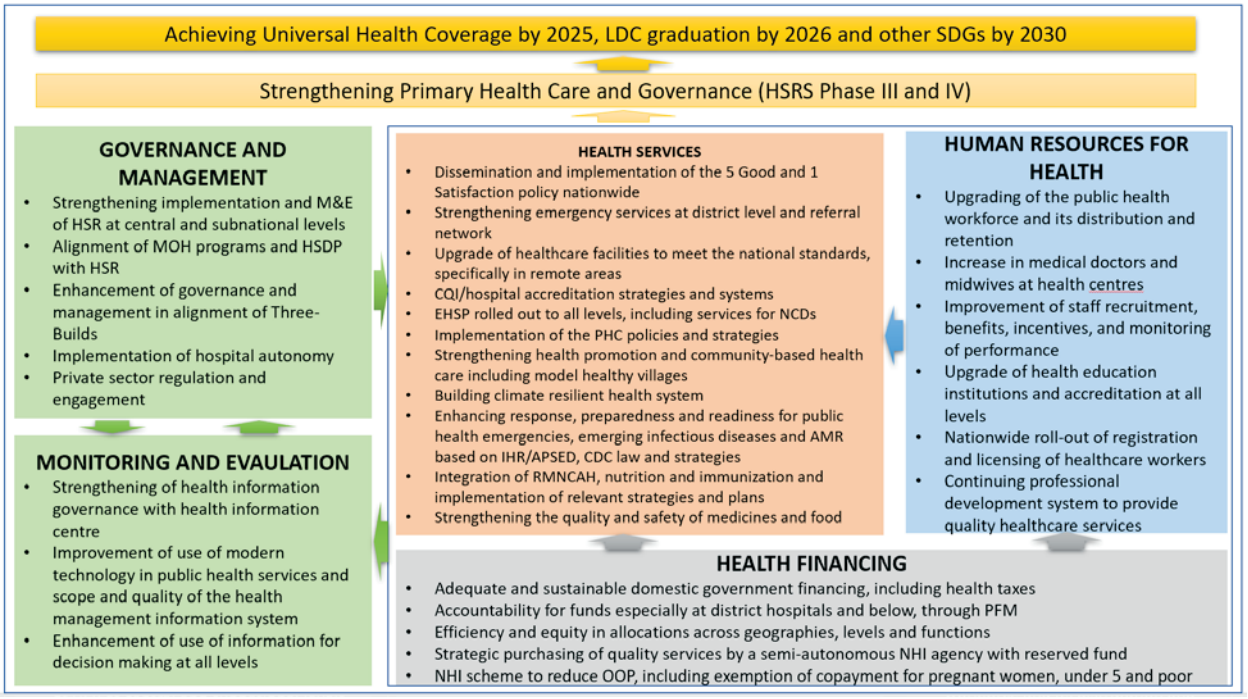
4. HSRS Phase III (2021–2025) and Phase IV (2026–2030)

This section introduces HSRS Phase III (2021–2025) and Phase IV (2026–2030). The development of the health sector in each aspect and at each level of the HSRS focuses on concrete reform and is driven by a multi-sector approach at central and sub-national levels. HSRS Phase III and IV outline expectations and comprehensive strategies for each of the five HSRS pillars: (1) Health Service Delivery, (2) Human Resources for Health; (3) Governance, Management, and Coordination, (4) Health Financing, and (5) Health Information, Planning, Monitoring and Evaluation.

The formulation of HSRS Phase III (2021–2025) is based on the achievements, shortcomings, and lessons learned from the implementation of HSRS Phase I and II as well as the implementation of the 8th Five-Year Health Sector Development Plan (HSDP) (2016–2020). At the same time, it was based on the resolutions of the 11th National Congress of the LPRP, the 9th NSEDP and the 9th National Congress of the Ministry of Health. In order to achieve the targets set, HSRS Phase III and Phase IV focus on reforms in the priority areas described by the five HSRS pillars.

The pillars are interconnected with Health Service Delivery at the core. Together, they strengthen PHC and governance which in turn contributes to the HSRS objectives of UHC by 2025, LDC graduation by 2026, and SDGs by 2030. The relationship between pillars and HSRS objectives, as well as priorities for improvements related to each pillar, are outlined in the figure below:

Figure 1. Priorities of the Health Sector Reform Phase III and IV to achieve UHC by 2025 and SDGs by 2030



4.1. Pillar 1: Health Service Delivery

4.1.1. Responsible Program

MOH Program	Responsible Department/Unit
Curative Health Services	Department of Health Care and Rehabilitation
Hygiene and Health Promotion	Department of Hygiene and Health Promotion
Prevention and Control of Infections	Department of Communicable Disease Control
Food, Drugs and Medical Supplies Consumer Protection	Department of Food and Drugs

4.1.2. Situation

As part of efforts to improve health service delivery, the Five Goods, One Satisfaction Policy, the national policy on improvement of the quality of health care services, has been disseminated and implemented throughout the country. However, the policy is quite vague and has been ineffective in meeting its set objectives. The cost of services in many hospitals vary. Many hospitals have a shortage or lack of medicines to treat patients. PHC at the sub-national level is not strong and the referral system in case of emergency is not executed in a systematic and timely manner. Vaccination rates in the target population in many places have not met expectations, with an average annual reach of only 70%. Every year, there are still outbreaks of some diseases that can be prevented by vaccination. Furthermore, there are widespread outbreaks of seasonal diseases in many provinces, especially dengue and malaria. In addition, natural disasters have impacted health infrastructure, including district hospitals and health centers being damaged, and access to clean water systems and latrines being cut-off or limited.

4.1.3. Targets

Targets for Health Service Delivery by 2025 and 2030 are as follows:

No.	Targets	By 2025	By 2030
1	Continue to disseminate and implement the Five Goods, One Satisfaction Policy throughout the country and increase effectiveness by using the Scorecard system	✓	✓
2	Increase the number of district hospitals type A (DH-A) able to provide emergency surgery services	35 DH-A	40 DH-A
3	Upgrade the standards of infrastructure in health facilities in remote, rural areas	50%	75%
4	Ensure all private hospitals and clinics at each level (central and sub-national) are monitored, inspected and licensed to operate in accordance with the law	70%	90%
5	Complete the pilot for hospital autonomy at the central level and roll it out to provincial hospitals	5 hospitals	22 hospitals
6	Ensure that all health care facilities, from the central to the sub-national level, have adequate essential medicines, including non-communicable drugs, for quality, prevention and treatment	85%	95%
7	Increase the number of hospitals accredited for Good Hospital Pharmacy Practice	15 hospitals	30 hospitals
8	Ensure district and provincial hospitals across the country provide emergency life-saving services 24 hours a day, 7 days a week	90%	100%
9	Continuously improve the quality of health services through strengthening licensing and quality assurance system of hospitals	50%	85%
10	Roll out the Essential Health Services Package at all levels across the country	85%	95%
11	Implement and monitor strategies and policies for PHC	✓	✓
12	Increase the proportion of accredited model healthy villages	85%	>85%

4.1.4. Activities

1. Continue to disseminate and implement the Five Goods, One Satisfaction Policy across the country, using the Scorecard system.
2. Continuously improve the quality of health services through strengthening licensing and quality assurance system of hospitals.
3. Roll out the Essential Health Service Package including services for NCDs across all levels nationwide.
4. Review current health centers and district hospitals to restructure and improve the infrastructure, upgrade district hospitals from type B (DH-B) to DH-A according to the targets (35 by 2025 and 40 by 2030) and equip them with necessary medical equipment and qualified human resources for health.
5. Strengthen the referral system to more equipped facilities at an appropriate level of services by using IT systems, especially Digital Health, to integrate diagnosis and treatment so that hospitals at all levels provide treatments to patients more efficiently.

6. Improve and upgrade health infrastructure of hospitals at all levels to meet the national quality standards.
7. Manage private hospitals and clinics to provide health promotion and treatment services in line with the Law on Health Care.
8. Increase hospital autonomy gradually along with strengthening financial management in a transparent and sustainable manner.
9. Review and set service fees for consulting and health care services at each health facility with a clear and reasonable price.
10. Ensure the medicine and medical equipment meets the level of service facility/hospital and hospitals implement the National Good Pharmacy Practice Guideline.
11. Build and improve warehouses and storage systems for medicines and medical products from the central and sub-national levels to meet the standards to support storage and distribution services in a timely manner.
12. Strengthen the packaging system of food, medicines, and medical products to achieve the principles of good production for wholesale and retail to ensure quality, safety and consumer protection.
13. Develop regulations for setting prices of medicines and medical equipment and strengthen regulations on quality control and assurance.
14. Establish a food quality assurance association.
15. Implement the National COVID-19 Strategic Preparedness and Response Plan for Health 2020–2025 efficiently and effectively.
16. Monitor and respond to health emergencies in accordance with international health regulations and strategies, and the Law on Prevention and Control of Communicable Disease, including for HIV/AIDS, TB, malaria, dengue, avian influenza and others.
17. Build the resilient health system for effective and timely response, preparedness and readiness in preparation for any future public health emergencies, emerging infectious diseases, AMR, and climate change.
18. Strengthen health interventions based on the Three-Builds and PHC policies by reviewing and improving the methods and mechanisms for multi-sectoral coordination between sectors, for instance, the ministries of home affairs, finance, transport and public works, and mass organizations, at the central and local levels, on health activities at the village level, such as, village health committees, village health volunteers, and others.
19. Define health policy at the village level with a set of basic priority services that must be provided, for example, disease prevention and promotion of health.
20. Implement health promotion activities to prevent NCDs and reduce risk factors of NCDs such as diabetes, high blood pressure, cancer and other chronic diseases with appropriate methods. For instance, improving the environment for daily living, health care for the elderly, community mental health care, promotion of physical activity and reducing obesity, smoking, consumption of sugary drinks, alcohol, and others.
21. Strengthen the implementation of accredited model healthy villages to increase their proportion and achieve the set targets.

4.1.5. Expected results by 2025 and 2030

1. Health care service standards have been improved and upgraded (infrastructure, medical equipment and supplies, diagnostic and clinical services) according to each level of care and treatment. Health personnel at each level are trained and skilled.
2. Utilization of sub-national hospitals has been improved to reduce overcrowded provincial and central hospitals.
3. With strengthened district hospitals, the referral system to deliver emergency services has been enhanced to be in a timely manner, even in remote areas.
4. Health care facilities at PHC level have been improved and are a driving force for promoting the health of the Lao people, of all ethnic groups, at the grassroots level and support remote areas to have access to quality and timely health care services.
5. Integrated RMNCAH and nutrition have been improved and implemented to be of better quality and more accessible.
6. Improved cooperation in all fields to promote an environment and facilities for living, job creation and good health to enable people of all ethnic groups to live a quality, happy and long lives, and community health and nutrition services under model health villages have been fully developed.
7. Disease preparedness, surveillance and response systems have been strengthened.
8. Reasonable use of drugs to avoid side effects has been widely promoted and covered.

4.2. Pillar 2: Human Resources for Health

4.2.1. Responsible program

MOH Program	Responsible Department/Unit
Health Personnel Management, Development and Health Sciences Research	Department of Health Personnel Healthcare Professionals Council University of Health Sciences Health sciences colleges and provincial health education institutions

4.2.2. Situation

Although great efforts have been made to build human resources for health through training, improved staff distribution and other approaches in order to respond to the health needs of communities, limited personnel in terms of both quantity and quality is a challenge. We lack skilled doctors and specialists in various fields, both at the central and sub-national levels. Data from the 2020 Annual Report on Health Personnel Distribution show that the ratio of physicians, nurses and midwives per 1,000 population in the country is 1.46, far below the WHO recommendation of 4.45. The proportion of health workers per 1,000 population in urban and rural areas is very different at 6.16 in urban areas and 1.94 in rural areas. While urban areas still have limited or a lack of clinical expertise and specialists, remote rural areas have very limited numbers of medical staff. Data from the report3 indicated that there were 1,057 health centers across the country and, of these, 867 (82%) had two or more staff and 781 (73.9%) had midwives or obstetricians (including contract staff). Pre-service training of health personnel replacements in health care facilities are not timely managed, and the gap between senior and young medical personnel may be a challenge in the future.

The above-mentioned issues have had a negative impact and pose major challenges to the improvement of health service quality, including issues of overcrowding and disruption in provincial and central hospitals.

On the other hand, district hospitals and health centers are often underutilized, making it difficult for public hospitals to upgrade their service quality and sustainability.

Efforts have been made to strengthen health education institutions to improve the quality of teaching and learning with well-coordinated mechanisms for clinical placement between health education institutions and health facilities where students can enhance their clinical knowledge, skills and experiences. Further, there are also key priorities to make Medical Teaching Units available and improve the technical capacity of health personnel for continuing professional development, ensuring that graduates are competent in alignment with the standards and scope of practices of health care professions.

The health sector has a system of health education institutions from the diploma level up to the master's degree and specialist level II. There are 11 health education institutions under MOH: one University of Health Sciences, one Tropical and Public Health Institute, three Colleges of Health Sciences, three public health schools, one technical nursing school, and two public health training centers. Each year, more than 30 health professions are trained, with an average of 2,181 graduates per year through both direct and bridge systems.

In the past, improvements in health education institutions have focused on the quality of the health education institutions; linking health education institutions and health facilities where medical students practice their skills; establishing a Medical Teaching Unit; Quality Assurance; upgrading teachers in both theory and practice, domestically and internationally; reviewing, revising and developing curricula in various disciplines; building the capacity of each medical profession; and developing plans for each health education institution including legislation for management, monitoring and evaluation. Nevertheless, the quality of teaching and learning in many health education institutions is still a challenge and needs to be addressed urgently. It has led to public complaints on the ability and medical ethics, among other issues, of graduates who work in many health care facilities. Therefore, relevant departments and universities, colleges, and schools must review, assess, evaluate and implement comprehensive reform in terms of infrastructure, teaching and learning materials, curriculums, criteria for student entrance, and the quality of teachers.

4.2.3. Targets

Targets for Human Resources for Health by 2025 and 2030 are as follows:

No.	Targets	By 2025	By 2030
1	Distribute, add and retain health personnel, especially family physicians and surgeons, more effectively	✓	✓
2	Increase the number of staff in health centers to have at least three staff: a physician, nurse and midwife	80%	85%
3	Monitor, encourage and improve the performance of health personnel	✓	✓
4	Update the quality assurance rating of health education institutions annually	✓	✓
5	Improve the teaching-learning of all levels of health education institutions to be modern and responsive, with the equipment and facilities required to meet needs	30%	100%
6	Ensure all care providers have a health professional license and are registered	✓	✓
7	Ensure all medical professionals complete continuous professional development in order to be able to renew their health professional license	✓	✓

4.2.4. Activities

1. Improve planning, distribution and retention of health personnel.

a. Develop and update job descriptions and staffing needs projections based on standards of health services and staffing in accordance with the Law on Health Care and relevant policies, and the current and future health needs of the Lao PDR population.
b. Identify the needs of professions in clinical and administration sections in each hospital, both at the central and sub-national levels, to enhance and create opportunities for technical and administrative health staff.

2. Improve the quality of work performed by health personnel.

a. Improve organizational structure to be concise and adaptive to the specific situation and the actual working conditions in each location. Define clear mandates, roles, responsibilities, and job descriptions.
b. Improve systems, mechanisms and methods for selecting, recruiting, or replacing staff to be more efficient.
c. Create an enabling environment with a focus on improved facilities, staff safety and relevant policies that are in accordance with the rules and regulations for the implementation of professional duties along with education, self-development, and more efficient and effective workplans.
d. Improve the system for monitoring and evaluation of the performance of each unit and individual personnel by creating tools and legislation, with detailed instructions for implementation. Implement the reward system for those who have achieved outstanding results; and provide guidance, advice, criticism, or discipline in accordance with the rules and regulations to those who do not perform their duties well or have violated the rules and regulations.

3. Improve the quality of health education.

The quality of health education must be improved by reviewing the system, teaching methods and curriculum to identify achievements, strengths, weaknesses, and key challenges to improve the quality of health education institutions.

a. Upgrade the quality of health education institutions with a quality assurance system in accordance with standards. There should be further investment in building the infrastructure, facilities and environment of health education institutions that are suitable for education and study of all disciplines.
b. Review and improve the curriculum and develop new curricula for each department to meet quality standards in line with the Human Resources for Health pillar.
c. Strengthen the selection of students and teachers who will come to study and teach in health facilities, selecting those who study well, have a passion for the medical profession, and have a sincere desire to serve the nation and people.
d. Promote the continued learning of teachers in each health profession, with rewards for teachers who perform well to encourage continued efforts and further progress.
e. Encourage staff to work in remote, rural areas and ethnic areas.
f. Establish a system for monitoring, inspecting, evaluating and training staff who have completed their studies to ensure that they continuously upgrade their theoretical and behavioral knowledge, and undertake research to improve clinical practice and services by combining theoretical education with research in medical science, diagnosis and treatment of diseases, and others.

4. Strengthen the licensing and registration system for health care professionals.

a. Continue to organize the national licensing exam and issue licensing/registration for existing health care providers.
b. Establish clear policies, strategies and action plans to create an enabling environment for the health care professionals council to perform their duties effectively, with financial and technical assistance from multi-stakeholders, continuous monitoring and evaluation, and such work being considered as an integral part of the process of improving the quality of health services.

4.2.5. Expected results by 2025 and 2030

1. The health workforce at central and local levels performs their duties efficiently, effectively and with quality.
2. Competent and qualified human resources for health has been built.
3. A system has been developed for monitoring, inspection, and evaluation on the implementing unit and individuals.
4. Outstanding students and teachers with passion for the medical profession who are dedicated to serving the nation are selected to study or teach in public health education institutions.
5. Health personnel in facilities at each level have continuously upgraded the standard, quality and safety of health care services.
6. Service standards of health personnel have been improved to ensure quality, ethics, and morality. Collaboration for improving medical services with neighboring as well as ASEAN countries to achieve good results, while maintaining the interests of Lao people, has been established.

4.3. Pillar 3: Governance, Management and Coordination

4.3.1. Responsible program

MOH Program	Responsible Department/Unit
Management and Inspection	Cabinet Office Department of Health Care and Rehabilitation Department of Health Personnel National Health Insurance Bureau Department of Inspection Department of Planning and Finance

4.3.2. Situation

Governance has been a government and HSRS priority, yet there remains many areas to be improved. The approval of documents requires many stages, making the implementation of various tasks slow. There is a lack of ownership with regards to dissemination and enforcement of health sector laws, legislation, and guidelines including MOH guidelines, the implementation of the HSRS and priority projects in the health sector. For example, the implementation of the Three-Builds Policy is not yet as strong, in-depth or comprehensive as it should be.

Supervision is integrated into all areas of work and is considered as regular work and a priority which is indispensable for the leadership of the party and state management. Party organization at all levels, all party members, and all civil servants should be under inspection and supervision.

4.3.3. Targets

Targets for Governance, Management and Coordination by 2025 and 2030 are as follows:

No.	Targets	By 2025	By 2030
1	Implement a strong system of supervision, guidance, coordination and monitoring at the central and provincial levels	✓	✓
2	Implement a digital system to coordinate and exchange progress reports on the implementation of activities across provinces and MOH departments	✓	✓
3	Ensure the MOH governance structure integrates various projects and integrates the HSDP into the HSRS	✓	✓
4	Improve the management of health administration utilizing the Three-Builds Policy approach, with the provincial level setting the strategy, the district level managing and allocating the budget, and the village level leading in the implementation, with individuals, families, communities and organizations participating in planning and implementing development plans	9 provinces	18 provinces
5	Complete legislation on the transformation of hospital autonomy at the central and provincial levels	✓	
6	Approve and implement legislation on private sector engagement	✓	✓

4.3.4. Activities

1. Use existing roles and responsibilities of the National Commission for Health Sector Reform at each level to guide, coordinate, monitor and support the implementation of the HSRS.
2. Strengthen the coordination mechanism of the Secretariat of the National Commission for Health Sector Reform by encouraging relevant ministries to participate in the reform work and establishing a technical group.
3. Ensure the Secretariat develops guidelines and manuals related to the reform work and raises awareness at the provincial and district levels on the reform work through the implementation of the HSDP and MOH's annual workplans.
4. Improve the organizational structure of MOH to be in line with the actual needs of the health sector and integrate projects with similar forms under a sub-program to make implementation more effective.
5. Develop a training plan on administrative management for district administrators.
6. Complete the formulation of legislation for hospital autonomy and implement at central and sub-national levels.
7. Improve legislation and increase the capacity for inspection, provision of services and issuance of licenses to hospitals, clinics and medical professionals in the private sector.
8. Develop and implement regulations on joint ventures with the private sector.

4.3.5. Expected results by 2025 and 2030

1. Ensure coordination and information exchange among policy makers and DPs, led by the proper use of health information systems.

2. The MOH organizational structure has been adjusted effectively to be in line with the realistic needs of the health sector.
3. Policies and legislation have been developed and approved for the implementation of hospital autonomy.
4. Regulations on joint ventures with the private sector, including legislation, capacity strengthening, and licenses issued to hospitals, clinics and medical professionals, have been completed.

4.4. Pillar 4: Health Financing

4.4.1. Responsible program

MOH Program	Responsible Department/Unit
Health Financing	Department of Planning and Finance National Health Insurance Bureau

4.4.2. Situation

In 2012, the National Assembly agreed to allocate 9% of government budget to the health sector. However, in practice, each year the health sector receives an average of 7% of government budget. In addition, most of the annual budget allocated is disbursed in the middle of the year, leading to challenges in implementing various activities as planned. In 2019, domestic government spending on health (excluding donor funding) as a share of general government expenditure (GGE) was 4.9%; general government health expenditure (GGHE) (including donor funding) as a share of GGE was 8.9%.[5]

In 2019, GGHE (including donor funding) was 1.8% of GDP and current health expenditure (CHE) was 2.6% of GDP,[6] which is very low compared to other countries in the ASEAN region, as seen in Table 3.

Table 3. Current health expenditure (CHE) as % of GDP in ASEAN countries[5]

No.	Country	Code	2014	2015	2016	2017	2018	2019
1	Brunei	BRN	1.9	2.4	2.5	2.3	2.4	2.2
2	Cambodia	KHM	6.7	6.2	6.1	5.7	6.3	7.0
3	Indonesia	IDN	3.0	2.9	3.0	2.9	2.9	2.9
4	**Lao PDR**	**LAO**	**2.3**	**2.5**	**2.4**	**2.5**	**2.2**	**2.6**
5	Malaysia	MYS	3.7	3.8	3.7	3.7	3.7	3.8
6	Myanmar	MMR	4.4	5.5	5.1	5.1	4.9	4.7
7	Philippines	PHL	3.7	3.9	4.0	4.0	4.0	4.1
8	Singapore	SGP	3.9	4.2	4.4	4.4	4.1	4.1
9	Thailand	THA	3.7	3.7	3.8	3.8	3.8	3.8
10	Vietnam	VNM	4.6	4.6	4.5	4.7	5.0	5.2

The 9th HSDP (2021–2025) estimates the average budget needed to achieve UHC as US$ 500–600 million per year with continued increase. According to the budget trend, only 50–60% of actual budget needs could currently be provided. To meet health-related indicators, there should be more efforts for mobilization of funds to increase resources from internal and external sources, as well as society. Average domestic government health expenditure (DGHE) (excluding donor support) per capita in 2019 is only US$ 26 and CHE per capita is US$ 68.5 In comparison to some other ASEAN countries, the figures show large gaps, as seen in Table 4.

[5] Ministry of Health of Lao PDR, Lao National Health Account; 2021.

[6] WHO global health expenditure database: https://apps.who.int/nha/database/Select/Indicators/en

Table 4. Current health expenditure (CHE) per capita (US$) in ASEAN countries[5]

No.	Country	Code	2014	2015	2016	2017	2018	2019
1	Brunei	BRN	799	744	692	649	763	672
2	Cambodia	KHM	73	72	78	79	93	113
3	Indonesia	IDN	104	97	108	111	112	120
4	**Lao PDR**	**LAO**	**46**	**53**	**55**	**62**	**58**	**68**
5	Malaysia	MYS	426	380	362	380	426	437
6	Myanmar	MMR	53	62	58	58	59	60
7	Philippines	PHL	110	117	122	124	129	142
8	Singapore	SGP	39	42	44	44	41	41
9	Thailand	THA	219	214	225	253	279	296
10	Vietnam	VNM	117	118	124	140	163	181

In addition to the budget allocation issues mentioned above, another important issue to be addressed urgently is the management of public health finances in a strict, transparent, and auditable manner. Monitoring and evaluation of the efficiency and effectiveness of spending on all sources of investment, including government funds, loans and grants from other countries and international organizations that invest in the health sector each year is still weak. The approval process for utilization, implementation and reporting goes through many stages, leading to long delays of payments and making the implementation of tasks complicated, and activities sometimes duplicated and difficult to monitor or verify. Moreover, Lao PDR is preparing for graduation from LDC status by 2026 and the transition to domestic financing for health, requiring a much higher level of domestic funding for health in the context of donor transition (e.g., Gavi and Global Fund).

To achieve UHC by 2025, the government rolled out the NHI scheme in 2016 by merging the existing informal health insurance schemes (HEF: Health Equity Fund; FreeMNCH: Free Maternal, Newborn and Child Health; and CBHI: Community-Based Health Insurance), implementing in 17 provinces (all provinces except Vientiane Capital), managed by the National Health Insurance Bureau under MOH. Following the new policy direction, the integration of the formal health insurance schemes of the National Social Security Fund (SASS: State Authority for Social Security; and SSO: Social Security Organization), under the Ministry of Labor and Social Welfare, was integrated into NHI in 2019 under the management of the National Health Insurance Bureau. As a result, the coverage of all social health protection schemes reached 94% of the total population.

However, there are still many challenges, such as the sustainability of the implementation of the tax based NHI scheme of which 90% is from the government budget. Health insurance contributions from the beneficiaries of the NHI scheme is too small. Delayed payment to health facilities is another serious issue, causing a lack of budget for purchasing medicines, medical equipment and medical consumables. These lead to difficulties for hospitals in providing health services to their patients and in improving the quality of services. Consequently, hospitals are at risk of losing the trust of the Lao people in health services and of receiving more complaints from the public.

4.4.3. Targets

Targets for Health Financing by 2025 and 2030 are as follows:

No.	Targets	By 2025	By 2030
1	Increase state budget in the health sector	9%	9%
2	Increase expenditures from domestic sources in the health sector	40%	40%
3	Allocate budget from the public sector per capita and per unit of services to ensure equity in all provinces	✓	✓
4	Develop minimum standards for public financial management	Every district	Every health center
5	Reduce OOP expenditure	To reach 35%	To reach < 35%
6	Strengthen copayment exemption for mothers, children under 5 and the poor	✓	✓

4.4.4. Activities

1. Request the government to allocate a budget equal to or more than 9% of government expenditure each year as approved by the National Assembly.
2. Ensure adequate and sustainable public investment in the health sector.
3. Intensify efforts for the collection and application of pro-health tax in the health sector.
4. Establish a mechanism to allow health facilities to use technical revenue to improve the quality of services and other activities, with legislation supporting the introduction and implementation of hospital autonomy.
5. Increase responsibility for the implementation of the budget through the formal public financial management system.
6. Encourage and support services units that have income/revenue to gradually become autonomous and sustainable.
7. Review accounting records in accordance with the financial management guidelines, the health accounting report and relevant policies in the allocation and use of funds.
8. Improve the efficiency and equity of budget allocation.
9. Improve the budget allocation method according to geographical location, level of services and types of services, while focusing on PHC.
10. Integrate all sources of funding by using the budget allocation system according to program needs (program-based budgeting).
11. Develop a guideline and plan to improve public financial management.
12. Establish an IT system for public financial management, including a hospital information management system.
13. Create and improve legislation to support public and private investment in hospital construction.
14. Reform investment mechanisms and procurement and investment bidding methods to ensure timeliness, transparency and auditability.
15. Ensure the NHI scheme covers disease prevention, health promotion and treatment services in public hospitals and manages services provided in private hospitals and clinics.

16. Review and redefine the policies, measures and procedures for the implementation of UHC, in which policy makers and implementers monitor and evaluate the progress of UHC with specific roles and responsibilities.
17. Establish a semi-independent National Health Insurance Bureau, with off-budget funding.
18. Review the mechanisms and rates of payment, and determine the rules on fees for services that the NHI scheme has not yet covered, based on the results of costing studies.
19. Strengthen copayment exemptions for vulnerable groups such as pregnant women, children under 5 and the poor.

4.4.5. Expected results by 2025 and 2030

1. The budget for health expenditure per person per year has increased.
2. GGHE has increased to more than 1.8% of GDP.
3. OOP payments have been gradually reduced.
4. There is adequate and sustainable financing to achieve UHC.
5. By 2025, all Lao people have access to quality, equitable and fair essential health services under the management of the NHI scheme.
6. The NHI scheme has been strengthened to cover more services (including prevention, health promotion and treatment services) and is more sustainable.
7. Health service facilities receive funds in a timely manner and in line with socio-economic growth in each period.

4.5. Pillar 5: Health Information, Planning, Monitoring and Evaluation

4.5.1. Responsible program

MOH Program	Responsible Department/Unit
Planning, Cooperation, and Information	Department of Planning and Finance Cabinet Office Department of Inspection National Health Information Centre

4.5.2. Situation

In the past, great effort and investment has been made in the field of health information, planning, monitoring and evaluation by improving the quality of health information, especially with the use of DHIS2. However, there is uncertainty regarding the quality of information obtained and the level of confidence of many parties is low as each program has a different system, form and method of data collection. These challenges lead to increases in workload and create difficulties and confusion for the collector, and for information compilation and reporting at the grassroots level. Staff at each level still have limited understanding of the operation of DHIS2 which includes reporting, automated data analysis and image creation in a pre-programed system. The Family Folder data (off-site health services data) is not timely updated which hinders the ability to plan and define policies appropriately. In addition, the vaccination program is often mismatched with the projected and actual target population, impacting the planning process.

4.5.3. Targets

Targets for Health Information, Planning, Monitoring and Evaluation by 2025 and 2030 are as follows:

No.	Targets	By 2025	By 2030
1	Ensure the National Health Information Centre is fully established and adequately resourced	✓	
2	Expand the health information system to private and community services	✓	✓
3	Establish hospital financial information systems at the central and provincial level	✓	✓
4	Ensure and improve the use of modern technology in health services	✓	✓
5	Ensure technology has been used to improve health information	✓	✓
6	Ensure accurate information has been incorporated into health policy formulation and development plans	✓	✓

4.5.4. Activities

1. Establish the National Health Information Centre in line with Prime Minister's Decree approved in 2018.
2. Expand the scope of the information management system to be able to link to sources such as reports, surveys and scientific research papers used in policy decisions.
3. Improve the scope and quality of the health information management system.
4. Develop a standardized digital health reporting infrastructure (Digital Health) that can be interoperable with other systems.
5. Establish a hospital information management system that can record electronic medical information in accordance with the International Classification of Diseases.
6. Strengthen health information management, including capacity building for health information management curricula, to be able to monitor and evaluate the results of indicators related to UHC, LDCs, and SDGs.
7. Improve the DHIS2 database to be able to collect and report outbreaks of COVID-19, as well as monitor the progress of COVID-19 vaccination coverage.
8. Establish and strengthen the birth and death notification system and ensure cause of death is recorded in patients' death certificates and in the national birth and death registration system, Civil Registration and Vital Statistics (CRVS).
9. Increase the capacity to use information to make policy decisions at the provincial and district levels.
10. Build capacity at all levels by using the information system in the medical curriculum, training management, staff training and scholarships.
11. Incorporate health information into planning and monitoring of indicators, evaluating outcomes and deciding on policies related to the sector and beyond.
12. Use IT systems to upgrade the use of webmail and the centralized document management system of the MOH.
13. Create a Dashboard for senior staff to monitor the progress of the implementation of activities in the field.
14. Use health information related to health care treatment, health personnel and financial management to make data-informed policy decisions.

4.5.5. Expected results by 2025 and 2030

1. Document management by MOH is modernized through use of IT systems.
2. The collection of information on the implementation of health-related activities at the community level has been expanded and the health services of the private sector have been linked to the public health information system of the public sector.
3. The Digital Health Architecture is used to strengthen health information management systems along with other sources of information so that health information is complete, accurate, reliable, and is an important reference for health policy making and planning.

5. Estimated budget

According to the HSRS principles, the process of implementing HSRS Phase III and Phase IV must be in line with the NSEDP and should be linked to the planning and implementation of the 9th HSDP (2021–2025) and the 10th HSDP (2026–2030). This includes MOH's annual workplans for central and sub-national levels and using budget from all sources, including government budget and ODA without other specific program and budget support.

Hence, the estimate of the budget requirement for HSRS Phase III will be based on and use the budget estimates of the 9th HSDP (2021–2025), which in this period can be estimated as the total GGHE of US$ 2,755 million or US$ 65 per capita per year, as outlined in Table 5 below. The estimated budget of HSRS Phase IV (2026–2030) is US$ 2,979 million or US$ 74 per capita per year, as outlined in Table 6 below.

Table 5. General government health expenditure (GGHE) 2021–2025

Budget implemented	Unit	Realized	Projected					
		2020	2021	2022	2023	2024	2025	2021–2025
Domestic GGHE	Bil.LAK	1,496	1,991	3,310	3,707	4,164	4,689	17,861
ODA	Bil.LAK	1,101	1,080	827	1,075	1,398	1,187	6,197
Total GGHE	**Bil.LAK**	**2,597**	**3,071**	**4,137**	**4,782**	**5,562**	**6,506**	**24,058**
Total GGHE	**Mil.US$**	**291**	**334**	**438**	**491**	**555**	**629**	**2,755**
% GDP	%	1.5	1.6	1.9	2.0	2.1	2.1	1.9
GGHE in % GGE	%	8.0	8.0	10.0	10.0	10.0	11.0	10.0
DGHE (No TR*) in % GGE	%	4.6	5.7	8.5	8.7	8.9	9.1	8.3
Total GGHE per capita	US$	40	46	59	65	73	81	65
% Domestic	%	58	65	80	78	75	72	74
Exchange Rate	LAK	8,920	9,191	9,449	9,737	10,027	10,336	9.813
Population projected	N	7,231,210	7,337,783	7,442,794	7,545,792	7,646,723	7,745,249	

* No TR: no technical review

Table 6. General government health expenditure (GGHE) 2026–2030

Budget implemented	Unit	Realized	Projected					
		2020	2026	2027	2028	2029	2030	2026–2030
Domestic GGHE	Bil.LAK	1,496	5,000	5,200	5,300	5,400	5,500	26,400
ODA	Bil.LAK	1,101	1,500	1,500	1,500	1,500	1,500	7,500
Total GGHE	**Bil.LAK**	**2,597**	**6,500**	**6,700**	**6,800**	**6,900**	**7,000**	**33,900**
Total GGHE	**Mil.US$**	**291**	**602**	**598**	**591**	**595**	**593**	**2,979**
% GDP	%	1.5	2.1	2.2	2.3	2.4	2.4	2.3
GGHE in % GGE	%	8.0	8.0	11.0	12.0	12.0	12.0	11.6
DGHE (No TR*) in % GGE	%	4.6	11.6	9.5	9.6	9.7	9.7	9.5
Total GGHE per capita	US$	40	9.2	75	74	73	72	74
% Domestic	%	58	77	78	78	78	79	78
Exchange Rate	LAK	8,920	10,800	11,200	11,500	11,600	11,800	11,380
Population projected	N	7,231,210	7,842,539	7,938,274	8,032,365	8,124,617	8,215,004	

* No TR: no technical review

6. Implementation measures

In order to implement the HSRS effectively and efficiently, we should strengthen the management capacity of all party members across all levels- central, provincial, district and village levels- based on the following principles:

- The HSRS Phase III and IV defines clear government policies, vision and mission. The NSEDP is a master plan suggesting the direction of national development in line with the regional and international development which promotes application of advanced technology for health care services. Therefore, the implementation of the HSRS will be aligned with policy directions of the NSEDP in each phase by developing a clear and integrated programme for health sector.
- The government will strengthen the leadership, promote innovation and encourage change and accountablity across all areas of health sector. Further, coordination among line ministries will be enhanced for effective use of existing human resources, improvement of health care services and promotion of medical researches by using advanced technologies.
- The government will create opportunities and enabling environment to improve engagement and collaboration across sectors with clearly defined roles and responsiblities of line Ministries, relevant departments, provinces and districts. Further, we will develop a clear policy to engage with private hospitals and clinics to provide equitable and quality healthcare servcies under the overall management of the government.

- The government will disseminate the HSRS Phase III and IV to all parties in the health sector and relevant ministries at central and subnational levels.
- The government will focus on inspection, monitoring and evaluation of the implementation of the HSRS at each level regularly with the participation of multi-stakeholders.
- The HSRS Phase III (2021-2025) aims to achieve the UHC targets which improves equitable access to quality healthcare services while ensuring financial protection by strengthening primary health care as a critical foundation through the impelemtnaton of Three-Builds policy. Currently, the Ministry of Health is implementing the HSRS Phase II with additional policies and targets in order to ensure coherence between the HSRS Phase II and III to reflect the existing situation and the future health needs.
- The HSRS Phase IV (2026-2030) aims to achieve the health related SDG targets, focusing on the governance reform and enforcement of laws and regulations in an effective and efficient maner to move towards the state of being "governed by law".

The reform process must be integrated and linked to the planning and implementation of the Five-Year HSDP and the annual health development plan of the health sector at both the central and subnational levels, using all available financial resources: the government budget plan, investment plans, offical development assitance from friendly countries, international organizations, societies and loans. The implementation of the HSRS should also be based on the development of concrete action plans on the implementation of key priority activities and M&E at both central and subnational levels.

The reform means accelerating changes of the existing conditions to achive the government's goals, especially changes in governance structure, working mechanism, coordination, and development of the necessary legislation and regulations towards a strong, profound, comprehensive and fundamental change. To achieve such fundamental changes, the key priority is to assess the current situation, objectives and targets and to embrace changes to improve the current situation.

7. Governance mechanism for HSRS implementation

7.1. Overview

Implementation of the HSRS covers all stages of the reform, from the conceptual framework to the formulation of legislation for planning and budgeting the implementation of the overall plan. Since the development of the HSRS, a number of reforms have been proposed, some of which have been approved and initiated, and many of which have already been implemented. For example, areas that require increased reform efforts are infrastructure planning, personnel management and budgeting, all of which are key areas in improving the quality and efficiency of public health services. Furthermore, the Three-Builds Policy has not been implemented as well as it should have been and will require more intensified efforts to move it forward.

The HSRS is a core strategy and a driving force for change and development. To achieve the goals of the health sector reform, political guidance and coordination, and a strong system of planning, coordination, monitoring, evaluation, and reporting are required.

Guidance: At the central level, there is an organizational structure for health sector reform, starting with the National Assembly, the National Commission for Health Sector Reform and Secretariat under the MOH, which is responsible for the Three-Builds Policy and the Health Sector Working Group. The organizational structure is comprehensive and fully integrated, however, leadership capacity, full-time staff and budget are limited.

Under the guidance of the party and the government, the National Assembly is in charge of leading and issuing legislation for reform. The government has set up the National Commission for Health Sector Reform to lead reforms in many areas to improve the work of the health sector. However, this reform is still focusing on the health sector alone and has not yet actively involved other sectors. There are still some chronic issues that affect the health sector, such as delays in budget allocation, overall health budget cuts and staff quotas. These issues have not been well addressed and understanding of the health reform work is not yet uniform and well-integrated. All of these will need to be resolved urgently.

❖ The National Commission for Health Sector Reform: Roles and Responsibilities

The National Commission for Health Sector Reform is chaired by the Deputy Prime Minister for Social Development, with the Minister of Health and the Vice-Ministers of Finance and Planning and Investment as Vice Chairs, and other vice-ministers, the Deputy Director of the Central Party Committee, and representatives of mass organizations as members. The role of Commission's are to develop reform i plans,mobilize and support government organizations, mass organizations, international organizations and civil society throughout the country for the effective implementation of the HSRS so as to achieve UHC by 2025 and health-related SDGs by 2030. The Commission is to meet twice per year. Its responsibilities include: (i) consider and approve HSRS implementation plans; (ii) propose a newly reformed health system and health reform related laws, regulations and legislations to the government and National Assembly for endorsement; (iii) provide leadership and coordination with other ministries, organizations equal to ministries, and authorities at different levels, and collaborate with DPs in implementing the HSRS; and (iv) mobilize resources from the public and private sectors, and external sources in implementing the HSRS.

To accelerate and enhance the impact of the HSRS, MOH must strengthen the Cabinet in terms of health sector reform coordination, including multi-sectoral cooperation, implementation, monitoring and reporting. MOH should consider teaming up with Department of Planning and Finance and create a think tank for technical and financial support from friendship countries and international organizations.

❖ The Secretariat of the National Commission for Health Sector Reform: Roles and Responsibilities

The Secretariat of the National Commission for Health Sector Reform is chaired by the Chief of Cabinet, MOH, and includes Deputy Director Generals within MOH. The MOH Steering Committee provides oversight of the Secretariat and submits reports and plans to the National Commission for Health Sector Reform. The main functions of the Secretariat are to: (i) study and prepare health sector reform implementation plans under each program annually and periodically; (ii) cooperate with sectors, friendly countries, DPs, international organizations, and social organizations at central and sub-national levels to support the implementation of the HSRS; and (iii) take ownership in supervision, monitoring, evaluation, and reporting health sector reform to the National Commission for Health Sector Reform quarterly, semi-annually, annually, and five-yearly, and fulfil other responsibilities as assigned by the National Commission for Health Sector Reform.

At provincial level, the vice provincial governor in charge of socio-cultural development chairs the provincial health sector reform committee consisting of senior officials from a broad range of provincial departments including health, finance, planning and investment, education and agriculture. This may be integrated with the provincial health committee to avoid overlapping mandates and fragmentation, focusing on efficiency of work implementation. The provincial health sector reform committee will take responsibility for planning, implementation and monitoring of the provincial health sector reform plan through annual workplans, and any extra-budgetary funding.

At the district level, a similar organizational structure may be used, or more committees may be required to carry out such work. The district health committee is chaired by the vice governor and heads of the concerned offices. Village chiefs and leads of mass organizations at the district level are involved in the planning process in order to ensure involvement of the community and mobilize support for the implementation of the HSRS.

Coordination: HSRS ownership, leadership and management capacity are essential to ensure alignment, trust, and coordination with other sectors, communities, government agencies, and DPs. Cabinet leadership and management capacity will be further strengthened and managed alongside that of provincial reform teams.

First, the Secretariat of the National Commission for Health Sector Reform in the Cabinet will plan the alignment of the HSRS with government directives, policies in the health sector and other sectors, the HSDP and annual workplans. Second, the Secretariat will strengthen the HSRS implementation structure and capacity, and mobilize support, technical assistance, and funding for priority actions. Third, it requires will support leadership, departments and provinces to show ownership in calling for participation from civil society and DPs. Fourth, it will improve the level of understanding of the conceptual framework and the reform process to ensure clarity in the implementation, coordination, and mobilization of internal funding. Fifth, it will strengthen the monitoring, evaluation and reporting system. Monitoring will be digitized under existing reporting and information systems.

In general, the Cabinet and Department of Planning and Coordination will ensure that the HSDP and annual workplans are developed in alignment with the HSRS. This may take the form of an annual HSRS implementation plan submitted to the National Commission for Health Sector Reform via the MOH Steering Committee and the Secretariat, including (i) overall progress in the HSRS process as reported by departments and provinces, and (ii) priority actions to be integrated into the annual workplans, including annual targets and indicators set to track progress.

The Cabinet will receive technical assistance and a budget to be used to strengthen the Secretariat in charge of annual and periodic health reform plans by having full-time planning and implementation staff, with a clear, responsible, and accountable administrative structure, and regular coordination and reporting using digital systems to monitor progress and budgets for implementation. Provincial and district levels must have a strong organizational and technical structure.

Management: As the departments and provinces show continued motivation to carry out reforms, the leadership of the Cabinet will have to update the implementation progress, reduce fragmented activities, ensure clear responsibilities, improve coordination with other partners, carry out reforms, as well as monitor and share progress and challenges on a regular basis. This may be the first step of a Think and Act Tank.

The existing technical capacity of most departments will be enhanced, and funding should be mobilized. A second role of the Think and Act Tank may be to build capacity and mobilize technical assistance, as well as to provide opportunities for departments to collaborate with DPs for long-term engagement.

Shifting the health sector in the most optimal direction requires a shift in mindset in line with the government's guidance in the Four Breakthroughs ideology and Three-Builds Policy. The National Commission for Health Sector Reform should strengthen the dissemination and introduction of the HSRS to all sectors and DPs to recognize, understand and align their support with the HSRS.

Achieving results will not depend on resources alone, but also on realizing a reorientation of the health system, shifting basic services from referral hospitals to PHC, from quantity to quality, and from inputs driven routine to results-based management. Managing the planning process to reorient the health system to PHC may be the third role of the Think and Act Tank.

The proposed hospital autonomy may risk further commercialization of hospitals, competition with PHC for patients and staff, and less access for the poor. Measures will be put in place such as job descriptions, recruitment criteria, incentives, deployment of staff to health facilities at PHC level and review of the Essential Health Services Package. Much analytical and planning work is required in the field of hospital autonomy.

7.2. Multi-sectoral Cooperation

Under the leadership and coordination of the National Committee for Health Sector Reform, other sectors also play an active role in implementing the HSRS to achieve specific objectives and results as follows:

(1) Ministry of Education and Sports:

- Promote sports and active lifestyle;
- Incorporate health education in the curriculum;
- Promote adolescent health and lifestyle choices including non-smoking;
- Promote sibling immunization, healthy diet, deworming, hygiene and others;
- Build toilets and provide safe drinking water in all schools; and
- Help conduct a health and nutrition project in the community.

(2) Ministry of Planning and Investment:

- Rationalize infrastructure investments;
- Coordinate development plans with other sectors;
- Coordinate with DPs in the health sector; and
- Oversee implementation of the 9th and 10th NSEDP.

(3) Ministry of Finance:

- Ensure adequate and timely distribution of financial resources to the health sector;
- Monitor local government budget allocation to the health sector;
- Develop alternative means of resources, e.g., pro-health-tax policy and other sources; and
- Strengthen financial management and audit.

(4) Ministry of Home Affairs:

- Develop appropriate salary and incentive policies for rural areas and village volunteers in remote areas;

- Arrange contracting for volunteers;
- Provide appropriate health workforce quota based on actual needs at central and provincial levels; and
- Strengthen civil service structure and personnel management.

In addition, the National Assembly is expected to play an important role, especially in supporting government agencies to develop and approve relevant legislations and regulations that can facilitate the implementation of the HSRS.

7.3. Cooperation and Coordination Mechanism

Implementing the HSRS is not possible without effectively aligning cooperation across government agencies at different levels and with DPs. Under the current fiscally decentralized management system, it is critically important to get local governments actively engaged in the process of developing and implementing the HSRS in order to obtain the "buy-in" of various stakeholders. In addition, the private sector must focus on and use their potential for reform; the private sector already exists in many provinces (with strong infrastructure) but has not yet been systematically organized and engaged.

Many multi and bilateral organizations and NGOs have been active in supporting health development in the country. Development assistance has concentrated on infrastructure development, maternal and child health, and communicable diseases priority programs, with less attention for NCDs and health system strengthening. Efforts should be made to better balance ODA based on sector priorities.

Sector-Wide Coordination (SWC) facilitates sharing to and inputs from experts and DPs. The Health Sector Working Group (Policy level), co-chaired by WHO and the Embassy of Japan, plays an important role with regards to policy, funding and coordination with the government and DPs. The Health Sector Working Group (Operations level) coordinates health projects supported by various donors to make aid more effective and contribute to addressing cross-cutting issues related to health development. Technical working groups (TWGs) have been established for each HSRS pillar; all are active, except for pillar three (Governance, Management and Coordination). TWGs are also responsible for coordinating and monitoring the process of planning and implementing the HSRS. In addition, there is a specific technical group for each program.

For the coordination mechanism to be consistent and up-to-date, and to reduce the number of mechanisms, it is necessary to align the current structure of TWGs with the five HSRS pillars.

8. Monitoring and Evaluation

8.1. Progress Monitoring

The Cabinet, Department of Planning and Finance, and the Department of Inspection take lead and coordinate monitoring, supportive supervision, inspection and evaluation of the implementation of the HSRS. In order to achieve this, focus should first be on creating a baseline to use as reference for monitoring. Establishing a system to monitor and evaluate the implementation of the HSRS will support and encourage its success. Attention must also be paid to personnel recruitment and distribution, and allocation of budgets to meet program needs.

8.2. Outcome Monitoring

Apart from progress monitoring, the HSRS will be monitored through the overall national health indicators, especially the 11 health indicators approved by the National Assembly, to review progress on the objectives of UHC, LDC graduation and SDGs. Monitoring and evaluating the progress and results of the implementation of the HSRS will be based on the DHIS2, other reporting systems, the Technical Working Group (Operational level), the Health Sector Working Group (Policy level) and existing survey reports according to the five pillars of the HSRS.

8.3. Result Framework

Define linkages and develop monitoring frameworks to identify impacts, outcomes, outputs, processes (activities) and inputs as well as assumptions and risks affecting the theory of change. Attention should be paid to the analysis of challenges, programs and contributions to the theory of change so that the implementation of the HSRS, and the implementation of MOH's annual workplans and the HSDP, is in accordance with the HSRS framework and aligned to the HSRS targets and objectives.

Annex: HSRS Framework Based on the Five Pillars

HSRS Pillar	MOH Program	Responsible Department/Unit	Priority Activities
Health Service Delivery	1. Curative Health Services 2. Hygiene and Health Promotion 3. Prevention and Control of Infections 4. Food, Drugs and Medical Supplies Consumer Protection	1. Department of Health Care and Rehabilitation 2. Department of Hygiene and Health Promotion 3. Department of Communicable Disease Control 4. Department of Food and Drugs	1. Continue to disseminate and implement the Five Goods, One Satisfaction policy across the country. 2. Review current health centers and district hospitals to restructure and improve the infrastructure, upgrade district hospitals from type B (DH-B) to DH-A according to the targets (35 by 2025 and 40 by 2030), and equip them with equipment and qualified human resources for health. 3. Strengthen the system for referral to more equipped facilities by using IT systems, especially Digital Health, to integrate diagnosis and treatment so that hospitals at all levels provide treatments to patients more efficiently. 4. Improve and upgrade health infrastructure of hospitals at all levels to meet quality standards. 5. Manage private hospitals and clinics to provide health promotion and treatment services in line with the Law on Health Care. 6. Increase hospital autonomy gradually along with strengthening financial management in a transparent and sustainable manner. 7. Review and set service fees for consulting and health care services at each health facility with a clear and reasonable price. 8. Ensure provision of medicines and medical supplies meets the level of service provision of each level of the health facility. 9. Build and improve warehouses and storage systems for medicines and medical products from the central and local levels to meet the standards to support storage and distribution services in a timely manner. 10. Strengthen the packaging system of food, medicines, and medical products to achieve the principles of good production for wholesale and retail to ensure quality, safety and consumer protection. 11. Develop regulations for setting prices of medicines and medical equipment, selling medicines and controlling the quality. 12. Establish a food quality assurance association. 13. Implement the National COVID-19 Strategic Preparedness and Response Plan for Health 2020–2025 efficiently and effectively.

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			14. Monitor and respond to health emergencies in accordance with international health regulations and strategies, and the Law on Prevention and Control of Communicable Disease, including for HIV/AIDS, TB, malaria, dengue, avian influenza and others. 15. Strengthen health-related activities based on the Three-Builds policy and PHC; Review and improve the methods and mechanisms for multi-sectoral coordination between, for instance, the ministries of home affairs, finance, transport and public works, and mass organizations at the central and local levels, on health activities at the village level, such as, village health committees or councils, volunteers, and others. 16. Define health policy at the village level with a set of basic priority services that must be provided, for example, disease prevention and promotion of health. 17. Implement health promotion activities to prevent and reduce the effects of NCDs such as diabetes, high blood pressure, cancer and other chronic diseases with appropriate methods. For instance, improving the environment for daily living, health care for the elderly, community mental health care, promotion of physical activity and reducing obesity, smoking, consumption of sugary drinks, alcohol, and others. 18. Establish model healthy villages to achieve the set targets.
Human Resources for Health	Health Personnel Management, Development and Health Sciences Research	Department of Health Personnel; Healthcare Professionals Council; University of Health Sciences; Health sciences colleges and provincial health education institutions.	1. Improve planning, distribution and retention of health personnel. a. Develop and update job descriptions and staffing needs projections based on standards of health services and staffing in accordance with the Law on Health Care and relevant policies, and the current and future health needs of the Lao PDR population. b. Identify the needs of professions in clinical and administration sections in each hospital, both at the central and local levels, to enhance and create opportunities for technical and administrative health staff. 2. Improve the quality of work performed by health personnel. a. Improve organizational structure to be concise and adaptive to the specific situation and the actual working conditions in each location. Define clear mandates, roles, responsibilites, and job descriptions. b. Improve systems, mechanisms and methods for selecting, recruiting, or replacing staff to be more efficient. c. Create an enabling environment with a focus on improved facilities, staff safety and relevant policies that are in accordance with the rules and regulations for the implementation of professional duties along with education, self-development, and more efficient and effective work plans.

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			d. Improve the system for monitoring and evaluation of the performance of each unit and individual personnel by creating tools and legislation, with detailed instructions for implementation. Implement the reward system for those who have achieved outstanding results; and provide guidance, advice or discipline in accordance with the rules and regulations to those who do not perform their duties well or have violated the rules and regulations. 3. Improve the quality of health education. The quality of health education must be improved by reviewing the system, teaching methods and components to identify achievements, strengths, weaknesses, and key challenges to improve the quality of health education institutions. a. Upgrade the quality of health education institutions with a quality assurance system in accordance with standards. There should be further investment in building the infrastructure, facilities and environment of health education institutions that are suitable for education and study of all disciplines. b. Review and improve the curriculum and develop new curricula for each department to meet quality standards in line with the Human Resources for Health pillar. c. Strengthen the selection of students and teachers who will come to study and teach in health facilities, selecting those who study well, have a passion for the medical profession, and have a sincere desire to serve the nation and people. d. Promote the continued learning of teachers in each health profession, with rewards for teachers who perform well to encourage continued efforts and further progress. e. Encourage staff to work in remote, rural areas and ethnic areas. f. Establish a system for monitoring, inspecting, evaluating and training staff who have completed their studies to ensure that they continuously upgrade their theoretical and behavioral knowledge, and undertake research to improve clinical practice and services by combining theoretical education with research in medical science, diagnosis and treatment of diseases, and others. 4. Health care professionals licensing and registration system a. Organize the national licensing exam and issue licensing/registration for existing health care providers. b. Establish clear policies, strategies and action plans to create an enabling environment for health care professionals to perform their duties effectively, with financial and technical assistance from multi-stakeholders, continuous monitoring and evaluation, and such work being considered as an integral part of the process of improving the quality of health services.

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Governance, Management and Coordination	Mangement and Inspection	Cabinet Office; Department of Health Care and Rehabilitation; Department of Health Personnel; National Health Insurance Bureau; Department of Inspection; Department of Planning and Finance.	1. Use existing roles and responsibilities of the National Commission for Health Sector Reform at each level to guide, coordinate, monitor and support the implementation of the HSRS. 2. Strengthen the coordination mechanism of the Health Sector Reform Secretariat by encouraging relevant ministries to participate in the reform work and establishing a technical group. 3. The Health Sector Reform Secretariat develops guidelines and manuals related to the reform work and raises awareness at the provincial and district levels on the reform work through the implementation of the HSDP and the annual workplans. 4. Improve the organizational structure of MOH to be in line with the actual needs of the health sector and integrate projects with similar forms under a sub-program to make implementation more effective. 5. Develop a training plan on administrative management for district administrators. 6. Complete the formulation of legislation for hospital autonomy and implement at central and sub-national levels. 7. Improve legislation and increase the capacity for inspection, provision of services and issuance of licenses to hospitals, clinics and medical professionals in the private sector. 8. Develop and implement regulations on joint ventures with the private sector.
Health Financing	Health Financing	Department of Planning and Finance; National Health Insurance Bureau	1. Request the government to allocate a budget equal to or more than 9% of government expenditure each year as approved by the National Assembly. 2. Ensure adequate and sustainable public investment in the health sector. 3. Intensify efforts for the collection and application of pro-health tax in the health sector. 4. Establish a mechanism to allow health facilities to use technical revenue to improve the quality of services and other activities, with legislation supporting the introduction and implementation of hospital autonomy. 5. Increase responsibility for the implementation of the budget through the formal public financial management system. 6. Encourage and support services units that have income/revenue to gradually become autonomous and sustainable. 7. Review accounting records in accordance with the financial management guidelines, the health accounting report and relevant policies in the allocation and use of funds.

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			8. Improve the efficiency and equity of budget allocation. 9. Improve the budget allocation method according to geographical location, level of services and types of services, while focusing on PHC. 10. Integrate all sources of funding by using the budget allocation system according to program needs (program-based budgeting). 11. Develop a guideline and plan to improve public financial management. 12. Establish an IT system for public financial management, including a hospital information management system. 13. Create and improve legislation to support public and private investment in hospital construction. 14. Reform investment mechanisms and procurement and investment bidding methods to ensure timeliness, transparency and auditability. 15. Ensure the NHI scheme covers disease prevention, health promotion and treatment services in public hospitals and manages services provided in private hospitals and clinics. 16. Review and redefine the policies, measures and procedures for the implementation of UHC, in which policy makers and implementers monitor and evaluate the progress of UHC with specific roles and responsibilities. 17. Establish a semi-independent National Health Insurance Bureau, with off-budget funding. 18. Review the mechanisms and rates of payment, and determine the rules on fees for services that the NHI scheme has not yet covered, based on the results of costing studies. 19. Strengthen copayment exemptions for vulnerable groups such as pregnant women, children under 5 and the poor.

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Health Information, Planning, Monitoring and Evaluation	Planning, Cooperation and Information	Department of Planning and Finance; Cabinet Office; Department of Inspection; National Health Information Centre	1. Establish the National Health Information Centre in line with Prime Minister's Decree approved in 2018. 2. Expand the scope of the information management system to be able to link to sources such as reports, surveys and scientific research papers used in policy decisions. 3. Improve the scope and quality of the health information management system. 4. Develop a standardized digital health reporting infrastructure (Digital Health) that can be integrated with other systems. 5. Establish a hospital information management system that can record electronic medical information in accordance with the International Classification of Diseases. 6. Strengthen health information management, including capacity building for health information management curricula, to be able to monitor and evaluate the results of indicators related to UHC, LDCs, and SDGs. 7. Improve the DHIS2 database to be able to collect and report outbreaks of COVID-19, as well as monitor the progress of COVID-19 vaccine coverage. 8. Apply the process of birth and death notification and cause of death recorded in patients death certificate to the national birth and death registration system (CRVS). 9. Increase the capacity to use information to make policy decisions at the provincial and district levels. 10. Build capacity at all levels by using the information system in the medical curriculum, training management, staff training and scholarships. 11. Incorporate health information into planning and monitoring of indicators, evaluating outcomes and deciding on policies related to the sector and beyond. 12. Use IT systems to upgrade the use of webmail and the centralized document management system of the MOH. 13. Create a Dashboard for senior staff to monitor the progress of the implementation of activities in the field. 14. Use health information related to health care treatment, health personnel and financial management to make data-informed policy decisions.