1. Country and Sector Background

Despite health gains that have been sizable in absolute terms and relative to its Millennium Development Goals (MDGs), Vietnam faces many challenges in the health sector. The country remains vulnerable to infectious diseases, including traditional threats such as malaria as well as a number of potentially devastating, “emerging” diseases like SARS and avian flu. At the same time, the overall disease burden has shifted towards non-communicable diseases (NCDs), injuries, and accidents which now account for almost 75% of reported deaths. Meanwhile, the poor face health outcomes far inferior to those of other groups--income-related differences in access to care and region-specific factors appear to have exacerbated these disparities.

Continued weaknesses in service delivery and persisting health status disparities are of particular concern in view of the intensive efforts made over the last 15 years to develop effective policies. Policy tools have included user fees and fee schedules, social health insurance, National Health Programs to address critical problems, a regulatory framework for the private sector, and drug registration and quality inspection. Targeted demand-side financing was introduced in the Free Health Card scheme in 1999, and strengthened in Decision 139 (2002) which set up province-level Health Care Funds for the Poor (HCFP) to finance care for low income and other eligible groups. Lastly, in addition, Decree 10 (2002) provides increased autonomy to government revenue-producing units.

In 2005, Politburo’s Resolution 46 assessed past interventions and in concluding, attributed sector weaknesses to a disconnect between supply and demand side policies. For example,
previous supply side measures were thought to have had little net impact because of their insensitivity to dimensions of service demand, such as income gains and quality concerns. Looking ahead, supply-side responses are expected to include outlays directed at selected district level facilities, particularly in remote areas. But for the most part, the focus would be on the facilities, i.e., the provincial and inter-district hospitals, that the public look to for accessibility, availability of key inputs, and service quality. Provincial hospitals are expected to provide leadership and support on quality of care matters, equipment maintenance, and treatment of NCDs. Eventually, with provincial hospitals specializing in curative care, district and commune facilities will largely provide preventive services. On the demand side, the government is taking steps to sustain patient interest and health service use. The group of principal interest in this respect are the poor, since they generally seek care less often and/or intensively than non-poor individuals in order to avoid potentially devastating costs (or sacrificing assets, taking loans on unfavorable terms, and so forth). Government thinking on how to protect low income individuals medically and financially and to improve outcomes has evolved and now involves steps to:

**Raise the poverty line and expand the number eligible for free health insurance.** A new poverty line has been approved by the Prime Minister, and local governments are busy re-estimating the incidence of poverty. As a consequence many provinces are likely to experience a dramatic, up to six-fold, increase in the number of people defined to be poor, and therefore, the number of people who should receive free health insurance.

**Address operational problems in the HCFPs and provide coverage for catastrophic costs.** The HCFPs have achieved gains in coverage, but experienced recurrent difficulties, including incomplete inclusion of the poor and lack of awareness on their part; complaints about low average levels of financial support and the quality of care provided to the insured; low disbursement rates in some provinces; weak accountability mechanisms and insufficient commitment from one managing unit, Vietnam Social Security (VSS); and excessive work burdens for staff. Also of concern is that efforts to control spending have led to ceilings on patient reimbursements that run counter to the goal of protecting against catastrophic costs. The ceilings could even be reinforced as the new poverty line takes hold and many more become eligible. Decree 63 (effective July 2005) responds to the above problems by establishing health insurance as the only mechanism for the HCFPs, expanding mandatory health insurance to the formal sector and broadening the benefits package, bringing private providers into the health insurance system; and setting the stage for developing means to protect the poor from catastrophic levels of health spending.

**Extend insurance coverage to the large number of near poor.** This previously ill-defined group was left out of the mandatory health insurance program but also has not responded to voluntary health insurance packages. Following Decree 63, provinces will now encourage uptake of voluntary insurance by those ineligible for free coverage. The Government is aware that the above policy directions need to be elaborated, evaluated, and adjusted. These tasks were assigned to region level projects that are conducive to pilot efforts—such initiatives may help to enhance policy coherence broadly while producing solutions to specific regional issues. The Mekong provinces have been designated as the first such regional initiative (see Annex 1 for description of the Mekong Region).
In such settings and in other regions, gains are within reach provided demand- and supply-side interventions are well designed and integrated effectively. As discussed, a menu of policy directions is taking shape on the demand side that should allow the scaling up pro poor. In tandem with improving the implementation of demand-side measures through support to Decree 63 and Decision 139, greater resources and better policy design are required to upgrade provincial and inter-district hospitals, set up a regional hospital, build the health workforce, and improve preventive health measures.

2. Objectives
The project aims to improve health services in the Mekong region and to enhance access to and coverage of these services, especially for the poor through: (i) strengthening the health financing policy framework and increasing the financial accessibility of health services for the poor and near poor; (ii) improving the availability and quality of curative care, including responsiveness to changing disease patterns; (iii) increasing the capacity of preventive health activities; and (iv) building the capacity of the health workforce. The project therefore blends support for demand for health care services among the poor and near poor with outlays that address supply-side opportunities and needs while building physical and human resource capacity.

Key outcome indicators include:

- Percentage of patients and service users, poor and non-poor, and other groupings satisfied with the provision of different levels of health services, including hospital care
- Percentage of poor and near poor to whom health insurance cards have been issued in project locations
- Percentage of poor patients in selected project areas with increased use of quality health care.

The Country Assistance Strategy (CAS) for 2003-2006 supports implementation of Vietnam’s Comprehensive Poverty Reduction and Growth Strategy (CPRGS), in which enhancing equitable, inclusive, and sustainable development is a key objective, and “providing basic social services to the poor” was outlined among the sub-themes. For the health sector, the January 2004 Progress Report on the CAS recognizes that the needs of the poor are best addressed through complementary supply- and demand-side investments. It also underscores the importance of narrowing the gap between rich and poor provinces and promoting effective decentralization. The proposed Project also supports the Government’s Master Plans for key elements of the health system, and helps address sector weaknesses highlighted in Politburo Resolution No.46 (02/23/2005).

3. Rationale for Bank Involvement
With long-term engagement in service delivery and disease control programs through several projects in Vietnam, the World Bank is well-placed to support health development in the Mekong region that is outcomes-based and pro-poor. The World Bank is also one of the key agencies working on health financing issues and sector reforms. The Project design draws on best practice examples from World Bank-supported and other initiatives, as well as the Bank’s experience with decentralized health sector reforms and project management issues in countries similar to Vietnam.
4. Description
The project consists of five components:

COMPONENT ONE: Protecting the Poor and Near Poor (US$8.0 million)
This component aims to support the central and provincial government efforts to ensure access to health care services for poor and near poor households. To this end, it will support capacity building for the management of provincial HCFPs by providing decision makers and staff training and consulting services for the HCFP to help develop management models; find ways to identify newly defined target beneficiaries; strengthen coordination and collaboration among involved agencies; improve the flow of information; and develop an information technology system. It will also mobilize technical assistance to help MOH and VSS identify key issues and constraints for the shift from supply- to demand-side financing. To foster the expansion of health insurance, the component will support coverage of catastrophic health care costs for the poor and near poor through pilot schemes in three to four provinces. It will inject resources to finance above-ceiling health costs as well as consulting services to identify eligibility criteria, benefits packages, and other parameters. It will also support assessments and impact evaluations.

The component will also support enrollment of the near poor in the voluntary health insurance scheme. The project will develop a financing support model that introduces improvements into the recently adjusted voluntary health insurance scheme. It will then support selected provinces in testing the model through direct financing for capitation payments to help lower the costs for the near poor of enrolling in voluntary health insurance. It will also finance evaluations of implementation experience and impact as well as support replication or scaling up.

Finally, the component will support innovative pilot schemes to improve the effectiveness of the HCFPs. Such schemes could establish targeting mechanisms to better reach ethnic minority people, ensure access to services for mobile populations such as migrant laborers, or set up public-private partnerships in health care for the poor. Provincial health departments will prepare work programs with a detailed description of the pilot schemes they wish to undertake. The project will also finance evaluations of these innovative pilots.

COMPONENT TWO: Curative Care Quality and Capacity (US$38.0 million)
This component aims to improve the quality and capacity of hospital services in the Mekong region. It will invest in equipment for provincial hospitals and the Can Tho Central General Hospital (CTCGH) and in a region-wide hospital information system (HIS), and will also assist the integration of private providers into the health insurance system as newly mandated by Decree 63. The provincial hospitals will receive investment in two stages. The first stage will ensure that provincial hospitals can provide an essential level of care and the second stage will allow provincial hospitals to expand selected clinical services in response to demand. The CTCGH will also be supported through a two-stage investment. The first phase will provide equipment for core, tertiary-level services while the second phase will allow expansion of services based on demand. The hospital information system will finance a system design based on end users’ needs, followed by investment in software, hardware, and training to improve information about hospital performance and disease patterns across the region. Finally, the private sector regulation initiatives will help integrate the private sector in the health insurance system by financing guidelines, tools, and information dissemination to assist the government in
accrediting and monitoring private providers. Medical waste management will also be supported under this component.

The two-stage equipment investment process is a distinctive feature of the Project. Second-stage investments will be determined based upon a review of proposals and evidence submitted by the provinces. This review will focus on the bottlenecks associated with delivering quality health care to the poor Mekong residents, and the plan for equipment operation, including financial sustainability. The budget for second-stage investments will be allocated to provinces using a mechanism which favors provinces with higher numbers of poor, higher unmet demand for hospital care, especially among the poor and stronger demand- and supply-side performance. This process will provide flexibility in project allocations, link support to demand and performance, and promote competition among provinces while targeting poorer provinces.

COMPONENT THREE: Preventive Health (US$6.5 million)
This component helps build the capacity of the region’s preventive health system to address long-standing and emerging infectious disease threats as well as new health challenges arising from economic growth in the region. It will invest in laboratory capacity and will support the implementation of an improved surveillance system in the Mekong’s 13 Provincial Preventive Medicine Centers (PPMCs). The investment in laboratory capacity will be through equipment for essential services in all provinces and for more advanced services in the Can Tho PPMC. Support to the region’s surveillance system will be through financing computer hardware and installation of surveillance software. These investments will be complementary to reforms in the Preventive Health system at the national level and to investments in the remaining provinces of Vietnam through the ADB Preventive Health System Support project. In particular, national-level surveillance software will be developed under the ADB project. Satisfactory completion of this software will be a condition for Project disbursement for surveillance.

COMPONENT FOUR: Human Resources Development (US$8.0 million)
This component aims to improve the capacity of the health workforce to deliver quality health services, especially for the poor and near poor. It will do this by financing training activities for health teams at different levels of the health system, by supporting the CTUMP in delivering and organizing priority training activities, and by piloting non-training human resources (HR) initiatives. Importantly, this component provides the training inputs to complement investments in the Curative Care and Preventive Health components to ensure efficient use of new equipment. Training activities for local health staff will be determined through a bottom-up planning exercise looking at linkages to services for the poor and near poor, skill gaps based on demand and projected population growth, and skills needed for project-financed equipment. Support to the CTUMP will include training teaching staff to develop new or supplementary teaching capacities crucial for the training needs of local health staff, and the provision of essential teaching equipment. Non-training HR initiatives will include an HR planning exercise to help pilot provinces understand the existing HR situation and to make strategic choices in addressing labor market constraints, including schemes to bring in health workers from outside to address staff shortages in poor areas. It will also finance an HR information system for planning, monitoring and evaluation in the region. Each initiative will initially be piloted in one or two provinces and findings and lessons learned will be shared among all 13 provinces at the mid-term.
COMPONENT FIVE: Project Management, Monitoring and Evaluation (US$ 6.5 million)
This component will support the establishment and operation of the Central Project Management Unit (CPMU), Local Project Management Units (LPMUs), and Regional Advisory Committee (RAC) by funding (i) consulting services to cover technical issues as well as procurement, financial management, and disbursement; (ii) training of project management staff; (iii) provision of office equipment; and (iv) incremental operating costs. This component will also finance data collection through baseline, mid-term, end-of-project surveys, and evaluations.

5. Financing
Source: ($m.)
BORROWER/RECIPIENT 10.0
INTERNATIONAL DEVELOPMENT ASSOCIATION 70.0
Total 80.0

6. Implementation
1. Partnership arrangements (if applicable)
World Bank support to preventive health is being coordinated with the ADB, which is financing a Preventive Health System Support Project. The ADB-financed project covers 46 provinces; another five provinces in the Central Highlands are being supported through a second ADB-financed project, while the 13 Mekong provinces would be supported by the proposed IDA project. The IDA-funded project builds on the ADB model, while integrating preventive health within the health system development of the Mekong region.

2. Institutional and implementation arrangements
Implementation of the Project will be overseen by the Central Project Management Unit (CPMU) in the Ministry of Health Planning and Finance Department and the Local Project Management Units (LPMUs) for each of the 13 provinces, the CTCGH, and the CTUMP. In addition, a Regional Advisory Committee (RAC) will be established to foster decentralization and regional coordination.

Central Project Management Unit (CPMU). The role of the CPMU will be to: (i) support and guide the Project activities; (ii) provide technical support and guidance to the provinces on developing action plans, equipment proposals, and procurement plans; (iii) coordinate and manage major procurement activities; (iv) manage the project Special Account and Financial Management System; (v) monitor and evaluate implementation in the provinces; (vi) undertake an annual audit review; (vii) facilitate internal and Bank reviews and approvals of project and procurement documentations, including no objections from the Bank; (viii) coordinate with other MOH departments, Ministries and line agencies, and the World Bank; (ix) prepare project progress reports and participate in Bank supervision missions; and (x) organize the project Mid-Term Review, annual review meetings, and end-of-project review.

Local Project Management Units (LPMUs). Each LPMU will be expected to: (i) coordinate and manage provincial-level project activities, including procurement; (ii) develop a specific action plan for the province/CTCGH/CTUMP in line with the project components; (iii) support the Fund Management Boards in each province in their task of implementing HCFPs; (iv) prepare a
procurement plan; (v) ensure timely disbursement of funds; (vi) monitor and supervise the implementation of action plans; and (vii) assemble the required reports on performance and participate in project reviews.

Regional Advisory Committee (RAC). Initially, the role of the RAC will be to support the CPMU to: (i) coordinate project activities at provincial levels; (ii) assist the LPMUs in developing province-level action plans; (iii) participate in supervision missions; and (iv) identify obstacles in implementation, propose changes as needed, and facilitate exchange of experiences among LPMUs. As a regional coordination mechanism, RAC is expected to take increased responsibilities over the life of the project to foster decentralization, build regional-level capacity, and enhance inter-provincial collaboration. The performance of RAC will be reviewed by Mid Term and depending on the effectiveness of RAC as a regional coordination mechanism for the project, the function of RAC could be re-defined or re-confirmed.

7. Sustainability
The project’s sustainability is enhanced by several factors. At the national level, the Government recognizes the importance of strengthening health care delivery and improving access to health services for the poor and near poor. This commitment has been demonstrated in the adoption of various policies and institutional changes, notably Decision 139. The Government also recognizes the importance of decentralizing responsibilities to address better the health challenges at the local level. Provincial health authorities, hospital officials, the CTUMP, and other stakeholders have also expressed strong ownership of the Project, recognizing the need for catch up through an integrated approach to the unique health issues of the region. The Project was designed in consultation with these stakeholders and responds to the challenges they have identified.

In terms of financial sustainability, the project’s equipment purchases will increase the overall recurrent costs by adding to maintenance costs. However, this burden is expected to be manageable given projected levels of government revenue and economic growth, as described below. For the HCFP, the large recurrent costs of subsidies to premiums and operating expenses will remain the responsibility of the Government. To maintain HCFP sustainability, the Government has indicated that it will provide the financing to cover increased recurrent costs resulting from an expansion in the number of beneficiaries during the project.

8. Lessons Learned from Past Operations in the Country/Sector
The IDA-supported National Health Support Project (NHSP), which will close in October 2006, offers several lessons for the proposed Project. For example, facility-level improvement efforts in NHSP suggested that greater attention is needed to the demand-side of interventions underpinning health quality and access. A second lesson concerns the need to work out arrangements for health sector decentralization, including how MOH can support this process while ensuring minimum standards are met. A third lesson relates to the capacity challenges posed by decentralization at both central and local levels, which underscore the advantages of adaptive administration. This approach is evident in the current Regional Blood Transfusion Centers Project, including the importance of local participation during project preparation and implementation. The proposed Project was designed in consultation with local stakeholders, including the DoHs, provincial hospitals, PPMCs, and the Information, Education, and
Communication (IEC) Centers of all Mekong provinces as well as the CTUMP. Also, like the Blood Project, the proposed Project limits geographic coverage in order to manage project complexity. The proposed Regional Advisory Committee will also help facilitate the exchange of experiences among the local project management units (LPMUs) and ensure the accountability and responsibility of the LPMUs.

9. **Safeguard Policies (including public consultation)**

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<td>Projects on International Waterways (OP/BP/GP 7.50)</td>
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10. **List of Factual Technical Documents**
- ADB. March 2005. *Report and Recommendation of the President to the Board of Director on a proposed loan and grant to the Socialist Republic of Vietnam for the Preventive Health System Support Project*
- Essential Equipment Reference List for Provincial Hospitals
- Ministry of Health. 2002. *List of Medical Equipment for Provincial General Hospital – District Hospital - Intercommunal Polyclinic – Communal Health Station – Village Medical Set*, Hanoi
- Ministry of Health. *Health Statistics Year Book 2003*
- Ministry of Health. *Hospital Survey 2004*

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties’ claims on the disputed areas
- Resolution No. 46-NQ/TW dated February 2005 by the Politburo on People’s health protection, care and promotion in new context

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