PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: PIDC502

<table>
<thead>
<tr>
<th>Project Name</th>
<th>VN - Health Professional Education and Training Project (P131825)</th>
</tr>
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<tbody>
<tr>
<td>Region</td>
<td>EAST ASIA AND PACIFIC</td>
</tr>
<tr>
<td>Country</td>
<td>Vietnam</td>
</tr>
<tr>
<td>Sector(s)</td>
<td>Health (75%), Tertiary education (25%)</td>
</tr>
<tr>
<td>Lending Instrument</td>
<td>Specific Investment Loan</td>
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<td>Project ID</td>
<td>P131825</td>
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<td>Borrower(s)</td>
<td>Socialist Republic of Vietnam</td>
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<td>Implementing Agency</td>
<td>Ministry of Health</td>
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<td>Environmental Category</td>
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<td>Date PID Prepared</td>
<td>23-Jul-2012</td>
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<tr>
<td>Estimated Date of Appraisal Completion</td>
<td>30-Sep-2013</td>
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<td>Estimated Date of Board Approval</td>
<td>04-Feb-2014</td>
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<td>Concept Review Decision</td>
<td>Track I - The review did authorize the preparation to continue</td>
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I. Introduction and Context

Country Context
In less than 20 years, Vietnam has transitioned from a centrally planned economy to a market economy and from an extremely poor country to a lower middle-income country. The economic performance has been impressive. Between 1990 and 2010, Vietnam’s economy has grown at an annual rate of 7.3%, on average. Per capita income has increased by almost five folds, while the poverty rate has declined from almost 60% in 1993 to about 15% in 2008. Total health spending has increased continuously from 5.2% of the gross domestic product in 2000, to 6.4% in 2009, while Government health spending has reached around 11% of total government spending. These numbers are high compared to other countries with similar income levels.
The health status of the population has also improved significantly. Infant mortality rate fell from 44.4 to 16/1,000 live births during the 1990-2009 period, while maternal mortality ratio has dropped from 223 to 69/1,000 live births during the same period. Vietnam is experiencing a demographic and epidemiologic transition and the disease pattern is changing. While the incidence of communicable diseases such as malaria and tuberculosis has declined nationally, the incidence of non-communicable diseases (NCDs) and injuries are increasing rapidly. Despite the success in improving the national health status, some health system challenges remain. There are large disparities in access to health care across regions and among income quintiles. Unequal distribution of health workforce and non-standardized health service has led to unequal quality of care across the country. Addressing these health system issues have become the government’s priority for the next
ten years. The Socio-Economic Development Strategy (SEDS) 2011-2020 for example, has emphasized improving equity and quality of health care as a priority. Vietnam has also set universal health coverage as a strategic goal for the 2011-2020.

Sectoral and Institutional Context

Despite the growing health care demand in Vietnam due to population growth and changes in disease patterns, there are significant gaps in human resources for health (HRH) policies resulting in an inefficient service delivery system. Vietnam’s health policy on improving access to health care has had an impact on increasing significantly the number of HRH during the last decade. By 2008, the Government of Vietnam had employed almost 300,000 physicians, assistant physicians, pharmacists, nurses, midwives, medical technicians, traditional medicine practitioners, and secondary health providers. Nevertheless, existing data show imbalance in their distribution and skills mix across regions and across levels of care. On average, although the urban population is only 28%, about 59% of physicians and 55% of nurses concentrate in urban areas. Less than 18% of the total workforce is currently working at the commune-level and a third of the commune health stations (CHS) is without a physician.

The quality of HRH education and training has been affected over the years by a weak and incomplete policy framework and a fragmented organizational structure. Currently, there are 14 public medical schools and it is believed that there is a growing interest from the private sector to invest in private medical education. Formal medical education (general practitioners) in Vietnam is for six years and follows a framework curriculum developed by the Ministry of Health (MOH) and approved by the Ministry of Education and Training (MOET). In 2006, a Knowledge, Attitude, and Skills (KAS) book, developed with donor support, was approved by Government as the basis for a standard curriculum for medical schools in the country. However, implementation of medical school curricula or their adequacy to develop the required competencies needed to address the changing disease pattern in the country was never systematically assessed.

The existing quality assurance system has failed to ensure consistency and standard quality of graduates and training programs. Quality assurance/quality improvement efforts in medical schools have been limited so far to internal quality control. There is no national accreditation system or peer review system to assess the quality of education in the medical schools. At the completion of training, students are assessed in-house by the schools as there is no independent national examination. This limits the opportunity for an objective assessment of student competencies to ensure their readiness for practice. Some ongoing medical reform efforts are supported by several international organizations, but they have been uneven among the medical schools and have amplified the quality gap among them. Concerns about the quality of medical education and a possible proliferation of private medical schools have prompted Government to call for the need to establish an accreditation system for medical programs, as well as for a national examination to standardize the quality of the graduates.

The increase in the number of students admitted to medical programs is not matching the increase in the investment in infrastructure and lecturers, resulting in an inadequate opportunity for students to conduct appropriate clinical practice. In 2009, Vietnam had 6.59 physicians per 10,000 people. The government policy to increase the number of physicians to meet the target of 10 physicians per 10,000 people by 2020 has led to an increase in the number of students admitted to medical schools. Moreover, most medical universities train not only physicians but also other medical workers such as assistant physicians, pharmacists, and nurses. Over the past ten years, the number of new
university students has increased by 10% on average each year, but investment in training institutions has been inadequate and has negatively affected the quality of training. In general, the training of medical doctors is hospital-based and clinical practice is essential for students to get prepared for work with access to specialists. There is little preparation for work at the primary care level.

Although the Government aims to have 80% of the communes staffed with a physician by 2020, it’s been challenging to attract physicians to work at the CHS. While almost all communes have a CHS, most of them are not supported with adequate infrastructure, equipment, or medicine to deliver good quality primary health care (PHC). As a result, the community which perceives low quality of care at the CHS tends to bypass it and seeks care directly at the district or even provincial level facilities, causing a serious overcrowding at the district and referral hospitals. On the other hand, low utilization means less income and less professional satisfaction for the physicians, making CHS posting less attractive to the physicians compared to hospitals at the district or provincial level. The situation is even more difficult when the CHS is located in rural/remote areas with less possibility to have a successful private practice. In addition, new medical graduates lack the confidence to work independently at the CHS without close technical supervision and support.

Vietnam has an acute shortage of adequately trained health workers in rural and remote areas, where health needs are greatest. During the last few decades, health service delivery policies, including the hospital autonomy policy, have distorted the incentive system within the health sector, and have led to overutilization of hospitals. At the commune-level, PHC is underdeveloped, understaffed, and underfunded. The state of PHC infrastructure, staffing, accountability mechanism, and drug-availability varies significantly across regions. There is not enough funding and capacity to systematically organize refresher training for CHS staff to upgrade their knowledge and skills once they commence work. As a consequence, many of them lack necessary knowledge and skills to meet needs for care, especially for primary and secondary prevention, chronic disease management, coordinated care, and soft skills to work in teams and counsel patients. In general, there is little incentive to work in rural areas and therefore, rural to urban migration of health professionals is a common problem.

There is evidence that some pilot interventions have been successful in maintaining patients at the CHS for appropriate PHC services and diverting them from seeking care for such services at the overcrowded hospitals. This has been accomplished by improving the skills and confidence levels of physicians at the CHS. For example, the MOH has been implementing a pilot in Khanh Hoa Province to strengthen PHC and improve utilization at the CHS level with the help of the Atlantic Philanthropy and Boston University. Under the pilot, physicians who work in a CHS were given the opportunity to take a two-year further training at the medical universities to become specialists (CK1 level) in family medicine. Meanwhile, resources were allocated to improve the infrastructure, and to procure the equipment and medicine to adequately support the practice of a family healthcare specialist. This pilot has been replicated successfully in six provinces throughout the country. Discussion is ongoing between the Technical Group on Continuing Medical Education (CME) under the MOH Department of Science and Training (DST) and the development partners to scale-up this approach nationally.

Relationship to CAS
The CPS 2012-2016 supports the government’s SEDS 2011-2020 and Socio-Economic Development Plan (SEDP) 2011-2015 under Pillar 1, to strengthen the country’s competitiveness in the regional and global economy. Good health status of the population is fundamental for successful economic development. The proposed project will contribute to improve health status of the people by supporting the Government in its efforts to develop the quality of health service delivery. This is consistent with Pillar 1 of the CPS and will be achieved by improving the quality of medical education and by improving physician competencies in providing PHC at the grass root level. The proposed project is also linked to Pillar III – poverty and inequality - where service delivery belongs.

The CPS applies clear criteria for inclusion of operations in the country partnership program. The proposed project meets the criteria in the following ways: (i) the World Bank has the appropriate engagement and instruments to support long term institutional capacity development programs like those planned under this project; (ii) the objective and approach of the project will leverage systemic and institutional change both at the MOH and at the medical school levels; and (iii) the likelihood for sustaining the impact is high as improving quality of service is a government priority under both the SEDS and the SEDP. The proposed project is also in line with the World Bank’s overall agenda on improving governance.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)
The proposed PDO would be to improve professional competencies and practice environment of human resources for health in Vietnam, especially at the commune-level.

Key Results (From PCN)
- At least 80% of existing medical doctors at CHSs in selected provinces are upgraded to CK 1 level family medicine;
- All CHSs staffed with doctors/assistant physicians trained and confident in providing primary health care in the selected provinces, and supported with adequate infrastructure, equipment, and medicine;
- A national peer-based accreditation board is established;
- At least three medical education programs have been reviewed with peer-based national accreditation standards; and
- All medical education programs adhere to a national examination that determine the readiness of a medical graduate to practice medicine.

III. Preliminary Description

Concept Description
The objective of the proposed project would be met through:
- Improving the quality assurance system of medical education;
- Establishing a national consensus examination for core competencies; and
- Upgrading the knowledge, skills, and competencies of existing workforce at commune-level within a strengthened PHC system.

IV. Safeguard Policies that might apply

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V. Tentative financing

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<td>International Development Association (IDA)</td>
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VI. Contact point

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VII. For more information contact:

The InfoShop
The World Bank