



Public-Private Partnerships for Health in Vietnam

Issues and Options

Sang Minh Le, Ramesh Govindaraj, and Caryn Bredenkamp

INTERNATIONAL DEVELOPMENT IN FOCUS

Public-Private Partnerships for Health in Vietnam

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SANG MINH LE, RAMESH GOVINDARAJ, AND CARYN BREDEKAMP

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Executive Summary

INTRODUCTION

The gap between the need for investment and the capacity of the state to finance it has focused the government of Vietnam's attention on the mobilization of private resources for public development goals, including through public-private partnership (PPP) models. Over the past two decades, 336 PPP contracts have been signed, mainly for developing infrastructure in the transport, energy, water, and commercial sectors. PPPs have thus emerged as a new way to deliver health infrastructure and services in Vietnam, supplementing other forms of public-private arrangements that have been used since the government introduced the "socialization" policy (aimed at mobilization of private resources for health and other sectors) in the early 1990s.

The objective of this report is to inform the decision-making of the government of Vietnam on health PPPs, including the PPP Investment Law and its associated regulations, as well as the policies of relevant ministries and the decisions by city and provincial authorities regarding individual PPP transactions. This report should not be interpreted as endorsing PPPs as the only or even the optimal approach to engaging the private sector in improving health care in Vietnam. Rather, given the government's wish to implement PPP models, the report seeks to provide examples of global good practice and the lessons learned in the formulation and implementation of PPPs worldwide to support the government of Vietnam in its decisions.

HEALTH PPPs AROUND THE WORLD

Health care PPPs have been used widely in developed countries, as well as in lower-middle-income countries. Usually, a PPP contract bundles together multiple project phases or functions, such as design, build, finance, maintain, operate, and deliver services. Depending on the roles and responsibilities that the private sector takes on, health PPPs can be classified into five types: managed equipment services, operation and management services, specialized services, health facility, and integrated PPPs. Each health PPP type has certain advantages

and disadvantages; therefore, a “one size fits all” approach (in which a country elects to adopt only one type of PPP model) is unlikely to yield significant economic and health care dividends. It is also worth noting that even in mature markets, managing health PPP contracts is challenging.

Most countries with dynamic health PPP programs rely on a sound PPP framework, and some even enact legal changes to support PPP development. Government support, direct or contingent, is necessary to improve project viability and bankability. The public sector’s capacity to evaluate PPP proposals and take on its part of implementation is a critical requirement for operationalizing health PPP projects. Some countries establish a technical PPP unit or node within the Ministry of Health (MOH), in addition to the PPP unit that is usually in place in other oversight ministries, to formulate policy, standardize documentation, coordinate the relevant players, provide technical support, raise awareness, and build the capacity of public officials. In addition, government agencies (whether line ministries or subnational governments) require resources to prepare and tender PPP projects, monitor project performance, and deal with unexpected changes to projects during the contract term. Political will, private sector readiness, and stakeholder engagement are also critical factors for health PPP projects.

DESIGN AND IMPLEMENTATION OF HEALTH PPPs IN VIETNAM

PPP projects in Vietnam are governed by different laws and regulatory documents, which have changed several times over the past decade. The most important legal document is Decree 63/2018/NĐ-CP on PPP investment forms. The definition of PPP used in this decree addresses only investment projects and does not include service-related PPP types. It also does not include key characteristics of a typical PPP contract, such as the long-term nature of the contract, sharing of risks or management responsibility between the public and the private sectors, and the use of performance-based payments based on mutually agreed-on parameters. Eight PPP contract types are regulated: Build-Operate-Transfer (BOT), Build-Transfer-Operate (BTO), Build-Transfer (BT), Build-Own-Operate (BOO), Build-Lease-Transfer (BLT), Build-Transfer-Lease (BTL), Operate-Manage (O&M), and mixed contracts. The PPP development process in Vietnam is similar to those used in other countries. Several regulations in the current PPP framework, including preparation, procurement, and contract management, also compare favorably with most other lower-middle-income countries.

Vietnam follows a decentralized model of governance for PPP projects, which shifts power away from the central government to assigned state agencies (ASAs), including line ministries and subnational governments. Decree 63/2018/NĐ-CP defines the following roles for the national and provincial institutions: a Steering Committee at the national level that is responsible for assisting the state and the Prime Minister in directing and coordinating PPP investment forms; a PPP Office within the Ministry of Planning and Investment (MPI), which is responsible for assisting the Steering Committee; ASAs, which sign and implement project contracts; PPP units, which are responsible for managing and organizing the implementation of PPPs within each ASA; and Project Management Units, which are responsible for preparing and implementing specific PPP projects.

Under the health care socialization policy, PPPs are among the many contracting tools that the public sector can use to mobilize private finance for the provision of health infrastructure and services. At least 25 contract types are applicable in the health sector, all of which are regulated in various legal documents. Only those specified in Decree 63/2018/NĐ-CP are legally considered to be PPPs, even though one of them—the BT contract—is not internationally regarded as a PPP. The remaining contract types are not regarded as PPPs, regardless of the extent to which the private sector shares responsibilities and risks. Among non-PPP contracts, the joint venture (JV) and the business cooperation contract are the most commonly used by public health institutions. In practice, several JVs share common characteristics with PPPs, such as a long-term contract, significant transfer of risks and responsibilities to the private sector, and performance-based payments for the project company. The Public Asset Use and Management Law allows public entities to enter into either a PPP or a JV contract with the private partners, while the Investment Law allows private investors to enter into either a PPP or a business cooperation contract with the public sector.

The application of PPPs in the health sector is still limited despite several facilitators such as the promotion of socialization of health care activities, deepening of hospital autonomy, the expansion of universal health insurance coverage, and the development of health care credits. A long “wish list” of 63 projects remains in the health PPP project pipeline. This high number is indicative of ineffective PPP project screening criteria rather than high potential, and only a small percentage of these projects are expected to reach implementation. Most health PPP projects are proposed and developed at the subnational level, especially in Ho Chi Minh City. They focus on hospital infrastructure and services rather than on preventive and primary health care and are oriented toward higher-income groups in urban areas rather than the disadvantaged groups in rural areas. The proposed health PPP pipeline, therefore, raises serious questions about equity and efficiency in public sector health service delivery.

The project preparation, appraisal, and approval processes are prolonged, and good governance practices are lacking. To date, only 18 projects have completed pre-feasibility studies and 10 projects have completed feasibility studies. The procurement process for selecting a private partner is ineffective and not sufficiently competitive or transparent. Out of eight projects under procurement, four projects awarded contracts directly to the investors who proposed them, and three projects applied competitive bidding but none or only one of the bidders passed prequalification. Achievements in actual implementation of health care infrastructure and service delivery PPPs are similarly modest. Out of three signed health PPP contracts, a BOO contract for the development of a 500-bed general hospital was terminated; a BOT contract for the development of a 200-bed on-demand hospital, although effective since 2014, has been having problems for several years; and a BT contract for the construction of a public health university, although completed, missed the opportunity to have the private sector share in the maintenance responsibility.

BARRIERS TO THE DEVELOPMENT OF HEALTH PPPs IN VIETNAM

Despite recent improvements, the current PPP framework has numerous limitations, especially with respect to its application to PPPs in the health sector. The definition of PPPs is oriented toward infrastructure-type PPPs,

downplaying the role of the service-type PPPs that are common in other countries. The definition also does not mention long-term contracts, transfer of risks or management responsibility from the public to the private sector, or performance-based payments. Crucial regulations and technical guidelines for screening PPP projects, allocating risks, developing key performance indicators, providing government support, and managing unsolicited proposals are lacking in the PPP framework. There are also inadequacies and inconsistencies among the legal documents governing PPP projects. Furthermore, PPPs have not been embedded in health policies and related health regulations, hampering the use of PPPs to expand infrastructure and improve services in the health sector. Stakeholders have far greater motivation and incentives to engage in health care projects using the JV-type model that was made possible through the socialization policy rather than to go the (more complicated and prolonged) PPP route.

The public sector lacks the institutional capacity to manage complex health PPP contracts. The MPI and the Departments of Planning and Investment in Ha Noi and Ho Chi Minh City have established PPP units to carry out the day-to-day activities related to PPP projects, but none has set up a health PPP task force. The team in charge of health PPPs in the MOH consists of three employees, who are not allocated full-time to PPP work and are inexperienced in health PPPs. Public health managers at all levels lack the competencies to manage PPP projects. In a 2019 survey, the percentage of public health managers who rated their PPP project management competencies as “weak” ranged from 32 percent to 41 percent for planning skills, from 32 percent to 39 percent for financial skills, from 24 percent to 33 percent for legal and procurement skills, from 26 percent to 32 percent for technical skills, and from 15 percent to 20 percent for contract management skills. Moreover, lack of financing and informational constraints are barriers to effective PPP project management within the sector. Half of the public health managers described their teams as too underfinanced and underinformed to undertake the different steps required throughout the PPP project cycle.

The private sector has strengths in infrastructure development but faces a shortage of highly skilled clinicians. As a result, most public-private engagements in the health sector in Vietnam have had to rely on the recruitment of public sector providers to staff these facilities. Also, the large private health care chains, which possess significant resources and operational experience, have shown only tepid interest in partnering with the government in PPPs. In the absence of government financial support for PPP projects, the private sector will recover costs and generate income fully or partially from patients (households), even if this payment model compromises the government’s aspirations of universal health care coverage and financial protection for all people.

Although short-term and medium-term credit for health remains plentiful, the provision of long-term credit to PPP project enterprises is constrained by the short-term nature of deposits and relatively high transaction costs. Revenue-based loans, nonrecourse financing, and limited recourse financing are not common in Vietnam because local banks often provide loans with an associated mortgage. The financial market has a limited range of long-term financial products, hindering the financing of infrastructure in Vietnam.

THE WAY FORWARD: RECOMMENDATIONS

In the current context, health PPP models and contracts should be adopted with caution. The “asset-heavy, service-light” PPP models, such as equipment PPPs and facility PPPs, seem to be the most feasible options. Small-scale “asset-light, service-heavy” PPP models, such as specialized services PPPs and integrated PPPs at the primary health care level, may be suitable for selected projects for which the private sector has a competitive advantage. Vietnam, however, does not yet seem to be ready for a fully integrated hospital PPP model because of various barriers in the existing regulatory framework as well as the capacity mismatch between the public and private sectors. Four of the regulated contract types—BLT, BTL, BOT, and BTO—are feasible in the health sector. BOO contracts are not recommended, given the fact that neither the public nor the private sector is prepared for such a full transfer of responsibilities and risks to the private sector.

In the long term, the government of Vietnam should reorient health PPPs toward equity and efficiency, two objectives of the national health system. All potential health care PPP projects should go through a rigorous screening process to ensure that they are suited to the universal health coverage goals and provide value for money (VfM) under this modality. Only eligible health PPP projects should be included in the health sector development plan and midterm investment plans. On this basis, the government should be able to provide support to health PPP projects, especially those that target vulnerable groups, to make them financially viable and attractive to private investors. If not, then there is a risk that PPP projects (like most of the current JV projects) will tend to focus on geographical areas with high revenue potential, mainly benefiting middle- or high-income groups rather than helping close gaps in access for all Vietnamese. Health PPP contracts should be monitored by key performance indicators, and private partners should be remunerated based on their performance.

Vietnam is developing a PPP Investment Law, which is a great opportunity to refine PPP concepts and optimize the processes and procedures for PPP project development. The definition of PPP in the legal framework should highlight the long-term nature of the contracts for service delivery, the importance of optimal sharing of risks and management responsibilities, and the key role of performance-linked payments in fostering effective PPPs. The scope of PPP contracts should not be limited to “build and operate/lease” infrastructure facilities but rather should be expanded to deliver high-quality public services to the population. The pre-feasibility study should include a qualitative VfM assessment to determine whether the proposed contracting model for the project has the potential to deliver greater VfM than a traditional contracting model. The feasibility study should expand the qualitative VfM exercise to a quantitative VfM analysis, which will assist the ASAs in designing an optimal risk-sharing framework. Rather than focus on inputs, PPP contracts should specify the required outputs or desired outcomes and link payments to the project company to the achievement of these outputs and outcomes. The weaknesses and uncertainties around unsolicited proposals should be addressed. The PPP Investment Law should also allow ASAs to provide public financial support and establish mechanisms to calculate, account for, and monitor fiscal commitments. Detailed regulations and guidance should be provided in a supporting decree by the government and in circulars issued by the MPI and Ministry of Finance.

The MOH should also develop a circular guiding the screening, preparation, implementation, monitoring, and evaluation of health PPP projects.

The institutional arrangements for managing public-private engagements and partnerships in the health sector should be reinforced. At the central level, the MOH should establish a dedicated unit within the Department of Planning and Finance to facilitate the preparation, implementation, and monitoring of the public-private engagements program, including PPP projects in the health sector. A dedicated health PPP task force is required in the cities and provinces with large portfolios of PPP projects. PPP units at the central and provincial levels should estimate and mobilize resources for developing health PPP projects, where appropriate. Public health managers should be trained to augment their capacity to prepare and implement health PPPs. The PPP unit within the MOH could consider establishing a graduated training program—at the introductory, intermediate, and advanced levels—to improve awareness and the health PPP-related competencies of public officials.

Further development of the private sector and local capital markets would create more opportunities for the public sector to build effective and sustainable partnerships with the private sector through health care PPP projects. Also, building PPP managerial capacity within the private health care sector is as important as building public sector management capacity. Finally, the MOH, in association with the MPI and subnational governments, should maintain communications with stakeholders and engage them throughout the process of policy making and PPP project development.

Abbreviations

ASAs	assigned state agencies
BLT	Build-Lease-Transfer
BOO	Build-Own-Operate
BOT	Build-Operate-Transfer
BT	Build-Transfer
BTL	Build-Transfer-Lease
BTO	Build-Transfer-Operate
CPC	City People’s Committee
DOH	Department of Health
DPF	Department of Planning and Finance
DPI	Department of Planning and Investment
FS	feasibility study
GDP	gross domestic product
HCMC	Ho Chi Minh City
HFIC	Ho Chi Minh City Finance and Investment State-Owned Company
JV	joint venture
KPI	key performance indicator
MOF	Ministry of Finance
MOH	Ministry of Health
MOT	Ministry of Transport
MPI	Ministry of Planning and Investment
NCB	national competitive bidding
O&M	Operate-Manage; operation and management
PDF	Project Development Facility
PFI	Private Finance Initiative
PPC	Provincial People’s Committee
PPE	public-private engagement
PPP	public-private partnership
pre-FS	pre-feasibility study
PSI	Patient Satisfaction Index
SBV	State Bank of Vietnam
SPV	special purpose vehicle
SSS	single source selection

UHC	universal health coverage
UMP	University of Medicine and Pharmacy
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
VfM	value for money
VGf	viability gap funding
VND	Vietnamese dong
VSS	Vietnam Social Security
WHO	World Health Organization

All dollar amounts are US dollars unless otherwise indicated.

1 Introduction

ECONOMIC DEVELOPMENT AND THE EMERGING ROLE OF PUBLIC-PRIVATE PARTNERSHIPS

Vietnam has made a successful transition from an economy that was largely closed and centrally planned to one that is dynamic, market-oriented, integrated, and connected to the global economy. Premised on the economic reforms under *Đổi Mới* in 1986, the country has established an enviable track record of rapid economic development and poverty alleviation. In 2009, Vietnam reached middle-income status. By 2016, the incidence of poverty had fallen to 9.8 percent (according to the national General Statistics Office–World Bank poverty line), down from nearly 60 percent in 1993 (World Bank 2019). Gross domestic product (GDP) grew at an average rate of 6.14 percent per year from 2011 to 2017, ending 2018 with 7.08 percent annual growth. About 70 percent of Vietnam’s population can now be classified as economically secure, including the 13 percent who are now part of the global middle class (World Bank 2018).

Economic growth has been spurred by a high level of investment. Between 2008 and 2015, infrastructure investment averaged 8 percent of GDP, much higher than the global average (ADB Institute 2016). Vietnam improved its global infrastructure ranking to 79th position in 2016 (up from 95th in 2012) (World Economic Forum 2017). However, its infrastructure competitiveness is still modest in comparison with more advanced economies in the region, and the sentiment of infrastructure experts (as well as Vietnamese leaders and the Vietnamese people) is that more investment is needed. In 2013, the World Bank estimated that to meet its infrastructure needs during 2016–20, Vietnam would need \$25 billion annually (World Bank 2013). In 2018, the United Nations (UN) estimated that the financing gap for infrastructure investment in the transport, energy, information and communications technology, and water and wastewater sectors was about \$12 billion annually (UNESCAP 2017).

The demand for investment exceeds the fiscal capacity of the government. The government is in a period of fiscal consolidation in an attempt to address its persistent deficits and high level of public debt. Public debt peaked at 63.8 percent of GDP in 2016 before improving to 61.4 percent in 2018. Strict fiscal discipline is being exercised to keep the annual deficit below the target of 4 percent of GDP and the public debt below the ceiling of 65 percent of GDP in 2016–20.¹ In the

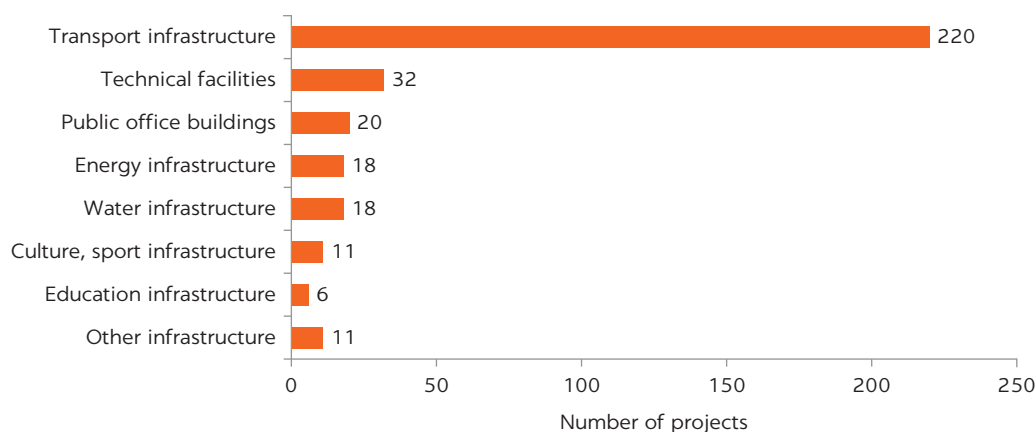
meantime, official development assistance funds that have historically made an important contribution to infrastructure investment have declined since the country reached middle-income status.

The gap between the need for investment and the capacity of the state to finance it has focused government attention on the mobilization of private resources for public development goals, including through public-private partnership (PPP) models. PPPs were introduced into the regulatory framework in 1997 through Decree 78/1997/NĐ-CP, which focused on investment in Build-Operate-Transfer, Build-Transfer-Operate, and Build-Transfer contracts. However, the PPP market in Vietnam was still considered to be emerging as recently as 2014 (Economist Intelligence Unit 2014). Since then, the PPP general framework has been substantially strengthened by revised decrees and relevant regulations, including in 2015 and 2018 (see chapter 3).

Over the past two decades, 336 PPP contracts have been signed in Vietnam, mobilizing more than 1,600 trillion Vietnamese dong (VND) (about \$72 billion) from the private sector for infrastructure development.² Most PPP projects are for the transport, energy, and water sectors, as well as for public office buildings (figure 1.1). Although many PPP projects are considered to have had a positive impact on infrastructure quality, there have also been many difficulties. In particular, a number of PPP toll road projects have encountered problems, with concerns raised about their financial sustainability. Consequently, the State Bank of Vietnam (SBV) has asked credit institutions to improve risk management of Build-Operate-Transfer and Build-Transfer transport projects.³ Credit for Build-Operate-Transfer infrastructure projects, therefore, has begun to decline.

As the government continues to face the challenge of balancing the need for economic expansion with its limited fiscal capacity, addressing the barriers in the design and implementation of PPP projects has become a public policy priority. In 2017, the Communist Party Central Committee promulgated Resolution No. 10/NQ-TW to strengthen the framework for PPPs in infrastructure development and to facilitate private sector participation in public service provision. In response, the government revised the PPP regulatory framework in 2018. A new PPP Investment Law is under preparation and the National Assembly has agreed to have it in place by 2020.

FIGURE 1.1
Number of signed PPP projects in Vietnam, by sector, as of 2019



Source: Vietnam Ministry of Planning and Investment.

DEMAND FOR EXPANDED HEALTH CARE SERVICES BUT LIMITED FISCAL SPACE

Vietnam has made remarkable progress in health outcomes, but demographic, epidemiological, and social changes present a new set of challenges to the health system. Vietnam is one of the most rapidly aging countries, and the 65 and older age group is expected to increase 2.5 times by 2050 (Vietnam, GSO, and UNFPA 2016). This aging is contributing to a sharp shift in Vietnam's burden of disease toward noncommunicable diseases, which increased from 46 percent of the disease burden (measured in disability-adjusted life years) in 1990 to 74 percent in 2017⁴. This will increase the need for resources for the screening and treatment of cancers and cardiovascular disease, along with their risk factors such as hypertension and diabetes. As Vietnam grapples with the shifting disease burden, it will also face the challenge of the rising expectations of a growing middle class, which will demand better quality and more technological sophistication in health care.

These demographic and epidemiological shifts will require expansion and strengthening of the health care network. At the primary care level, the capacity of Vietnam's 11,000 commune health stations and regional polyclinics and nearly 32,000 private clinics will be important in preventing, detecting, and managing noncommunicable diseases. However, the basic infrastructure, equipment, and competencies are lacking in many communes. In 2016, only 69.76 percent of rural communes met the 2014 national commune health benchmarks (Vietnam, Central Steering Committee for the Census of Rural Areas, Agriculture and Aquaculture 2016). Moreover, those largely structural benchmarks do not provide any assurance that the commune health stations are capable of appropriately dealing with specific medical conditions in line with diagnostic and treatment guidelines for those conditions and in close coordination with higher-level facilities. The secondary and tertiary care levels are supported by 1,451 public hospitals together with 240 private hospitals. In general, the overall health care system is hospital-centric, and the rate of hospital admissions and average length of stay are higher than regional averages (OECD and WHO 2016), resulting in overcrowding and patient perceptions of insufficient investment in hospital infrastructure.

Quality of care and patient satisfaction have improved in recent years; however, concerns remain about physical facility and health care costs. Since the Ministry of Health (MOH) published the first hospital quality scorecard in 2013, many hospitals have reported improvements across the dimensions of quality. The average patient satisfaction index⁵ in Vietnam reached 4.04 out of 5 in 2018, slightly higher than its score of 3.98 in 2017. This improvement should mean that the quality of care in public hospitals meets 80.8 percent of inpatients' expectations. However, the media are replete with the public's complaints about hospital infrastructure and facility conditions, particularly at the provincial and district levels, especially from those of higher income levels.

While the demand for more and better health care services is expected to increase, fiscal space—the scope to increase government spending on health—to meet that demand is expected to be only modest (Teo et al. 2019). On the one hand, the benefits of robust economic growth will be felt by all sectors so that even if government spending on health as a share of GDP remains unchanged at 2.8 percent, total government spending on health would increase to VND 196 trillion in real terms by 2023 (up from VND 126 trillion in 2016). On the

other hand, with Vietnam already allocating 9.3 percent of its government budget to health—a share that has held roughly steady over the past 10–15 years—further prioritization of state budget resources toward health is unlikely despite (soft) expenditure earmarking (through government pronouncements) that the health budget should increase faster than the rate of general government spending. Also, compared with other countries of a similar level of economic development, government expenditure on health in Vietnam is high. Considering these factors and the lack of policies that generate major efficiency gains in existing government spending, the scope to generate additional fiscal resources for health care will be relatively limited.

So, like other sectors in Vietnam, the health sector faces a mismatch between the demand for health sector investment and the fiscal space available to meet this demand. Determining the size of this gap is not easy, but there are some estimates. In 2010, it was estimated that the public health care network would need infrastructure investment of VND 68,000 billion for 2010–15;⁶ in 2016, it was estimated that VND 176,000 billion would be needed in 2016–20.⁷ Since 2010, the government has allocated VND 76,000 billion from its domestic budget and \$400 million (equivalent to VND 80,000 billion) from official development assistance funds (Vietnam, Ministry of Health 2019), meeting only about 64 percent of capital demand for that period. The government of Vietnam sees private resources as critical to filling that gap, with government master plans for facility investment explicitly directing the MOH and hospitals to mobilize funding from the private sector.

RECENT POLICIES HAVE CREATED AN ENVIRONMENT FAVORABLE TO THE MOBILIZATION OF PRIVATE RESOURCES FOR HEALTH

As part of its overall macroeconomic reforms in the early 1990s, and to address its resource constraints, Vietnam embarked on initiatives to encourage the mobilization of “all possible resources in society” toward key public services. In theory, this “socialization” policy was intended to share costs and responsibilities between the state and society for the provision of and payment for services. In reality, the government reduced its subsidies, allowing public institutions to collect user fees for services and mobilize resources from the private sector and social organizations with considerable discretion. Over the subsequent decades, socialization became an increasingly important policy in the social sectors, simultaneously filling a resource gap and expanding the services available to people. In the health sector, the socialization policy built on previous government initiatives to mobilize private financing for health care, such as the introduction of user fees in public health care facilities (1989), legalization of private health care providers (1989), and the introduction of contributory social health insurance (1992). On the supply side, the socialization policy framework includes two key measures aimed at strengthening the role of the private sector in health service delivery: (1) the expansion of private health care provision and (2) the increasing financial autonomy of public health institutions, including with respect to mobilization of private resources for development.⁸

The expansion of private service providers has been dramatic. It has transformed the Vietnamese health care system into a mixed public-private one. Since private medical practices were first allowed in 1993,⁹ the number of private

providers has increased rapidly, at an average of 1,300 new private clinics and 9.6 new private hospitals per year. In 2018, there were about 35,000 private clinics across the country, nearly triple the number of commune health stations and regional polyclinics within the public sector. The number of private hospitals reached 240 by the end of 2018 (up from only one in 1996, 43 in 2005, and 182 in 2015 [Vietnam, Ministry of Health 2017, 2018]), accounting for 14 percent of all hospitals and 6 percent of all hospital beds nationwide. Currently, 50 of the 63 provinces have at least one private hospital, with an average of 1.7 private beds per 10,000 population. While the five centrally managed cities (Ho Chi Minh, Ha Noi, Da Nang, Hai Phong, Can Tho) account for 45 percent of private hospitals, the provinces with the highest number of private beds per 10,000 population are Binh Duong, Vinh Long, Thanh Hoa, and Nghe An (map 1.1). Altogether, private health facilities account for 32.2 percent of outpatient services and 6.3 percent of inpatient services provided to the Vietnamese people.¹⁰ Some evidence also indicates that private health care is meeting the expectations of the emerging middle-income class: in exit interviews at facilities in Ho Chi Minh City (HCMC), patients at private hospitals reported shorter waiting times, more comfortable amenities, friendlier behavior by providers, and better consultations than those visiting public hospitals (Ho Chi Minh City DOH 2019).

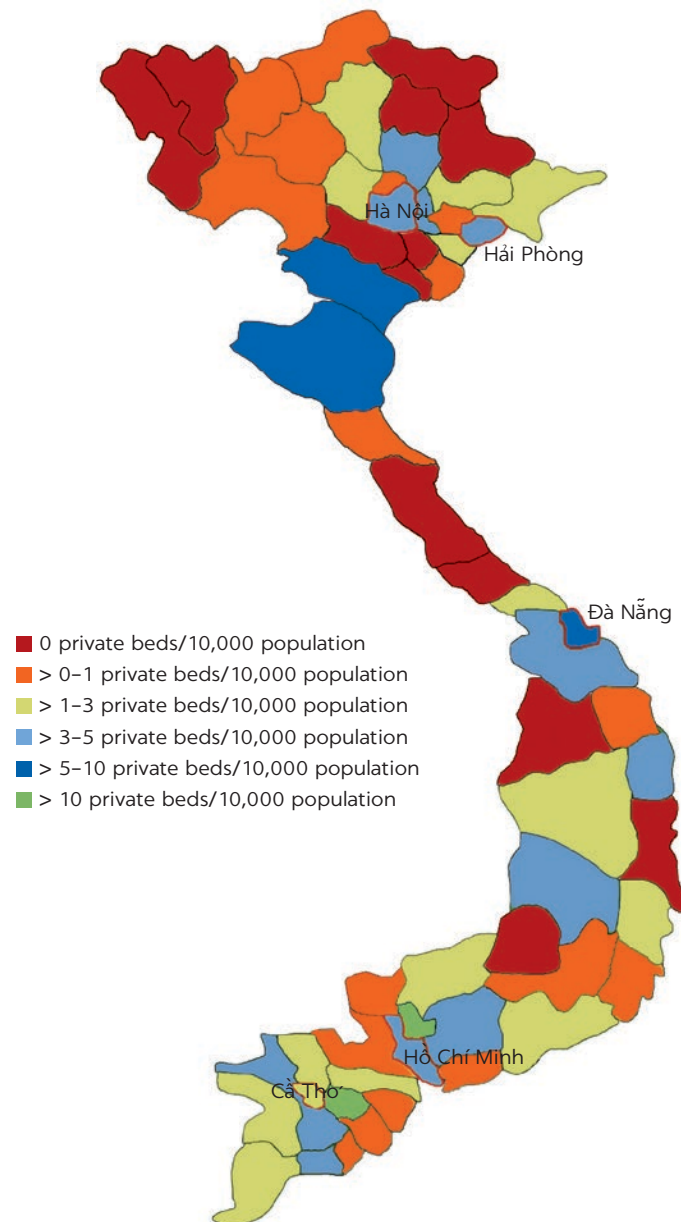
Different financing modalities have been used to mobilize private capital for new investment in infrastructure and equipment. One modality is for government health facilities to take on debt to purchase assets. When hospitals do so, they assume the entire responsibility for and risk of the asset once construction or installation is completed. By 2016, central hospitals under the MOH had incurred total debt of VND 1,945 billion (Vietnam, Ministry of Health and Health Partnership Group 2018), and government health facilities under the HCMC Department of Health (DOH) had incurred total debt of VND 3,929 billion from commercial banks.

Another common model is a joint venture (JV) for provision of medical equipment through which private investors (which may include the staff of the hospital)¹¹ purchase and install new medical equipment at public hospitals. They are permitted to charge higher fees for use of this private equipment than for publicly provided equipment, and the health insurance fund will reimburse these services at the administratively set fee level applied for public services. Imaging equipment accounts for the largest share of such equipment, followed by examination equipment and laboratory equipment (figure 1.2). In 2016, investment by hospital staff accounted for 15 percent of total private sector investment in JVs. This investment modality is widespread: in 2017, there were more than 810 JV projects in 19 central hospitals and 22 provinces and cities, from which central hospitals under the MOH had mobilized total capital of VND 2,043 billion¹² and public health institutions in HCMC and Ha Noi had mobilized VND 1,100 billion¹³ and VND 262 billion,¹⁴ respectively.

In recent years, the private sector has also entered into JVs for the construction and operation of private facilities within public health institutions (figure 1.3). The co-location of public and private services is typically implemented through a business cooperation contract without a project company. Examples include high-quality examination and treatment centers in public hospitals or vaccination centers in public centers for disease control. In recent years, there have also been several large-scale co-branded, co-located hospitals, following the business cooperation contract model with establishment of a joint stock project company, in which the private partner contributes

MAP 1.1

Private hospital beds per 10,000 population in Vietnam mainland, by province, 2019

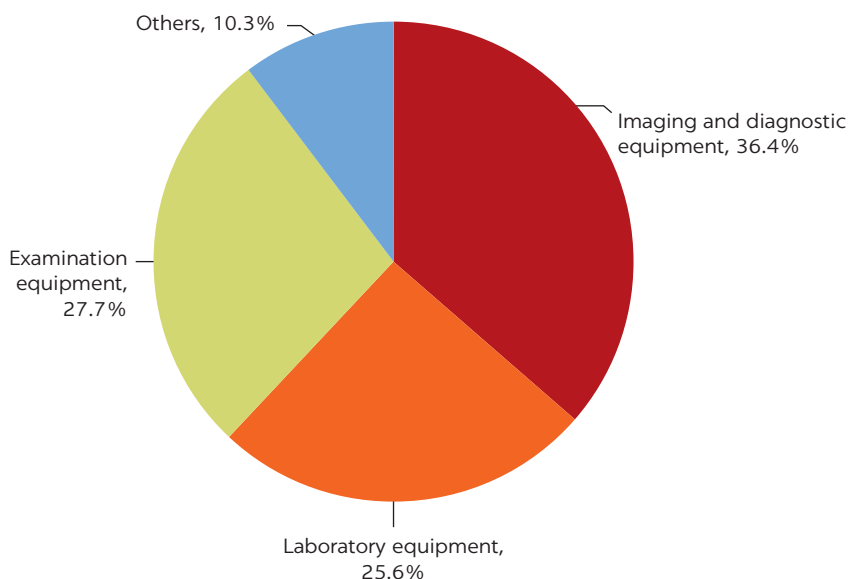


Source: Original map for this publication.

investment capital and holds larger shares while the public hospital contributes its brand name and skilled staff and holds smaller shares. Joint-stock, co-branded hospitals include Dong Nai provincial general hospital (700 bed Block B) and Binh Dinh provincial general hospital (600 bed block), which together mobilized total investment capital of VND 2,600 billion from the private sector.

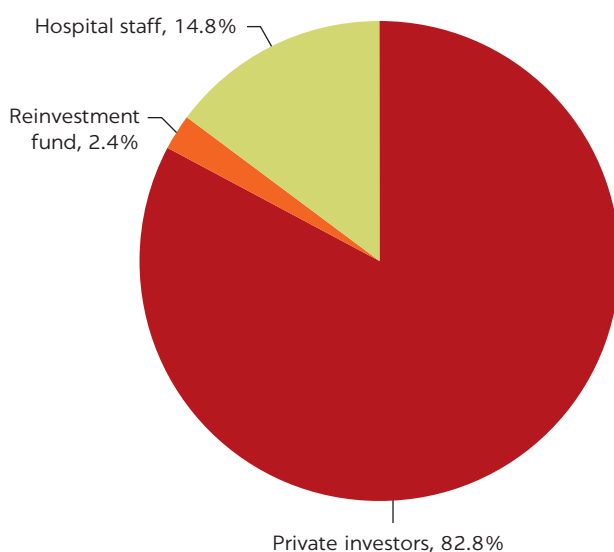
Despite the impressive growth of the private health sector in Vietnam and the benefits that have accrued to the population as a consequence, the

FIGURE 1.2
Joint venture projects, by equipment type



Source: Vietnam, Ministry of Health and Health Partnership Group 2018.

FIGURE 1.3
Joint venture projects, by sources of financing



Source: Vietnam, Ministry of Health and Health Partnership Group 2018.

socialization and autonomy policies have also had unintended consequences. Socialization efforts have generally focused on geographic areas with high revenue potential, resulting in higher out-of-pocket expenses for individuals able to afford it (Vietnam Ministry of Health and WHO 2016). At the same time, it has not necessarily expanded access to care for those living in poorer areas who are unable to afford the services that are provided by privately mobilized capital. Central hospitals and those in large cities, as well as the patients

that they serve, are more able to benefit than those in poorer provinces and rural areas (Vietnam Ministry of Health et al. 2011). Socialization projects have also tended to focus on smaller-scale projects, with a shorter payback period, rather than on large-scale projects requiring a higher level of commitment from the government (Procurement Newspaper 2017).

The most controversial trends related to autonomization and mobilization of private finance are the intensive installation of high-tech diagnostic equipment and the rapid expansion of “on-demand services.” More than 62 percent of JVs have invested in imaging and laboratory equipment, leading to overprovision of laboratory tests and overutilization of technologically sophisticated diagnostic equipment. The powerful incentives for hospitals to offer expensive, high-tech services may be resulting in care that is not necessarily medically appropriate (that is, overservicing) but is demanded by patients because it is perceived as a signal of quality. Public hospitals have even established on-demand services buildings or zones within their campuses to maximize revenue by offering greater choices of accommodation and medical services but charging higher fees than “regular services” for “normal patients.” In 2012–17, beds for on-demand services accounted for 11.1 percent of total beds in central hospitals and 4.8 percent of total beds in provincial hospitals.¹⁵ Provision of costly profit-generating services for middle- or high-income groups has also raised concerns about the equity and efficiency of public services as well as questions about whether the profit-sharing JV model is a good fit for the socialization policy objectives.

The weak management of JV projects poses another challenge. Private investors are not required to submit a bid for proposed JVs, leading to mounting concerns about nontransparent selection of the private partner, noncompetitive procurement of assets, and ineffective appraisal of the financial plan. Once in operation, the JV is not required to undergo standard performance monitoring or follow standard financial accounting procedures. With so much of the capital for equipment investment contributed by hospital staff, who then stand to benefit privately from its use, it is reasonable to think that this would encourage even more supplier-induced demand for services and overuse. Media coverage of improper management practices in the various privately funded services has been extensive. The MOH and other agencies have therefore had to make course corrections in policy related to JVs for equipment investment and on-demand services within the public health system during the past decade.¹⁶

THE NEED FOR A HEALTH PPP STUDY IN VIETNAM

Experience in advanced economies shows that well-designed and implemented PPP projects can address the concerns noted above. Originally confined to the traditional infrastructure sectors of transport, water, and energy, PPPs are increasingly being used in the social infrastructure sectors around the world, particularly for the delivery of health infrastructure and services. The value drivers that allow PPPs to deliver value for money, in addition to mobilizing additional funding and ensuring a single-minded focus on the tasks specified in the contract, include whole-of-life costing, optimal risk sharing

between the public and private parties, an up-front commitment by the private operator to provide maintenance for the asset over the tenure of the contract, innovation fostered by specifying outputs rather than prescribing inputs in the contract, optimal use of assets, and greater accountability associated with linking public payments to performance.¹⁷ In addition to the efficiency and quality gains in the health sector that can accrue from PPPs, when supplemented by appropriate government financing to ensure access for the poor and vulnerable, PPPs can also be used as an instrument to promote equity. As such, they are highly relevant to Vietnam's efforts to improve the access of its population to good-quality health care services.

The government of Vietnam recognizes PPPs as an important means to overcoming infrastructure challenges, including in the health sector, but faces difficulties in their design and implementation. Health facilities have been included in the eligible areas for PPP investment in the Prime Minister's Decision No. 71/2010/QĐ-TTg on piloting PPPs and also in successive PPP decrees (No. 15/2015/NĐ-CP and No. 63/2018/NĐ-CP). In 2016, the MOH started drafting a circular on PPP investment in the health sector but has not yet completed it. Several assigned state agencies have called for private investment in public hospital construction. Despite such efforts, the track record on PPPs in the health sector remains poor.

PPPs are now also an important tool, among others, in the World Bank Group's response to health challenges in lower-middle-income countries, as reflected in the 2013 World Bank Group Strategy, the 2008 World Bank Group Health Development Strategy, and the 2015 joint World Bank Group Approach to Harnessing the Private Sector in Health (World Bank 2016).

Several assessments of PPPs have recently been conducted in Vietnam. They have generally focused on three broad analytic domains: macroeconomic factors, the enabling environment for PPPs in the country, and PPP projects in the traditional infrastructure sectors. However, only limited research and analysis of PPPs in the health sector has been conducted. The need for an in-depth study on health PPPs has become more urgent as the National Assembly and the government seek to advance the PPP Investment Law to 2020.

Acknowledging an uncomfortable fit between the existing PPP framework and what is needed to transform the health system, this study focuses primarily on the enabling environment for health PPPs as well as issues related to the design and implementation of PPP projects in Vietnam's health sector. It also discusses international experience in using PPPs to improve health service delivery and health sector outcomes for the population. It is hoped that evidence from the study will help assigned state agencies improve the preparation and implementation of health PPP projects, the MOH to finalize health PPP regulation, and the government and National Assembly to refine the PPP Investment Law.

It should be emphasized that this report does not seek to endorse PPPs as the only or even the optimal approach to engaging the private sector in improving health care in Vietnam. Rather, it is intended to leverage global best practice and the lessons learned about PPPs worldwide in the formulation and implementation of PPPs in Vietnam, given the government's desire to solicit private sector participation in health care financing and service delivery.

STUDY OBJECTIVES, SCOPE, AND METHODOLOGICAL APPROACH

Study objectives

The study on health sector PPPs in Vietnam has the following objectives:

- To introduce international experience and lessons learned in health PPPs
- To review progress and achievements in the implementation of health PPPs in Vietnam
- To identify barriers to the implementation of health PPPs in Vietnam
- To propose feasible and actionable recommendations so that the government can consider tackling the identified barriers and further the successful design and implementation of health PPPs

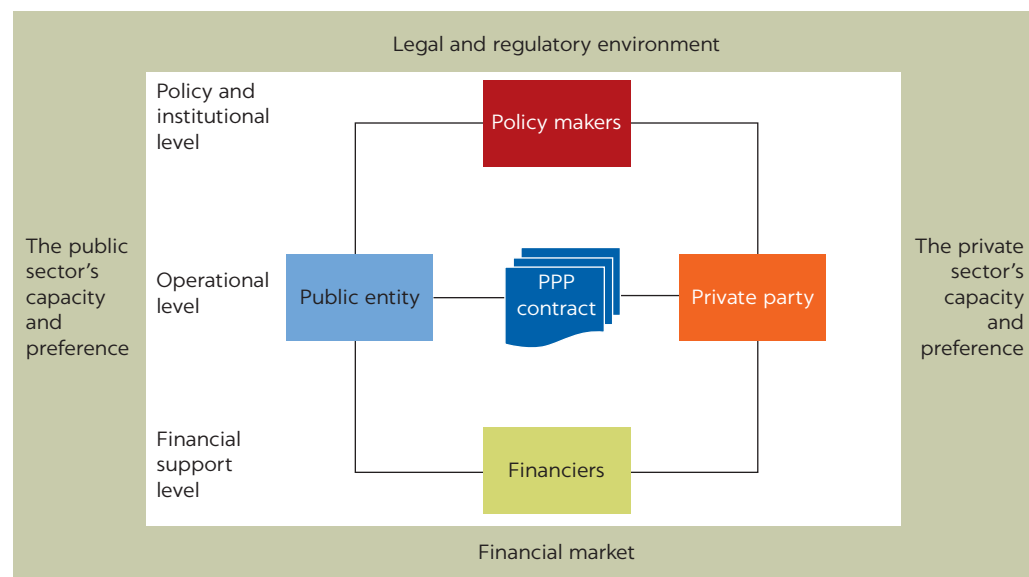
Definition of PPP

The study notes that there is no single internationally accepted definition of a PPP and therefore uses the definition proposed by the World Bank (see details in chapter 2). According to this definition, a PPP is “a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility and remuneration is linked to performance” (World Bank 2017, 5).

Study framework

This study is underpinned by a conceptual framework (figure 1.4) that encompasses policy and institutional, operational, and financial aspects and examines the issues from the perspectives of different stakeholders (policy makers, expert community, public entities, private parties, financial institutions, health staff, and patients).

FIGURE 1.4
Framework for assessing health PPPs in Vietnam



Source: Original figure for this publication.
Note: PPP = public-private partnership.

Study scope

Aligned with the objectives, the study entails four main parts, as follows:

- *Characterization of health PPPs, drawing on international examples.* This part of the study (chapter 2) clarifies critical features of PPPs in comparison with other public-private engagements in the health sector; introduces common health care PPP types worldwide, including their application, advantages, and disadvantages or pitfalls; and synthesizes successful factors and lessons learned for effective governance of health PPPs.
- *Progress and achievements in the implementation of health PPPs in Vietnam.* This part (chapters 3 and 4) encompasses a review of the legal and regulatory framework for health PPPs in Vietnam and also examines how health PPPs are implemented on the ground. Detailed case studies of each major type of health PPP in Vietnam are presented and their achievements and challenges documented.
- *Barriers to the implementation of health PPPs in Vietnam.* This part (chapter 5) identifies barriers at various levels including the policy and institutional level, operational level, and financial support level. Critical issues are analyzed and discussed from the perspectives of different stakeholders involved in the preparation and implementation of health PPP projects, such as policy makers, public entities, private investors, financiers, health professionals, and patients.
- *Feasible and actionable steps that can be taken to tackle the identified barriers and to do health PPPs better.* This part of the study (chapter 6) proposes actions that can be taken by the MOH and relevant government agencies to overcome barriers and strengthen health PPPs in Vietnam, based on findings of the current study.

Data collection methods

The study brings together rich qualitative and quantitative information from primary sources (self-administered surveys, semi-structured interviews, consultative workshops) and secondary sources (literature review). In addition, information sources include websites of ministries and PPP units in different countries. The data collection methods used in different parts of the study are summarized in table 1.1.

TABLE 1.1 Data collection methods applied to different parts of the study

STUDY PARTS	METHODS			
	LITERATURE REVIEW	SELF-ADMINISTERED SURVEY	SEMI-STRUCTURED INTERVIEW	CONSULTATIVE WORKSHOP
Characterization of health PPPs	+			
Progress and achievement	+		+	+
Facilitators and barriers	+	+	+	+
Options to tackle barriers	+	+	+	+

Source: Original table for this publication.

Note: PPPs = public-private partnerships.

- The literature review entailed an examination of published and unpublished international literature (studies, reports, guidelines, and so on), as well as published and unpublished literature from Vietnam.
- A total of 53 semi-structured interviews were undertaken in both public, private, and financial sectors. Informant interviews involved six policy makers in charge of PPPs at the central government level (MOH, Ministry of Planning and Investment [MPI], Ministry of Finance [MOF]); 23 policy makers and implementers at the provincial authority level (DOHs, Departments of Planning and Investment, and so on); 11 directors or deputy directors of health institutions (hospitals, district health centers, and medical universities); 5 directors of private health care chains; 2 managers from international nongovernmental organizations; and 6 domestic or international financiers.
- In addition, a survey on PPP management capacity was undertaken among high- and middle-level government officials and health facility managers who participated in training courses and workshops organized by the MOH and the World Bank. A total of 386 public health officials and managers nationwide participated in the survey by filling out a self-administered questionnaire that comprised (1) a self-assessment of PPP-related competencies,¹⁸ (2) an assessment of perceived resource availability for PPP project management, and (3) an assessment of perceived issues in the implementation of PPP and recommendations for strengthening health PPPs. Another survey using a similar approach (convenience sampling and a self-administered questionnaire) was conducted to understand the perspectives of the private sector. A total of 40 representatives from private hospitals, clinics, and equipment and pharmaceutical companies participated.
- Four consultative workshops were organized to solicit information from relevant stakeholders during different phases of the study. The first workshop with the HCMC People's Committee, followed by a discussion with the provincial DOH in March 2019, introduced global experience in PPPs and examined the health PPP program in this most dynamic economic center. The second and third workshops, in Ha Noi and HCMC in May 2019, allowed various public and private players to present PPP projects and discuss regulatory and operational issues. At the fourth workshop in July 2019, the initial findings of the study were shared with relevant stakeholders and their feedback was collected on the findings as well as on options for moving forward. These consultative workshops involved more than 400 representatives, including officials from the MOH, MPI, MOF, and the DOHs; nongovernmental organizations; private for-profit entities; and representatives of the financial sector.

NOTES

1. National public debt and foreign debt strategies in 2016–20 and vision to 2030 in accordance with Prime Minister's Decision No. 958/QĐ-TTg dated July 27, 2012.
2. Government Report No. 25/BC-CP dated January 30, 2019, on PPP project implementation status.
3. State Bank of Vietnam, official letter No. 6395/NHNN-TD requesting credit institutions to strengthen risk control in the provision of credit to transport Build-Operate-Transfer and Build-Transfer projects.
4. Institute for Health Metrics and Evaluation. Global Burden of Disease Results Tool. Data downloaded November 20, 2018.

5. The Patient Satisfaction Index (PSI) was jointly developed by the Vietnam MOH, the Vietnam Initiative network, and the United States' Indiana University in the framework of the Equitable Healthcare through PSI project funded by Oxfam Vietnam. The PSI covers six factors influencing quality of medical treatment and patient satisfaction: ability to access medical service, transparent information on examination and treatment, medical staff's attitude and competency, drug distribution and guidance for use, examination and treatment expenses, and hospital infrastructure. The surveys were conducted by phone interviews with 3,000 patients and their family members at 29 hospitals in 2017, and with 7,500 patients and their family members at 60 hospitals in 2018.
6. Vietnam Health Economics Association 2010 (<http://vhea.org.vn/print-html.aspx?NewsID=201>).
7. MOH's plan on protection, care and improvement of people's health in the period of 2016–2020 (No. 139/KH-BYT dated March 1, 2016).
8. Government Resolution No. 05/2005/NQ-CP dated April 18, 2005, on enhancing socialization of activities in education, health, culture, and sport.
9. President's Ordinance No. 26/L/CTN dated September 30, 1993, on private medical practices.
10. Vietnam household living standards survey 2017.
11. Government Decree No. 69/2008/ND-CP on socialization promotion in education, training, health, culture, sport, and environment activities.
12. "The health sector attracts socialized investment" (<http://thoibaotaichinhvietnam.vn/pages/nhip-song-tai-chinh/2018-08-22/linh-vuc-y-te-hut-von-dau-tu-xa-hoi-hoa-61163.aspx>).
13. "Promoting autonomy and socialization in the health sector" (<http://dangcongsan.vn/khoa-giao/day-manh-tu-chu-va-xa-hoi-hoa-trong-nganh-y-te-427653.html>).
14. "Socialization of medical equipment investment" (<https://Hanoimoi.com.vn/tin-tuc/Xa-hoi/867434/xa-hoi-hoa-dau-tu-trang-thiet-bi-y-te>).
15. "The health sector attracts socialized investment" (<http://thoibaotaichinhvietnam.vn/pages/nhip-song-tai-chinh/2018-08-22/linh-vuc-y-te-hut-von-dau-tu-xa-hoi-hoa-61163.aspx>).
16. Ministry of Health. Official documents No. 3295/BYT-KH-TC dated May 26, 2010; No. 5106/BYT-KH-TC dated August 16, 2013; No. 05/CT-BYT dated May 22, 2014; and No. 4364/BYT-KH-TC dated August 3, 2017 on correcting issues related to JVs for equipment investment and on-demand services in public health institutions.
17. Public-Private Partnerships, Victoria, Australia website (<https://www.dtf.vic.gov.au/infrastructure-investment/public-private-partnerships>).
18. See box 2.6 on competencies of public officials in the PPP project teams, as proposed by UNESCAP (2008).

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2 Definition, Characteristics, and Types of Health PPPs

INTRODUCTION

This chapter describes the nature of public-private partnerships (PPPs) in the health sector. It defines health-related PPPs, describes their key characteristics, and develops a taxonomy of the different types of PPPs that exist in practice, illustrated by international examples. Finally, it suggests some conditions for successful implementation.

WHAT IS A PPP AND WHAT ARE ITS DEFINING CHARACTERISTICS?

Governments engage with the private sector in health financing and service delivery through a wide range of models, distinguished by purpose, scope, functions, duration, payment method, and other characteristics (Viswanathan and Seefeld 2015; WHO 2010; Whyte and Olivier 2016). These engagements can be referred to as *public-private engagements (PPEs)*, of which PPPs are a distinct subset.

One type of PPE is *public financial support* to privately delivered health services through grants from the state budget to providers or social health insurance covering services delivered by the private sector. These systems are typically not performance based. Another is short-term, input-based *construction contracts* under which the private sector is responsible for delivering infrastructure. Varieties could include construct-only, design-construct, construction management, or the management of contractor contracts. There may also be *service contracts*, which are often short term and performance based, under which a public authority delegates responsibility for providing a service to the private sector. In *social franchising*, an agency (franchisor) markets a brand and builds networks of health care providers (franchisees) that are equipped with the knowledge, training, and supplies needed to deliver health services with an assurance of a minimum standard of quality. *Co-location arrangements* are long-term partnerships through which a portion of a public health facility's premises is granted to a private provider for its use, in return for payment and specified

benefits to the public party. These arrangements present an opportunity for revenue generation, as well as provide private infrastructure management of the public health facility.

On the demand side, PPEs can also include *voucher schemes* that use demand-side subsidies with defined benefits to transfer purchasing power for selected goods and health services to the poor and *social marketing*, which uses private sector communication and marketing techniques to increase uptake of a product with a public health benefit or to change health-related behaviors.

PPPs are not the same as privatization. Privatization involves permanent transfer to the private sector of a previously public-owned asset and permanent responsibility for delivering a service to the end user (ADB et al. 2016). A PPP necessarily involves a continuing role for the public sector as a partner in an ongoing relationship with the private sector (Farquharson et al. 2011).

There does not appear to be a single internationally accepted definition of a PPP; different definitions are used in different jurisdictions, often emphasizing different features of the PPP arrangement. The World Bank's PPP reference guide defines PPPs as “a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility and remuneration is linked to performance” (World Bank 2017, 5).

A key feature of a PPP is, therefore, that the public sector and the private sector share both risks and responsibility. The appropriateness of the allocation of risk and responsibility is a critical factor in the success of a PPP. By shifting responsibilities to the private partner, the public partner can mitigate risks during project construction and operation. Risks within PPP projects generally fall into two main categories: general risks and project risks. The general risks are often associated with political, legal, macroeconomic, social, and natural conditions that occur beyond the project boundary but whose consequences have an impact on project performance. Project risks include those found within the project boundary and involve all stages of the project cycle (project selection, design, construction, finance, and operation and management [O&M]). Compared with other sectors, health PPPs have a particular political and public sensitivity linked to the public entitlement to care being provided by the private (particularly for-profit) sector, uncertainty around future health care needs caused by demographic changes and technology development, medical risks relating to the medical services contracted for and referral of patients from and to other health facilities, and financial risk associated with reimbursement by health insurance. The allocation of responsibility and risk between the public and private sectors must be clearly laid out in the PPP contract.

Another defining feature of a health PPP is the payment mechanism. The payment mechanism should be structured in such a way that the net remuneration of the private party is linked to performance, providing incentives to the private party to complete activities on time and deliver services at the performance and quality levels outlined in the contract. Generally, payments to the private party in health PPPs fall into three categories:

- *User payments*. These are payments collected by the private party directly from service users (patients, visitors) or indirectly through health insurance reimbursement.
- *Government payments*. These are payments made by the government to the private party for infrastructure construction or maintenance (or both) or

service delivery. Examples include *availability payments*, which are made by the government to the private party once the health facility is ready, usually covering the cost of infrastructure and maintenance; *up-front subsidies* based on achieving certain construction milestones; *output-based subsidies* reflecting use of certain services (ambulance, dialysis services); and *capitation payments* based on the population served, such as in the “Alzira model” PPP in Spain (see the section titled “Integrated PPP” for details of this model).

- *Bonuses and penalties.* PPP contracts may also include bonus payments that are paid if specified outputs are achieved or, conversely, deductions in payment or penalties payable by the private party if certain specified outputs or standards are not achieved.

A PPP payment mechanism could include some or all of these types of payment, which should be fully defined in the contract and should include specification of the timing and mechanism for making the payments in practice (World Bank 2017).

Some countries (including Australia, Canada, Japan, the United Kingdom) define and describe their PPPs by the functions that are transferred to the private sector, such as Design-Build-Finance-Operate-Maintain or Design-Build-Finance-Operate contracts. Some other countries (including the Republic of Korea, the Philippines, Turkey) focus on legal ownership and control of assets in PPPs, using terms such as Build-Operate-Transfer, Build-Transfer-Operate, Build-Own-Operate-Transfer, Build-Lease-Transfer (BLT), and Build-Transfer-Lease. For PPPs that involve the management of existing infrastructure, the terms O&M, lease, management, or concession contracts may be used.

A PPP contract is usually implemented by a PPP company called a special purpose vehicle (SPV) that the private party constitutes subsequent to the award of the contract to perform assigned functions and responsibilities. This project company raises financing through a combination of equity provided by the project company’s shareholders, borrowing (financed by banks), bonds, or other financial instruments. An SPV enters into downstream contracts, for example, construction contracts and O&M contracts, with relevant contractors. These arrangements allow the SPV to share risks with third parties and bring in additional management and technical capacity. In some service PPPs in which the private entity can perform all assigned tasks by itself, an SPV is likely not necessary. In integrated PPPs, Portugal has experimented with the “twin SPV” model, under which a project company is responsible for infrastructure and the other (twin) is responsible for clinical management and all soft facility management services (Carlos and Marques 2013).

TYPICAL SCOPE AND FUNCTIONS OF HEALTH CARE PPPs

PPPs in the health sector tend to focus on the construction, maintenance, or both of health care infrastructure and service delivery. *Infrastructure PPPs* usually involve significant capital investment; the main objectives are developing and managing infrastructure over the long term. Many PPPs involve new health facilities, often called greenfield projects. Others may transfer responsibility for upgrading and managing an existing health facility to a private company, so-called brownfield projects. *Service PPPs* help expand the service delivery capacity of existing health facilities. The private sector is made responsible for

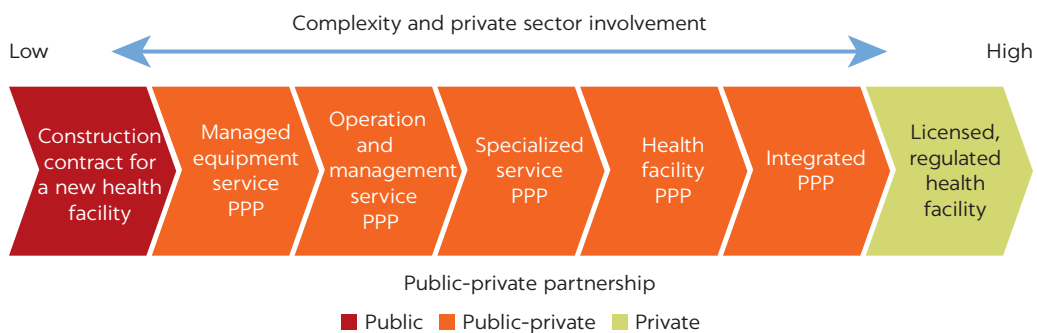
operation and management of the health facility or delivery of specific, often specialized, services without intensive capital investment in new infrastructure. *Integrated PPPs* require the private sector to perform a comprehensive set of infrastructure and service delivery functions.

Usually, a PPP contract will bundle together multiple project phases or functions, and the functions for which the private party is responsible will vary and depend on the type of infrastructure and service involved. Still, some typical functions of a PPP can be identified.

- *Design.* Design involves developing the project from initial concept and defining the output requirements through to construction-ready design specifications.
- *Build or renovate.* When PPPs are used for new infrastructure, the private party will be responsible for constructing the facility and installing all equipment. When PPPs involve existing infrastructure, the private party may be responsible for renovating or extending the facility.
- *Finance.* When a PPP includes building or rehabilitating an asset, the private party is typically also required to finance all or part of the necessary capital expenditure.
- *Maintain.* These PPPs assign responsibility to the private party for maintaining an infrastructure asset to a specified standard over the life of the contract.
- *Operate and deliver services.* The operating responsibilities of the private party can vary widely, depending on the nature of the underlying asset and associated services. Examples of the types of responsibilities that the private party could take on in a hospital PPP include the following:
 - “Hard” facility management services, such as architecture and engineering, O&M of outdoor facilities, house and room management, and so on
 - “Soft” facility management services, such as reception and security, central telephone, internal mail services, archive services, event and media services, waste management, bed preparation, washing and disinfection, central sterilization, staff and patient catering, and so on
 - Medical equipment and information communication technology services
 - Supply chain services, including drugs and consumables
 - Clinical support services, such as laboratory and imaging
 - Clinical services, potentially including the full range of care provided at a hospital (such as medical emergency services, outpatient and inpatient services, nursing services, rehabilitation services)
- *Other functions as an integrated part of the health system.* The most innovative integrated PPP projects expand their functions beyond hospital boundaries to health system functions including referral management, integration of health care delivery at different levels, and achievement of public health goals and population-level health outcomes.

COMMON HEALTH CARE PPP TYPES AND EXAMPLES

Health PPPs were first implemented in high-income countries in the 1990s and then spread across middle- and low-income countries. Based on data compiled by the authors, it is estimated that, currently, there are more than 1,000 health PPPs worldwide. The mature markets of Europe and North America have the most operational projects, while the dynamic economies of Asia have the most

FIGURE 2.1**Five common health PPP types**

Source: Original figure for this publication.

Note: PPP = public-private partnership.

projects in construction, procurement, or preparation. Countries use a wide and varying range of contract types. In general, though, health PPPs are of the following five types: managed equipment services (MES), O&M services, specialized services, health facility, and integrated PPP. These types differ in the degree and complexity of the role assigned to the private sector (figure 2.1).

Managed equipment services PPP

Under MES contracts, major equipment suppliers own and manage all of the equipment required for health facility operations. The operations include procurement, delivery, installation, commissioning, user training, asset management, troubleshooting, maintenance, performance monitoring, replacement, and disposal. An MES arrangement ensures that public hospitals have access to modern health equipment services over an agreed-on period, with the government making regular, prearranged payments based on established performance parameters. An MES contract allows the public sector to transfer technological, operational, and financial risks to the private sector. Increased equipment reliability and sustainability is another strength of the MES model.

However, MES contracts have several limitations. The private partner is only responsible for ensuring that equipment is operational. There is no guarantee that equipment will be fully utilized if the government has not performed a full needs analysis of the demand for care, availability of requisite infrastructure, presence and incentives of medical specialists, and patient referrals. A functioning hospital information system is necessary to track the utilization and impact of the MES arrangement.

The MES model is popular in the United Kingdom and European countries. This type of PPP has also been introduced in developing countries (box 2.1), with some early positive outcomes, which have triggered take-up in other developing countries as well.

Operation and management services PPP

Under an O&M services PPP, a private partner is contracted to operate and manage a hospital, health facility, or health network in exchange for a management fee. Governments can benefit from private sector management practices and processes while freeing up the time of public sector staff to focus on overarching

BOX 2.1**Kenya managed equipment services public-private partnership**

Kenya is pioneering a large-scale project that involves outsourcing the provision of medical equipment for 98 hospitals across 47 counties. The project comprises seven-year contracts between the Ministry of Health and five contractors for the supply, installation, maintenance, replacement, and disposal of various equipment, as well as training and reporting for the entirety of the contract period. The total tender sum for the managed equipment services (MES) amounts to \$432,482,160 paid in quarterly installments of \$15,445,790.

The project has been delivering tangible benefits for the government and the people in many counties.

For example, the contract for the provision of radiology equipment improved access to radiology services, increased the skill set of health care workers, and reduced patient referrals. However, several facilities have not yet been able to benefit from the MES arrangement. Reasons include contractual issues, lack of requisite infrastructure and support systems for the equipment, lack of specialized health personnel to operate the equipment, high charges for the specialized services being provided following the installation of equipment, underutilization of installed equipment, and so on.

Source: Parliament of Kenya, http://www.parliament.go.ke/sites/default/files/2018-11/MES%20Brief_Nov%202018%20%285%29_%20With%20Suggested%20Questions%20.pdf.

BOX 2.2**Management contract for health facilities in Sindh province, Pakistan**

The government of Sindh has contracted out government health facilities across the province, including the district headquarters, *taluka* headquarters, and regional health centers. The government awarded the performance-based management and services contracts to nationally and internationally accredited organizations. The selection process was transparent and undertaken with the assistance of the Public-Private Partnership Node of the Health Department.

The contractual agreements were signed in March 2015 with a term of 10 years. The private sector partners agreed to perform in line with key performance indicators and their performance is measured and assessed by a third-party monitoring mechanism. Private sector partners are also responsible for ensuring the availability of basic equipment, furniture, and fixtures in line with the services provided by the health unit or facility.

Source: Public-Private Partnership Unit, Finance Department, government of Sindh, https://www.pppunitsindh.gov.pk/projects_new.php?pid=6&pstatus=Executed.

facility (network) objectives, policies, and priorities. This PPP type is relatively easy to implement from an industrial relations viewpoint. However, it limits the private partner in operational terms because government still controls staffing and finance, which, in turn, means that the private sector has less incentive to reduce costs.

There is some debate as to whether O&M contracts fall under the definition of a PPP, particularly if a contract is of short- or medium-term duration and involves minimal private sector capital investment. However, many O&M contracts are performance based, become long term once extended, and shift additional risk to the private sector (such as for maintenance or replacement of equipment and technologies)—arguing for consideration as PPPs. O&M contracts are commonly used in South Asia (box 2.2) for O&M of hospitals, primary health care networks, medical emergency systems, and so on.

Specialized services PPP

Specialized services PPPs involve a government contract with a private partner to deliver specific services at public health care facilities, such as specialized clinical services (dialysis, radiotherapy, day surgery, and so on) or diagnostic services (laboratory services, imaging, nuclear medicine, and so on). These PPPs are used to improve quality and access to specific clinical services in an “asset-light” format with reduced cost and complexity. These arrangements are relatively simple to implement and monitor and easy to replicate. Contracts are usually small scale, single service, and medium term in duration but can become longer term as the contracts are extended. Specialized services PPPs have been implemented in many countries around the world, including developing countries (box 2.3).

Health facility PPP

In a health facility PPP, the government retains control of clinical services, but the private sector provides some combination of the detailed design, construction, and refurbishment of infrastructure. In addition, the private sector is responsible for provision of hard facilities management or a mix of hard and soft facilities management.

This is a long-standing model of health infrastructure financing that allows governments to access needed capital to finance major infrastructure projects and transfers design, construction, and maintenance risks to the private sector. Over 20 years, the United Kingdom has implemented more than 130 health facility PPP schemes with £13 billion of capital value through its Private Finance Initiative (PFI). The United Kingdom’s National Audit Office has found that most PFI hospital contracts are well managed with a low level of deductions (penalties) and high levels of satisfaction. Hospitals with PFI buildings spend more on maintenance annually than non-PFI hospitals because the contracts require them to be maintained to a specified high standard. However, the cost and performance of hoteling services (cleaning, catering, and portering) are similar to those in non-PFI hospitals (United Kingdom, National Audit Office 2010).

Building on the United Kingdom’s experience, other countries around the world have developed their own PFI-type programs to provide health care infrastructure and associated services. Canada has processed more than 100 hospital

BOX 2.3

India’s National Dialysis Program

The Pradhan Mantri National Dialysis Program under India’s National Health Mission was announced in the Union Budget 2016–17. The guidelines for implementing the Dialysis Program include provision of dialysis services through a public-private partnership (PPP) as a cost-effective approach. The private service providers are required to provide the medical human

resources, dialysis machine, water plant infrastructure, dialyzer, and consumables. The government entities should provide space in district hospitals, drugs, power, and water supply and pay for the cost of dialysis for poor patients. A majority of states in India are delivering dialysis services through a PPP outsourcing model as per the guidelines.

Source: Ministry of Health and Family Welfare, government of India, https://www.nhp.gov.in/pradhan-mantri-national-dialysis-programme_pg.

BOX 2.4**Adana Health Complex in Turkey**

The Adana Health Complex entails the construction, operation, and maintenance of an integrated health complex in Adana, a key health sector hub in Anatolian Turkey. The health complex has a 1,550-bed capacity and is composed of six hospitals. Total project costs were estimated to be about €500 million.

Under the Build-Lease-Transfer (BLT) structure, the winning consortium is responsible for financing, building, maintaining, and managing the facilities and providing or coordinating medical support services, while the Ministry of Health (MOH) will deliver core medical services. The MOH will pay the private partner to use the facilities (availability payments) and for services provided (service payments). By separating

the service payments from the availability payments, this model makes financing easier than if the UK model were adopted. It does, however, mean that the government bears more risk and must ensure that it has the means to manage that risk. The BLT agreement includes debt guarantees, compensation for early termination, and key performance indicators to be achieved. The construction period was expected to last 36 months, followed by a 25-year concession period.

Following a transparent bidding process, an agreement was signed between the MOH and a consortium in 2014. The health complex is now operational. This is a pioneering project for the Turkish government's Hospital Public-Private Partnership Program.

Source: IFC 2011.

PPPs valued at more than Can\$29 billion through the Design-Build-Finance-Operate, Design-Build-Finance-Operate-Maintain, Build-Finance, and Design-Build-Finance models.¹ In Japan, by 2016, 17 hospitals had been constructed and 17 other projects were in procurement under Japan's PFI program (JICA 2016). The government of Turkey launched its Health PPP Program in 2010, consisting of 50 projects with an estimated €20 billion investment value (see box 2.4 for an example).

With a clearly defined metric of success—the opening of a new facility on time and within budget—the health facility PPP model tends to easily get political support. However, a facility that is built for political reasons rather than to address patient demand could end up being underoccupied during operation. Also, this type of PPP, although relatively easy to do, may not drive efficiency, quality, and innovation because the private partner is not involved in patient care down the line. Infrastructure and facility management services have only marginal impacts on cost efficiency and quality of clinical service delivery. The government may be locked into long-term contracts and lose some level of the flexibility needed to implement facility changes. Moreover, a large facility PPP program may lead to fiscal risk, especially if adequate care has not been taken to control contingent liabilities (European Union 2013).

Integrated PPP

In integrated PPPs, a private partner is contracted to design, build, finance, and operate facilities, as well as to deliver nonclinical and clinical services. These arrangements cover design, construction, or refurbishment of infrastructure (for hospitals, ambulatory care, polyclinics, primary care facilities, maternal and pediatric clinics, and so on), as well as all services, including clinical services

BOX 2.5**Hospital PPP in Lesotho**

In 2006, the government of Lesotho launched a public-private partnership (PPP) to build a 425-bed national referral hospital to replace its outdated hospital. The Lesotho PPP structure was a first for Africa. In addition to the design, construction, and full operation of the hospital and associated health care facilities, the private operator delivers all clinical services, with the objective of providing vastly improved, high-quality health care services at an affordable cost. The government made significant up-front payments for hospital construction and will provide the private operator with an annual fixed payment for 18 years. The PPP agreement includes performance monitoring of both clinical and nonclinical service indicators. An independent monitor conducts a quarterly audit of the private

operator's performance. A penalty deduction is applied if performance is not achieved.

Following a competitive tender process, a consortium was selected and the PPP agreement was signed in 2008. The hospital and clinics were opened in 2011. In the initial operation, the project faced a number of challenges, including excessive demand for its services, payment delays, a lack of physicians, and negative media reaction. Despite these challenges, both public and private parties reported significant achievements. This PPP has demonstrated that it is possible for a lower-middle-income country to embark on an ambitious project that is affordable for the country and patients. The successful implementation of the Lesotho hospital PPP has been attributed to political commitment, leadership, and advice received on how to set up a PPP transaction.

Source: International Finance Corporation of the World Bank Group, <http://documents.worldbank.org/curated/en/925991484654860294/pdf/111339-PPPStories-TurkeyAdanaHospitalComplex.pdf>.

(outpatient or inpatient), on a long-term basis typically ranging from 10 to 30 years. This PPP type can maximize the potential for innovation and efficiency in the private sector and allow governments to focus on quality and regulation rather than service delivery.

Integrated PPPs, although less common than other types, have been implemented in high-income (Australia, Portugal, Spain), middle-income (Fiji, India, Lesotho, Peru), and low-income (Afghanistan) countries (box 2.5). The integrated PPP in Valencia, Spain (known as the Alzira model) took the further step of bundling hospital care and primary care with a capitation payment mechanism in a PPP contract. From a financial perspective, this arrangement has been assessed as having achieved significant cost efficiencies (Sosa Delgado-Pastor et al. 2016). From a clinical perspective, though, it has not generally outperformed public providers, although in some areas of care its development has been found to be outstanding (Comendeiro-Maaløe et al. 2019).

The integrated PPP is the most complex of all PPP types. It requires that the private partner be ready to take on substantial risk—not only the risks associated with delays and cost overruns in the construction phase (as with other types of PPPs) but also for service delivery. It also requires robust referral management and a transition from public to private management for health care professionals. The government must have appropriate regulations in place and the capacity to manage a long-term contract, which requires a complex set of agreements with the private partner and the flexibility to make changes over the length of the contract. Monitoring and evaluation of clinical performance is another challenge. It is worth noting that even in mature markets, implementing integrated PPP projects remains challenging.

PREREQUISITES FOR A SUCCESSFUL HEALTH PPP

PPPs are context specific and therefore a “one size fits all” approach is unlikely to yield significant economic and health care dividends. Nonetheless, empirical evidence accumulated over the past two decades from both developed and developing countries points to certain fundamental requirements for successful PPP engagements, which are described in this section.

Macroeconomic factors

A stable macroeconomic situation and a sound national public financial management system are necessary ingredients for the successful design and implementation of PPPs. Equally important is strong government engagement in the PPP process, accompanied by good governance and accountability and transparency structures that include robust anticorruption measures. Effective public sector capacity for oversight and management of PPPs and effective intragovernmental coordination—including a clear delineation of the roles and responsibilities of the various government entities—are also vital. Finally, a favorable investment climate and an effective foreign direct investment regime, and the availability of long-term finance and capital markets, are critical to the success of PPPs in a country.

Political factors

Political will, starting from the highest level of government and cascading down, is indispensable for advancing the prospects of PPPs; without it, PPPs are unlikely to be either successful or sustainable. Even where political will and support for PPPs exist in the top echelons of government, it is necessary to undertake continuous advocacy until support for PPPs is entrenched at all levels of government and an effective ecosystem for PPPs has been built. When PPPs are implemented at the provincial or lower levels, the national government has an important responsibility to foster local ownership, but it must—at the same time—continue to take an active role in catalyzing actions at the local level. Equally important for political and social acceptability is to ensure that PPPs are not seen as an instrument for providing (additional) services only to those who can pay, but that efforts are made to ensure that PPPs respond to the needs of the poor and that the poorer segments of the population can also use the quality services that PPPs are expected to provide. Thus, in addition to the efficiency and quality considerations that often motivate PPPs, it is important that equity of access to these services be safeguarded by the government. Finally, PPPs must not be viewed as a short-term fix for immediate service delivery gaps but rather as an institutionalized long-term strategy.

Legal and regulatory framework

PPPs must be supported by a sound policy, institutional, legislative, and regulatory framework. Most countries with successful health PPP programs rely on a sound PPP framework, which consists of the policies, procedures, institutions, and rules that together define how PPPs will be identified, assessed, selected, prioritized, budgeted for, procured, monitored, and accounted for and who will

be responsible for these tasks (World Bank 2017). Governments can add specific regulations and guidelines for the health sector as they expand their health PPP programs. Legal changes may be needed to enable health PPP projects to move forward. For example, the United Kingdom had to enact the National Health System (Private Finance) Act 1997 to give trusts the legal power to enter into PFI arrangements. Turkey passed Law No. 6428 (known as the BLT Law 2013) to authorize the use of BLT contracts in the health sector. The Indian Ministry of Finance and Ministry of Health and Family Welfare have developed a suite of guidance and model tenders and agreements for various PPPs in the health sector, contributing to widespread use of health PPPs across states.² The legal and institutional framework should also ensure harmonization of the different laws and regulations across sectors.

Equally important to the success of PPPs is ensuring that the national PPP policy framework is consistent and well integrated with health sector policies and strategies, as well as with relevant sectoral reform choices. Thus, before embarking on a PPP project, it is important for the government to assess whether PPP is the most appropriate choice compared with other investment options. The assessment should include technical considerations such as efficiency gains, as well as comprehensive value-for-money and due diligence analyses. In addition to establishing coherence between the overall health and PPP policies, it is vital to ensure that viable supportive health system building blocks (that is, financing, human resources for health, drug supplies, and so on) underpin the PPP effort, without which the PPP program is unlikely to succeed.

PPP unit and PPP pipeline

By default, a ministry or department of health is usually responsible for providing health infrastructure or services to the population, and PPP experts are responsible for evaluating the suitability of a PPP for a given situation and supporting the PPP procurement. To implement health PPP projects successfully, public health entities need a range of expertise in planning, technical and financial appraisal, procurement and contracting, and project management of PPPs (box 2.6). A dedicated PPP unit at the central level that concentrates all of these skills has been shown to be a critical facilitator. Countries with significant health PPP programs may want to establish a technical PPP unit or node within the MOH, in addition to the PPP unit that is usually in place in other oversight ministries (such as ministries of finance, budget, or planning). Health PPP units appear in ministries of health in high-income (France, Portugal, the United Kingdom), middle-income (Kenya, the Philippines, Turkey), and low-income (Afghanistan) countries. Responsibilities of a PPP unit or node often include formulation of PPP policy, standardization of documentation, coordination across all the relevant players, awareness raising and capacity building among government officials, promotion and dissemination of good practices, and technical support during the entire PPP project life cycle (UNESCAP 2017). An active PPP unit can help establish a viable PPP pipeline so that the government's plans are made explicit and the private sector gets a clear sense of direction. In the United Kingdom, the PPP unit also facilitated a coherent development strategy with HM Treasury (finance ministry) and the development of a forum for discussions with industry (builders, financiers, service providers).

BOX 2.6**Required expertise of public officials involved in PPP project management**

Project planning expertise. Project identification and structuring; economic and financial evaluation; value for money as a public-private partnership (PPP) project; marketing of the project

Financial expertise. Development of a robust business case for the project; identification of the risks and development of an optimum risk-sharing arrangement; structuring of payment mechanisms considering responsibilities, risks, and rewards for both parties; analysis of the tender proposals received from the bidders, scrutiny of the financial proposals and their implications, and verification of cost analysis and financial models; review of the contract clauses that have financial implications for the public sector

Legal expertise. Preparation of the tender documents, PPP contract, and applicable lease agreements; ascertaining the best possible method of procurement or bidding following the government procurement rules and laws; legal matters involving taxation, property rights, building and planning regulations, environmental law, and legal provisions

in any other relevant laws that have implications and need to be considered in tender documents and contract and lease agreements; contract negotiation; legal aspects of contract renegotiation caused by unforeseen circumstances

Technical expertise. Technical and outcome specifications and service standards for the services to be provided; formulation of safety and security standards and compliance with the standards by the private sector; technical evaluation of proposals and bids; assessment of the capacity of private sector bidders to deliver the project and subsequently operate and manage it; quality control during construction, assessment of technical risks and their mitigation measures, and contractor compliance; appropriate performance measures and monitoring systems to determine the performance of the service provider

Project management expertise. Contract management; monitoring of the quality of service and contractor compliance; performance monitoring; partnership relationship management

Source: UNESCAP 2008.

Public financial support

Few health PPPs are developed and implemented successfully without government financial support. A number of forms of government support can help with the financing of health PPPs. One model is a *project development fund*, which is established to provide the necessary resources to conduct studies and design, structure, and procure the PPP. Indonesia's project development fund has developed four health PPP projects. *Direct support* involves the government committing direct financial support to a PPP project company, such as provision of land or equipment, waivers of fees and tax liability, provision of loans or up-front capital subsidies, or output-based payment per unit or user of a service. For example, the government and states of India can provide health PPP projects with viability gap funding of up to 20 percent of the total project cost, output-based subsidies for selected health services for the poor, and so on. *Contingent support* involves the government taking on certain contingent liabilities such as guarantees on demand remaining above a specified level or on exchange rates remaining within a certain range, compensation clauses, termination payment commitments, debt guarantees, or other credit enhancements. In the Turkey Health PPP Program, the government provides guarantees on lease payment, patient volume, debt repayment, and compensation for early termination (World Bank 2017).

Public sector capacity and contract management ability

Many governments are also discovering that forging PPPs can be fraught with difficulties, as reaffirmed by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) PPP Survey,³ in which limited knowledge and capacity related to PPPs was identified as a major obstacle to PPP development⁴ (figure 2.2).

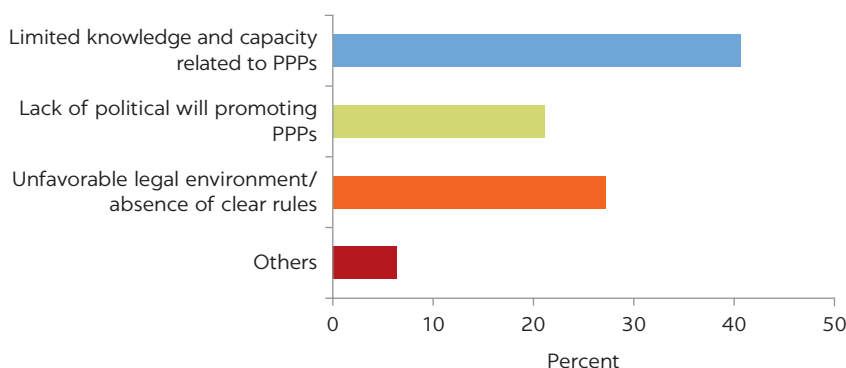
To resolve this issue, PPP units in countries with significant PPP programs have developed PPP training programs for their public officials in collaboration with national training institutions. Multilateral organizations (the World Bank, the Asian Development Bank, the United Nations, the Public-Private Infrastructure Advisory Facility) have also supported PPP training programs such as PPP Massive Open Online Courses and the APMG PPP Certification Program. Public officials involved in the PPP projects should have a clear understanding of the whole process and should be familiar with the issues involved in PPPs from different perspectives (UNESCAP 2008). The expertise that they need to have falls under the five broad areas of project planning, financial, legal, technical, and project management, as described in box 2.6.

Success in the implementation of PPPs hinges on the drafting of clear and mutually binding contractual agreements. However, international evidence suggests that flexibility on both sides is key—given the constantly changing demands in the health sector, rigid and inflexible contractual stipulations can constrain PPP projects, particularly those focused on health service delivery. Also important for a successful PPP is a mutual willingness and ability to learn from failures, as well as from successes; in many instances, sharing and learning from failures enables the partnership to emerge stronger over the longer term. A well-designed PPP contract can achieve the desired outcomes only if it is managed well by the government; effective contract management is thus fundamental to the success of PPPs.

Private sector readiness

Adequate investor interest, strong private sector (both for profit and nonprofit) capacity, and a minimum level of competition within the private sector are vital for the successful implementation of PPPs. There is also a need to build trust

FIGURE 2.2
Perceived obstacles to PPPs in the Asia-Pacific region



Source: United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) PPP Survey.
Note: PPPs = public-private partnerships.

among the private and public sector stakeholders, with mutual accountability, mutual respect, and a commitment to the achievement of mutual benefit. Trust is fostered by each side's understanding of the other's motivations and objectives and their mutual ability to educate each other constantly so that they can develop and share a common language.

Stakeholder communication and engagement

Health PPP projects will fail if the clinicians are not engaged and politicians and the population do not support them. This issue is particularly important when transforming an existing public facility into a PPP one and if the public and private sector labor regulations and management practices differ significantly (European Union 2013). To address such resistance, governments and private partners need to communicate openly with the public, civil society, the media, and health care staff about the intended objectives of the PPP. Transparency—including making information available about the bidding and selection process and ensuring good communication about facility opening and changes in management—can help mitigate public and staff concerns (Abuzaineh et al. 2018).

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3 Framework for the Health PPP Program in Vietnam

INTRODUCTION

This chapter assesses the regulatory and institutional framework for the health public-private partnership (PPP) program in Vietnam. It commences with a discussion of the content of the laws, decrees, and circulars governing PPPs in Vietnam; sheds light on how PPPs are defined in Vietnam and the types of PPP contracts permitted by law; and compares PPPs to other private sector engagement models that are widely used in the health sector. It then describes the institutional arrangements as well as financing and accountability mechanisms for PPPs in Vietnam at the national and subnational levels.

GENERAL PPP FRAMEWORK

The evolving legal and regulatory framework for PPP

There is not a single unified legal document that governs all aspects of a PPP project in Vietnam. Rather, a PPP project is governed by an array of laws and regulatory documents. The laws cover a wide range of issues, including investment rules, enterprise management, land acquisition and valuation, construction, ownership of assets, the PPP process, and fiscal management. In addition, there are regulations related to the operation of a PPP project, for example, regulations on government incentives, tolls, accounting, auditing, taxation, finance, contract management, monitoring, and dispute resolution (World Bank Vietnam and Castalia Limited 2019).

The legal and regulatory framework for PPPs is still under development. Over the past decade, the government has revised and amended the regulatory framework for PPPs three times. In 2010, Decision 71/2010/QĐ-CP regulated the piloting of PPPs. In 2015, Decree 15/2015/NĐ-CP on PPP investment forms was promulgated, and was replaced by Decree 63/2018/NĐ-CP in 2018. In 2019, Decree 69/2019/NĐ-CP was enacted to regulate payment for Build-Transfer (BT) projects. As of 2020, the National Assembly is reviewing the draft PPP Investment Law and expects to have this law enacted in 2020. In this changing environment, the only ministry that has issued a circular regulating PPP projects

within its sector is the Ministry of Transport. The Ministry of Health (MOH) began developing a circular regulating health PPP projects in 2016 but has not yet finalized this document (figure 3.1).

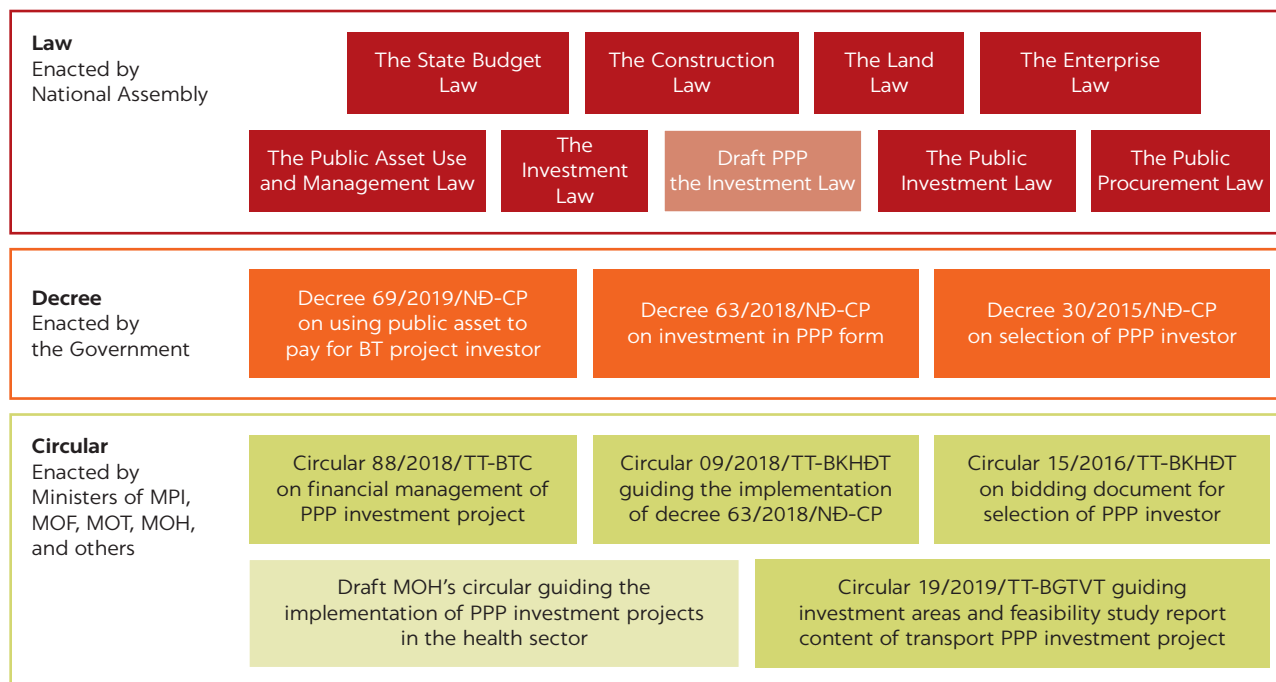
PPP definition and contract types

Decree 63/2018/NĐ-CP defines PPP as “a form of investment conducted based on a project contract between a competent State agency and the investor and/or project enterprise to construct, improve, operate, and manage an infrastructure project and to provide public services.” This definition differs considerably from how PPPs are defined internationally (see the section in chapter 2 titled “What is a PPP and what are its defining characteristics?”).

Decree 63/2018/NĐ-CP specifies eight PPP contract types (which are also proposed in the draft PPP Investment Law) as follows:

- Build-Operate-Transfer (BOT)
- Build-Transfer-Operate (BTO)
- Build-Transfer (BT)
- Build-Own-Operate (BOO)
- Build-Lease-Transfer (BLT)
- Build-Transfer-Lease (BTL)
- Operate-Manage
- Mixed

FIGURE 3.1
Overview of Vietnam’s PPP regulatory framework



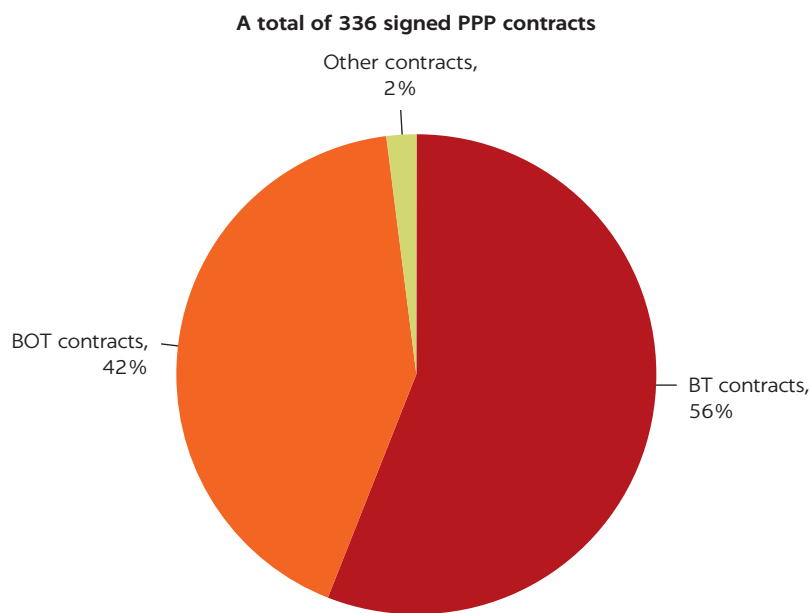
Source: Original figure for this publication.

Note: BT = Build-Transfer; MOF = Ministry of Finance; MOH = Ministry of Health; MOT = Ministry of Transport; MPI = Ministry of Planning and Investment; PPP = public-private partnership.

Internationally, the BT contract is not regarded as a PPP because the contract duration is short term and the private sector takes on limited risks and management responsibility. However, in the Vietnamese environment, the BT contract is the most commonly used contract type, accounting for 188 (or 56 percent) of 336 signed PPP contracts. BOT contracts are also common, accounting for 42 percent of the total number of signed PPP contracts. Other contract types including BOO, BLT, and BT-BOT mixed contracts account for just 2 percent (figure 3.2). No BTO, BTL, or Operate-Manage contracts have been signed in Vietnam.

The definition of PPPs used in Decree 63 addresses only investment projects. Non-investment service PPPs (such as “at risk” long-term service and management contracts or concessions for clinical services) are not included in the current PPP decree. Internationally, PPP covers both investment (infrastructure) PPPs and non-investment (service) PPPs. The draft PPP Investment Law also continues to define PPPs as an “investment” or an “infrastructure project,” thereby neglecting or giving little attention to non-investment service PPPs, which are common in the social sectors, including health. There is also no mention in the PPP definition of a long-term contract, transfer of risks or management responsibility from the public to the private sector, or performance-based payments based on mutually agreed-on parameters. These omissions make it difficult to differentiate PPPs clearly from other forms of public-private enterprises in Vietnam, including joint ventures (JVs) under the health care socialization policy.

FIGURE 3.2
Use of PPP contracts in Vietnam



Source: Ministry of Planning and Investment, 2019 submission of PPP Investment Law proposal to Government.

Note: BOT = Build-Operate-Transfer; BT = Build-Transfer; PPP = public-private partnership.

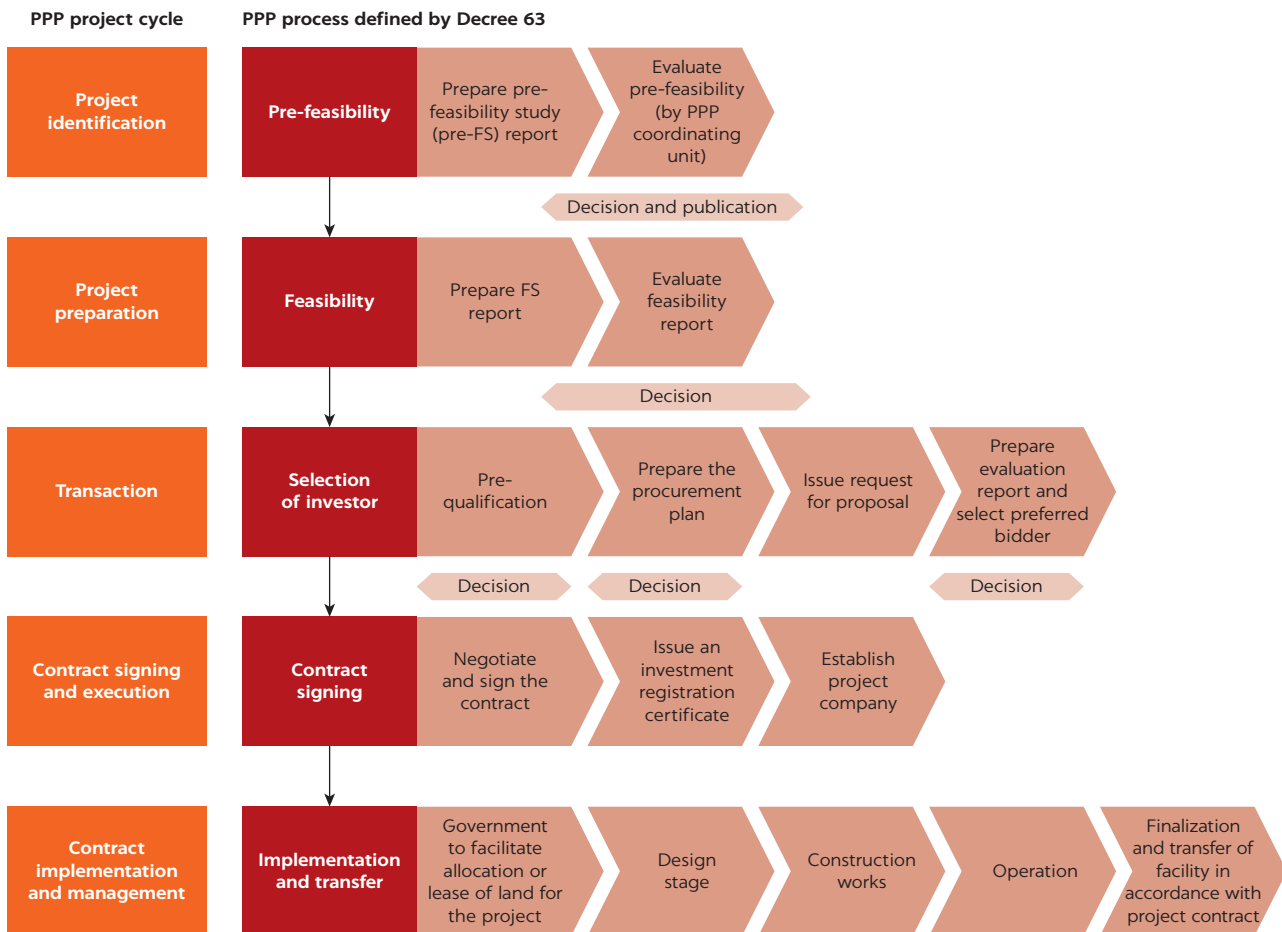
PPP development process

The current legal framework provides for a PPP development process of five stages, as illustrated in figure 3.3. This process is similar to the PPP development process used in other countries.

International benchmarking of Vietnam’s PPP regulatory framework

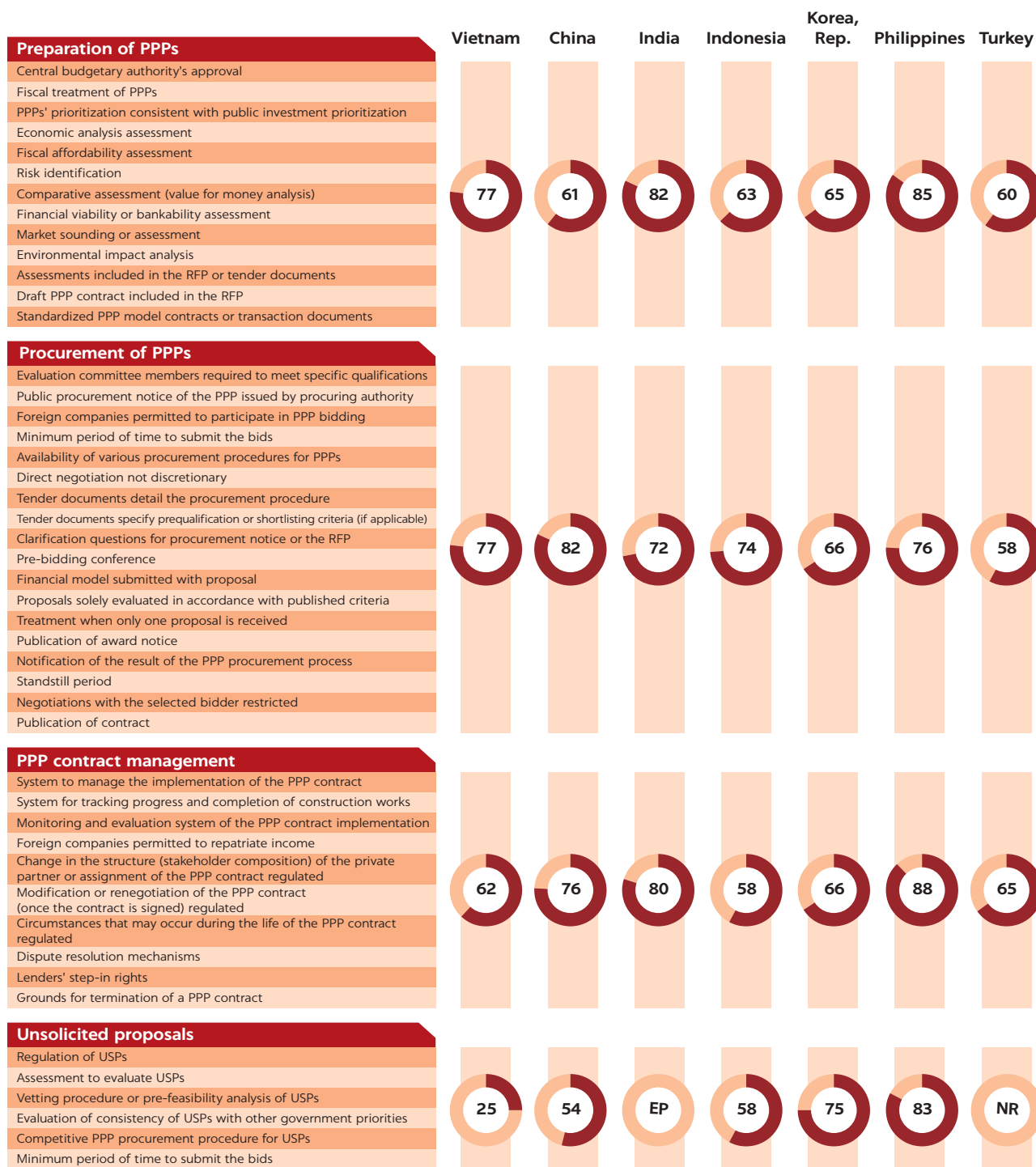
Despite the gaps in the PPP policy and regulatory and institutional framework noted in this chapter, the PPP framework in Vietnam compares favorably with most other lower-middle-income countries, with the possible exception of China, India, and the Philippines. Benchmarked against internationally recognized good practices, Vietnam’s regulatory framework meets 77 percent of PPP preparation, 77 percent of PPP procurement, and 62 percent of PPP contract management good practices (figure 3.4). However, management of unsolicited proposals is still underregulated.

FIGURE 3.3
Typical PPP development process in Vietnam



Source: World Bank Vietnam and Castalia Limited 2019.
Note: FS = feasibility study; PPP = public-private partnership; pre-FS = pre-feasibility study.

FIGURE 3.4
Benchmarking PPP regulatory frameworks of selected countries against internationally recognized good practices
Percent of good practices met



Source: World Bank 2018.

Note: EP = expressly prohibited; NR = not regulated; PPP = public-private partnership; RFP = request for proposal; USP = unsolicited proposal.

Comparing PPP with other contracting tools for private engagement in health care in Vietnam

In Vietnam’s legislative framework, at least 25 contract types are applicable in the health sector and they are regulated in various legal documents. Only those specified in Decree 63/2018/ND-CP are legally considered to be PPPs, even though one of them—the BT contract—is not internationally regarded as a PPP. The remaining contract types are not regarded as PPPs, regardless of the extent to which the private sector shares responsibilities and risks (figure 3.5). Among non-PPP contracts, the JV and the business cooperation contracts are most commonly used by public health institutions to mobilize private finance for provision of health infrastructure and services. The Public Asset Use and Management Law allows public entities to enter into either a PPP or a JV contract with private partners; meanwhile the Investment Law allows private investors to enter into either a PPP or a business cooperation contract with the public sector. Whereas a business cooperation contract does not share ownership, a JV may result in the establishment of a company co-owned by the public health institution and the private partner to run the project. In practice, several JVs share common characteristics with PPPs, such as long-term contracts, significant transfer of risks and responsibilities to the private sector, and performance-based payments for the project company.

PPP is only one of the financial and regulatory tools that the government has at its disposal to mobilize resources and expertise from the private sector, expand the availability and quality of the health care network, and enable the people to benefit from improved access to health services.¹ PPP is a contracting tool. Other financial tools (taxes, loans, and so on) can be combined to make a PPP project financially viable. In the operational phase of a health PPP, regulatory tools (licensing, quality monitoring, public information, price schedules, and so on) can be applied.

FIGURE 3.5
Applicable PPP and non-PPP contracts in Vietnam’s health sector



Source: Original figure for this publication.

Note: EC = Engineering-Construction; EP = Engineering-Procurement; EPC = Engineering-Procurement-Construction; PC = Procurement-Construction; PPP = public-private partnership.

INSTITUTIONAL ARRANGEMENTS FOR HEALTH PPPs

Vietnam follows a decentralized model of governance for PPP projects, which shifts power away from the central government to assigned state agencies (ASAs), including line ministries and subnational governments. Decree 63/2018/NĐ-CP defines the following roles for the national and provincial institutions: a Steering Committee at the national level that is responsible for assisting the state and the prime minister in directing and coordinating PPP investment forms; a PPP Office within the Ministry of Planning and Investment (MPI), which is responsible for assisting the Steering Committee; ASAs, which sign and implement project contracts; PPP units, which are responsible for managing and organizing the implementation of PPPs within each ASA; and Project Management Units, which are responsible for preparing and implementing specific PPP projects.

The line ministries of the central government (including the MOH) and the subnational governments, that is, the City People’s Committee (CPC) or Provincial People’s Committee (PPC), act as the ASAs and are responsible for identifying, preparing, procuring, and implementing PPP projects under their respective jurisdictions. The role of ASA that is bestowed on the subnational government and the central government line ministries enables them to bind their respective subnational governments or ministries to long-term PPP projects, which may be complex and have long-term fiscal implications for the central government. Given the decentralized nature of governance, each ASA is at liberty to put in place its own approval processes, subject to the overall requirements of the PPP decree. The institutional arrangements and roles for implementation of health PPPs are discussed further in the sections that follow.

National-level Steering Committee

Consistent with international practice, Vietnam has a national-level PPP Steering Committee, which is headed by a deputy prime minister and comprises senior government officials from selected ministries and PPCs.² The PPP Steering Committee acts as an advisory board to the Prime Minister on PPP-related matters and has the following responsibilities: (1) studying and putting forward the orientation, plans, and strategic solutions for efficient implementation of the PPP model; (2) assisting the prime minister to direct, encourage, and coordinate activities between ministries, sectors, and localities in implementing the PPP model; (3) directing the relevant ministries and sectors to build and complete the legal documents system; (4) directing line ministries and localities in establishing, presenting, and approving the list of prioritized PPP projects, as well as the financial support mechanism for these projects; and (5) directing the summary, assessment, and proposal to build legal policies on PPP.³ The committee meets every six months or at the special request of the chair. Among the committee members, the slot assigned to a Vice Minister of Health has been vacant for a year, subsequent to the retirement of a previous Vice Minister. No successor has been assigned to the Steering Committee to date.

PPP Office within the MPI

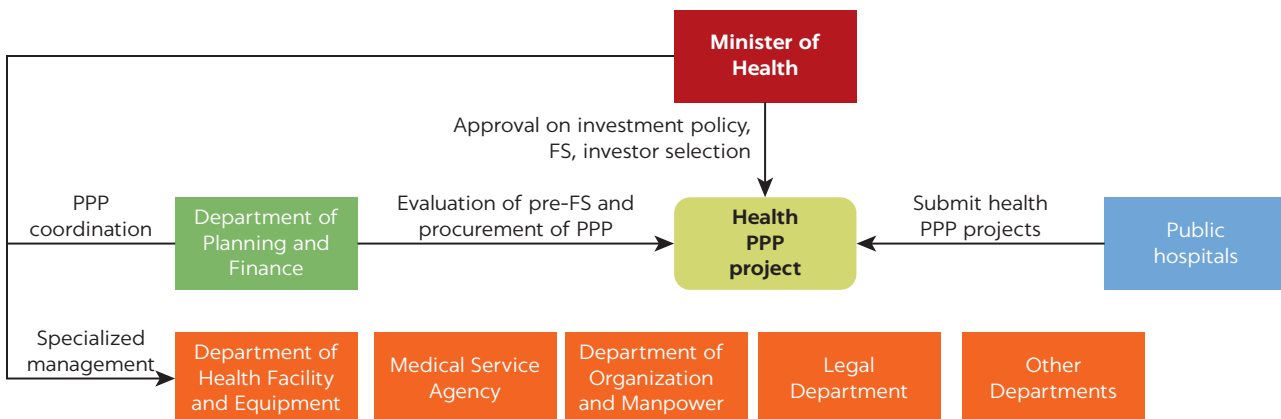
The MPI is the lead agency responsible for PPP policy and investment in Vietnam. The broader PPP dialogue, however, is anchored within both the MPI and the Ministry of Finance (MOF), given that the policy issues cut across sectors (energy, transport, water, and so on) and include subnational governments. Within the MPI, a PPP Office was established in 2012 under the Public Procurement Agency⁴ to assist the Minister of Planning and Investment to carry out responsibilities and coordinate activities related to PPPs across the various departments of the MPI. This PPP Office is not a national-level PPP unit or center but simply a division of the Public Procurement Agency. The PPP Office is actively involved in the development of PPP regulatory documents. Upon the request of the ASAs, the PPP Office can provide technical support on specific matters (such as comments on project documents, training, knowledge-sharing). The PPP Office has 12 staff whose competencies are at various levels: all have had at least basic-level PPP training while other staff members' knowledge is deeper and still others have received training overseas. However, their experience in health PPPs is largely limited to introducing the PPP framework to health managers through conferences and training workshops organized by the MOH.

PPP units within line ministries, including the MOH

Under the current framework, line ministries can either assign an existing department to manage PPP projects or establish a new department responsible for PPP projects. So far, only the Ministry of Transport has established a PPP management department. It has contributed to the development and implementation of numerous PPP investment projects in this sector.

The MOH assigned the Department of Planning and Finance (DPF) as the primary contact for health care PPP projects and intergovernmental PPP-related activities. Within the DPF, the Investment Unit is charged with PPP project appraisal, project evaluation, and coordination with other departments and central public hospitals (figure 3.6).

FIGURE 3.6
Institutional arrangement for PPP within the Ministry of Health



Source: Original figure for this publication.
 Note: FS = feasibility study; PPP = public-private partnership; pre-FS = pre-feasibility study.

The Investment Unit's core team consists of three employees responsible for the synthesis, appraisal, and evaluation of health care PPP projects in the pipeline. The employees are not allocated full-time to the PPP subgroup; the remainder of their time is spent on other activities, as required by the Investment Unit. Only a few proposed PPP projects are submitted by sponsors or investors directly to the MOH. The team's experience level is therefore limited. Interviews with staff suggest that the most challenging issue for them is the many ambiguities in the legal framework. They also emphasized that project selection is a critical capacity shortfall at the DPF-MOH level and in public hospitals.

PPP implementation arrangement at the subnational level

According to the Public Investment Law and the PPP Decree, the CPC or PPC has the authority to approve the pre-feasibility study (pre-FS) report, make decisions on investment policy, approve the feasibility study (FS) report, and approve the selection of investors. The CPC or PPC can enter into PPP contracts for Group A health projects (VND 800 billion and above) and can authorize the DOH to sign contracts for Group B health projects (VND 45 billion to VND 800 billion) and Group C health projects (less than VND 45 billion). Under the CPC or PPC, Departments of Planning and Investment (DPIs) are responsible for overall coordination of PPP implementation. Responsibilities include, but are not limited to, the following:

- Provision of guidance to relevant city or provincial authorities on identification and selection of projects, preparation and appraisal of pre-FS and FS, and public disclosure of PPP projects
- Preparation of the annual budget and the allocation of budget resources for preparation and transaction costs associated with PPP projects
- Preparation of the annual and five-year public investment plans incorporating the aggregated provincial state contributions to PPP projects
- Organization of the appraisal and evaluation of pre-FS and FS studies
- Implementation of the PPP procurement steps to select private investors
- Management of the implementation of PPP projects

To date, two DPIs (one in Ha Noi and one in Ho Chi Minh City [HCMC]) have established PPP units to conduct the day-to-day activities related to PPP projects. The PPP Unit under the HCMC DPI serves as a one-stop shop for licensing and supervising PPP projects, which has contributed to the success in PPP implementation in HCMC. It mobilizes technical assistance to support PPPs, engages in PPP capacity building, and provides information to investors and other interested parties.

The provincial DOH manages both public and private health service delivery in a city or province. It is responsible for licensing health care institutions and practitioners, evaluating technical aspects of health technologies and services, coordinating health professionals and the referral system, pricing of medical services, and assessing the quality of health care. It is also responsible for assessing health facility investment needs and developing city or provincial health system development plans, in which PPP procurement can be considered one investment option. In HCMC, for example, the DOH and public health institutions in collaboration with the DPI and PPP Unit developed a list of nine health PPP projects. Once a health PPP has been procured, the DOH can be authorized by the CPC or PPC to sign the contract with a special

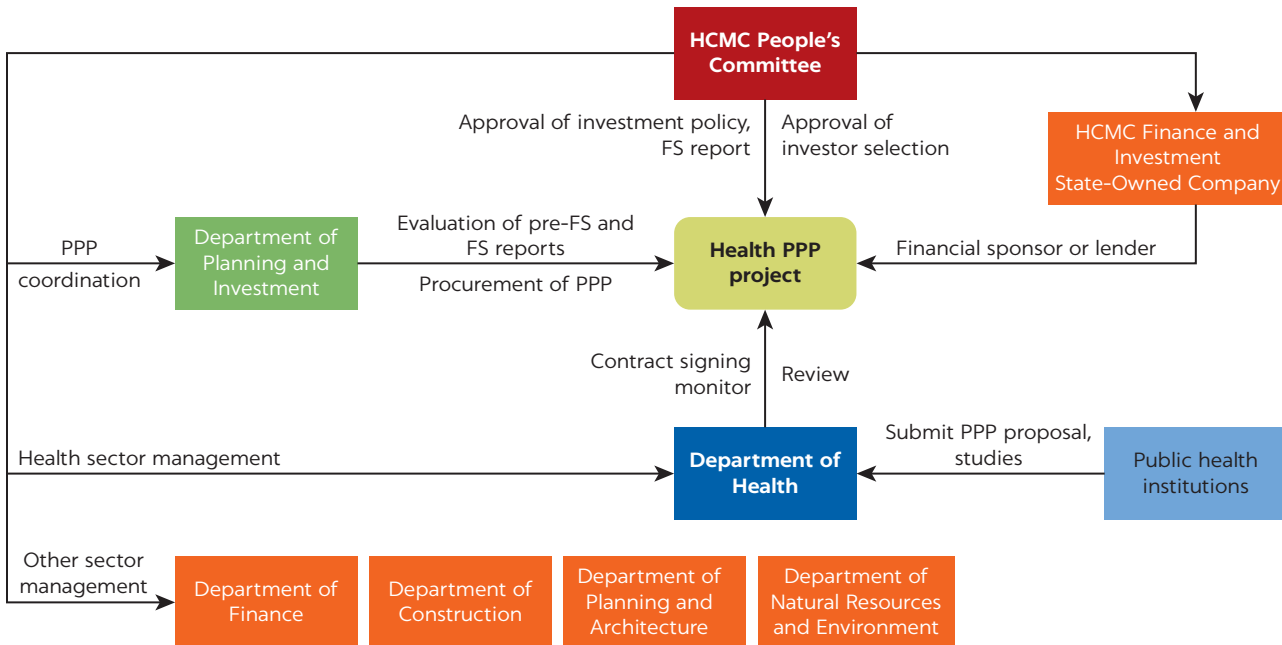
purpose vehicle. The DOH thus plays a vital role in the successful development and operation of health PPPs. The institutional arrangements for health PPPs in HCMC are illustrated in figure 3.7.

A special vehicle used by the HCMC CPC to stimulate private investment in PPP projects (including health) is the Ho Chi Minh City Finance and Investment State-Owned Company (HFIC). It is the financial sponsor of and lender to many PPP projects in the city through a variety of different modalities, including investing directly in the projects, lending to projects at concessional interest rates, and providing financial services and investment consulting services on request. HFIC is supporting at least two health PPP projects in HCMC. HFIC can potentially “act as a bridge between the public and private sectors, policy makers, managers, and investors, and financial institutions in PPPs. HFIC provides investment ‘capital bait’ into PPP project enterprises, thereby attracting social capital towards important infrastructure projects.”⁵

Empowerment of public health facilities and private investors to initiate a PPP

Either a public health facility or a private investor can initiate a health PPP project proposal. Since 2002, the government of Vietnam has gradually granted increasing levels of autonomy in service delivery, organization, human resources, and financing to government health care facilities as part of a wider public administrative reform.⁶ The overarching policy objective is for public hospitals to become financially autonomous, which entails a reduction of direct subsidies

FIGURE 3.7
Institutional arrangement for health PPPs in HCMC



Source: Original figure for this publication.
Note: FS = feasibility study; HCMC = Ho Chi Minh City; PPP = public-private partnership; pre-FS = pre-feasibility study.

for recurring costs and an increase in user fees for curative services to ensure that public hospitals are able to recover costs. By 2018, 27.4 percent of public hospitals could self-finance their operations fully, while 68.4 percent of public hospitals became partially financially autonomous.⁷ Autonomy and socialization policies allow Health Facility Management Boards to initiate PPP project proposals to mobilize private resources to deliver assets or services and generate surplus revenues. The self-administered survey conducted as part of this study found that 98 percent of health managers at various levels agreed with the introduction of PPPs in the health sector. From their perspective, PPPs help “autonomized” health facilities overcome budget constraints and infrastructure challenges, mobilize resource and management capacity from the private sector, improve access to technologies and service quality, increase the income of health staff, and improve competition with other health facilities.

The private sector has shown a corresponding interest in increasing its engagement in the health sector because it sees the growth of the middle class and the increased levels of disposable income in Vietnam as unexploited market opportunities for health care public-private enterprises. Private investors may initiate unsolicited proposals for PPP projects provided that such projects are not included within the midterm investment plan of the national or subnational government. An unsolicited proposal, if approved by the relevant ASA, is still subject to competitive tender and is required to undergo a Swiss Challenge process (World Bank Vietnam and Ernst and Young 2019): the ASA invites other private parties to submit proposals but the original proponent of the project is given an advantage of 5 percent of the bid price.⁸ The private sector has demonstrated great interest in the development of infrastructure. With respect to PPPs, the private sector looks favorably upon the stronger government contractual commitments (since the government signatory is an ASA) inherent in PPP contracts.

FINANCING AND ACCOUNTABILITY MECHANISMS FOR A HEALTH PPP PROJECT

Financing sources and payment mechanisms

A health PPP project in Vietnam can mobilize various financing sources in some combination of equity and debt. The project investor’s equity contribution must be at least 20 percent of the total investment capital if the project value is up to VND 1,500 billion.⁹ Equity contributors might include state-owned enterprises like HFIC. In the absence of bond financing, debt is usually obtained from commercial lenders. Many local commercial banks have committed concessional credit programs for health investment projects such as VietinBank’s credit of VND 30,000 billion, Vietcombank’s credit of VND 30,000 billion, and Bank for Investment and Development of Vietnam’s (BIDV’s) credit of VND 20,000 billion. BIDV financed the expansion of the Dong Nai and Binh Dinh provincial general hospitals that are sponsored by the private Cotec Healthcare group.¹⁰ Project investors accept corporate financing for PPP projects based on their own balance sheets rather than the project itself, given that the project financing arrangement is not yet common in the local capital market. The lenders’ step-in rights in certain scenarios, such as payment default, are clearly recognized by Decree 63/2018/NĐ-CP on PPP and have been included in most foreign-invested BOT projects (Hogan Lovells 2015).

The private operator of a government facility is paid through either availability or fee-for-service payments. Availability payments are applied to a few BLT and BTL contracts; fee-for-service payments are applied to many BOT, BTO, BOO, and O&M contracts. Fee for service is the most commonly used provider payment mechanism for the payment of health care services in Vietnam. The regulated fee schedule determines the prices that hospitals charge for their services in the regular wards. Both Vietnam Social Security (VSS) and households pay according to the fee schedule. Since 2012, user fee schedules (whose levels are set by the government) have been raised substantially following an official timeline to eventually ensure full cost recovery of recurring costs and depreciation and the elimination of supply-side subsidies, as facilities become financially autonomous. This creates a perverse incentive for overservicing. From the perspective of providers operating under the fee-for-service payment mechanism, a higher volume of services provided translates directly into higher revenues and profit. Public hospitals can also top up staff incomes from the operating surplus. The socialization policy encourages public hospitals to raise capital from the private sector (including from their own staff)¹¹ to invest in new medical technologies and on-demand services and charge higher fees for the use of the private equipment and services. These factors create powerful incentives for hospitals to offer expensive, high-tech services, some of which may be medically unnecessary¹² but are also interpreted by patients as a signal of quality.

There is no revenue-risk-sharing mechanism in the general PPP framework. Health care providers tend to induce demand for PPP services, which is likely assured by the combination of households' increasing capacity to pay and expanded health insurance coverage. Total health expenditure in Vietnam was 5.9 percent of GDP, or VND 2.8 million (US\$129) per capita, in 2016, which is comparable to countries at a similar income level (Teo et al. 2019). Spending for health, including both households' out-of-pocket and social health insurance, has been increasing significantly. Out-of-pocket payments at the point of care have remained persistently high at 43 percent in 2015. Patients' higher capacity to pay has also fostered an expectation of better-quality services that are at least on par with what populations in other countries at a similar income level receive, as well as a sense among beneficiaries that their expectations of quality care are more likely to be met in the private sector. Unofficial data suggest that Vietnamese pay about US\$2 billion annually for overseas examinations and treatments,¹³ where patient demand is not met by public hospitals or expensive overseas treatment, health care PPPs can offer medical services to medium- and higher-income patients.

Expanded access to health insurance coverage, along with the fact that private, socialized, and PPP health care facilities are now able to contract with VSS and receive payments from VSS for serving patients, is another important facilitating factor. Health insurance coverage has grown rapidly, from 13.4 percent in 2000 (Vietnam, Ministry of Health 2007) to 90 percent in 2019,¹⁴ and social health insurance expenditures have grown an average of 9.0 percent per year. Social health insurance offers a generous benefits package, including more than 18,000 eligible technical services and 1,000 eligible drugs. Also, as indicated previously, the fees reimbursed by health insurance have increased, and dramatically so—consumer prices for medical services and pharmaceuticals rose by 45 percent in 2012, by a further 19 percent in 2013, and in 2016 by 56 percent.¹⁵ Together, these factors make health care a more attractive market for private investors, whether for direct investment or through PPPs.

Financial accountability mechanisms

Health PPP project enterprises, like other companies doing business in Vietnam, are required by law to comply with the Vietnam Accounting Standard, which guides how revenues, expenses, the balance sheet, cash flows, and so on must be recorded. The Vietnam Accounting Standard was developed based on the International Financial Reporting Standards; however, there are some differences between the two systems, including terminology, applied methods, and presentation scope. Enterprises' financial statements, therefore, do not accurately reflect the value of assets and liabilities according to international practices. Unlisted PPP project companies are not subject to internal audit practices (although many public health institutions are),¹⁶ but PPP projects might undergo spot audits by the State Audit Agency of Vietnam. So far, the audit agency has audited more than 80 BOT and BT projects, including one BT project in the health sector. In many cases, the audit agency has recommended reduction of a project's total investment capital and shortening of the contract duration.

VSS is another key actor in financial accountability relationships. VSS enters contracts with licensed health care providers—both public and private—reimbursing them for certified services at negotiated price schedules that link to the hospital's technical capacity. To contain fraud and misuse of health insurance funds, VSS uses an electronic medical review system to scrutinize eligible services, drugs, and materials delivered by the health facilities. This electronic system is connected to all contracted health care providers, enabling VSS to process more than 176 million claims with total value of VND 98,116 billion per year.¹⁷ Although the primary accountability role that VSS plays is associated with financial control, its electronic medical review system can strongly influence compliance with prescribed inputs and procedural standards, as well as performance accountability of health service delivery networks, including health PPP facilities.

Performance accountability mechanisms

In response to public demand for transparency and accountability, Government Decree 63/2018/NĐ-CP has established a mechanism to disclose PPP project information throughout the project cycle. PPP project announcement, bidding documents, and selected project contract information must be accessible to the public on the national procurement website. ASAs must supervise compliance of the investor and the project enterprise with their obligations prescribed in the project contract. However, there is neither a regulatory requirement nor a technical guideline for public and private parties to monitor, report, and disclose project performance against key performance indicators. Therefore, individual PPP contracts rarely set out an effective performance monitoring system, and payment for the private operator is minimally linked to performance.

The MOH and provincial DOHs have mainly relied on regulation, licensure, and self-assessment to ensure the quality of PPP health care providers. All health care professionals and institutions must be licensed to practice. Hospitals are required to self-measure their quality against the MOH's 83 quality criteria, of which the majority reflect structural and nonclinical factors, and are expected to report to relevant health authorities for evaluation once a year. Quality criteria for preventive and primary health services are not developed. Measurement of clinical process and outcomes against key performance indicators is rarely

carried out. The national health care accreditation system is still underdeveloped, and only some pioneer hospitals have been accredited against international standards.

Patients hold health care service providers accountable for service quality by voicing their complaints through different channels, such as in face-to-face meetings, telephone hotlines with managers, or weekly patient council meetings in the hospital. In addition, patients may send their grievances directly to health authorities (provincial DOH and MOH) or Peoples' Councils at different levels. Patient complaints can trigger inspection visits by health inspectors, financial sanctions, or revocation of medical licenses. Health care providers can be prosecuted for fatal medical errors. The grievance mechanism is regulated in the Examination and Treatment Law and applied to both the public and private sectors.

NOTES

1. Government Resolution No. 05/2005/NQ-CP, dated April 18, 2005, on enhancing socialization of activities in education, health, culture, and sport.
2. Decision 1624/QĐ-TTg of Prime Minister, dated October 29, 2012, on the establishment of PPP Steering Committee, and Decision 2048/QĐ-TTg of Prime Minister, dated October 27, 2016, on strengthening the PPP Steering Committee.
3. Decision 369/QĐ-BCĐPPP on the operational rules of the PPP Steering Committee.
4. Decision 392/QĐ-BKHĐT of the Minister of Planning and Investment, dated March 30, 2012, on the Establishment of the Public Private Partnership Office under the Public Procurement Agency.
5. "PPP Helps Solve the Funding Problem for Infrastructure Development of HCMC," HFIC (<http://www.hfic.vn/chi-tiet-bai-viet/30738/300/Tin-HFIC/PPP-gop-phan-giai-bai-toan-von-phan-trien-ha-tang->).
6. Decree 10/2002/NĐ-CP was replaced by Decree 43/2006/NĐ-CP and Decree 85/2012/NĐ-CP.
7. Ministry of Health. 2019. Report No. 1124/BC-BYT, dated October 1, 2019, on the implementation of public hospital autonomy policy and legislation.
8. Decree No. 30/2015/NĐ-CP, dated March 17, 2015, on government regulating several clauses of the Procurement Law on investor selection.
9. According to Decree 63/NĐ-CP, the equity ratio of an investor shall be determined in accordance with the following principles: (1) for a project with capital up to VND 1,500 billion, the equity ratio must not be less than 20 percent of such portion; (2) for a project with capital of more than VND 1,500 billion, the equity ratio must not be less than 20 percent with respect to the capital portion less than VND 1,500 billion; and the equity ratio must not be less than 10 percent with respect to the capital portion above VND 1,500 billion.
10. "Extension of Dong Nai General hospital" (<https://cotehealthcare.com.vn/benh-vien-da-khoa-dong-nai-phan-mo-rong>).
11. According to Decree No. 69/2008/ND-CP, "Units implementing social mobilization are permitted to mobilize capital through sales of stocks, capital contributed by workers in the unit...to invest in construction of physical facilities."
12. For example, the cesarean section rate has risen rapidly from 20 percent in 2011 to 27.5 percent in 2014, while the share of births in government hospitals increased from 69.9 percent to 78.6 percent over the same period. (Data from General Statistics Office and UNICEF. 2011/2014. Vietnam Multiple Indicator Cluster Surveys.)
13. "Patients spent \$ 2 billions for oversea medical care" (<https://tuoitre.vn/nguoi-benh-vn-chi-2-ti-usd-nam-di-nuoc-ngoai-kham-choa-benh-20190115180355785.htm>).
14. "The number of people enrolling in voluntary insurance in 2019 compares to the decade number" (<https://baodauthau.vn/tai-chinh/so-nguoi-tham-gia-bao-hiem-tu-nguyen-nam-2019-tang-bang-ca-thap-ky-118963.html>).

15. Calculated from the General Statistics Office service price index and cited in Teo et al. (2019).
16. According to Decree No. 05/2019/NĐ-CP on internal audit.
17. “The medical review system of health insurance is more and more improved and effective each day” (<http://bvxhhn.com.vn/bvxh/he-thong-thong-tin-giam-dinh-bhyt-ngay-cang-hoan-thien-phan-huy-hieu-qua-tot.html>).

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4 Health PPP Project Design and Implementation

INTRODUCTION

This chapter provides a greater understanding of the types of public-private partnership (PPP) projects that are currently planned or implemented in Vietnam. It starts with an overview of the PPP project pipeline in Vietnam, then examines important issues in the design, preparation, and implementation of health PPPs in Vietnam using eight case studies of projects in different phases of the project cycle. Of these, two PPPs are in the planning phase, three are in the procurement phase, one is currently under implementation, one was terminated, and one is a co-location model (which is not considered a PPP in Vietnam). The case studies were chosen to highlight the different types of PPP models and, given how few PPPs are currently under implementation in the health sector of Vietnam, could be considered to be representative of the types of PPPs in the sector. In addition to a description of each project, an assessment of the risk sharing, payment mechanism, and performance metrics is provided, along with a set of takeaway messages.

HEALTH PPP PROJECT PIPELINE: NUMBER AND TYPES OF PROJECTS

There is no credible, consolidated list of PPP health care projects in Vietnam available in the public domain. The Ministry of Planning and Investment (MPI), as the national authority responsible for administering PPP investments, has established a website on PPPs that provides a partial and outdated list of proposed PPP projects.¹ Provincial authorities, such as the local Departments of Planning and Investment (DPIs), maintain their own PPP project pipeline lists; some of these provinces publish PPP project information on their websites, but the majority do not. Ho Chi Minh City's (HCMC's) DPI maintains a PPP website² and posts its PPP project pipeline and status updates for certain projects. However, this website suffers from the same gaps as the one maintained by the MPI. The Ministry of Health (MOH), the provincial DPIs (other than HCMC),

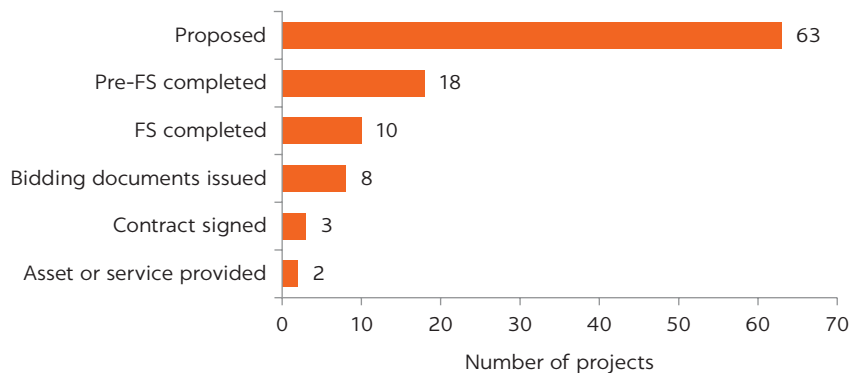
and the provincial Departments of Health (DOHs) do not maintain websites or provide any information on PPPs. Since there is no central list of planned projects, the information presented in this chapter was collated from the MOH, the MPI, local provinces, and private investors.

According to this report's estimates, there are 63 projects in the health PPP project pipeline. It should be noted that this number reflects those projects that the government of Vietnam considers to be PPPs. For example, Build-Transfer (BT) contracts, although they are not universally accepted as PPPs, are included in the list. Joint venture (JV) projects may also be included in this list because the project proponents may label them as "PPP" at the initial stage before there is clarity on the exact arrangements. Projects appearing in the list may also not necessarily eventually be feasible (because of the lack of application of PPP project screening criteria in Vietnam). However, this "wish list" is still useful in giving a sense of the types of PPP-type health activities that local authorities and the private sector are most interested in developing.

Very few projects in the pipeline make it through to procurement and eventual implementation. From the initial list of 63 health care PPPs, tabulations were made of the number of projects for which at least one step in the project preparation phase has been completed successfully (see annex 4A) as well as the further subsets of PPPs that have reached procurement phase (see annex 4B). These PPPs were then classified by the stage of the PPP project cycle, assigned state agency (ASA), sponsor, location, types of facilities involved, the scope of the project, and project size. Figure 4.1 presents a funnel chart of the number of projects that have completed each of the major steps in the project life cycle.

Figure 4.1 clearly shows that achievements in the implementation of health care PPPs in Vietnam have been limited, with only eight projects proceeding to the procurement phase, of which four projects selected an investor through direct award, one project was suspended because only a single investor participated in the competitive bidding tender, and only three projects signed contracts. The signed contracts include one completed BT project for construction of the campus of Ha Noi School of Public Health, one Build-Operate-Transfer (BOT) project for a 200-bed hospital in Ca Mau that is in operation but with poor financial performance, and one cancelled Build-Own-Operate (BOO)

FIGURE 4.1
Health care PPP project count, by project life cycle



Source: Original figure for this publication.

Note: FS = feasibility study; PPP = public-private partnership; pre-FS = pre-feasibility study.

project for Cam Pha General Hospital in Quang Ninh. At the time of writing, only two projects had actually delivered the asset or service they were contracted for. Failure to garner private investor interest is the most important reason for the lack of credible bid submissions.

These outcomes are indicative of at least some of the difficulties faced in processing PPPs, including in the bidding process. In particular, interviews with stakeholders suggest that limited private participation in the bids was most commonly due to private investors not being aware of the opportunity because of a lack of publicity or transparency of the project; the projects submitted for bidding not being attractive enough, financially or technically; the assumption among potential private investors that there may be a preferred bidder; and the requirements set out for bidders not being appropriate or feasible, among other factors.

To illustrate the types of health PPPs in the pipeline, table 4.1 categorizes the number of health care PPPs according to the ASA, the sponsor, the location, the type of health facility involved, the scope of the PPP, and the size of the project.

Although a long list of public projects need investment, most health care PPPs are still prepared as unsolicited proposals by the private sector. The competent public authorities have limited capacity and resources to prepare detailed, accurate, and complete technical and financial offerings. In discussions undertaken with the MPI and provincial authorities as part of this study, it became clear that most of the projects submitted are based on demand from

TABLE 4.1 Number of health care PPPs, by ASA, sponsor, location, facility type, scope, and size

CATEGORY	TYPE	BOT	BLT	BOO	BT	OTHER	TOTAL
ASA	Ministry of Health	1	1		1		3
	PPC or CPC	7	1	2	4	1	15
Sponsor	Government	2	2			1	5
	Private	6		2	5		13
Location	HCMC, Ha Noi, Da Nang, Hai Phong	6	2		5		13
	Quang Ninh, Ca Mau, Ben Tre, Quang Nam	2		2		1	5
Facility	Hospital	5	2	2	3	1	13
	Polyclinic and CHS	2					2
	Preventive health center				1		1
	Health school	1			1		2
Scope	Equipment				1	1	2
	Facility and accommodation	2	2		4		8
	Integrated facility and services	6		2			8
Size	Group A (VND 800 billion and above)		1		1		2
	Group B (VND 45 to 800 billion)	6	1	2	4		13
	Group C (less than VND 45 billion)	2				1	3
Total		8	2	2	5	1	18

Source: Original compilation for this publication.

Note: ASA = assigned state agency; BLT = Build-Lease-Transfer; BOO = Build-Own-Operate; BOT = Build-Operate-Transfer; BT = Build-Transfer; CHS = commune health station; CPC = City People's Committee; HCMC = Ho Chi Minh City; PPC = Provincial People's Committee; PPP = public-private partnership; VND = Vietnamese dong.

local authorities. Local authorities have limited knowledge of PPPs and do not have a budget to engage professional advisers to assist them in project screening and selection. As a result, most health care PPP projects are prepared by the private sector in the form of unsolicited proposals.

The private sector has shown significant interest in PPPs. Out of 18 projects, only 5 were sponsored by the government, while the remaining 13 originated from the private sector. The 13 private sector-sponsored projects represent an aggregate capital investment of 5.2 trillion Vietnamese dong (VND) (US\$226 million³) or 50.5–53.5 percent of the capital required for the overall projects.⁴ Barring one outlier, the government has been sponsoring fewer and smaller (that is, Group B) projects. The government is sponsoring four projects with total capital of VND 4.5 trillion to VND 5.1 trillion, which puts them in the Group B category. The single outlier is the HCMC General Hospital project, which accounts for 33.7 percent⁵ of the total capital invested in the PPP project pipeline.

The MOH is the ASA for only three projects, with various Provincial People's Committees (PPCs) or City People's Committees (CPCs) taking the lead as the ASA on the majority of PPP projects. The MOH is the ASA for two medical schools (universities) and only one hospital. Despite the paucity of relevant capacity in most provinces, most of the PPP projects originated in the provinces and cities. HCMC is the most important geographic area for PPPs, both by number of projects and by total capital. Out of the 18 projects, 9 are in HCMC, and VND 74 trillion is earmarked for projects in HCMC, representing 76.1 percent⁶ of total capital flows. However, this dynamic city has not yet signed any health PPP contracts. The first health PPP contract (a BOT hospital project) was signed by Ca Mau PPC in 2014 and the second one (a BOO hospital project) was signed by Quang Ninh PPC in 2015.

Almost all PPP projects include major investment in infrastructure (equipment and facilities), even though eight projects also integrate clinical service delivery. There are no management services PPP projects nor specialized services PPP projects in the pipeline. Investors generally prefer BT contracts. Of the four projects currently going through investor selection, three are BT projects. In general, in Vietnam, the private sector seems to prefer the BT contract structure, where it does not bear significant risk and the remuneration paid is not linked to its performance. Among the non-BT projects, only BOT projects have made meaningful progress. Both BOO projects ended early and both BLT projects are stuck at the pre-feasibility study (pre-FS) stage. The key reason for delays in advancing non-BOT-type projects seems to be a lack of implementation regulations on BOO and BLT PPP forms. Local authorities are often hesitant to move forward on such contracts without clear regulations and guidance from the MPI.

PPP PROJECTS IN PREPARATION PHASE

Case study 1: Block F in Thu Duc District Hospital in HCMC

The Building Block F—Medical treatment area of Thu Duc District Hospital project (Thu Duc Project) was proposed by the public hospital and prepared by the HCMC subnational government. The project's objective is to construct a new building block within the existing land plot of the hospital that will serve as

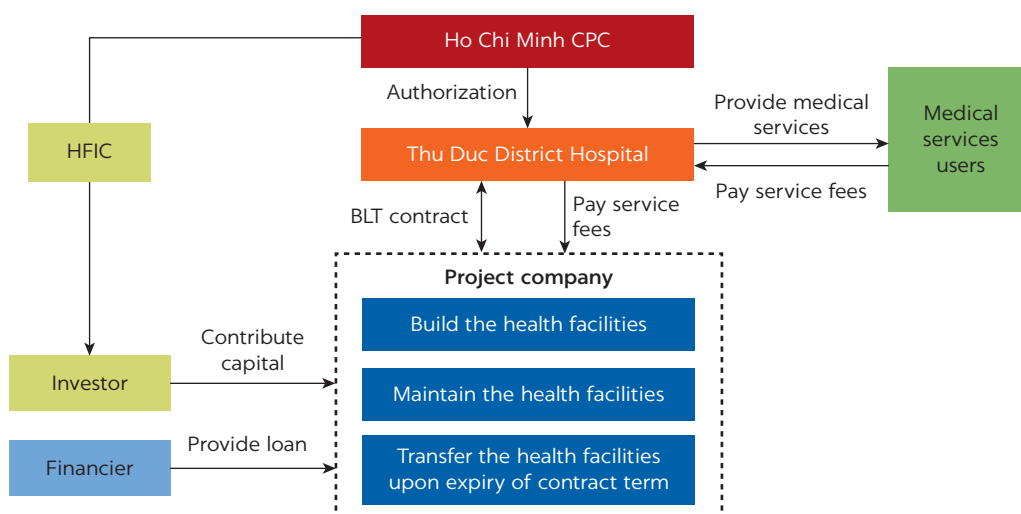
a modern and high-quality medical treatment facility with a capacity of 280 beds. The hospital submitted the pre-FS to the HCMC DPI in the middle of 2018 and it is still pending approval by the Ho Chi Minh CPC as of the writing of this report.

Project structure. Thu Duc District Hospital proposes to implement the Thu Duc Project under a BLT model, in which the selected investor(s) will finance and build the new building. Upon completion of construction, Thu Duc District Hospital will lease the new building and pay the project company service fees for maintaining the facilities of the new building block for a proposed term of 22 years. The hospital will provide medical services in the new hospital building block. Upon expiry of the leasing term, the project company will transfer the facilities to the public hospital. The capital required for the Thu Duc Project was estimated at VND 571 billion (about \$24 million) of which 30 percent will consist of the sponsor's equity and the remainder will be financed by loans from commercial banks. As proposed by the hospital, the PPP contract will be between the public hospital and the project company (figure 4.2).

Risk sharing and allocation. Under the BLT contract, the public hospital, being the health care service provider, will bear the risks related to the services and service demand, and the private investor will bear the risks relating to the facility design, construction, commissioning, equipment, and finance.

Payment mechanisms, outputs, and performance monitoring. Thu Duc District Hospital will pay a service fee to the private investor for its maintenance of facilities. The targeted outputs of the Thu Duc Project include building a new block with a design capacity of 280 beds with new and modern medical equipment. There is no indicator for performance monitoring in the pre-FS.

FIGURE 4.2
Structure of the Thu Duc Project



Source: Original figure for this publication.

Note: BLT = Build-Lease-Transfer; CPC = City People's Committee; HFIC = Ho Chi Minh City Finance and Investment State-Owned Company.

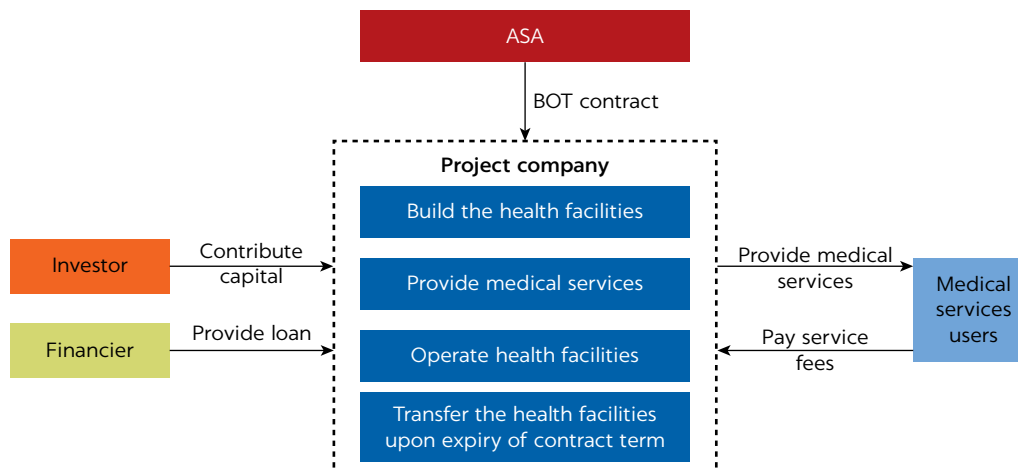
Case study 2: Tan Phu District Hospital in HCMC

The expansion of Tan Phu District Hospital (Tan Phu Project) was initiated in 2016 by TWG, a Vietnamese construction corporation, and Hoan My Medical Corporation, the largest private medical group in Vietnam. This project was proposed by the private sector as an unsolicited proposal. The project objectives were to upgrade and expand Tan Phu District Hospital from a design capacity of 150 beds to 500 beds with new and modern medical equipment to deliver better-quality medical services to the local community. The investors first submitted the pre-FS to the HCMC DPI in March 2017. The initial proposal was subject to several revisions caused by changes to the proposed PPP model (from BOO to BOT plus O&M to BOT) as well as changes to the PPP regulations (that is, from Decree 15 to Decree 63). As of the writing of this report, the pre-FS of the project is still pending approval by the Ho Chi Minh CPC.

Project structure. The investors proposed to implement the Tan Phu Project under the BOT model in which the investors would design and build the two new buildings on vacant sites at the location of Tan Phu District Hospital. Upon completion of construction, the project company would operate the two new hospital buildings and provide all types of medical services and collect medical service fees directly from the users (patients). The proposed project term is for a period of 40 years. Upon expiry of the operation term, the project company would transfer the two new hospital buildings to the ASA. The capital required for the Tan Phu Project was estimated at VND 797 billion (about \$34 million), of which 30 percent would consist of sponsor's equity and the remainder would be financed by loans from Vietnamese commercial banks. According to the latest pre-FS, the PPP contract is proposed to be signed between an agency authorized by the Ho Chi Minh CPC and the project company (figure 4.3).

Risk sharing and allocation. Under the proposed BOT model, most of the risks in the project would be borne by the investors, including design and construction risk, facility commissioning risk, medical equipment risk, financial risk, clinical and nonclinical service risk, clinical service demand risk, and political and

FIGURE 4.3
Structure of the Tan Phu Project



Source: Original figure for this publication.

Note: ASA = assigned state agency; BOT = Build-Operate-Transfer.

regulatory risk. The government only bears the risk relating to the project location and shares the force majeure risk with the private investors.

Payment mechanism, outputs, and performance monitoring. Under the proposed commercial model, the investors would collect medical service fees from users (patients) as revenue. The targeted outputs of the Tan Phu Project include upgrading and expanding the Tan Phu District Hospital from a design capacity of 150 beds to 500 beds with new and modern medical equipment and delivery of better-quality medical services to the local people. There is no indicator for performance monitoring in the pre-FS.

Key takeaways from the two case studies

- Expansion and upgrading of the facilities of public hospitals is needed to meet the increasing demand for medical services in HCMC. PPPs appear to be a useful tool for the public hospital to raise capital from private investors to update and expand the hospital facilities, given that public hospitals are expected to be financially autonomous and receive little or no state budget transfer.
- Private investors have strong interest and capacity to invest in health care projects under the PPP modality. For example, when initiating the Tan Phu Project, the private investors (TWG and Hoan My Medical Corporation) saw an opportunity to extend their business through cooperation with the public hospital, which already attracted many patients, using their existing expertise in financing and developing high-quality health care facilities in the private sector.
- The capacity and within-government cooperation among authorities in evaluating the pre-FS appear to be limited, as evidenced by the lengthy review and appraisal process. It has been more than three years since the private investors initiated the Tan Phu Project, but the pre-FS has yet to be approved. Guidelines to facilitate the choice of the appropriate health PPP model are lacking, which may have been a contributing factor to the proposed PPP model being changed several times.
- Developing an integrated health care PPP (or service delivery PPP) is difficult, especially given the limitations of the legal and regulatory framework and lack of guidelines. For authorities, it is challenging to assess the appropriate operational scheme for the project company, determine the pricing of medical services, and determine the working arrangement for medical staff who work in the current public hospital and in the future will also serve in the wards or facilities constructed with private investment. The BLT model appears to be the preferred one for a public hospital when implementing a PPP because the private sector investor faces several constraints when it comes to delivering medical services in a public hospital. Accordingly, the medical services would still be provided by the public hospital.

PPP PROJECTS IN PROCUREMENT PHASE

All BT projects in the health sector have been procured through direct award or single source selection (SSS). Some health PPP projects went through a competitive process at the early phase but shifted to SSS because only one investor passed the prequalification. It should be noted that this procurement situation is

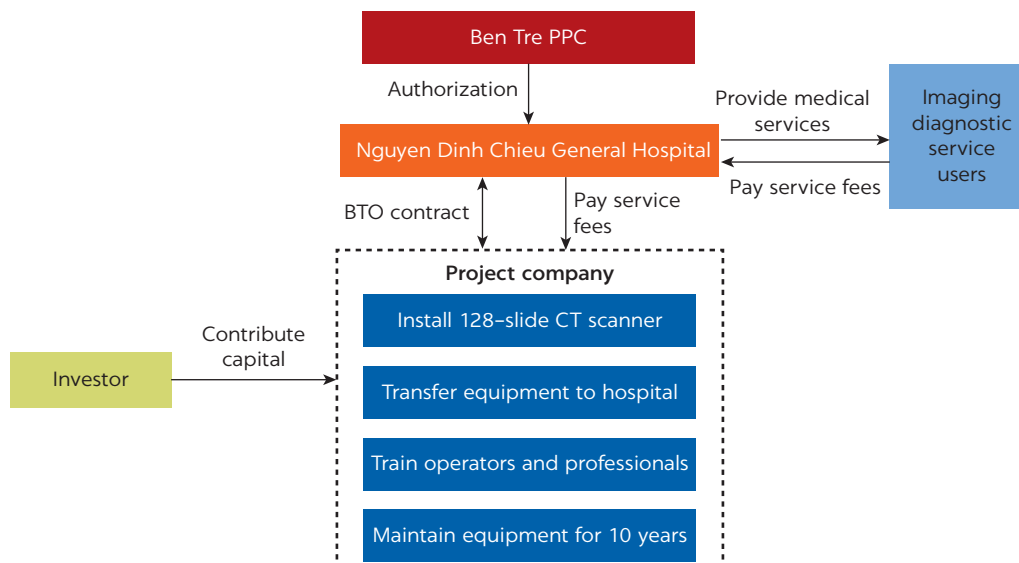
also common in other sectors. For example, 74 of 75 transport PPP projects in 2002–17 were procured through the SSS method (State Audit Office of Vietnam 2018). After revision of the PPP framework in 2018, only 31 percent of PPP projects were procured through national competitive bidding (NCB). Having only one investor passing prequalification is the main reason that procuring agencies shift from NCB to SSS.²

Case study 3: CT scanner equipment service in Nguyen Dinh Chieu General Hospital

Nguyen Dinh Chieu General Hospital in Ben Tre province initiated a JV project for provision of a 128-slide computed tomography (CT) scanner. The project investment cost is VND 27 billion (\$1.6 million), of which the hospital will contribute existing facilities and staff at the value of VND 1 billion (\$43,000) while the private investor will contribute a new 128-slide CT scanner at the value of VND 26 billion (\$1.57 million). The selected investor will finance, install, and transfer the new 128-slide CT scanner to the hospital and then maintain and repair the equipment for 10 years. The hospital will be responsible for the physical facility, consumables, staffing, and operation of the CT scanner. Project revenue will be collected by the hospital from users' fees for imaging diagnostic services. The revenue will be shared with the hospital at the minimum rate of 15 percent in the first four years, 20 percent in the three succeeding years, and 35 percent in the final three years. Ben Tre PPC approved the project proposal by Decision 1804/QĐ-UBND dated August 31, 2018.

The hospital had proposed the O&M model in 2018 but shifted to the BTO model in early 2019 (figure 4.4). NCB was used to select the investor, following the PPP procurement procedure for the first time in an equipment JV project. The private sector entity that offered the highest benefit-sharing rate with the hospital through an NCB was to be selected. In mid-2019, three private investors

FIGURE 4.4
Structure of the BTO equipment service project



Source: Original figure for this publication.

Note: BTO = Build-Transfer-Operate; CT = computed tomography; PPC = Provincial People's Committee.

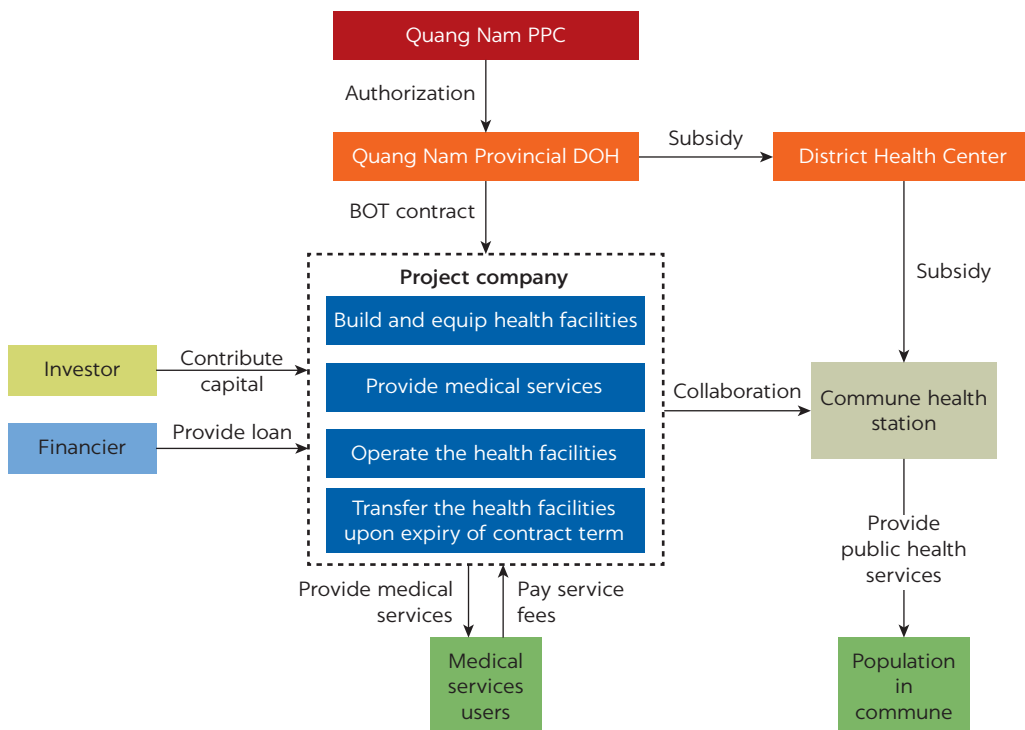
passed prequalification. However, for whatever reason, the hospital returned to the O&M model and reselected an investor through NCB again at the end of 2019.

Case study 4: Primary health care facilities in Quang Nam province

Quang Nam DOH accepted a project proposal to upgrade a regional polyclinic and a commune health station (CHS) through PPP (the primary health care project) in 2017 and obtained the approval of Quang Nam PPC in June 2018. The project cost is VND 28.3 billion (\$1.2 million) and the proposed contract type is BOT. The private sector will be responsible for renovating, equipping, and maintaining two health facilities as well as providing additional health professionals to deliver medical services to the population. Project revenue will be collected from users’ fees for services under the regular price schedule. The public sector will transfer diagnostic and treatment services to the private sector but maintain the preventive health functions and continue salary payment for the public health workers at project health facilities. The project structure is illustrated in figure 4.5.

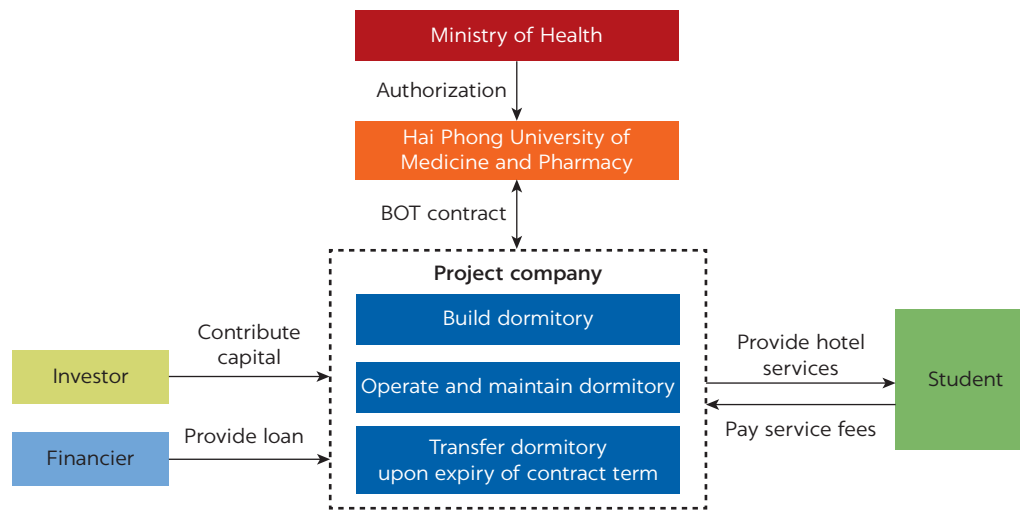
An NCB was organized in November–December 2018. However, only one bidder passed the prequalification. As a result, the Quang Nam PPC decided to select a private investor through the SSS method with a proposed contract term of up to 47 years after the completion of construction.

FIGURE 4.5
Structure of the primary health care project



Source: Original figure for this publication.
Note: BOT = Build-Operate-Transfer; DOH = Department of Health; PPC = Provincial People’s Committee.

FIGURE 4.6
Structure of the dormitory project



Source: Original figure for this publication.
 Note: BOT = Build-Operate-Transfer.

Case study 5: Dormitory in Hai Phong University of Medicine and Pharmacy

Hai Phong University of Medicine and Pharmacy (UMP) proposed the building of a new student dormitory through a BOT contract. The private sector will be responsible for building, operating, and maintaining the dormitory and delivering accommodation services to students. The university has responsibility for clearing land for building the dormitory and managing its students. Project revenue will be collected from users' fees for services. The project structure is illustrated in figure 4.6. The MOH approved the pre-FS and FS reports and authorized the Hai Phong UMP to be the procuring agency in 2018. The Hai Phong UMP organized an NCB for selecting an investor in 2019. However, no investor participated in the bidding.

Key takeaways

Procurement procedures are slow, ineffective, and, arguably, not subject to good governance. Many health PPP projects are eventually procured through direct awards or through sole sourcing, even though some of them had run competitive bidding at the early stages of the procurement process. In general, most of the procured projects are unsolicited proposals; a competitive bidding process is generally not properly executed (World Bank 2018).

PPP PROJECT IN IMPLEMENTATION PHASE

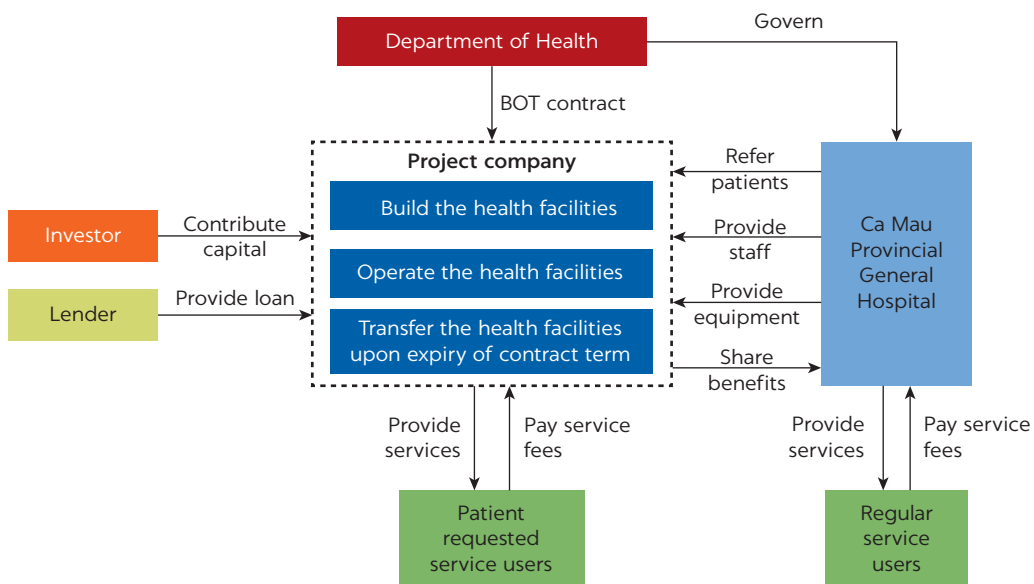
Case study 6: Ca Mau BOT Hospital Project

Ca Mau BOT Hospital Project (Ca Mau Project) was approved by the PPC in 2013 and the BOT contract was signed in early 2014 between the provincial DOH and a local private investor. The objective of the Ca Mau Project was to build a

200-bed hospital block in the existing location of Ca Mau General Hospital—a 900-bed public hospital managed by the local DOH. The Ca Mau BOT hospital was expected to reduce overcrowding at the public hospital by adding capacity funded by the private investment. After three years in operation, because project revenue was far below initial projections and disputes arose over profit sharing, the project company was in financial trouble and offered Ca Mau General Hospital the opportunity to take over the project. Ca Mau General Hospital and the local DOH supported this option, but the deal has not been approved by the local provincial authority.

Project structure. The BOT contract was signed between the DOH and the project company for a term of 30 years. The project company was granted an exemption from land-use fees during the contract term. The private sector is responsible for total project capital of VND 40 billion for building and operating the new 200-bed hospital block and bearing the risks relating to the facility design, construction, commissioning, hotel equipment, and finance. The public sector—Ca Mau General Hospital—mobilizes its medical staff for the BOT hospital and provides clinical services, bearing the risks related to the services and service demand. Upon completion of construction, the project company was to operate its new hospital building and collect medical service fees directly from patients (as well as from social health insurance for the portion of fees covered by insurance and for those patients who have health insurance coverage). The partnership between the public and private sectors is on a profit-sharing basis—the private sector receives 90 percent of the profits after tax while the public hospital gets the remaining 10 percent of profits after tax. Upon expiry of the operational term, the project company will transfer its hospital building and equipment to the public sector (figure 4.7).

FIGURE 4.7
Structure of the Ca Mau BOT Hospital Project



Source: Original figure for this publication.
Note: BOT = Build-Operate-Transfer.

Payment mechanism. Under the BOT contract, the project company collects service fees from patients (in the form of patient room charges) as revenue. The Ca Mau BOT hospital offers better services than the adjacent public hospital and consequently charges higher prices. The BOT hospital block is qualified to collect monies from Vietnam’s social health insurance scheme but the insured must pay any cost differentials not included in social health insurance.

Outputs and performance monitoring. The key output of the Ca Mau Project is the number of hospital beds offered (200 beds). The private investor is responsible for providing the hospital beds and the public hospital oversees provision of clinical services. There is no indicator or system in place to monitor project performance. The project company is required only to report its financial statements and the profit sharing between the two parties.

Key takeaways

- There is a lack of performance monitoring, transparency, and enforcement of compliance with contractual obligations. As cited in a public source, the project company charged patients higher prices than what was set forth in the project contract. The profits were thus not transparent,⁸ causing conflicts between the public and private sectors. There are no indicators for monitoring the private sector’s nonclinical performance as well as the public sector’s clinical services.
- Project feasibility was not correctly assessed. Overestimated demand and overoptimistic initial financial projections are likely to have put the project at financial risk, which will probably result in project failure. A project needs careful planning, including a buffer of financial resources to cover cash shortfalls in periods of adversity.

HEALTH PPP PROJECT IN TERMINATION

Case study 7: Cam Pha BOO Hospital Project

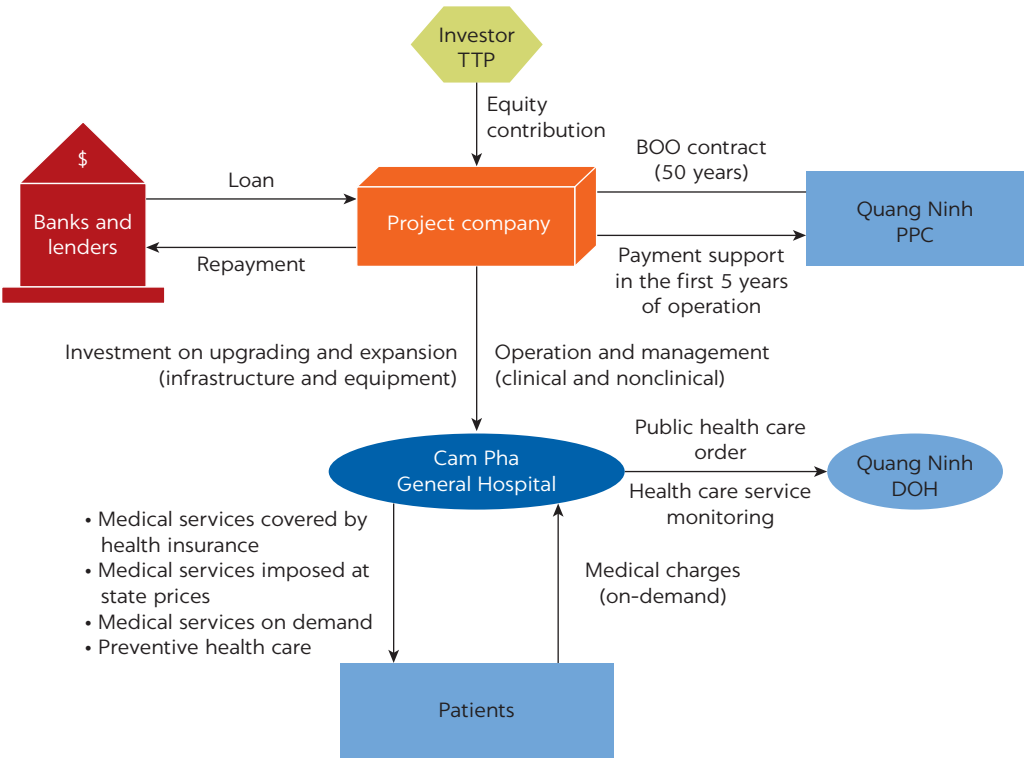
In 2015, the Quang Ninh PPC entered a BOO contract with the TTP Industrial Development Joint Stock Company—a local investor in the business of coal mining and retailing—to improve hospital infrastructure and service quality at Cam Pha General Hospital. This was the first PPP contract in the local health sector implemented under Decree 15/2015/ND-CP on PPP. The BOO hospital was designed for 500 beds, and construction commenced right after the contract was signed in 2015. However, because of disagreement among the medical staff⁹ and protracted issues with the legal procedure for transferring public assets (land) to the project company under the BOO modality, the project could not continue. Finally, the PPC had to cancel the project without compensation to the private sector.

Project structure. Cam Pha General Hospital’s BOO contract involved transfer of the existing hospital to the investor. The investor was to be responsible for financing, design, construction, provision of clinical services, and maintenance of the new hospital facility for a period of 50 years. The investor was to develop and construct a new 13-story hospital and consolidate it with an

existing 4-story building while providing all the required facilities management. The capital required for the Cam Pha Project was estimated at VND 800 billion (\$36 million). Quang Ninh PPC was the contracting agency (figure 4.8; table 4.2).

Payment mechanisms. The BOO hospital was to provide medical services to patients covered by social health insurance, and examination and treatment services were to be charged for at the public prices set by the local government. These services are currently claimed under the cost-recovery initiative and partly subsidized by the local government budget. In the BOO contract, the shortfall in cost recovery was to be repaid by the local government in the first five years of operation. The amount paid was to equal the current level of subsidy to the hospital, adjusted for annual inflation and the increased capacity required for patients covered by social health insurance and charged at public prices. The private investor was to repay the local government the residual values for the hospital building and return all the old medical equipment purchased by the public sector to the local DOH. The investor was to assume demand and revenue risk without the support of any local government guarantee. On-demand medical services (charged at prevailing market prices) were expected to generate more than 50 percent of the project revenues. Revenue from payments by social health insurance and public health services (charged at public prices) were to contribute the remaining.

FIGURE 4.8
Structure of the Cam Pha BOO Hospital Project



Source: Monitor Consulting Limited.
 Note: BOO = Build-Own-Operate; DOH = Department of Health; PPC = Provincial People’s Committee.

TABLE 4.2 Responsibilities of the public and private sectors under the PPP contract for the Cam Pha BOO Hospital Project

PUBLIC SECTOR	PRIVATE SECTOR
<ul style="list-style-type: none"> • Transfer the existing hospital to the private sector for upgrading and management • Make annual payments in the first five years of operation, based on the current local government subsidy to the existing hospital, escalated by the annual inflation rate and increased capacity for patients covered by social health insurance and medical services charged at public prices • Tax incentive: Corporate tax exemption in the first four years from the first year of accrued profits and applied at 10 percent rate on the remaining years of the project contract 	<ul style="list-style-type: none"> • Mobilize finance and construct the new 500-bed hospital based on the approved design • Provide all clinical and nonclinical services • Provide preventive health care and disease control in Cam Pha district • Provide free health care for eligible patients • Allocate 250 hospital beds for patients with social health insurance • Recruit and contract with highly credited medical doctors from central hospitals • Recruit and train young medical staff, including doctors and nurses, and contract with medical universities and colleges for recent graduate employment • Contract with central hospitals for specialized treatments and technical transfer • Repay the residual values for existing hospital building and return the public medical equipment

Source: Original compilation for this publication.

Note: BOO = Build-Own-Operate.

Outputs and performance monitoring. According to the contract, the DOH will monitor all the examination and treatment activities of the BOO hospital and place the orders for public health care services. However, there are no key performance indicators in place to monitor the BOO hospital performance.

Key takeaways

- This project was to have been the pioneer integrated PPP hospital in Vietnam with an innovative design, where the private sector was to provide all the assets and clinical and nonclinical services. The private sector was even to have been responsible for disease prevention and control in the district.
- However, too many risks were shifted to the private sector. The risks were neither well allocated nor mitigated appropriately between the two parties. The private sector assumed the demand-side risks (that is, risk associated with lack of patient demand), which is not recommended under an integrated PPP health model. The private sector was also burdened with other significant risks, including regulatory changes and force majeure causes.
- No key performance indicators were identified to monitor the project's outputs and no specific contract terms and conditions were stipulated to measure the private sector's performance. The DOH also had no key indicators with which to monitor the health care service quality of the PPP hospital.
- Public sector medical staff are key stakeholders and their views can impact the viability of a PPP. Although the investor had offered a better remuneration package to the existing hospital staff, complications arising from the medical staff's rights in the public hospital marred the project. The issue was not about a shortage of skilled medical staff but instead reflected the conflicts of interest involved and the resistance of the public medical staff to PPP health models.

- The regulations do not provide clear procedures for the transfer of public assets (land and facilities) to the private sector for the sake of public services under a PPP contract.¹⁰
- No dispute resolution mechanism is in place. As observed, there was no fair and transparent dispute resolution mechanism between the local government and the private investor that could be used when the project failed.

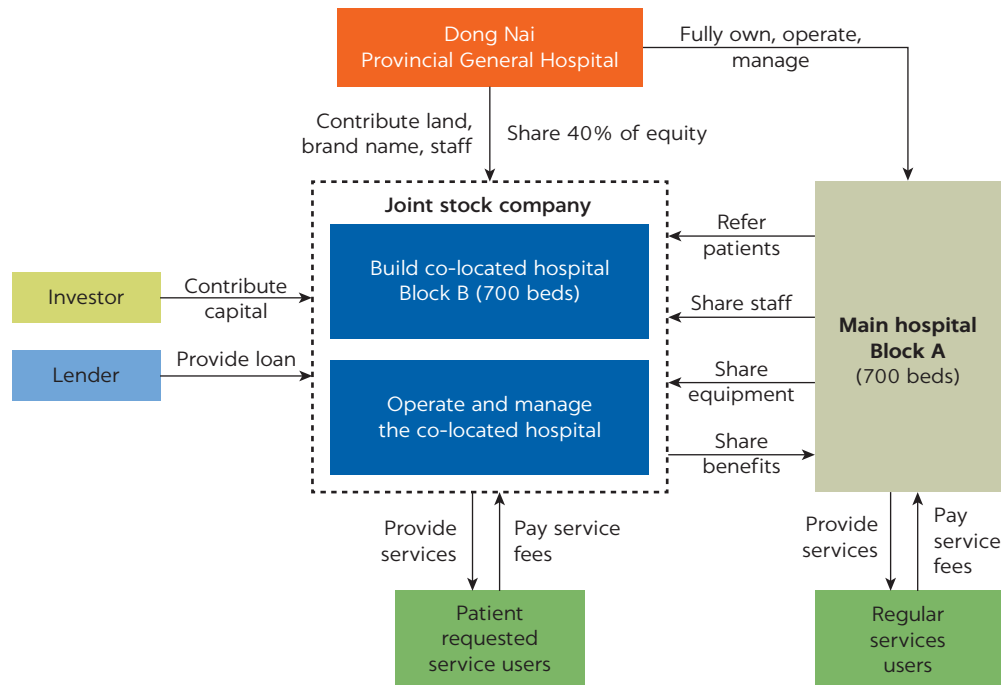
CASE STUDY OF A JV (NON-PPP) PROJECT

In general, JVs are far more prevalent than PPPs as a form of public-private engagement in the Vietnam health sector. By 2017, more than 185 health JVs had been implemented in Vietnam, but only very few health care PPP projects.¹¹ In fact, even among the few PPP projects that have been implemented, many have been through BT contracts, which, as noted, are not internationally accepted as “real” PPPs. Mobilization of private capital (in the form of JVs) through the government’s socialization policy has resulted in large increases in the availability of privately provided medical equipment and patient-requested services in the public hospitals.¹²

JVs in health in Vietnam follow four main business models.

- *Equipment provision and maintenance.* A JV is established between a private investor and a public health facility to install, operate, and maintain equipment and share benefits at a negotiated rate. The private investor is responsible for financing, installing, and maintaining equipment and training the operator. The public hospital is responsible for operating the equipment to provide services and collecting fees. The MOH or provincial DOH approves the investment policy.
- *Specialized services delivery.* A medium- or long-term contract is enacted between a private investor and a public health facility to deliver specialized services in the public health facility and share benefits. The private investor is responsible for financing, designing, constructing, operating, and managing the facility; staffing, training, and assurance; and managing brand and supply chain. The public health facility shares land and health staff. The provincial DOH approves the investment policy and provides the operating license. The typical example of this business model is the high-quality vaccination clinics within provincial centers for disease control, which have spread all over the country.
- *Facility construction, operation, and management.* A long-term (50-year) contract between a private investor and a public hospital is negotiated to develop a high-quality service facility in the public hospital and share benefits. The private investor is responsible for financing, designing, constructing, operating, and managing the facility. The private investor transfers the facility to the public hospital after the contract ends. The public hospital is responsible for sharing its brand, land, patients, and staff. The PPC approves the investment policy. This business model is used in Nghia Lo Regional Hospital (Yen Bai province), which mobilized VND 300 billion from the private sector.
- *Co-branded, co-located hospital.* An agreement is signed between a private investor and a public hospital to develop a co-located and co-branded hospital with the establishment of a joint stock project company; the private investor holds a larger share (60 percent) than the public hospital (40 percent).

FIGURE 4.9
Business model of co-branded, co-located joint stock hospital



Source: Original figure for this publication.

This business model was initiated by the Cotec Group—a leading construction corporation—and applied for the first time in Dong Nai Provincial General Hospital, as illustrated in figure 4.9.

Case study 8: Co-branded, co-located hospital in Dong Nai province

The first project of Cotec Healthcare under this model was Dong Nai General Hospital B Block, which started construction in 2012 and commenced operations in 2015. The project has a 700-bed capacity and 41 departments with a total investment of VND 3,370 billion (\$150 million) and is expected to reach the status of a 4- or 5-star hotel hospital.

Project structure. The Cotec Group and Dong Nai General Hospital established a joint stock company, Dong Nai General Hospital Joint Stock Company. Cotec Group contributed cash equity of 60 percent. Dong Nai General Hospital contributed 40 percent in the form of its land value, hospital brand, and medical staff. The project profit will be shared between the parties, based on the proportion of their respective capital contributions.

The partnership arrangement is based on each party's strengths and advantages. Whereas Cotec Group is experienced in building and financing hospital buildings, the public hospital has available land at the existing hospital's location and can mobilize medical staff for the hospital expansion. Both the private sector and the public sector are responsible for medical examinations and treatment. The private investor is responsible for financing, designing,

constructing, operating, and managing the project hospital and company; and holding the positions of president, chief executive officer, and chief financial officer. The public hospital is responsible for sharing land, brand name, patients, and equipment; managing and operating professional activities; providing health care professionals; and holding the positions of vice president, chairman of the professional committee, and department managers. The PPC provided support through its approval of the investment policy and project company and exemption or reduction of the land tax and income tax. Dong Nai General Hospital Joint Stock Company will oversee and manage overall operations of the hospital.

Payment mechanisms, output, and performance monitoring. The project revenue is based on service fees charged to patients (some of which may be reimbursed by social health insurance). The total number of hospital beds is 700. Only 70 beds are reserved for patients charged mandated public health care prices, while the rest are charged higher prices (in excess of what is reimbursed by social health insurance). There are no key performance indicators or systems in place to monitor the performance of the JV hospital.

Key takeaways

- The co-location model of private sector investment in a large, well-known public hospital is relatively easy to implement and takes advantage of the relative strengths of the public and private investors. It combines the strengths and advantages of the local private investor in construction and financing with the advantages of the public hospital (land and medical staff), targeting patients with greater capacity to pay who are dissatisfied with the overcrowding and poor service at public hospitals.
- Although this model serves the interests of investors, it may not serve the public's interests. One of the downsides and risks of implementing this model is that services are more expensive and, thus, the joint stock hospital tends to be more focused on the needs of high-income patients. Also, under the JV arrangement, both parties are subject to incentives to maximize profits, which may result in excess service provision. The existing public hospital must share its skilled medical doctors with the private sector, which may affect the quality of public sector medical services. The public health care service's main objectives—equity, access, and efficiency—may not be achieved.
- Valuing the public sector contribution to the joint stock project company is a challenge. The valuation of land, hospital brand, and medical staff is quite difficult to justify, so the capital contribution proportion among parties depends heavily on the negotiation outcomes.

CROSS-CUTTING LESSONS LEARNED FROM THE CASE STUDIES

The eight case studies highlight some overarching findings relevant to health care PPPs compared with other forms of private sector contracting in Vietnam and point to several challenges in developing and implementing health care PPPs.

Despite the popularity of the socialization route for public-private health care engagements, the benefits of these (non-PPP) projects are unlikely to

reach lower-income households and other vulnerable population groups in Vietnam. These socialization models largely serve the needs of the middle- and higher-income segments of the population. Their revenue-generation model usually involves charging higher fees (for perceived better facilities or services) than the state-regulated price that is reimbursed by health insurance, with clear incentives to overprovide diagnostic and curative services to maximize their profits. These non-PPP facilities are also more likely to be located in urban centers, concentrated in higher-level health care facilities, and focused on profitable, specialized health services, all of which are more likely to benefit the richer segments of the population and widen the gap between the rich and the poor. The mobilization of the already scarce health human resources by these facilities is likely to further weaken service delivery in the public sector. Non-PPP socialization projects are thus likely to aggravate existing inequities in health care service delivery in Vietnam, in addition to compromising the efficiency and quality of health care service delivery. In contrast, experience in more advanced countries shows that PPPs, if appropriately designed (for example, through equity-enhancing measures written into the contracts) and funded by the government (for example, through subsidies for the poor and vulnerable), can be used as an effective instrument to enhance health care equity while providing better health outcomes and responsiveness to the health care needs of the population.

A number of operational challenges related to the preparation and implementation of PPPs also arise, including appraisal, procurement, risk sharing, the payment mechanism, and performance metrics. The review and appraisal of PPP projects by the public sector often take a long time, and the proposed PPP model is often changed during project preparation. The procurement process for health care PPPs is also not consistent with international good practice. Most PPPs are the result of unsolicited proposals and, even when initiated by the government, many health PPP projects are eventually procured through direct awards or sole sourcing, even if competitive bidding was envisaged in the early stages of procurement. This situation is due to gaps in public sector management capacity, compounded by reticence among private investors to compete on PPP procurements given perceived regulatory and institutional uncertainties. Risk allocation between the public and private sectors is not always thought through carefully and not always appropriate. In many cases, the public sector bears little to no risk but in at least one case (Cam Pha BOO Hospital), too much risk was shifted to the private sector. Furthermore, it is unusual to find PPP projects that include indicators for monitoring project performance or use performance-based payments or penalties. Finally, integrated health care PPPs remain rare in Vietnam, with only one implemented to date; BLT models (PPP) and JV models (non-PPP) are generally favored. These issues are explored further in chapter 5.

Still, while relatively small in number, health care PPPs in Vietnam do appear to be a useful instrument for the public sector to mobilize resources from the private sector to respond to the increasing demand for more and better health care. There is clear investor interest and there is also public sector demand.

ANNEX 4A HEALTH CARE PPP PROJECTS IN WHICH AT LEAST ONE STEP IN THE PROJECT PREPARATION WAS COMPLETED

TABLE 4A.1

	PROJECT NAME	LOCATION	STATUS, JULY 2019	PROJECT SPONSOR	TYPE	SERVICE TYPE	PAYMENT TYPE	CONTRACT TYPE	START DATE	TYPE OF FACILITY	CAPITAL (BILLION VIETNAMESE DONG)	ASA
1	Campus of Ha Noi University of Public Health	Ha Noi	Completed	Private	New	Facility	Government pay by land	BT	2010	Health school	644	MOH
2	Building District 7 Hospital – Phase 2	HCMC	Ongoing, pre-FS	Private	New	Facility	Government pay by land	BT	2006	Hospital	270	CPC
3	Building Saigon General Hospital	HCMC	Ongoing, investor selection	Private	New	Facility	Government pay by land	BT	2016	Hospital	1,000	CPC
4	Building District 7 Preventive Centre	HCMC	Ongoing, investor selection	Private	New	Facility	Government pay by land	BT	2017	Preventive health facility	99	CPC
5	Upgrading and operation of commune medical stations in District 3	HCMC	Ongoing, FS	Private	Existing	Integrated	User pay	BOT	2017	CHS	117	CPC
6	Building Block 1 – Medical examination and treatment service area of Children’s Hospital 1	HCMC	Ongoing, FS	Private	New	Integrated	User pay	BOT	2017	Hospital	721	CPC
7	Expansion of Tan Phu District Hospital	HCMC	Ongoing, pre-FS	Private	New	Integrated	User pay	BOT	2017	Hospital	797	CPC
8	Building the on-demand medical examination and treatment service area of District 2 Hospital	HCMC	Ongoing, pre-FS	Private	New	Integrated	User pay	BOT	2018	Hospital	320	CPC
9	Building Block F – Medical treatment area of Thu Duc District Hospital	HCMC	Ongoing, pre-FS	Government (public hospital)	New	Facility	Government pay	BLT	2018	Hospital	571	CPC
10	High-tech diagnosis and treatment center (500 beds) in Cho Ray Hospital	HCMC	Ongoing, pre-FS	Government (MOH)	New	Integrated	Government pay	BLT	2018	Hospital	3,277	MOH
11	Dormitory in Hai Phong UMP	Hai Phong	Ongoing, investor selection	Government (public university)	New	Integrated	User pay	BOT	2017	Health school	123	MOH

continued

TABLE 4A.1, continued

	PROJECT NAME	LOCATION	STATUS, JULY 2019	PROJECT SPONSOR	TYPE	SERVICE TYPE	PAYMENT TYPE	CONTRACT TYPE	START DATE	TYPE OF FACILITY	CAPITAL (BILLION VIETNAMESE DONG)	ASA
12	Supply of medical equipment for Da Nang Obstetric and Pediatric Hospital	Da Nang	Ongoing, pre-FS	Private	Existing	Facility	Government pay by land	BT	2017	Hospital	144	CPC
13	Hospital in Da Nang University of Medical Technology and Pharmacy	Da Nang	Ongoing pre-FS	Government (MOH)	New	Integrated	User pay	BOT	2017	Hospital	315–900	MOH
14	Obstetric and Pediatric Hospital Phase 2	Quang Ninh	Ceased at FS	Private	New	Integrated	User pay	BOO	2017	Hospital	373	PPC
15	Cam Pha General Hospital	Quang Ninh	Ceased at contract implementation	Private	New	Integrated	User pay and government pay	BOO	2015	Hospital	800	PPC
16	Upgrading several health facilities in Quang Nam province (general clinic in Dong Que Son area and Tam Thanh CHS)	Quang Nam	Ongoing, investor selection	Private	New	Integrated	User pay	BOT	2018	Regional polyclinic and CHS	28	PPC
17	On-demand center in Ca Mau General Hospital	Ca Mau	In operation	Private	New	Integrated	User pay	BOT	2013	Hospital	40	PPC
18	128-slide CT scanner in Nguyen Dinh Chieu General Hospital	Ben Tre	In procurement	Government (hospital)	New	Equipment	User pay	BTO	2019	Hospital	27	PPC

Source: Original compilation for this publication.

Note: ASA = assigned state agency; BLT = Build-Lease-Transfer; BOO = Build-Own-Operate; BOT = Build-Operate-Transfer; BT = Build-Transfer; BTO = Build-Transfer-Operate; CHS = commune health station; CPC = City People's Committee; CT = computed tomography; FS = feasibility study; HCMC = Ho Chi Minh City; MOH = Ministry of Health; PPC = Provincial People's Committee; PPP = public-private partnership; pre-FS = pre-feasibility study; UMP = University of Medicine and Pharmacy.

ANNEX 4B HEALTH CARE PPP PROJECTS REACHING PROCUREMENT PHASE

TABLE 4B.1

NO.	PROJECT	CITY	PROJECT SPONSOR	CONTRACT TYPE	PROCUREMENT METHOD	REMARKS
1	Campus of Ha Noi University of Public Health	Ha Noi	Private	BT	Direct award	Construction completed; campus is operational
2	Building Saigon General Hospital	HCMC	Private	BT	Direct award	Suspended because of revision of BT decree
3	Building District 7 Preventive Center	HCMC	Private	BT	Competitive bidding	Only one bidder submitted bid; suspended due to revision of BT decree
4	Dormitory in the Hai Phong UMP	Hai Phong	Government	BOT	Competitive bidding	No bidders submitted bid applications
5	Cam Pha General Hospital	Quang Ninh	Private	BOO	Direct award	Project was cancelled
6	Upgrade several health facilities in PPP form	Quang Nam	Private	BOT	Competitive bidding	Only one investor is prequalified
7	On-demand center in Ca Mau General Hospital	Ca Mau	Private	BOT	Direct award	In operation
8	128-slide CT scanner in Nguyen Dinh Chieu General Hospital	Ben Tre	Government	BTO	Competitive bidding	In procurement

Source: Original compilation for this publication.

Note: This list represents the authors' best efforts at building a complete list, but as outlined in the narrative, it may not be exhaustive. BOO = Build-Own-Operate; BOT = Build-Operate-Transfer; BT = Build-Transfer; BTO = Build-Transfer-Operate; CT = computed tomography; HCMC = Ho Chi Minh City; PPP = public-private partnership; UMP = University of Medicine and Pharmacy.

NOTES

1. The MPI PPP website can be found at <http://ppp.mpi.gov.vn/>.
2. The HCMC DPI PPP website can be found at <https://ppp.tphcm.gov.vn/>.
3. Using an exchange rate of \$1 = VND 23,000; this exchange rate is for illustrative purposes only.
4. VND 5,200 billion out of VND 9,718 billion or VND 10,303 billion, depending on the size of the Da Nang University hospital.
5. VND 3,277 billion out of VND 9,718 billion.
6. VND 7,400 billion out of VND 9,718 billion.
7. “Single source selection of investor for project using land shares the major portion” (<https://baodauthau.vn/dau-thau/lua-chon-nha-dau-tu-du-an-ppp-su-dung-dat-chi-dinh-thau-chiem-ty-le-lon-107102.html>).
8. “Mess in on-demand 200 bed facility BOT project in Ca Mau general hospital” (<http://www.sggp.org.vn/linh-xinh-du-an-bot-khu-dich-vu-200-giuong-trong-benh-vien-da-khoa-ca-mau-548601.html>).
9. During the inception phase, the medical staff was surveyed on whether they wanted to work for the PPP hospital and their responses were 100 percent positive. However, after the project contract was signed, their opinions changed and they became opposed to working for the PPP hospital.
10. Decree 151/2017 on the guidance of the Law on public assets management and usage dated December 26, 2017, provides a procedure for transferring public assets as government support to PPP projects. However, the Cam Pha BOO Hospital contract was signed two years before the issuance of that decree.
11. PPP health care projects in the form of BT arrangements are excluded because they do not transfer risks to the private sector and there is no performance-based remuneration.
12. Private investment under “socialization” mainly focuses on high-tech medical diagnosis and treatment equipment such as positron emission tomography (PET), computed tomography (CT), magnetic resonance imaging (MRI), and test equipment (“The health sector attracts socialized investment,” <http://thoibaotaichinhvietnam.vn/pages/nhip-song-tai-chinh/2018-08-22/linh-vuc-y-te-hut-von-dau-tu-xa-hoi-hoa-61163.aspx>).

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5 Barriers to the Implementation of Health PPPs

INTRODUCTION

This chapter examines in greater detail the barriers that have hampered the successful design and implementation of health care public-private partnerships (PPPs) in Vietnam. These barriers may be broadly categorized as (1) barriers in the PPP policy and regulatory framework, (2) barriers in the public sector, (3) barriers in the private sector, and (4) barriers in the financial sector. The discussion of the barriers in the design and implementation of PPPs in Vietnam is organized around the analytical framework presented in chapter 1. If PPPs are to become viable as a means to further health sector objectives—enhancing access, efficiency, quality, and equity—it is critical that these barriers be addressed.

BARRIERS IN THE PPP POLICY AND REGULATORY FRAMEWORK

The current PPP framework has numerous limitations despite recent improvements

Although the current PPP framework has been improved recently, it still has a number of limitations, especially with respect to its application to PPPs in the health sector. First, the definition of PPPs is oriented toward infrastructure-type PPPs, downplaying the role of the service-type PPPs that are common in other countries. The definition also does not include mention of a long-term contract, transfer of risks or management responsibility from the public to the private sector, or performance-based payments.

Second, key regulations and technical guidelines for PPP project development and implementation are absent, including the following:

- *PPP screening tool and value for money (VfM) assessment.* The current framework does not include any guidance or criteria for assessing the suitability of a PPP for a project or its VfM.
- *Risk allocation.* The current framework does not provide any guidance on risk allocation but defers to assigned state agencies to negotiate and reach agreement with the private partners and sponsors. The lack of guidance and

successful models leaves assigned state agencies and private parties struggling with this issue.

- *Key performance indicators.* The requirements of the private partners are still input driven rather than output driven. There is no guidance for measuring the performance of the private partner in a PPP project.
- *Government support to make projects financially viable and bankable.* Although viability gap funding (VGF) has been contemplated, there is no guidance on VGF procedures and provision in a project. The existing framework does not enable the government to provide critical guarantees to private investors such as minimum revenue and foreign exchange conversion.

Third, existing regulations on unsolicited proposals are insufficient, meeting only 25 percent of international good practices (World Bank 2018). There is no requirement for the private sector to demonstrate that the project is consistent with national priorities or that it is an innovative or cost-effective service delivery mechanism for an important public service. Unsolicited proposals are not subjected to the same robust appraisal and contract management procedures. Provision of a 5 percent advantage for qualifying (see the section in chapter 3 titled “Empowerment of public health facilities and private investors to initiate a PPP”) raises concerns about the perverse effect of giving less innovative solutions a competitive advantage and ultimately deterring others from participating in the Swiss Challenge process (World Bank Vietnam and Ernst and Young 2019).

Fourth, the legal documents governing a PPP project are insufficient and inconsistent. The legal framework for PPP is fragmented. The PPP process—starting from project identification until the termination stage of a PPP contract—follows different laws, which sometimes overlap. In addition, individual laws fail to consider some important features of PPP projects. The shortcomings of the laws include the following:

- *The Public Investment Law* requires PPP projects to go through an appraisal procedure similar to that of public projects. This process introduces some complexities and negative externalities for private investors such as extensive paperwork, many layers of approvals, and government bureaucracy.
- *The Investment Law* does not address government guarantees or special considerations for long-term contracts and capital-intensive PPP projects.
- *The Public Procurement Law* has no special section governing PPP projects; thus, PPP projects must adjust to fulfill the requirements set out by this law.
- *The Public Asset Use and Management Law* does not adequately address the valuation of assets contributed by the public sector to PPP projects, which has limited the public contribution and, therefore, slowed PPP project development.
- *The State Budget Law* is inflexible and prescriptive. Planning, estimation, and disbursement are fixed processes and PPP projects find it difficult to comply with the law while still obtaining government support and making the project bankable. Any budget for PPP project development, whether in the form of a VGF, government pay system, or availability payment, must comply with the requirements set out in the law.
- *The Construction Law* is prescriptive and input driven. There are numerous regulations governing preparation of project proposals, feasibility studies (FSS), and regulated costs.
- *The Land Law* does not allow mortgage of land use rights with international lenders, making debt financing from international lenders quite difficult. There are no firm regulations on the valuation of land.

- *The Enterprise Law* does not regulate PPP project companies. Full equity must be paid into a company bank account within 90 days after registration, which makes it a challenge for large capital projects in which the sponsors will retain most of the capital until financial close.

PPPs are not well embedded in the health policy and regulatory framework

PPPs have not been embedded in health policies and related health regulations, hampering the use of PPPs to expand the infrastructure and improve services in the health sector. The most important health policies at the central level, including the National People's Health Care Strategy¹ and the Central Communist Party's Resolution on enhancing health care in the new situation,² did not provide the market with a clear signal concerning the political commitment to health PPPs. At the subnational level, only Ho Chi Minh City (HCMC) (among 63 cities and provinces) referred to the contribution of PPP in its health system development plan.³ Because there is no strategic and systematic approach to developing a credible PPP project pipeline, health PPP projects are often prepared and implemented on an ad hoc basis. It is therefore not surprising that, although Vietnam has a long list of health care PPP projects proposed by local provinces and public hospitals, many of those projects are not well suited for the use of the PPP modality.

Furthermore, health PPP projects in Vietnam are regulated by both health sector regulations and general PPP regulations. The failure to address the regulatory intricacies of health care PPP entities has led to ambiguity among stakeholders about how to prepare and structure the delivery of PPP health care projects. Table 5.1 highlights the key challenges investors face when designing and implementing PPP health care projects.

The Ministry of Health (MOH) is currently working on a draft circular to guide the development of health care PPP projects; the circular is expected to provide guidance on topics such as the preparation of pre-FSs and FSs as well as the use of PPPs in specific health subsectors (for example, pharmaceuticals and medical equipment). The current version of the circular, however, does not address other issues, noted earlier, that are relevant to making health care PPPs work, such as human resources for health and health insurance.

There are challenges at every step of the PPP project cycle

Even though Vietnam's PPP process is regarded as close to international good practice, challenges remain in each step of the PPP project cycle. Table 5.2 summarizes these challenges, including the lack of guidelines and regulations and the conflicts between them when they do exist.

In summary, Vietnam's PPP regulatory framework is still insufficient, fragmented, conflicted, and unclear, imposing a significant obstacle to the implementation of viable PPP projects, including those relating to health care. The relative weakness of the PPP framework is also acknowledged within Vietnam. In interviews carried out as part of this study, 75 percent of the respondents felt that the weak PPP legal and regulatory framework poses the greatest barrier to implementing health PPP projects.

TABLE 5.1 Key legal provisions governing health care PPP projects

ISSUE	LEGAL PROVISIONS	IDENTIFIED CHALLENGES
Health care services	Law on Examination and Treatment; Decree No. 87/2011/ND-CP detailing several articles of the Law on Examination and Treatment	No clarity on whether a PPP hospital, if located in the same land area as a public hospital, is considered an expansion or a new hospital
Prices of services	Decree No. 85/2012/ND-CP on the operational and financial regimes and the prices of health care services in public medical establishments; Circular No. 37/2018/TT-BYT on price schedule ceilings of uninsured medical services, pricing and payment of medical services in certain cases	No clarity as to whether PPP hospitals are required to follow the operational and financial regimes applicable to public hospitals and whether the prices of health care services provided by a PPP hospital are subject to the MOH's price ceilings
Human resources for health	Law on Cadres and Civil Servants; Law on Public Employees	No clarity on the regulations governing the conditions under which existing medical staff of a public hospital may co-work at a PPP hospital
Health insurance	Law on Health Insurance 2008; Decree No. 146/2018/ND-CP on elaborating and providing guidance on measures to implement certain articles of Law on Health Insurance	No clarity on whether a PPP hospital, if located in the same land area as the public hospital, needs to enter into a separate contract with the local social security authority for providing insured medical services
Medical equipment	Decree No. 36/2016/ND-CP and Decree No. 169/2018/ND-CP on medical equipment management; Draft circular on bidding to supply medical devices in public facilities	No clarity on whether PPP hospitals are required to follow the medical device procurement process stipulated for public hospitals
Pharmacy	Law on Pharmacy 2016; Decree No. 54/2017/ND-CP guiding the implementation of the Law; Circular No.11/2016/TT-BYT on bidding for drugs supply in public facilities	No clarity on whether PPP hospitals are required to follow the drug procurement process stipulated for public hospitals

Source: Original table for this publication.

Note: MOH = Ministry of Health; PPP = public-private partnership.

TABLE 5.2 Identified regulatory challenges in the PPP project cycle

PROJECT CYCLE	IDENTIFIED CHALLENGES
Pre-FS	<ul style="list-style-type: none"> Lack of PPP screening tool for assessing the suitability of a project for a PPP Too much detail required for pre-FS by Decree 63 No guidelines to address specific issues of health care PPPs No incentives given to the investor to prepare unsolicited proposals
FS	<ul style="list-style-type: none"> Input-driven process and norms-based costing in FS report No guideline to address specific issues of health care PPPs No guideline on risk assessment and risk allocation and mitigation strategy No guideline on government support to make projects viable and bankable
Selection of investor	<ul style="list-style-type: none"> Vague regulations on unsolicited procurement; no further guidance or specific criteria, other than that it be "reasonable" to assess whether an unsolicited project is qualified for direct appointment Restriction on state-owned enterprises participating in investor selection tender according to Decree 30/2015/ND-CP (Article 2.1(b))
PPP contract execution	<ul style="list-style-type: none"> Lack of draft clauses and guidelines for PPP contract: Circular 09/2018/TT-BKHDT only provides high-level guidance on the contents of a PPP contract and does not provide sample draft clauses along with an explanation of the risks and challenges of such provision Requirement of full equity contribution within 90 days after the enterprise registration according to the Enterprise Law Input-driven process in PPP contract
Project implementation and transfer	<ul style="list-style-type: none"> Conflicts between PPP decree and other laws used to implement and monitor the project No clarity on PPP projects in health care regulations (on health services, pricing, health insurance, human resources, equipment, and pharmaceuticals) No guidelines on key performance indicators, either general or health-sector specific, to measure the performance of the private investor

Source: Original table for this publication.

Note: FS = feasibility study; PPP = public-private partnership; pre-FS = pre-feasibility study.

Joint ventures, in contrast, are legally well established

Other business forms or public-private engagement (PPE) forms, and especially joint ventures (JVs), are well entrenched in the health policy and regulatory framework. Also, stakeholders in both the public and the private sectors are familiar with and prefer these engagement forms. The health care JV approval process is comparatively simple, and the JV framework allows public hospitals to work with the private sector on fast-track arrangements (table 5.3).

In general, the regulatory framework for JV project management—including the Public Asset Use and Management Law, Decree 151/2017/NĐ-CP, and Circular 144/2017/TT-BTC—is less fragmented than the

TABLE 5.3 Comparison of PPP and JV project procedures

DIMENSION	JV PROJECT	PPP PROJECT
Regulation	<ul style="list-style-type: none"> Government Decree 151/2017/NĐ-CP 	<ul style="list-style-type: none"> Government Decree 63/2018/NĐ-CP
Objective and scope	<ul style="list-style-type: none"> Provision of medical equipment, health facilities, and related services Provision of health services and supportive services 	<ul style="list-style-type: none"> Provision of health infrastructure and related services
Overall process	<ul style="list-style-type: none"> Step 1: Preparation, appraisal, and approval of JV project proposal Step 2: Selection of private partner Step 3: Contract negotiation and signing Step 4: Contract implementation and management 	<ul style="list-style-type: none"> Step 1: Preparation, appraisal, and approval of pre-FS report; making decision on investment policy Step 2: Preparation, appraisal, and approval of FS report Step 3: Selection of private investor Step 4: Contract negotiation and signing Step 5: Contract implementation and management
Project preparation	<ul style="list-style-type: none"> Preparation of one proposal in line with Decree 151/2017/NĐ-CP Appraisal and approval of one proposal by MOH or PPC 	<ul style="list-style-type: none"> Preparation of two studies (pre-FS, FS) in line with Decree 63/2018/NĐ-CP Appraisal and approval of two studies (pre-FS, FS) by MOH or PPC
Private partner selection method	<ul style="list-style-type: none"> Public notice inviting expression of interest from the private sector Evaluation and selection of investor based on predetermined criteria 	<ul style="list-style-type: none"> Prequalification of investors Preparation, appraisal, and approval of procurement plan Competitive bidding to select investor
Contracting	<ul style="list-style-type: none"> Contract type: JV contract with or without project company; identified at contract negotiation Contracting parties: Selected private partner signs contract with director of health facility Project company is not compulsory, established after contract signing 	<ul style="list-style-type: none"> Contract type: BT, BOT, BOO, BTO, BLT, BTL, O&M, or mixed contract; identified at the pre-FS stage Contracting parties: Leader of project company signs contract with Minister of Health or Chairman of CPC or PPC or authorized person Project company is compulsory, established before signing contract
Financial plan and payment mechanism	<ul style="list-style-type: none"> Revenues are generated from fees collected for services. Service price is calculated based on actual cost and expected profit Profit sharing is negotiated and agreed between parties 	<ul style="list-style-type: none"> Revenues are generated from fees for services collected, from government's availability payment, or from both Service price is identified through bidding Profit sharing is not regulated
Monitoring	<ul style="list-style-type: none"> Annual report on public asset management is required, but JV performance report is not 	<ul style="list-style-type: none"> Monitoring of contract implementation and performance is required

Source: Original table for this publication.

Note: BLT = Build-Lease-Transfer; BOO = Build-Own-Operate; BOT = Build-Operate-Transfer; BT = Build-Transfer; BTL = Build-Transfer-Lease; BTO = Build-Transfer-Operate; CPC = City People's Committee; FS = feasibility study; JV = joint venture; MOH = Ministry of Health; O&M = Operate and Manage; PPC = Provincial People's Committee; PPP = public-private partnership; pre-FS = pre-feasibility study.

framework for PPPs. The JV project preparation procedure is simplified, requiring a public health institution to submit the project proposal to the assigned state agency for appraisal and approval only once. Also, the private partner selection undergoes a competitive process but does not require national bidding. It also grants public health institutions greater authority and flexibility to negotiate a contract type and a financial plan with the private partner. There is no requirement for public health institutions to monitor, report, and disclose performance of the JV. It is a different matter, however, that even though Vietnam's highly decentralized health care system and autonomous hospital mechanisms have attracted substantial private investment through the socialization route, these forms of engagement do not necessarily further key Vietnamese public health care objectives such as access and equity.

Public hospitals have far greater motivation and stronger incentives to engage in health care projects using the JV-type model enabled by the socialization policy than to go the PPP route. Because public hospitals have a high degree of financial and organizational autonomy, public hospital managers can independently enter into JVs with the private sector. Public hospital managers and staff and private investors are motivated to invest in profitable specialties and take advantage of patients' dissatisfaction with overcrowding in public hospitals. By contrast, health care PPP projects require a higher public authority (for example, the MOH or Provincial People's Committee) to represent the public sector in working with the private sector, for which hospital autonomy does not provide any additional benefit. Health care socialization projects, such as JVs, are implemented on a profit-sharing basis and do not require government payment for the services. Health care PPPs, on the other hand, are aimed at delivering public health services within the overall national and provincial health care sector goals and strategies and government financing, particularly for the poor, and are therefore vital.

The private sector similarly prefers to engage in health investments through the socialization route because it provides opportunities to cooperate with a public hospital, usually without going through any public procurement process. The health care socialization appraisal process is quite simple and public hospitals have therefore readily adopted the project preparation process. In contrast, health care PPPs are more difficult to deploy because of the ineffective regulatory framework, the limited capacity of the public sector, and the government's lack of PPP readiness at the central and local levels.

BARRIERS IN THE PUBLIC SECTOR

Institutional arrangements for health PPPs

In addition to an enabling legal and regulatory environment, a key determinant of the success of PPP programs is the institutional framework. Countries with strong public sector institutions—such as Australia, the Republic of Korea, and the United Kingdom—have generally performed well in engaging with the private sector on PPPs. Public agencies in these countries typically have significant experience in overseeing PPPs and have developed the capacity to select,

evaluate, and implement PPP transactions. International experience suggests that having a single window for investor access—led by a professional unit empowered to lead the implementation of projects and make appropriate decisions during project selection, tendering, and negotiation of the deal—is often the key to the success of PPP programs. Examples of such PPP units across the world include the PPP Policy Team in the United Kingdom, Partnerships in Victoria state in Australia, the Public and Private Infrastructure Investment Management Center in Korea, the PPP Center in the Philippines, and the National Treasury PPP Unit in South Africa.

Vietnam is still in the process of developing a strong institutional structure to support its PPP program. Thus, it is currently ranked 17 out of 21 countries in the Asia-Pacific region assessed by the Economist Intelligence Unit (2014) on the PPP institutional framework. As noted, the need for health care PPP projects to comply with the provisions of several other national laws requires interactions with numerous government agencies at the provincial and national levels on issues related to construction, finance, land, and environment. For example, health care PPP proposals and evaluations being undertaken at the provincial level often require decisions to be made by central government agencies such as the Department of Health (DOH), Department of Planning and Investment (DPI), Department of Finance, Department of Construction, and Department of Natural Resources and Environment. However, the processes required to secure such opinions and approvals are rarely clearly specified, streamlined, or well coordinated. This lack of clarity leads to unnecessary bureaucratic delays in the preparation and approval of health care PPP projects, as illustrated in a comment from a hospital director during interviews undertaken as part of this study, “The evaluation of pre-FS of Block 1 Children’s Hospital PPP project took about a year and we don’t know whether the FS can get approved.”

As the lead PPP agency, the Ministry of Planning and Investment (MPI) is expected to provide key stakeholders, especially in the public sector, with legal and regulatory knowledge, specific management skills, and the technical knowledge needed to oversee and complete each of the key steps and procedures in the PPP project life cycle: project identification and selection, analysis, risk-allocation structuring, tendering, performance monitoring, and contract management. However, its role is limited to coordination and advice on general PPP policies. There is thus no agency at the national ministerial level specifically tasked with the responsibility for overseeing and guiding local authorities and working with sectoral ministries and provincial governments to facilitate PPP development in the health care sector.

So far, only the Ministry of Transport at the national level has set up a designated PPP unit to oversee PPP projects. At the MOH, the Department of Planning and Finance is the focal point for health care PPP projects and programs at the national level. The department, however, has many competing and important mandates under the investment scope of the MOH and therefore cannot function as a dedicated unit for PPP health care projects. The DPis are expected to play a similar role as the Department of Planning and Finance for health care PPP projects at the provincial level. Based on discussions with, and surveys of, the MOH, selected DPis, and public hospitals undertaken as part of this study, it is apparent that they do not have the in-house experience and expertise required to prepare pre-FSs and FSs. The public sector also does not have the budgetary resources necessary to engage professional consultants to conduct health care

PPP pre-FSs and FSs, which results in private investors often preparing the pre-FS and FS as unsolicited proposals.

The one exception to the absence of dedicated entities at the subnational level to oversee PPPs is HCMC, which embarked on a large and fairly successful PPP program and also set up a PPP unit in 2013 to oversee and coordinate the city's PPP program. However, even HCMC has faced challenges in successfully implementing PPP projects. The PPP unit in HCMC currently has eight permanent staff in charge of day-to-day tasks relating to PPP projects in HCMC. When evaluating the pre-FS and FS of health care PPPs, depending on the complexity of the projects, the PPP unit in HCMC collects evaluation opinions from various government agencies at the city level (for example, the DOH, Department of Finance, Department of Natural Resources and Environment, Department of Construction, and Department of Planning and Architecture as well as at the central level (for example, the MOH, MPI, Ministry of Construction). Information is collected by way of sending official letters and project dossiers by post to these agencies. There is no toolkit available for the appraisal of pre-FSs or FSs, and the role of each government agency is also not clearly defined. As a result, it can take one to two months for the government agencies to read the dossiers and provide responses to the PPP unit at the DPI. HCMC's PPP Unit is also responsible for maintaining HCMC's PPP website.

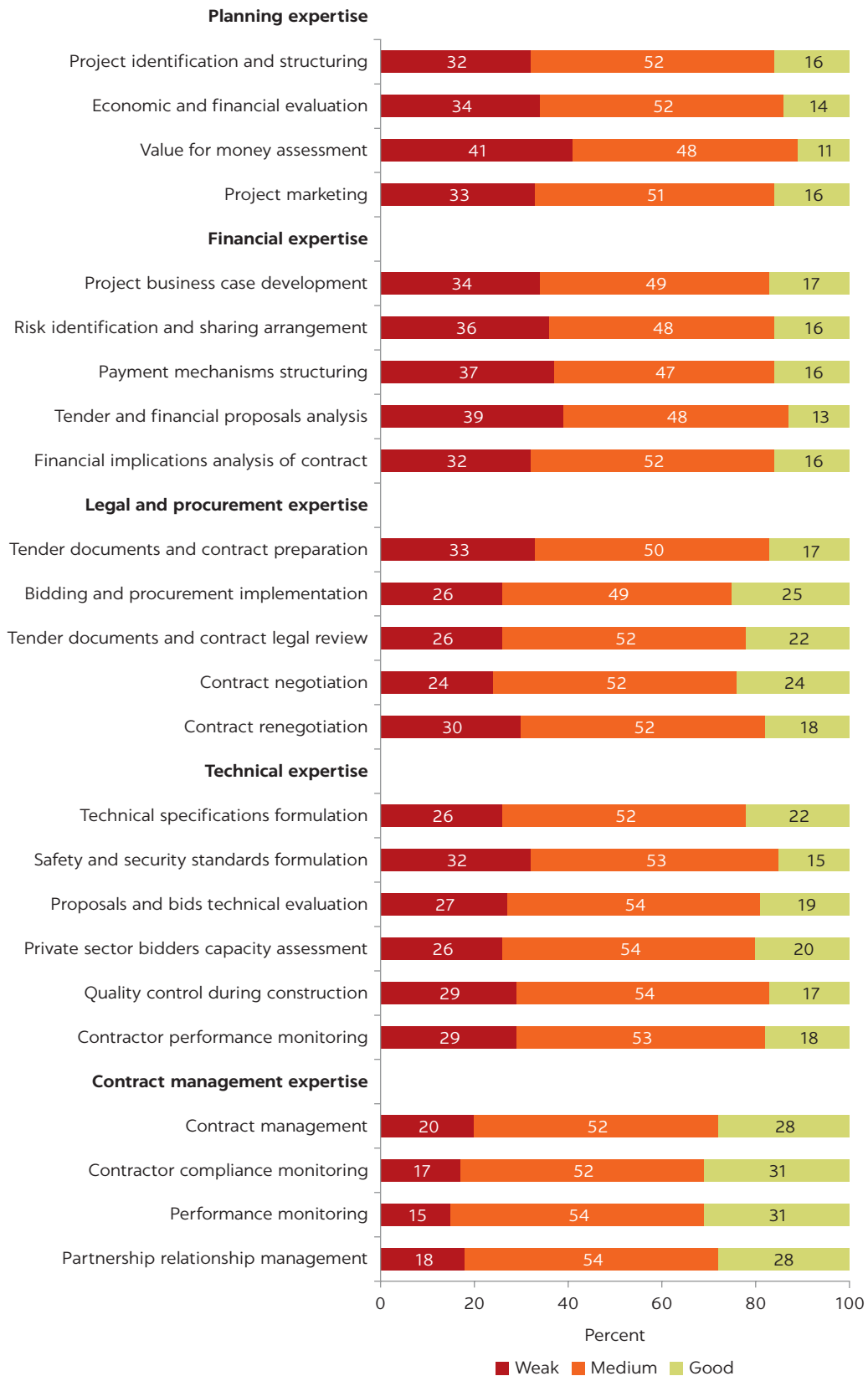
In addition, in May 2017, the Ho Chi Minh People's Committee approved, in principle, the establishment of a Project Development Facility (PDF) to finance the development of PPP projects in HCMC.⁴ The Ho Chi Minh People's Committee assigned Ho Chi Minh City Finance and Investment State-Owned Company (HFIC) to complete the procedure for setting up and managing the PDF with a value of VND 50 billion (about \$2.1 million).⁵ Establishing the PDF has, however, proved to be challenging, with HFIC yet to finalize an organizational structure, reporting mechanism, and policies and procedures around fund management.⁶

Using technical support from many donor agencies, there has also been some effort in Vietnam toward PPP capacity building for local government agencies at a basic and intermediate level. However, the high turnover of key officials responsible for PPP projects has made staff retention challenging and consequently the transfer of knowledge from one cohort of officials to another has been limited. The opportunities for key officials to be engaged in active projects have also been slight, given the meager project PPP pipeline, as described in more detail in the next section.

Competencies within the public sector for health PPP project management

In fact, the most limiting factor in the implementation of health PPPs in Vietnam might not be the weak regulatory framework but the serious shortage of public sector expertise to manage and oversee complex PPP projects. The self-administered survey conducted as part of this study found that the percentage of public health managers who rated their PPP project management competencies as "weak" ranges from 32 percent to 41 percent for planning skills, 32 percent to 39 percent for financial skills, 24 percent to 33 percent for legal and procurement skills, 26 percent to 32 percent for technical skills, and 15 percent to 20 percent for contract management skills (see figure 5.1).

FIGURE 5.1
PPP management competencies within the public health sector



Source: Original figure for this publication, based on public health managers' responses to a self-administered survey conducted in 2019.
 Note: PPP = public-private partnership.

FIGURE 5.2**PPP management competencies between the public health manager groups**

Source: Original figure for this publication, based on public health managers' responses to a self-administered survey conducted in 2019.

Note: PPP = public-private partnership.

The survey also found that the managers of hospitals, centers for disease control, district health centers, and health schools may be less competent in managing PPP projects than managers working at the MOH and provincial or city DOHs, given that the average competency score of health facility managers is significantly lower than that of administrative agency managers (figure 5.2).

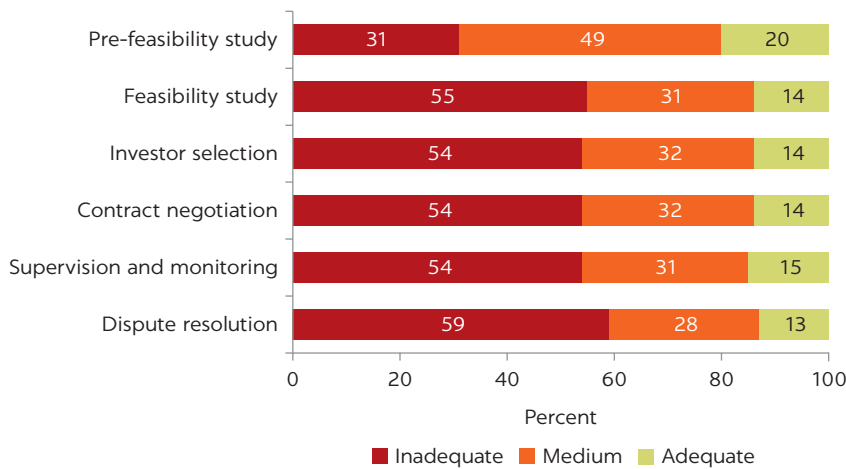
Availability of sectoral resources for PPP project management

In general, public financial support for health care PPP projects is largely absent. Although Decree 63 includes language describing public PPP financing functions, in practice Vietnam does not have a functional PDF, VGF, availability payments, or sovereign guarantees. In 2015, the Asian Development Bank and Agence Française de Développement contributed \$20 million and €8 million, respectively, toward establishing a PDF. The PDF, jointly managed by the MPI and the Ministry of Finance (MOF), was to be used by ministries and project sponsors to fund PPP project preparation activities such as conducting pre-FSSs, conducting FSSs, and engaging transaction advisers to structure deals and bring in the private sector for bidding. The PDF mechanism is designed such that winning bidders must repay the project development and transaction costs to the PDF. However, there is no clear and formal mechanism to apply to the PDF for funding. The PDF is treated as part of the state budget and disbursement applications must be approved by the MPI and the MOF. Because of the complex institutional issues and ambiguity around the disbursement policy, very few projects have accessed or are likely to access the PDF before it is phased out by 2020. There is no equivalent of a PDF at the local level in Vietnam.

In interviews with officials from the MPI and selected DPIs undertaken as part of this study, officials acknowledged that there is no history of applying a VGF under the current PPP decree or its predecessors, given that there is no allocation for VGF funds in the national and local budgets and there is no clear VGF application process.

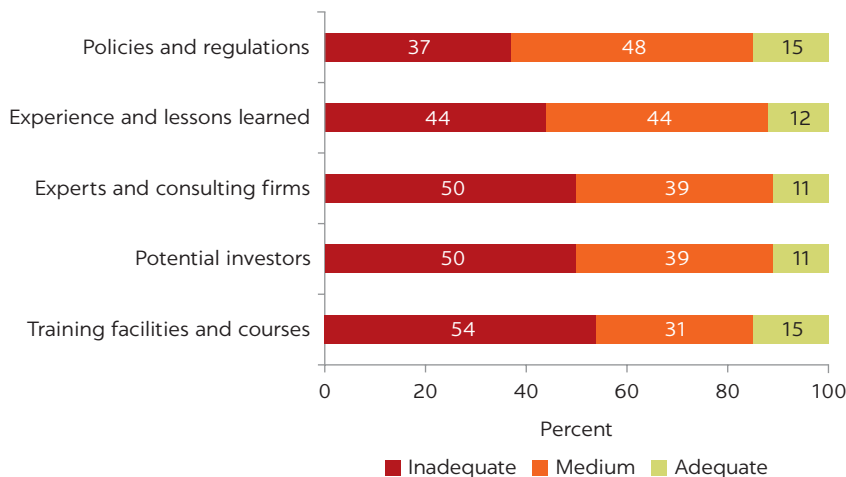
Lack of financing and informational constraints are barriers to effective PPP project management within the sector. The self-administered survey found that half of public health managers described their teams as underfinanced for performing the different steps required throughout the PPP project cycle (figure 5.3). Also, about 50 percent of public health managers reported that they have inadequate information for managing a PPP project (figure 5.4).

FIGURE 5.3
Availability of financial resources



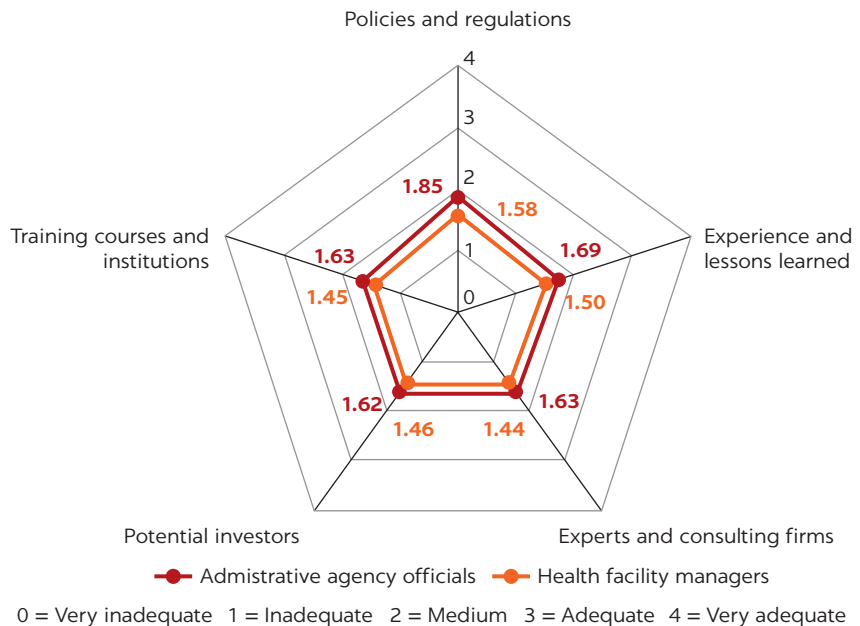
Source: Original figure for this publication, based on public health managers' responses to a self-administered survey conducted in 2019.

FIGURE 5.4
Availability of information



Source: Original figure for this publication, based on public health managers' responses to a self-administered survey conducted in 2019.

FIGURE 5.5
Access to information of health facility managers versus ministries and departments of health



Source: Original figure for this publication, based on public health managers’ responses to a self-administered survey conducted in 2019.

The survey also found that the managers of health facilities may have even less access to information for PPP project management than managers working at the MOH and provincial or city DOHs (figure 5.5).

BARRIERS IN THE PRIVATE SECTOR

In addition to the gaps in the legal, regulatory, and institutional framework, which constrain the private sector’s interest and ability to participate in health care PPPs, there are other barriers that private investors face in Vietnam. The key ones are discussed below.

Lack of skilled health care staff in the private sector

The lack of professionally trained health care human resources in the private sector is a huge impediment to the private sector’s ability to partner with the public sector in health care PPPs, particularly those focused on clinical service delivery. As a result, most public-private enterprise efforts in the health sector in Vietnam have had to rely on the recruitment of public sector providers to staff these facilities. In interviews undertaken for this study, it was not uncommon to hear comments such as, “Most private hospitals want to cooperate with public hospitals to share medical staff resources and patients.” In fact, public sector health care staff are among the assets most valued by the private sector in their public-private enterprises and PPPs. A senior private investor emphasized in a consultative workshop that, “Three major dominant factors to health PPPs are

land, brand-name, and human resources.” This is also illustrated by a comment from another senior private sector investor during interviews conducted for this study, “The public sector has two things to offer: hospital land and highly skilled medical staff.”

However, most medical doctors working in public hospitals belong to the government cadres or are civil servants and their employment is subject to the Law on Cadres and Civil Servants, which offers them job security. In addition to the salaries and bonuses paid by the public sector, public doctors can earn extra income from dual practice, which is still allowed in the Vietnamese health system. These arrangements make it difficult for PPP hospitals to compete. The chief executive officer of a large private hospital corporation who was interviewed for this study pointed out that, “Medical doctors from public hospitals are less likely to work for private hospitals because their income in public hospitals is improved. Large private hospitals like America International and Vinmec must pay high salaries to attract doctors. Even the FV international hospital loses medical doctors.” PPP hospitals also have to compete with international and large private hospitals for skilled medical doctors. As a consequence, health care PPP projects face an acute shortage of medical personnel and some projects have failed for this reason.

When PPP hospitals do succeed in recruiting doctors from the public sector, the quality of health care services in the public hospitals also suffers. This result was brought out starkly in a comment by the head of a major hospital interviewed as part of this study, who pointed out that, “mobilizing resources, especially quality manpower to PPP blocks, will affect the service quality of public hospitals. The only ones that will benefit from a PPP are the rich patients. Most patients will be negatively affected by PPPs because the public resources have to be shared by the public hospital with the PPP.”

Limited participation of large health care chains in health care PPPs

As has been shown, Vietnam has a large number of private sector entities involved in all functions of health care projects, including finance, design, construction, maintenance, operation, and service delivery. The private sector has demonstrated great interest in the development of health infrastructure, and possesses the financial and technical resources necessary to partner effectively with the public sector in health PPP projects. There are also 20 major private health care chains involved in service delivery countrywide, some of which have been established and developed in the course of engagement with the public sector.

It is therefore surprising that the large, domestic health care chains have shown only tepid interest in partnering with the government in PPPs. Many chains do not have any plans for establishing a PPP. Also, several domestic chains have halted co-investment projects with the public sector. Foreign investors and international hospital chains (for example, Clermont Group’s Hoan My Medical Corporation hospital chain and Icon Group) are more interested in the health care PPP market in Vietnam than domestic investors and chains are, but have not yet implemented any health PPP projects. In discussions and interviews undertaken for this study, representatives from health care chains raised a common concern about the lack of transparency and

negative influence of interest groups on decision-making in socialization and PPP projects. Other concerns about health PPP projects include the bureaucracy and the red tape in state agencies and challenges in the valuation of public sector contributions. There is no doubt that the absence of active participation of health care chains, which can offer significant value added in the delivery of clinical and nonclinical services, hampers the establishment and expansion of health care service PPPs in Vietnam.

Absence of government financial support for PPP projects

Because the primary motivation for the government of Vietnam to pursue PPPs is to mobilize financial resources from the private sector (given public sector budget constraints), there is virtually no budgetary support (for example, availability payments and “government-pays” PPP schemes) provided by the government for PPPs, even to subsidize the costs of providing care to the poor. The expectation is that the revenues of health care PPP projects will be collected directly from patients, even if this compromises the access of the poor to these services. Interestingly, of the private sector respondents in the surveys undertaken as part of this study, 65 percent expressed an intent to generate income fully from patients, and 35 percent wanted to also receive income from the government.⁷

In addition to receiving no direct financial support from the government, greenfield hospitals also face a challenge in qualifying to receive payments from social health insurance. Because social health insurance coverage in Vietnam is high,⁸ hospitals without access to insurance payments find it hard to compete with public hospitals that have a large client base of patients covered by health insurance.

Furthermore, the private sector does not seem to have full confidence in government guarantees and other forms of assurance for private investments. In the past, the government of Vietnam provided government guarantees for select power and transportation projects. It is unlikely, however, that government guarantees will be available for health care projects because of the debt ceiling and other government priorities. Without government guarantees on revenue, payments, foreign currency rates, foreign currency availability, and so on, foreign lenders have reservations about taking on the financial risks of health care PPP projects in Vietnam and these risks are not well addressed.⁹ Interviews with the private sector suggest that the key guarantee the private sector is seeking from the government is that the investor’s ownership of assets in Vietnam will be respected and guaranteed by the public sector.¹⁰

BARRIERS IN THE FINANCIAL SECTOR

The total investment in Vietnam’s health care sector from 2016 to 2020, as estimated by the MOH, will be about \$32 billion, accounting for 8.4 percent of total state budget expenditures.¹¹ As noted, PPPs are among the forms of financing, in addition to commercial loans and business cooperation contracts, that the MOH encourages for private investment to develop health care infrastructure. In all the PPP models in Vietnam, except for the Operate and Manage model, the private investor has to finance the PPP project and then collect payment either from the users or the government.

According to the PPP decree, for PPP projects with total investment capital of up to VND 1,500 billion (about \$66 million), the minimum equity requirement for private investors is 20 percent. For projects with total investment capital of more than VND 1,500 billion, the equity of private investors must be at least 20 percent of the capital portion of up to VND 1,500 billion plus at least 10 percent equity for the remaining capital portion exceeding VND 1,500 billion. That means, for most of the health care PPP projects, 80 percent of the investment capital can be sourced as loans from banks or nonbank investors (such as investment funds) to private investors. In other words, intermediary financial organizations such as banks and investment funds play a critical role in the feasibility of PPP projects.

There does not appear to be a shortage of capital in the short or medium term for PPPs, including in the health sector. The main barriers that private investors in PPP projects face in the financial sector are described next.

Duration mismatches limit financial institutions' ability to provide long-term financing

Health care investment projects usually require long-term financing. A duration mismatch between short-term deposits and long-term lending on commercial banks' balance sheets can limit the banks' ability to provide long-term financing to health care projects. Vietnamese commercial banks' medium- and long-term deposits are estimated to be 13–15 percent of their total capital.¹² The medium- and long-term-loans-to-total-capital ratio is estimated to be greater than 30 percent,¹³ meaning short-term deposits are used to fund medium- and long-term loans. Using short-term deposits to finance long-term loans is a duration mismatch and increases liquidity risk.

Since 2018, the limit the State Bank of Vietnam has imposed on the amount that commercial banks can allocate from short-term funding to medium- and long-term loans has been 40 percent.¹⁴ In public draft circulars, the State Bank of Vietnam proposes to further reduce the limit to 35 percent and 30 percent in 2020 and 2021, respectively, to help facilitate compliance with Basel II standards¹⁵ in the future. The limit reduction will further reduce commercial banks' long-term financing capacity for health care PPPs.

Limited availability of project financing in the local capital market

In general, local banks provide loans with an associated mortgage. Revenue-based loans, nonrecourse financing, and limited recourse financing are not common in Vietnam.¹⁶ Loans to infrastructure projects in transportation (specifically highways) and power sectors exist in Vietnam, but these loans require either a government guarantee or a sponsor guarantee, even with an off-take agreement or a minimum revenue agreement. Projects are evaluated based on tangible collateral and guarantees by the government of Vietnam, not on project cash flows. In this regard, a senior official of Vietcombank stated, "Revenue-generating projects with collateral will qualify for market rate finance. We can lend to project sponsors provided the loans are collateralized by corporate assets and/or guaranteed by the government."

However, in Vietnam domestic banks lack capacity to finance infrastructure PPP projects on a nonrecourse basis—a problem that is common in

developing countries with limited PPP experience. Additional issues inhibiting lending by domestic banks on a nonrecourse basis are challenges in assessing the creditworthiness of provincial governments and unclear regulations on the recourse available to banks if the provincial government defaults on its payment obligations (World Bank Vietnam and Ernst and Young 2019).

In many developed countries and emerging market economies, various types of securitization transactions can be used to assist in meeting infrastructure financing needs. However, Vietnam's current laws and regulations do not adequately allow for the use of project revenue bonds and securitization. Therefore, experience to date in using these modern project financing techniques has been limited in Vietnam.

Lack of interest from institutional investors in health care PPP projects, while regulatory hurdles deter other institutional investors

Many institutional investors, such as equity investment funds and venture capital funds in Vietnam and abroad, have expressed strong interest in Vietnam's health care sector given its high growth potential. However, their focus is on private hospitals or on participating in privatization opportunities, and complicated health care PPP projects do not interest them. The situation was explained in the following terms by the Chief Investment Officer of VinaCapital: "It would be easier for a hospital to obtain capital by approaching banks, rather than investment funds, because the conditions and requirements from investment funds are strict. Before investing in any project, an investment fund must agree in advance on an exit strategy, such as a public listing or sale of the shares of the project company. For a hospital, especially a PPP hospital, it is not easy to implement the exit strategy in either way."

Insurance companies, the social security funds, and other pension funds in Vietnam may be interested in investing in health care PPP projects. Most of their capital is invested in low-risk government bonds and bank deposits—frequently up to 85 percent—with remaining capital invested in corporate bonds, equity, and property.¹⁷ However, insurance companies and pension funds are subject to strict legal regulations on their investment activities, and the current regulations limit the ability of these institutions to invest in private projects. There is no limitation on the capital that can be invested by insurance companies in demand deposit accounts with Vietnamese financial institutions. Investments in fixed-income securities, equity, or other property, however, are limited by law and range from 10 percent to 50 percent depending on the type of insurance company.¹⁸ Social security funds and pension funds can invest in demand deposits and government bonds,¹⁹ but investing in other bonds or projects can only proceed under a decision from the prime minister.

In summary, despite the desire of the government of Vietnam to promote PPPs, including in the health sector, as well as factors that could potentially favor their successful implementation, many barriers in the authorizing environment and in the public, private, and financial sectors have constrained the adoption and rapid growth of health care PPPs.

NOTES

1. Prime Minister (2013). Decision No. 122/QĐ-TTg dated January 10, 2013, approving the National People's Health Care Strategy in the 2011–20 period with a vision to 2030.
2. Central Executive Committee of Communist Party (2017). Resolution No. 20-NQ/TW dated October 25, 2017, on enhancing people's health care in the new situation.
3. Ho Chi Minh CPC (2014). Decision No. 1865/QĐ-UBND dated April 16, 2014, approving the city health system development master plan until 2020, vision to 2025.
4. "HCMC to Set up PDF to Develop PPP Project," Vietnambiz (<https://vietnambiz.vn/tp-hcm-lap-quy-pdf-de-phat-trien-cac-du-an-ppp-22719.htm>).
5. Interview with HFIC.
6. "PPP—Challenges to be Overcome?" National Institute for Finance (https://www.mof.gov.vn/webcenter/portal/vclvcstc/r/m/ttsk/dtn/ttskdt_nchitiet?dDocName=UCMTMP122052&_afLoop=75930777366992422#!%40%40%3F_afLoop%3D75930777366992422%26DDocName%3DUCMTMP122052%26_adf.ctrl-state%3D10fuiji3p5_4).
7. Surveys conducted in the World Bank-KPMG joint roundtable workshops in Ha Noi (May 14, 2019) and HCMC (May 22, 2019).
8. By October 2018, social health insurance coverage in Vietnam reached 87.63 percent of the population ("Social health insurance coverage reaches 87.63 percent of the population," <http://tapchibaohiemxahoi.gov.vn/tin-tuc/ty-le-bao-phu-bhyt-dat-87-62-dan-so-ca-nuoc-20189>).
9. Vietnam Business Forum midterm meeting on June 26, 2019.
10. Surveys conducted in the World Bank-KPMG joint roundtable workshops in Ha Noi (May 14, 2019) and HCMC (May 22, 2019).
11. Plan No. 139/KH-BYT dated March 1, 2016, by the MOH on protection, care, and improvement of people's health in the period 2016–20.
12. "Banks enhance long-term capital mobilization" (<https://tbck.vn/ngan-hang-day-manh-huy-dong-von-cac-ky-han-dai-38932.html>).
13. "What percentage of short-term deposit is used for long-term lending in banks" (<http://nfsc.gov.vn/vi/dinh-che-tai-che/cac-ngan-hang-dang-co-ty-le-su-dung-von-ngan-han-cho-vay-trung-dai-han-nhu-the-nao/>).
14. Circular 36/2014/TT-NHNN and Circular 06/2016/TT-NHNN on revision to some articles of Circular 36/2014/TT-NHNN.
15. Basel II is the second of the Basel Accords, which are recommendations on banking laws and regulations issued by the Basel Committee on Banking Supervision.
16. Monitor Consulting, in interviews with Vietcombank, Vietinbank, Maritime Bank, LienVietPostBank, HSBC Vietnam, and Standard Chartered Bank Vietnam under the World Bank project Mobilizing Finance for Infrastructure Development in Vietnam—City Infrastructure Financing Facility.
17. "Vietnamese insurance enterprises invest mainly in bonds and bank deposits" (<http://vneconomy.vn/doanh-nghiep-bao-hiem-viet-chu-yeu-dau-tu-vao-trai-phieu-va-tien-gui-ngan-hang-20180511145030328.htm>).
18. Decree 73/2016/ND-CP of the government dated July 1, 2016, guiding the Law on Insurance Business, Article 62.
19. Decree 30/2016/ND-CP of the government dated April 28, 2016, detailing investment from social security and pension funds.

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6 Conclusions and Recommendations

CONCLUSIONS

This report shows that health care public-private partnerships (PPPs) have been used widely in developed countries as well as in lower-middle-income countries. A PPP contract will usually bundle together multiple project phases or functions, such as design, build, finance, maintain, operate, and deliver services. Depending on the roles and responsibilities that the private sector takes on, health PPPs can be classified into five types: managed equipment services, operation and management services, specialized services, health facility, and integrated PPPs. Each health PPP type has certain advantages and disadvantages, therefore a “one size fits all” approach is unlikely to yield significant economic and health care dividends. It is worth noting that even in mature markets, managing health PPP contracts remains challenging.

In Vietnam, the gap between the need for investment and the capacity of the state to finance it has focused government attention on the mobilization of private resources for public development goals, including through PPP models. Many PPP contracts have been initiated to develop infrastructure in the transport, energy, water, and commercial sectors. The application of PPPs in the health sector, however, is still limited despite several facilitating factors such as the promotion of the socialization of health care activities, deepening of hospital autonomy, expansion of universal health insurance coverage, and the development of health care credit. According to this report’s estimates, 63 projects are in the health PPP project pipeline, of which the majority would deliver hospital infrastructure and services for higher-income groups in urban areas, raising questions about equity and efficiency in public service delivery. The project preparation, appraisal, and approval processes are prolonged. To date, only 18 projects have completed pre-feasibility studies and 10 projects have completed feasibility studies. The procurement process for selecting a private partner is ineffective and not subject to good governance. Out of the eight projects under procurement, four projects awarded contracts directly to the investors and three projects applied competitive bidding but none or only one bidder passed prequalification. Implementation of health care infrastructure and service delivery through PPPs is also modest: out of three signed health PPP contracts, a Build-Own-Operate contract for

development of a 500-bed general hospital was terminated; a Build-Operate-Transfer contract for development of a 200-bed on-demand hospital, while effective since 2014, has been having problems for several years; and a Build-Transfer contract for construction of a public health university has been completed but missed an opportunity for having the private sector share the maintenance responsibility.

Designing and implementing health PPPs in Vietnam is constrained by significant barriers in the legal framework, institutional arrangement, and capacity of both the public and private sectors. Despite recent improvements, the current PPP regulatory framework still lacks key guidelines for screening PPP projects, allocating risks, developing key performance indicators (KPIs), providing government financial support, and managing unsolicited proposals. The health sector also does not have a clear strategy for health PPPs. The current institutional arrangements and public sector capacity are not strong enough to manage complex PPP contracts. Except for three general PPP units within the Ministry of Planning and Investment (MPI), and in the two largest cities, there are no health PPP units at the central and local levels. Even though most government health facilities face financial constraints, health managers lack the competencies and the necessary information to prepare and implement PPP projects. The private sector is competent in infrastructure development but suffers from a shortage of highly skilled clinicians and also lacks the motivation and incentives to deliver public health care services. Although credit for health is plentiful for short- and medium-term purposes, financial institutions have limited ability to provide long-term financing for health PPP projects.

RECOMMENDATIONS

In the current context, caution should be used in adopting health PPP models and contracts. The health PPPs implemented so far in Vietnam suggest that “asset-heavy, service-light” PPP models, such as equipment PPPs and facility PPPs, seem to be the most feasible options. “Asset-light, service-heavy” PPP models, such as specialized service PPPs and integrated PPPs at the primary health care level, are also well suited for selected projects where the private sector may have a competitive advantage, such as for diagnostic services. Vietnam, however, does not yet seem to be ready for a fully integrated hospital PPP model because of various barriers in the existing regulatory framework as well as the capacity mismatch between the public and private sectors. A partially integrated hospital PPP under a co-located, co-branded, and profit-sharing arrangement may be more feasible and commercially viable but would require the government to take measures to mitigate the potential adverse health equity impacts.

Four of the regulated contract types—Build-Lease-Transfer, Build-Transfer-Lease, Build-Operate-Transfer, and Build-Transfer-Operate—are feasible in the health sector. The Build-Lease-Transfer and Build-Transfer-Lease contracts are based on availability payments and are best suited for health projects for which the private sector is not able to assume revenue risks with respect to utilization by patients (for example, in equipment and facility PPPs). Build-Operate-Transfer or Build-Transfer-Operate contracts are well suited for health infrastructure PPPs but might also be applicable for specialized service and integrated PPPs, provided the operational responsibilities and risks are well defined in the contract. The Operate and Manage contract is a potential option for service PPPs, in theory, but has not

yet been applied in Vietnam. The Build-Own-Operate contract is not recommended, given the fact that neither the public nor the private sector is well prepared for such a full transfer of responsibilities and risks to the private sector.

In the long term, the government of Vietnam should reorient health PPPs toward equity and efficiency, two fundamental objectives of the national health system. All potential health care PPP projects should go through a rigorous screening process to ascertain whether they are well suited to universal health coverage (UHC) goals and provide value for money (VfM) under this modality. Only eligible health PPP projects should be included in the health sector development plan and midterm investment plans. On this basis, the government should be able to provide support to health PPP projects—especially those that target underserved populations—to make them financially viable and attractive to private investors. Health PPP contracts should be monitored by KPIs and the private partner should be remunerated based on its performance.

Vietnam is developing a PPP Investment Law, and this is a great opportunity to refine PPP concepts and optimize the processes and procedures for PPP project development. An expansion of the scope of the legal framework is critical to promote PPP engagement in the social sectors, where service delivery is at least as important as the development of sectoral infrastructure. The definition of a PPP in the legal framework should highlight, in particular, the long-term nature of the contracts for service delivery, the importance of optimal sharing of risks and management responsibilities, and the key role of performance-linked payments in fostering effective PPPs. The scope of PPP contracts should not be limited to “build and operate or lease” infrastructure facilities but rather should be expanded to deliver high-quality public services to the population by streamlining non-investment service PPPs that are common in the social sectors. The Build-Transfer contract, which is short term in nature and does not allocate any service delivery responsibility to the private party, should not be considered a PPP contract.

The PPP Investment Law should include a clear description of the purpose and the required content for each phase of the procurement process. The pre-feasibility study should include a qualitative VfM assessment to determine whether the proposed contracting model for the project has the potential to deliver greater VfM than a traditional contracting model. The feasibility study should expand the qualitative VfM exercise to a quantitative VfM analysis, which will assist the assigned state agencies (ASAs) in designing an optimal risk-sharing framework. The feasibility study should contain enough detail to determine the project’s commercial, financial, and technical viability (World Bank Vietnam and Ernst and Young 2019).

Rather than focusing on inputs, PPP contracts should specify the required outputs or desired outcomes and link payments to the project company to the achievement of these outputs and outcomes. This arrangement enables the private partner to be innovative in responding to requirements within the budget constraint and to ensure a minimum level of quality. This performance-based contracting requires a set of KPIs and targets to be monitored by ASAs throughout the project cycle. Contracting agencies should allocate resources and trained staff to monitor the performance of the project company on a monthly or quarterly basis throughout the contract term. More detailed guidance on how to source and prepare studies and contracts should be provided in a supporting decree or circular promulgated by the MPI.

The PPP legal and regulatory framework should set clear requirements on when unsolicited proposals should be allowed, and, where possible, unsolicited proposals

should be subject to a competitive procurement process. The criteria to be applied in assessing whether to take forward an unsolicited project proposal should include the requirements that (1) the unsolicited proposal should propose an innovative or cost-effective service delivery mechanism for an important public priority and (2) the project should not create a monopoly in terms of service provision. Unsolicited proposals should be subjected to the same robust project preparation and management procedures applicable to solicited proposals (World Bank Vietnam and Ernst and Young 2019). If an unsolicited proposal is selected for competitive tendering, the law should address a compensation mechanism for the original sponsor. The advantage of 5 percent given to the original proponent during the “Swiss Challenge” process should be removed. Amendments to the management of unsolicited proposals should be captured in the PPP Investment Law and supporting decrees and circulars by the MPI.

The PPP Investment Law should allow ASAs to provide financial support, including construction subsidies, availability payments, and guarantees. Many health PPP projects that can help attain UHC objectives, including those targeting underserved groups, are often considered unprofitable. Institutional investors will only invest in a commercially feasible PPP project, and banks will only provide credit to a PPP project if the project is financially viable over the concession term. The government should explore mechanisms for providing multiyear financial support to improve the viability and bankability of health PPP projects. In addition to the provision of land and the waiver of tax liabilities, the following options should be considered by the government in financing health PPP projects:

- Provision of concessional loans, such as the investment stimulus fund in Ho Chi Minh City
- Provision of output-based payments or case-based payments, such as the payment per hemodialysis case, by Vietnam Social Security
- Provision of construction subsidies, such as the one in the Republic of Korea, or upfront capital grants, such as the viability gap funding in India and in the Philippines
- Provision of guarantees on minimum revenue or demand, such as the Turkish government’s guarantee for a hospital occupancy rate of at least 70 percent
- Provision of guarantees on the government’s financial liabilities, such as the Indonesian infrastructure guarantee fund or Korea’s infrastructure credit guarantee fund

The PPP Investment Law and related legal documents should also describe in detail the roles and responsibilities of government agencies and ASAs for managing fiscal commitments associated with PPPs. It is recommended that (1) the role of the ASAs should include estimating, accounting, budgeting, monitoring, and reporting fiscal liabilities at their respective project and portfolio levels; and (2) the role of the Ministry of Finance should include monitoring the fiscal liabilities (both direct and contingent) entered into by each ASA as well as monitoring and managing country-level fiscal liabilities. Availability payments should be recognized as a form of long-term debt service upon contract signing. Contingent liabilities should be estimated and accounted for using tools such as the PPP fiscal risk assessment model developed by the World Bank and the International Monetary Fund (World Bank Vietnam and Ernst and Young 2019). Detailed regulations on public financial support, including eligibility criteria,

disbursement mechanism, support to subnational government projects from the central government, and the management of fiscal liabilities, should be developed by the Ministry of Finance in close consultation with the MPI.

The Ministry of Health (MOH) should develop a circular guiding the screening, preparation, implementation, monitoring, and evaluation of health PPP projects in line with equity and efficiency objectives. The key drivers that should be considered for health care PPP screening are the relevance to strategic priorities, including UHC goals; minimum project size; project scope, complexity, and opportunities for risk and responsibility transfer; financial viability of revenue generation and cost predictability; market acceptability; and availability of KPIs for measuring performance. Only health PPP projects that are consistent with the health sector's strategic priorities should be included in the health care network development master plan and midterm investment plans, serving as a basis for private capital mobilization and reimbursements from Vietnam Social Security. Having a credible list of health care PPP projects will send a strong signal that the government is committed to UHC goals and capable of working with the private sector on these initiatives.

The health PPP circular should contain health sector-specific considerations throughout the PPP project cycle, including expected output and outcome standards, principles for allocating risks and responsibilities for nonclinical and clinical service delivery, process-based and patient-oriented KPIs, performance-based payment, and requirements for monitoring and reporting PPP project performance. Uncertainties and the lack of clarity around the health services provided and managed by private companies in partnership with the public sector, such as service pricing, health insurance reimbursement, human resource management, and the procurement of medicines, should be addressed. The institutional arrangements, the assignment of responsibilities, and the allocation of resources for managing health PPP projects should be described for all MOH departments and city and provincial Departments of Health (DOHs).

Institutional arrangements within the health sector for managing public-private engagements (PPEs) and PPPs also need to be strengthened. At the central level, the MOH should establish a dedicated unit within the Department of Planning and Finance to facilitate the preparation, implementation, and monitoring of the PPE program including PPP projects in the health sector. This unit should have qualified staff to perform the following tasks:

- Formulate regulations and guidelines related to health PPEs, including PPPs
- Develop and deliver training courses for public health managers on health PPPs and PPEs and promote and disseminate good practices in health PPP and PPE project management
- Organize PPP-PPE conferences and communication events with the private sector
- Facilitate the creation of a credible health PPP project pipeline at the MOH level by providing central institutions with technical support in PPP suitability screening and health PPP project preparation
- Be involved in the appraisal and selection of private investors, and contract negotiation in health PPP projects managed by the MOH
- Monitor, supervise, and evaluate the performance of PPP and joint venture investment projects in the health sector
- Build a national database on health PPP projects

- Mobilize funds and technical assistance for the implementation of a PPP program
- Coordinate other health PPP-related activities across relevant players

Similar initiatives are required at the provincial and city levels. For example, Ho Chi Minh City DOH could consider establishing a dedicated health PPP task force. Responsibilities of the task force could include, but not be limited to, providing health institutions with training and advisory services on health PPPs and PPEs; involvement in the appraisal of project documents, selection of investors, and contract negotiations; and monitoring, supervising, and evaluating the performance of health PPPs and joint venture investment projects in the city. The Ha Noi city DOH and other city and provincial DOHs with large portfolios of PPP and PPE projects might also consider setting up dedicated task forces to enhance the implementation of health PPPs and PPEs in their domains.

PPP units at the central and provincial levels should estimate and mobilize resources for developing health PPP projects, where appropriate. The up-front costs of project preparation and tendering may be roughly 3–4 percent of investment costs for PPP projects costing less than \$100 million (Farquharson et al. 2011) and are often more expensive in small-scale health PPP projects. Setting up project development funds at the MOH and provincial levels, possibly with donor support, will help in delivering more effective and sustainable health care PPPs. In many jurisdictions, the winning bidders are required to pay back the monies received from the project development fund to bring the project to fruition, thereby making the project development fund self-sufficient. In addition, human and financial resources need to be allocated for contract management throughout the construction phase, the commissioning stage, and the operational stage. Once established, health PPP project management units require a budget to carry out regular monitoring of project performance including patient surveys, to implement the payment arrangements set forth in the contract, and to deal with unexpected changes in the project.

Public health managers should be trained to develop sufficient competencies to prepare and implement health PPPs. The PPP Unit within the MOH should establish a training program to improve the awareness and the health PPP-related competencies of public officials. Countries that have embarked on such training programs have structured them at different levels—introductory, intermediate, and advanced—depending on the responsibilities of the concerned staff. The introductory-level training is for those staff with a general interest in health care PPP programs. Such training provides the trainees with the definition and typologies of PPP, an exposure to global trends and experiences in health care PPPs, an overview of the national regulatory and institutional framework, and identification of major achievements and issues in the implementation of health care PPPs. Intermediate training typically targets public officials who are involved in the preparation and implementation of health PPPs. The typically day-long training provides, in addition to the introductory-level content, the necessary technical understanding for the identification, preparation, procurement, and implementation of a PPP project. The advanced training is typically for PPP practitioners who need to be proficient and highly skilled in managing health PPP projects. The training curriculum typically covers five broad areas of health PPP project management expertise: planning, legal issues, and financial, technical, and project management skills.

Initially, training of trainers should be carried out by experienced health PPP experts and practitioners. For the long-term sustainability of the training

program, the MOH should consider building the capacity of local training institutes to deliver such programs. It is also recommended that key stakeholders from the MOH and the MPI, as well as selected city and provincial DOHs and Departments of Planning and Investment with a healthy pipeline of health care PPPs, undertake internationally recognized PPP certification courses. Popular agencies providing such programs include APMG,¹ Euromoney,² PPP Experts,³ and UNESCAP.⁴ Attending international health care PPP conferences⁵ would also give the Vietnamese participants more extensive exposure to the health PPP projects in different countries.

Further development of the private sector and communication with potential investors both create more opportunities for the public sector to build effective and sustainable partnerships on health care PPP projects. Building capacity within the private health care sector is as important as building public sector management capacity. The government should therefore consider extending its capacity-building activities to private sector practitioners. The MOH, in association with the MPI and City and Provincial People's Committees, could maintain PPP-related websites and host periodic conferences. A website containing health PPP policies and health projects can be an effective tool for keeping the public and the market informed of opportunities in the health sector. Private investors would likely be more interested in health PPP projects if they were fully aware of health PPP policies, see successful health PPP projects under implementation, and can access information on future proposed health PPP projects. Administering the health PPP database requires the government and the MOH to put in place standard procedures for monitoring, reporting, exchanging, and publishing relevant information on PPP projects. PPP-related conferences are also an effective platform for communicating with and educating potential investors, contractors, and other stakeholders on the updated health PPP policies, the existing pipeline of health PPP projects, and the need for financing of such projects. Regular dialogue with the private sector through PPP-related conferences would also provide current and potential investors with a stronger voice in the health care PPP program. Health PPP communications should address the concerns of private sector stakeholders and engage them throughout the process of policy making and project development. The private stakeholders include lenders, equity investors, export credit agencies, contractors and equipment suppliers, and technical, financial, and legal advisers.

Finally, the development of local capital markets can improve the availability of long-term financing for health PPP projects. The government should continue to build the capacity of domestic banks to assess PPP projects and provide financing on a nonrecourse basis. This activity should be accompanied by the necessary legal and regulatory amendments to improve transparency in the financial reporting by provincial governments and provide clarity on the recourse available to banks in the event of default by provincial governments (World Bank Vietnam and Ernst and Young 2019).

NOTES

1. See "The APMG Public-Private Partnerships Certification Program" (<https://ppp-certification.com/>).
2. See "Infrastructure Finance & PPP" (<https://www.euromoney.com/learning/fin174/ppp-project-finance-infrastructure>).

3. See “PPP Training” (<http://ppptraining.uk/>).
4. See “Financing and Private Sector Participation” (<https://www.unescap.org/our-work/transport/financing-and-private-sector-participation/publicprivate-partnership-course>).
5. Such as the PPP Healthcare Summit 2020 (<http://www.ppphealth.com/>).

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ECO-AUDIT

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This book describes the nature of public-private partnerships (PPPs) in the health sector in Vietnam. It defines health-related PPPs, describes their key characteristics, and develops a taxonomy of the different types of PPPs that exist in practice, illustrated by international examples. It also assesses the regulatory and institutional framework for the health PPP program in Vietnam, as well as financing and accountability mechanisms for PPPs at its national and subnational levels. It provides an overview of the PPP project pipeline in Vietnam and analyzes important issues in the health PPPs' design, preparation, and implementation, using eight case studies involving projects in different phases of the project cycle.

This book also examines barriers that have hampered the successful design and implementation of health care PPPs in Vietnam. These barriers may be broadly categorized as barriers in the PPP policy and regulatory framework, in the public sector, in the private sector, and in the financial sector. It proposes feasible and actionable recommendations so that the government can consider tackling the identified barriers and advance the successful design and implementation of health PPPs.