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Report No: 74815-VN

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF (SDR100.1) MILLION

(US$150.0 MILLION EQUIVALENT)

TO THE

SOCIALIST REPUBLIC OF VIETNAM

FOR A

NORTH EAST AND RED RIVER DELTA REGIONS

HEALTH SYSTEM SUPPORT PROJECT

May 1, 2013

Health, Nutrition, and Population Unit
Human Development Sector Department
East Asia and Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective March30, 2013)

Currency Unit	=	Vietnam Dong (VND)
20,925 VND	=	US$1
US$ 1	=	SDR 0.67

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

BP	Bank Procedure	MSA	Medical Services Administration
CAS	Country Assistance Strategy	NCD	Non-communicable diseases
CPMU	Central Project Management Unit	NE	North East
CPS	Country Partnership Strategy	NORRED	North East and Red River Delta Regions Health System Support Project
CQI	Continuous Quality Improvement	OM	Operations Manual
DoH	Department of Health	OOP	Out-of-pocket payment
DPF	Department of Planning and Finance	OP	Operational Policy
EMDP	Ethnic Minority Development Plan	PCRA	Procurement Capacity and Risk Assessment
ESMF	Environmental and Social Management Framework	PDO	Project Development Objective
FM	Financial Management	PPC	Provincial People's Committee
GDP	Gross Domestic Product	PPMU	Provincial Project Management Unit
GoV	Government of Vietnam	PSC	Project Steering Committee
GSO	General Statistics Office	RRD	Red River Delta
HI	Health Insurance	SBV	State Bank of Vietnam
HID	Health Insurance Department	SDR	Special drawing right
HSPI	Health Strategy and Policy Institute	SEDP	Socioeconomic Development Plan
IBRD	International Bank for Reconstruction and Development	TA	Technical Assistance
IDA	International Development Association	TAG	Technical Advisory Group
IEC	Information, Education and Communication	UHC	Universal Health Coverage
M&E	Monitoring and Evaluation	VDIC	Vietnamese Development Information Center
MDGs	Millennium Development Goals	VHLSS	Vietnam Household Living Standards Survey
MMR	Maternal mortality ratio	VND	Vietnamese Dong
MOF	Ministry of Finance	VSS	Vietnam Social Security
MoH	Ministry of Health	WB	World Bank
MPI	Ministry of Planning and Investment		

Regional Vice President:	Axel van Trotsenburg
Country Director:	Victoria Kwakwa
Sector Director:	Xiaoqing Yu
Sector Manager:	Toomas Palu
Task Team Leader:	Kari Hurt

VIETNAM

North East and Red River Delta Regions Health System Support Project

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North East and Red River Delta Regions Health System Support Project (P122629)

PROJECT APPRAISAL DOCUMENT

EAST ASIA AND PACIFIC

EASHH

Report No.: PAD83

Basic Information			
Project ID	Lending Instrument	EA Category	Team Leader
P122629	Investment Project Financing	B - Partial Assessment	Kari L. Hurt
Project Implementation Start Date		Project Implementation End Date	
01-Nov-2013		30-Jun-2019	
Expected Effectiveness Date		Expected Closing Date	
01-Nov-2013		31-Dec-2019	
Joint IFC			
No			
Sector Manager	Sector Director	Country Director	Regional Vice President
Toomas Palu	Xiaoqing Yu	Victoria Kwakwa	Axel van Trotsenburg

Borrower: Socialist Republic of Vietnam			
Responsible Agency: Ministry of Health			
Contact:	Dr. Pham Le Tuan	Title:	Director of Planning and Finance Department
Telephone No.:	(84-4) 3846-4914	Email:	phamtuandr2003@yahoo.com

Project Financing Data(in US$ Million)

[ ]	Loan	[ ]	Grant	[ ]	Other
[X]	Credit	[ ]	Guarantee		

Total Project Cost:	154.00	Total Bank Financing:	150.00
Total Cofinancing:		Financing Gap:	0.00

Financing Source	**Amount**
BORROWER/RECIPIENT	4.00
International Development Association (IDA)	150.00
Total	154.00

Expected Disbursements (in US$ Million)

Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	0000
Annual	0.00	15.00	10.00	12.00	20.00	40.00	45.50	7.50	0.00
Cumulative	0.00	15.00	25.00	37.00	57.00	97.00	142.50	150.00	0.00

Proposed Development Objective(s)

The Project Development Objective is to increase the efficiency and equity in the use of hospital services in selected provinces of the North East and Red River Delta Regions.

Components

Component Name	**Cost (US$ Millions)**
Strengthening capacity of lower-level hospitals to deliver quality services	118.00
Reducing the financial barriers to access by the economically vulnerable	29.00
Project management, monitoring and evaluation	7.00

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change				
Sector (Maximum 5 and total % must equal 100)				
Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	85		
Public Administration, Law, and Justice	Compulsory health finance	15		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes		
Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Human development	Health system performance	100
Total		100

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	**X**	
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**

Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	Recurrent	Due Date	Frequency
Radiation Therapy	**X**		Yearly

Description of Covenant

Eligible expenditures will not include medical equipment for radiation therapy treatment until such time as the Ministry of Health issues the necessary guidelines to pilot the provision of radiation therapy on an outpatient basis and has disclosed an updated ESMF acceptable to IDA as described in Part D.2 Section I of Schedule 2 of the Financing Agreement.

Name	Recurrent	Due Date	Frequency
Implementation	**X**		Yearly

Description of Covenant

The Recipient shall maintain the implementation arrangements as described in Section I of Schedule 2 to the Financing Agreement.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Kari L. Hurt	Senior Operations Officer	Team Lead	EASHH
Anh Thuy Nguyen	Operations Officer	Operations Officer	EASHH
Susanna Hayrapetyan	Senior Health Specialist	Appraisal Stage Peer Reviewer	ECSH1
Agnes Couffinhal	Sr Economist (Health)	Appraisal Stage Peer Reviewer	ECSH1
Miguel-Santiago da Silva Oliveira	Senior Finance Officer	Senior Finance Officer	CTRLN
Martin M. Serrano	Senior Counsel	Senior Counsel	LEGES
Mai Thi Phuong Tran	Financial Management Specialist	Financial Management Specialist	EASFM

Thao Thi Do	Finance Analyst	Finance Analyst	CTRLN
Huong Lan Dao	Health Specialist	Health Specialist	EASHH
Minh Thi Hoang Trinh	Team Assistant	Team Assistant	EACVF
Sabrina Terry	Program Assistant	Program Assistant	EASHD
Sang Minh Le	E T Consultant	Quality Management and Hospital Waste Management	EASHH
Nghi Quy Nguyen	Social Development Specialist	Social Development Specialist	EASVS
Thuy Cam Duong	Environmental Specialist	Environmental Specialist	EASVS
Gerard Martin La Forgia	Lead Health Specialist	Lead Health Specialist	EASHH
Nguyen Hoang Nguyen	Procurement Specialist	Procurement Specialist	EASR2

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Vietnam	Tinh Ninh Binh	Tinh Ninh Binh		X	
Vietnam	Tinh Tuyen Quang	Tinh Tuyen Quang		X	
Vietnam	Tinh Yen Bai	Tinh Yen Bai		X	
Vietnam	Tinh Thai Binh	Tinh Thai Binh		X	
Vietnam	Tinh Hoa Binh	Tinh Hoa Binh		X	
Vietnam	Tinh Lang Son	Tinh Lang Son		X	
Vietnam	Tinh Bac Giang	Tinh Bac Giang		X	
Vietnam	Tinh Thai Nguyen	Tinh Thai Nguyen		X	
Vietnam	Tinh Phu Tho	Tinh Phu Tho		X	
Vietnam	Tinh Nam Dinh	Tinh Nam Dinh		X	
Vietnam	Tinh Ha Nam	Tinh Ha Nam		X	
Vietnam	Tinh Hai Duong	Tinh Hai Duong		X	
Vietnam	Tinh Hung Yen	Tinh Hung Yen		X	

I. STRATEGIC CONTEXT

A. Country Context

1. Vietnam is a densely populated country of about 87 million people which has achieved an impressive record of economic growth and poverty reduction over the last couple of decades. Vietnam is now a lower middle income country with a per capita income of about $1,374 (2011)[1]. GDP had been growing about above 8 percent a year, but has slowed to 5-6 percent in recent years[2]; this is due in part to external factors and structural inefficiencies in the economy. Using a consistent measurement of poverty, the national poverty rate has declined from around 60 percent in 1993 to about 14 percent in 2010.[3] Applying a new definition of poverty based on an updated basic needs package[4], the national poverty rate as measured by the Vietnam General Statistics Office (GSO) and the World Bank is about 20 percent of the population and concentrated among the ethnic minority population, in rural areas, and in smaller cities.

B. Sectoral and Institutional Context

2. Market-oriented reforms to promote high and sustained economic growth were critical to Vietnam's past success, balanced by socially oriented policies in the provision of basic services and access to opportunities for the poor. Over the same period of impressive economic growth, progress has also been substantial in other dimensions of well-being, such as significant improvements in health status, particularly for women and children. Vietnam is largely on track to meet its health-related Millennium Development Goals (MDGs) although there are concerns with respect to fully meeting the targets for reduction in maternal mortality and neonatal mortality. There are also concerns about growing disparities in health outcomes, particularly with the ethnic minority population not seeming to benefit from the progress that Vietnam has achieved. While these basic health challenges remain, there are also new challenges facing the

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[1] Source: World Bank, http://databank.worldbank.org

[2] Ibid

[3] Source: 2012 Poverty Assessment, World Bank. Ministry of Labor and Social Affairs official rural and urban poverty lines (VND 500,000 per person per month and 400,000 per person month, respectively). The Poverty Line was presented in the 2000 Country Economic Memorandum "Attacking Poverty" (World Bank, 2000) and is approximately $1.10 (2005 Purchasing Power Parity (PPP)). It was constructed on the basis of the consumption behavior of the poor in the 1993 Vietnam Household Living Standards Survey (VHLSS) and has been updated for inflation for each subsequent round (every other year) of the VHLSS.

[4] A new poverty line was estimated in 2010 by the General Statistics Office (GSO) and World Bank (referred to as the GSO-WB poverty line) that better reflects living conditions of the poor. The new poverty line is equivalent to $2.25 per person/day (2005 PPP).

country and the health sector specifically. Vietnam is an aging country with the population over the age of 60 growing at the fastest rate. Non-communicable diseases (NCD) account for almost two-thirds of mortality, followed by accident, injury and poisonings (more than 20 percent). One of the foremost challenges is meeting the growing demands of the population for improved social services delivery and safety nets.

3. To address the needs of the population for better access to health services, Vietnam chose the route of a national social health insurance system with the adoption of a law in 2008. Vietnam made the same package of health services not only available for formal sector workers and civil servants who contributed to the insurance system, but it also paid for the coverage of the poor and ethnic minorities living in difficult communes[5]. Children under the age of 6 are covered for free. The state also targeted partial premium subsidies to other vulnerable groups to encourage their voluntary enrollment[6] (near poor – 70 percent, students – 50 percent, and agricultural workers with less than an average income at 30 percent). The state policy of using general revenues to subsidize pro-poor inclusion has continued; in 2012, the government adopted a policy to increase its subsidy to the "near poor" vulnerable group from 50 percent to 70 percent of the premium. There is an estimated 10 percent to 30 percent of the population (varying across provinces) classified as near poor. The near poor are defined to have an average income between 100 percent and 130 percent of the official poverty line. Enrolling the near poor into the health insurance scheme is an important political goal for the government to continue realizing its pro-poor orientation and make a tangible improvement to the well-being of this population group. However, it will still be difficult to enroll any group close to the very low poverty line without a near complete subsidy of the premium; this group is still under the updated measurement of who is poor. Nationally, Vietnam had achieved a commendable 64 percent coverage rate of the population in 2012. It has set a goal to achieve 80 percent coverage by the year 2020. The government Universal Health Coverage Masterplan[7] anticipates a complete subsidy to the near poor in the next few years, depending on the government's fiscal capacity, as one of the strategies for achieving this target.

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[5] A 'difficult commune' is a specific Vietnamese terminology defined as an area targeted for poverty reduction measures as they are poor, remote, and largely comprised of Ethnic Minority.

[6] According to law, the enrollment for these partially subsidized groups becomes mandatory in 2014. However, the enforcement of this provision is not feasible and, therefore, the government will have to resort to other strategies for coverage of these groups.

[7] The Universal Health Coverage Masterplan was approved on March 29, 2013 by the Prime Minister (QD 538/QD-TTg).

4. It is also recognized that in order to scale up demand on health insurance and ensure that those insured remain in the system, the government has to improve the supply of health services, including the availability, financial accessibility and quality of health services. The most prominent and politically taxing issue is the problem with hospital overcrowding. Hospital overcrowding pervades all hospital levels but is rampant at most central and provincial hospitals. It is particularly evident in specialized services at provincial and central hospitals such as oncology, obstetrics, mental health, and pediatrics where supply of specialists is constrained. It appears to occur in all three categories of service: inpatient, outpatient and emergency. Bed occupancy rates are very high even accounting for "actual" beds, which are beds that have been added to "planned" beds on which government subsidies are based. Occupancy rates are especially high in central and provincial specialty hospitals, sometimes 2-3 patients per bed. But less than half of district hospitals suffer from high occupancy rates. Outpatient departments appear quite crowded with long queues in the morning. However, this also appears to be a patient management problem as the departments are empty in the afternoons and patient lines are often not well organized. Less is known about emergency where there has been less observation, but only anecdotal information.

5. Overcrowding of specific inpatient department/specialty areas is also evident. For example, at the central level all departments, both generalist and specialist, demonstrate overcrowded conditions. At the provincial level, high occupancy rates are noted for nearly all specialties but are particularly high for surgery, internal medicine, cardiology, infectious diseases and obstetrics. The MoH reported that in 2010 that 100 percent of cancer, cardiology, trauma and orthopedics central-level hospitals were overcrowded while 70% of obstetrics and gynecology departments as well as pediatrics departments at central hospitals suffered the same fate. At the district level, pediatrics, infectious disease and obstetrics tend to be overcrowded, but variation is high. Nevertheless, according to the same MoH report about 76 percent and 70 percent of provincial and district hospitals respectively suffered from overcrowding.

6. A number of reasons have been forwarded as to the underlying reasons for overcrowding. Although it is difficult to tease out the effects of any one reason, main causes can be categorized as follows: (i) increase in demand because of the aging of the population, increasing NCD morbidity, increased health insurance coverage and general economic development as well as inappropriate use of hospitals for basic health care; (ii) revenue enhancing incentives (and consequent behaviors) resulting from hospital autonomy policy, payment mechanisms and investments in medical equipment for profit in public hospitals; (iii) deficient and low quality supply at lower levels, including the perception of poor quality by users; and (iv) inefficient referral, clinical, and patient flow management. Based on international comparisons, the MoH also considers that limitation in the supply of beds at the central level is the main contributor to

overcrowding.[8] With the available information, it is not clear to what extent the bed supply is a constraint. Certainly, there is agreement that the profit-generating incentives induce hospitals to over-provide services, provide inappropriate care, undermine the referral system and drain scarce human resources from lower levels, and therefore are main drivers of overcrowding.

7. Hospitals essentially have three sources of income. The first is a subsidy from the state determined based on their planned bed numbers. With some exceptions, hospital bed capacities have been fixed at the same number administratively; this has been a decreasing share of the revenue and the state policy is to ultimately phase this source of revenue out for higher level facilities. The second and third sources respectfully are fees for services[9] from the national health insurance system and fees for services from the patients themselves in the form of copayments, additional payments or full payment from the uninsured. These streams of revenue provide the incentives to provide more services, particularly profitable services. Both the under-developed insurance system and the patients are at a disadvantage to evaluate the medical necessity of these services. The cross-sector autonomy policy of government agencies, applied to hospitals, allows for the partial sharing of any revenues exceeding the hospital costs among the staff, as well as provides a source for investments and additional operating revenue. The systems are not yet in place for the government to monitor or hold hospitals accountable for their performance; based on the current arrangements, hospital management is largely motivated to maximize revenue. Higher level hospitals – usually located in urban centers – are placed to take most advantage of this system; they can tap wealthier and insured clients to raise revenues, make additional investments, attract capable staff from lower levels, and ultimately dominate the health care market. This vicious cycle will result in an inequitable, inefficient and unaffordable health system.

8. A major cause contributing to overcrowding is the fact that patients skip lower levels and go straight to higher level for examination and treatment. A recent analysis of a sample of patient records shows a high rate of self-referrals.[10] Self-referral rates at general provincial hospitals is about 42 percent and at general central hospitals it is about 59 percent (to central

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[8] Only about 3% of hospital beds are private and concentrated in the large wealthy cities. There is a private sector, including public doctors with dual practices, but mainly for outpatient consultation services. The health insurance system contracts with the private providers on a limited basis for specialized services.

[9] The Fee Schedule is a very detailed fee structure, including fees based on bed day and medical examinations and procedures. The fee structure framework is set at the national level by the Ministry of Finance and adopted by each Province taking into account its own socio-economic conditions and negotiations with the providers. The health insurance system reimburses for the "cost" of medication procurement of which is decentralized largely to the facility level.

[10] "Hospital Overcrowding and Under-capacity: Issues and solutions", Health Strategy and Policy Institute, 2012.

level hospitals; for the specialist hospitals (pediatrics and obstetrics) this rate is as high as 93.5 percent. The same report provided the reasons for self-referral as expressed by most patients. The answer was trust – trust to provide proper diagnosis and quality of care. This factor accounted for 74.4 percent of self-referral cases in central general hospitals; the same rate is 64.2 percent at provincial level and 59.6 percent at district level. It was an even bigger factor in case of specialist hospitals. In obstetrics hospitals the rate varied between 84.1 percent and 89.7 percent. One of the usual policy instruments to address this is already used, but does not fully address the problem. Vietnam health insurance system already has a built in financial mechanism to dissuade self-referrals with the copayments increasing from 20 percent to 30 percent, 50 percent or 70 percent if there is self-referral to a district, provincial or central hospital respectively. There is no coordination mechanism or incentive for managing referrals between hospitals.

9. The lack of technical capacity of the lower level facilities was one part of the trust equation. In the same analysis of patient referrals mentioned previously, it was estimated that provincial hospitals may not be able to perform about a quarter of the medical functions required of them and in district hospitals the situation could be worse with facilities unable to provide up to a third of the functions according to the government mandate. Human resources are stretched thinly with maybe one or two persons able to perform certain tests, read scans, or do certain procedures.

10. It is also understood that trust in quality of care is more than about the availability of medical equipment and even trained human resources, but also about the systems and processes in place to ensure quality. The Vietnam health sector is just beginning to focus on the improvement of the quality monitoring and assurance practices. As the 2012 Joint Annual Health Review -- which had a particular focus on quality -- pointed out, the MoH and related institutions have developed hundreds if not thousands of technical guidelines, protocols, and patient safety related circulars but there has not been a system in place to monitor, enforce or support implementation. Signs of progress are there. The MoH has recently developed and is about to launch a quality monitoring and benchmarking system focused on improving the patient satisfaction with the overall experience, including waiting times, cleanliness of the facility and attitudes of the health personnel. This is a start to a more comprehensive quality system.

11. The North East (NE) and Red River Delta (RRD) Regions are two quite distinct regions, north of and around Hanoi[11]. Many of the locations are within one day's travel to Hanoi and,

[11] Hanoi is technically part of the Red River Delta Region, but not included in the sector background and analysis as it was excluded from the Project due to its particular circumstances and health system needs.

consequently, quite susceptible for the population to self-refer to Hanoi. The MoH has discussed an approach for developing the health system for both regions. As the RRD is more developed and more densely populated, the Ministry sees the potential for developing higher capacity services that act as a "satellite" of the central level hospitals. With the central level hospitals technical backing and with a sustained strategy of training and capacity development, these satellite facilities would develop a similar branding as the central hospitals and, therefore, inherit some of the trust that comes with that brand. The NE Provinces are less developed, the population more poor, and, as a mountainous region, more remote from Hanoi. The MoH's strategy for developing the health providers in the NE is to provide technical support from the central hospitals to ensure that the hospitals can perform the essential care with better quality and thus reduce the need for the population of this territory to incur the out of pocket expense and opportunity cost of travelling to Hanoi.

12. **Rationale for Bank Involvement**: The sector issues discussed represent a series of market failures in the public health service delivery system. Correcting these failures will take much effort, including changes in the financing system, service delivery organization, policy development, regulation, enforcement and public persuasion. Not addressing these issues will be to the detriment of population, in particular the poor and other vulnerable groups. The Bank has specific previous experience in supporting Vietnam with policy analysis and implementation support to address these challenges. The Bank is able to bring its regional and global experience with similar issues. The investment project will be one important vehicle for providing direct support and will also be an opportunity through which the Bank can engage on the broader set of reforms that should be undertaken to address these important problems. Two other complementary efforts that the government plans to address outside of this investment credit but with Bank support include: (i) changing the provider payment system to make some corrections to the incentives engendered by the current fee-for-service system; and (ii) strengthening the quality of health professionals, particularly focused on the teams providing primary health care. There is also a discussion about measures specifically oriented towards improving the primary health care system, including education of primary health care teams and potentially using a results-oriented financing approach to rebalance the incentives at the primary health care level. Analytical and advisory support is also being provided to improve the performance of the health insurance system and expand the coverage in a fiscally sustainable way. Unlike other development partners which are either strong in providing technical support or in providing financial and technical support in a more specific area, the Bank is in a unique position to provide the breadth of this system development support to Vietnam.

C. Higher Level Objectives to which the Project Contributes

13. One of the three pillars of the World Bank's Vietnam Country Partnership Strategy (CPS) for the period of FY12-FY16 calls for improved "Opportunity".[12] The CPS further defines two areas of engagement under this pillar, one of which is "improved basic infrastructure and public service delivery and access." Through this engagement area the Bank recognized the need to support the government's effort to expand health insurance coverage among the near-poor as well as to improve the delivery of health services. The proposed regional health support operation for the North East and Red River Delta regions (NORRED) was specifically mentioned as one of the indicative instruments for achieving this objective (page 27 of the noted CPS).

14. The CPS further explores two cross cutting priorities of integrating gender into the development strategies and projects, where appropriate, and in strengthening the governance environment through increased institutional capacity, transparency, accountability, participation and anti-corruption. It is recognized that each operation would not be able to address all facets, but the Bank's engagement at a country and sector level should address these priorities. NORRED has integrated gender in its analysis and, in part, in its plan for monitoring and evaluation (M&E) and in the project interventions to be supported. NORRED's support for strengthening the governance environment of the sector is less direct. Mainly, it focuses on supporting the nascent capacities in the area of quality monitoring and improvement. Information on quality of services provided is necessary for improving the management and accountability of the health service providers. The Bank is supporting improvements in the governance environment of the sector more broadly, including through analytical and advisory support. This includes a review of the health insurance system to inform policy dialogue on revising the health insurance law and the governance of the health insurance system as well as technical support to evaluate and produce a roadmap for reforming the provider payment system. The Korean government has also provided the MoH, through the Bank, a grant to analyze and develop proposals to improve the governance of the health service delivery system.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

15. The Project Development Objective (PDO) is to increase the efficiency and equity in the use of hospital services in selected provinces of the NE and RRD regions.

[12] Country Partnership Strategy Document dated November 7, 2011 and Report No. 65200-VN.

16. The PDO will be achieved through two principal means: (i) strengthening the capacity of local hospitals to deliver quality hospital services; and (ii) reducing the financial barriers to accessing health services by the economically vulnerable. Improved efficiency would be achieved when the strengthened capacity enables the provincial and district hospitals to provide a service and not refer patients to higher level facilities as well as to generate a willingness of the population to seek treatment from the local providers rather than to go directly ("self-refer") to the higher level facilities. Improved equity would be achieved through better access of the poor, ethnic minorities living in difficult communes and the near poor to health services. The better access will be facilitated by the inclusion of more near-poor in the health insurance system since insurance status results in more utilization; ability to attain financial protection against catastrophic expenditures by the poor, ethnic minority and near poor; as well as a focus on informing the public, particularly the poor, ethnic minority and near poor, about the benefits and rights under the insurance system.

B. Project Beneficiaries

17. The Project beneficiaries are the 15.1 million people living in the thirteen provinces participating in NORRED. Women and children are prioritized through ensuring that health services required by them in the hospitals are in the list of priority services (ob/gyn and pediatrics) and by extending health insurance to those who are defined as near poor conditional upon family enrollment which would extend the benefit to non-head of households (usually the wife) and children of school age (about 950,000 people). The economically vulnerable (including the poor, near poor, and ethnic minorities living in the difficult communes) would benefit from the protection against catastrophic payments and would have access to life saving treatment. Within the provincial population, those seeking health care at the hospitals that will directly benefit from the Project and their families will benefit from having increased access to services of enhanced quality closer to their homes. Close to one million family members of the near poor households in the provinces will benefit from having an increased access to health services and increased financial protection from catastrophic costs due to coverage under the national insurance system. The medical staff of the health facilities supported under the Project will benefit from increased professional opportunities and skill enhancement. Central hospitals will benefit from having their capacity to provide training to provinces further developed as well as from the reduced inflow of patients from the project provinces for the type of patients supported under the Project.

C. PDO Level Results Indicators

18. The following key indicators will be used to define and measure the progress towards the achievement of the PDO:

(a) Twenty percent reduction in the percent of inpatients referred from the participating provincial hospitals to central level hospitals specifically from the following

departments: (i) cardiology (internal medicine department); (ii) obstetrics/gynecology; (iii) pediatrics; (iv) oncology; and (v) trauma (surgery);

(b) Ten percent reduction in the percent of patients referred from participating district hospitals to provincial hospitals for deliveries, child pneumonia and appendicitis;

(c) Ten percent reduction in the self-referral rate of insured patients from the participating project provinces to the central level hospitals in the five specialty areas supported by the Project; and

(d) At least fifteen percent increase in the use of inpatient (IP) and outpatient (OP) health services by the poor and insured near poor in the local hospitals.

19. A detailed Results Framework including the source of data and definitions are included in Annex 1. It was considered whether and how it would be appropriate to disaggregate the above indicators by gender or ethnicity. The official source of information, however, is the management information system of the Vietnam Social Security (VSS); unfortunately, its information system does not capture information of the gender or ethnic minority of the beneficiaries. Intermediate indicators will use other sources of information that may be disaggregated in ways that would be meaningful. Patient satisfaction surveys could capture gender and ethnic minority status of the patient. The support to the hospitals on the data analysis would include the disaggregating and reporting the variables by important key variables.

III. PROJECT DESCRIPTION

20. The Project will be implemented in thirteen selected provinces of the NE and RRD Regions. The Project's funds would be provided to the participating provinces from the central government on a grant basis. The list and description of the Provinces is referenced in the Project Data Sheet as well as Annex 2. The rationale for the selection of these two regions was in response to the government's request to complete the support towards health system capacity development in the country in the two remaining regions not previously supported by either the Bank or the Asian Development Bank (ADB).[13]The Bank has previously supported three regional operations (in the Mekong, Northern Uplands, and in the Central North provinces).

[13] The Bank initiated the regional health support projects starting with a health system capacity development project in the Mekong region. The Bank has two on-going regional health support projects – one in the Northern Uplands region and one in the Central North region. Later, ADB also supported regional health operations including one in the Central South region and one in the Central Highlands. ADB is currently in discussion about extending more support to the Central Highlands which is one of the poorest and least developed areas of the country.

This would the last of the regional health system support operations planned to be supported by the Bank with the future pipeline focusing on national level policy issues.

21. The thirteen provinces in the Project were determined by (i) focusing on those provinces in the two regions that are net recipients of fiscal transfers from the national government to balance their budgets; and (ii) including only those provinces that did not receive support under the Bank supported Northern Uplands Region Health System Support Project which covered some of the NE region. Besides being in the north of Vietnam, the two regions are quite distinct. The RRD region is more developed, higher than average income, very densely populated and is home to less ethnic minority population whereas the NE is one of the poorer regions, mountainous, about five times less densely populated than the RRD and includes provinces that comprise a large share of ethnic minority population. The proposed Project design is appropriate for the conditions of both regions as it uses a flexible approach – based on the needs, priorities and capacities of the provinces – to vary the specifics on the Project support within an overall framework of the objectives of the MoH.

A. Project Components

22. **Component One: Strengthening the capacity of lower level hospitals to deliver quality services (estimated US$118.0million of which US$116.0 million IDA):** Component One aims to support the implementation of the government's Masterplan on Reducing Hospital Overcrowding[14] through increasing the capacity of the health system to provide more and better quality health services in the project provinces. It would consist of two subcomponents.

(a) Subcomponent 1a - Provincial Subprojects for the Development of Medical Services and Quality Improvement (estimated US$109.0 million of which US$107.0 million IDA). This subcomponent would provide technical and financial support directly to the Provinces to increase their capacity to deliver quality health services at their general provincial hospitals or specialized pediatric or obstetrics and gynecology hospitals as well as at least three district hospitals per province. This subcomponent would be implemented as a virtual "fund" as no amount of the Credit would be explicitly allocated to provinces. Provinces would apply to receive these funds to support the implementation of a subproject proposal. The first part of the proposal would include: a situation and needs analysis for developing the hospital capacity; a defined list of priority health services that the hospitals would be able to perform with Project support and with the sponsorship from central level hospitals which would provide the training and technical supervision; confirmation that the Provinces have the

[14]Master Plan to Reduce Hospital Overcrowding: Decision 92/QD-TTg dated January 9, 2013 signed by the Prime Minister.

basic necessary conditions to provide these services and that the Project support does not duplicate other state or donor investments; and the technical and financial support needs. The second part of the provincial subproject proposals would define specific measurements of quality or management improvement that would be implemented in certain identified areas (at least 5 percent of the IDA investment in the subproject cost). A few key quality and management improvement measures would be required for receipt of support for subproject implementation and others would be optional. The subprojects would largely be implemented by, and the funds would flow through, the provincial Departments of Health (DoHs) and their Provincial Project Management Units (PPMUs). For some large value procurement, the Central Project Management Unit (CPMU) of MoH would be responsible for implementation.

(b) *Subcomponent 1b - National Policy and Central Level Technical Support for Reducing Hospital Overcrowding and Quality Improvement (estimated US$9.0 million of which US$9.0 million IDA).* This subcomponent would support the MoH and the other national level stakeholders to provide quality technical support to the Provinces to achieve the Component goals. This subcomponent would be implemented by the MoH and its CPMU. This would include two Technical Advisory Groups (TAGs) (teams of national experts, including from national institutions and hospitals). The first TAG would support the Provinces in the preparation and implementation of the plan for transferring the knowledge and skills for providing certain medical services and conducting certain medical procedures between the central level hospitals and the hospitals within the province; the second TAG would support the Provinces in the preparation and implementation of a hospital quality and management improvement plan. Particularly in the area of quality improvement and management, the subcomponent would provide technical support to build the capacity of the TAG members and other national counterparts. Because the central hospitals are critical to providing the technical transfer of services to the lower level health facilities, the subcomponent would include direct support to the central hospitals, but only towards the development of their training capacity and their training programs. Finally, the subcomponent would support the MoH in defining national level strategies and sector policies which may be piloted in some of the participating provincial and district hospitals and in conducting research relevant to addressing the hospital overcrowding issue.

23. **Component Two: Reducing the financial barriers to access health services by the economically vulnerable (US$29.0 million of which US$29.0 million IDA).** Component Two aims to support the implementation of the government's Masterplan on Universal Health Coverage (UHC) through reducing the financial barriers to accessing health services, particularly for the poor and near poor. It would achieve this through three subcomponents:

(a) *Subcomponent 2a - Direct subsidy to support the purchase of health insurance by the near poor (estimated US$23.0 million of which US$23.0 million IDA):* Building on the similar and successful examples under the Mekong and Central North Regional Health System Support Projects, this subcomponent would support an additional subsidy of 20 percent of health insurance premiums (on top of the 70 percent subsidized by the state) for the near poor household members, conditional upon whole family enrollment. Those who enroll individually would not receive any support from the project. The support to household enrollment will help increase the coverage more quickly than individual enrollment, improve risk sharing between the healthy and sick and reduce adverse selection when only the sick enroll which are core principles of social health insurance. The support will provide experience and lessons for the MoH which is considering mandatory family enrollment as a national policy. The government has a policy for expanding health insurance coverage particularly for the vulnerable groups. The UHC Masterplan proposes that the government will extend the state support to this group within the project lifetime. As is the common procedure for identifying social program beneficiaries, the near poor, who want to purchase health insurance will be identified each year by the provincial VSS and certified by the provincial Department of Labor, Invalids and Social Affairs. The PPMU will reimburse the provincial VSS for the additional subsidy of the premium on a quarterly basis.

(b) *Subcomponent 2b – Supporting catastrophic health care expenditures at provincial hospitals (US$2.0 million of which US$2.0 million IDA).* As a mitigation measure to ensure that the insured poor, ethnic minority living in difficult communes and near poor have access to some of the services supported under Component One which may be of high cost, the subcomponent would reimburse the health care expenditures above the insurance cap for the eligible beneficiaries for acute health treatment costs until such time as the government program "Health Care Funds for the Poor" effectively provides the same support. The government has issued Decision 14 revising the Decree 139 re-establishing health care funds for the poor; however, the guiding circular for implementation is still under development. Among other things, Decision 14 indicates that the government will support the catastrophic health expenditures experienced by vulnerable groups[15]. Each province will eventually establish its own fund with government budget support and possible mobilization of funds from other sources. This is expected to take more time in the poorer provinces on the NE and Hoa Binh. In the meantime, the program will be managed by the PPMU/DoH to support the high out-of-pocket payment by the poor, ethnic minority

[15] The vulnerable groups defined by Decision 14 is expansive including the poor, ethnic minorities, social assistance beneficiaries, and patients with cancer, dialysis, heart operation and other high cost treatment without ability to pay.

living in difficult communes and near poor patients up to a cap to be defined as part of the Project Operations Manual (OM). Each case will be reviewed and endorsed by the hospital management board of the provincial hospital based on eligibility criteria. The PPMU will provide the reimbursement to the provincial or central hospital (for referred patients) directly on behalf of the patients.

(c) *Sub-component 2c - Information, Education and Communication (IEC) support towards increased and effective health insurance coverage (estimated US$4.0 million of which US$4.0 million IDA).* This sub-component will support IEC activities in the project provinces in order to: (i) promote the understanding of, and enrollment in, the voluntary health insurance scheme by the population, in particular Poor and Near-Poor; (ii) inform the potential beneficiaries of the project about the Insurance Subsidies and Catastrophic Payments; and (iii) raise the awareness of health service providers on actions they can take to reduce barriers to access to health services. Innovative IEC measures are encouraged to effectively target beneficiaries, particularly ethnic minority population. Technical assistance (TA) would be provided in the effective design and implementation of communication activities. The TA would be mobilized by the CPMU. The IEC activities would be implemented directly by the PPMU on behalf of the DoH or through the VSS and the Health IEC Centers (reimbursing the eligible expenditures).

24. **Component Three: Project management, monitoring and evaluation (estimated US$7.0 million of which US$5.0 million IDA):** The aim of this component is to ensure adequate management structure, processes and human resource capacities for the project, and to setup mechanisms for effective monitoring of activities and evaluation of results. Under this component, the project would fund the operation of project management units at the central and provincial levels. In addition to the direct support for the staffing and operations of the CPMU and PPMUs, the component would support the internal and external auditing of the project, monitoring and implementation of activities to ensure compliance with the safeguard policies, as well as M&E of the Project supported activities. Because of the need for significant coordination of the project activities as well as to build the capacity of the PPMUs, the component would support frequent workshops and training related events. Finally, the component would support some targeted capacity building of the responsible project management teams and related Ministerial, VSS and provincial departments.

B. Project Financing

25. **Lending Instrument.** An Investment Project Financing (IPF) instrument was selected because: (i) the project is focused on a specific set of activities and investments; (ii) a IPF is appropriate for ground implementation support between the central government and the provinces and for capacity building of the central government; and (iii) the investments

supported under the Project are not covered comprehensively by a definable government program.

26. **Project Cost and Financing.** The total Project Costs are estimated to be US$154.0 million equivalent of which US$150.0 million (equivalent to Credit amount of SDR 100.1 million) would be financed by IDA and US$4.0 million by the national and provincial governments participating in the Project. The costs by Component are shown below:

Table 1: Project Cost by Components

Project Components	Project cost (US$ Million)	IDA Financing (US$ Million)	IDA Financing (% of Project costs)[16]
1. Strengthening the capacity of lower level hospitals to deliver quality services	118.0	116.0	98
2. Reducing the financial barriers to access health services by the economically vulnerable	29.0	29.0	100
3. Project management, M&E	7.0	5.00	86
Total Baseline Costs	154.0	150.0	97
Physical contingencies			
Price contingencies			
Total Project Costs	154.0	150.0	97

27. Because all of the provinces participating in NORRED receive national government support to fulfill their annual budgets, counterpart funding requirements (estimated US$4.0 million) are low. Counterpart funding requirements would be applied to both the national and provincial implementation levels. It is expected that counterpart funds would be used to finance salary allowances for government staff seconded to the Project in accordance with government norms and regulations, pre-investment expenditures including incremental operating costs, per diems for civil servants participation in trainings and workshops as per government norms and regulations, and initial consulting services including those needed prior to Project approval such as in the preparation of the initial provincial proposals. Other expenditures may include the co-financing of provincial proposals, such as when larger infrastructure is required or when the

[16] The percentage of financing refers to the percent of financing of the total component costs. It does not refer to disbursement percentages of eligible expenditures. For the disbursement percentages refer to the appropriate information in Annex 3 of the PAD.

provinces use their own budget for the education of the needed human resources to develop a health service. These latter investments would depend on the specific proposals of the Provinces in case they decide to mobilize additional funds from the provincial People's Committee to support the subproject objectives.

A. Lessons Learned and Reflected in the Project Design

28. The project design draws heavily upon the lessons learned from the large and on-going Bank supported health program in Vietnam as well as reflections on global experience relevant to Vietnam. This is the fourth regionally focused health system support operation – each having a capacity building component of health providers and a component subsidizing demand -- which provides directly translatable experience for both the Bank and the MoH. The other regional operations have made progress in increasing the technical capacity of lower level hospitals primarily through the education of the staff, upgrading their qualifications, and provision of equipment. However, the projects have been less focused on ensuring that hospitals then provided additional techniques and services. Additionally, there has not been any arrangement for support and supervision from the central level hospitals which could be an important mechanism for both ensuring that skills are transferred as well as help build the trust in the local hospital services. Finally, the ground was not previously prepared to begin with more systematic quality assurance and monitoring mechanisms. The other regional operations have demonstrated the feasibility of using the Project resources to extend health insurance coverage and then transition to other activities as the state policy for premium subsidy was expanded. In addition, the implementation mechanisms for supporting health insurance coverage as well as for operating the health care funds for the poor at the hospitals will smooth implementation.

29. The lessons can be generalized in three areas: (i) overall project design and implementation approach; (ii) investment in the capacity of lower level health systems; and (iii) support for increasing access through insurance coverage. Each of these areas are considered in turn:

(a) *Overall project design and implementation approach:* The close involvement of the Provinces in the project design and the support of the Provincial People's Committee is key; the team responsible for project implementation should be involved in project preparation to ensure continuity and ownership; given the complexity of making changes to project designs during implementation due to Vietnam government procedures, it is important to keep the project design simple and also to build in flexibility; it is a workable design for the provinces to receive financial and technical support through the MoH coordination mechanism, but the attention needs to be paid to ensuring the deadlines for multi-level approval (i.e. by both the MoH and the PPCs) are met and that due attention is provided to the training and technical support needs of the CPMU and PPMU at the beginning of the project; and technical support

from the MoH and supervision by the Bank is enhanced with fewer and geographically concentrated provinces.

(b) *Investments in the capacity of lower level health systems:* decentralized procurement tends to move faster than centralized procurement, but the risk for noncompliance with Bank procedures also increases. Either way, there is a need to include increased capacity and diligence with respect to procurement, particularly for medical technologies including early review and agreement on the majority of technical specifications. The sustainability of the investments requires specific attention and support for proper planning and budgeting. General capacity building in terms of equipment and staff training is sometimes so diffuse that it is hard to determine results. It is better to have a results oriented focus in terms of capacity building, i.e. measured by the technical transfer of a medical service. Improvement in the capacity of providers in terms of education and equipment is insufficient for determining that quality has improved. Quality and management improvement requires direct measurement as well as a focus on the systems and processes of producing the care.

(c) *Increasing access through insurance coverage:* It is not advisable to define a new target beneficiary group for state subsidized health insurance premiums, not already identified through the social security and assistance system. There is little uptake to voluntary or even mandatory partially subsidized health insurance, except for those who are already ill (adverse selection). There can be significant uptake of insurance by the Near Poor and his/her household members with a combined approach to increasing the subsidy; active rather than passive enrollment; intensive supervision and monitoring by the higher level authorities; and support for information and education. Insurance coverage is not the only barrier to access and additional measures are required including more assurance in terms of the quality of care at local levels of the health system, information and education of both the insured population and the providers. There is a need for health policy reform, outside of the investment loan, for more effective universal health coverage including the financial protection of the population and for a more efficient primary health care focused system.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

30. Considering that this will be the final in the series of regionally focused operation, the proposed project management arrangements follow the same structure which has been applied by the MoH to all of its other operations. Looking forward to a future lending program, discussions were initiated with the MoH to look for opportunities to streamline project management structures. Looking at the existing project management units and the needs of NORRED in terms of management structure which should be led by the Department of

Planning and Finance (DPF) and include both the Medical Services Administration and the Health Insurance Department (HID), it was not possible to propose a streamlined structure at this time. However, the MoH has agreed to transfer some of the experienced team members from the Northern Uplands Region Health Support Project who would become available within one year of the NORRED start-up. The details of the project implementation related to the development, approval, implementation and monitoring of the provincial subprojects and related to the defined benefits and beneficiaries and financial management regulations of the health insurance component are detailed in the Operations Manual (OM) which would be maintained and updated as necessary during implementation.

31. **Management Structure.** The MoH will be responsible for the overall execution of the project. As per its common practice, the MoH will establish a Project Steering Committee (PSC) by a decision of the Minister of Health which will largely be a consultation body for discussing issues during project implementation. The PSC will be chaired by the Minister or a designated Vice Minister of Health, and will be composed of various senior managers of the relevant departments of MoH including, but not limited to the Medical Service Administration, HID and the Project Provinces. The MoH will also invite other key stakeholders to serve on the Committee, such as VSS, the Central Hospitals, the Ministry of Finance, Ministry of Planning and Investment and the State Bank of Vietnam. The key position is the Chair of the Steering Committee who will provide for the ultimate approval of the annual project workplans, financial plans and procurement plans. A CPMU has been established by the Minister of Health under the DPF of the MoH to be in charge of the implementation and coordination of the project. The Medical Services Administration would technically be responsible for Component 1 and the Health Insurance Department would technically be responsible for Component 2. A PPMU in each project province under the DoH as well as in Thai Nguyen Central Hospital located in Thai Nguyen Province will be responsible for the day-to-day operation of project activities.

32. Other stakeholders are critical to project implementation. The central hospitals – namely, Bach Mai, Viet Duc, K Hospital, National Pediatrics, and National Obstetrics and Gynecology Hospitals – will contribute technically to the development of the provincial proposals, provide the training and technical supervision support to the provincial and, in part, to the district hospitals. The MoH will provide the central hospitals with some direct support to enhance their training capacity. The Provinces will enter into an agreement (such as a memorandum of understanding) with central hospitals to provide the training and technical support. The provincial hospitals will be the primary beneficiary of the provincial proposals and will be active in the implementation, including planning the technical transfer and the quality and management improvement activities, participating in the procurement, monitoring and reporting. Provincial hospitals will, in part, provide training and technical support to the district hospitals. Provincial hospitals will also implement the Health Care Funds for the Poor and be responsible for management, financial and program reporting. The VSS and the provincial VSS offices will primarily be responsible for expanding the health insurance coverage to the near

poor and providing the necessary reporting documentation to receive reimbursement for the 20 percent premium subsidy. The Information Center of the VSS will provide routine monitoring of the referral, utilization and coverage indicators of the Results Framework.

B. Results Monitoring and Evaluation

33. The project outcomes and results indicators will be measured regularly throughout the project implementation with reference to the baseline values. To the extent possible, the project will rely on existing health information systems and data collection mechanism in the MoH and in provinces in order not to create any unnecessary burden to the current system. For the purposes of regular reporting on the outcome and intermediate results indicators, the data on health insurance coverage and health service utilizations will be collected from the routine reporting system by VSS and health facilities.

34. However, to report on a couple of specific indicators, it will be necessary to design specific data collection tools and conduct independent data collection (e.g. household surveys, patient exit surveys, health facility surveys). The baseline survey for recording patient satisfaction/experience and establishing the level of awareness and understanding of the health insurance and its benefits will be carried out within the first year of the project (as part of the approved 18 month procurement plan).

35. It is also expected that with project interventions on improving health service quality in hospitals and through the provision of training on reporting and coding, the information system of the hospitals will also be improved, thus helping to produce better quality data.

36. The Project Management Unit (PMU) at both central and provincial levels will be responsible for monitoring of project implementation and project results. The CPMU and each PPMU shall assign qualified M&E staff. For baseline, mid-term and end-project surveys, consulting firms shall be hired to complete the task with technical oversight by the CPMU and Bank Task Team. The CPMU will also contract with the Information Center of the VSS to provide regular and timely reports monitoring the progress of the PDO level indicators on referrals and utilization as well as intermediate indicators on health insurance coverage. Household, patient and facility surveys will be contracted out to professional survey firms/organizations as necessary.

37. Under the NORRED, gender impact will be monitored during project implementation to ensure that project beneficiaries are appropriately balanced and to raise gender differences in such important factors as satisfaction with the health services and knowledge of health insurance benefits. Gender disaggregation will be applied from the project supported surveys of household and beneficiaries. In monitoring the project direct beneficiaries (i.e. staff trained or patients benefitting from catastrophic protection) the project will collect and disaggregate the information by gender for monitoring performance. It is noted that the routine information

systems do not support the gender disaggregation which will limit the ability to disaggregate the data when relying on government systems.

C. Sustainability

38. The government continues to increase its investment in the health system, raising health spending faster than the growth of general budget revenues. This is appropriate for the near term and particularly for strategies that replace the large (about 50 percent) out of pocket spending by the population. Several policy decisions – such as expanding the state subsidy of the health insurance premium for the near poor from 50 percent to 70 percent and re-establishing the health care funds for the poor to pay for other direct out of pocket costs of seeking care -- have been adopted towards improving financial protection, particularly of the most vulnerable. Other policy decisions have supported improving the accessibility and quality of health services – such as investing in the technical transfer of services through staff rotation policies or through direct support in establishing satellite hospital departments and by adopting a set of quality indicators to be monitored. These decisions indicate that the MoH is committed to the project's objectives and will ensure its long-run sustainability.

39. The project would subsidize the cost of social health insurance for the near poor, and in doing so, help the government to increase the demand on health insurance among this target group. The enrollment would also be conditional upon family enrollment, bringing younger and probably less sick household members into the system. This project intervention will help the government better understand the option of mandatory family enrollment and its potential benefits of bringing in younger and non-sick members of households into the health insurance system.

40. The Project design, focusing on the technical transfer of know-how as opposed to general educational and degree attainment, supports a sustainable approach to improved quality of the staff skills. Official physician salaries are largely based on the level of education attained and seniority. These skill transfers are not likely to result in automatic upgrades in the salary structure of the hospital.

41. The maintenance costs of the capital investments at the provincial and district hospitals are not insignificant. However, the project support will directly translate into new services that the hospitals can offer. These services are likely to be revenue enhancing assuming that they are of higher complexity and price than other services. Increased hospital responsibility for maintenance is also entirely in line with the current trend of increasing hospital autonomy. The project will provide training as well as technical support in the maintenance of medical equipment and facilities as well in the development of appropriate budgets and strategies for facility maintenance.

V. KEY RISKS AND MITIGATION MEASURES

A. Risk Ratings Summary Table

Table 2: Risk Ratings Summary Table

Stakeholder Risk	**Low**
Implementing Agency Risk	
- Capacity	**Substantial**
- Governance	**Substantial**
Project Risk	
- Design	**Substantial**
- Social and Environmental	**Moderate**
- Program and Donor	**Low**
- Delivery Monitoring and Sustainability	**Moderate**
Overall Implementation Risk	**Substantial**

B. Overall Risk Rating Explanation

42. **The Overall Risk Rating is proposed as "Substantial".** The Project is closely aligned with the priorities of the MoH and the needs of the provinces for good ownership. This would be the fourth regional health support operation implemented by the Ministry, although each operation includes some different elements and although the Ministry establishes separate project management teams for each of its operations. The majority of the DoHs in the provinces have not been actively involved in previous Bank or other large development operations. Based on this, a number of the areas have been rated as a Substantial Risk. Mitigation measures have been identified to be implemented as part of implementation.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analyses[17]

43. As is the case with most health sector projects, no attempt has been made to quantitatively estimate the net present value of benefits resulting from the project through cost-benefit analysis. Not only is it difficult to assign a monetary value to expected improvements in

[17]In this project, appraisal was completed prior to April 8, 2013 when the new Economic Analysis Guidelines were to be applied.

health outcomes, it is also difficult to reliably estimate the impact of the project's investments in equipment and training on health outcomes. Instead of doing a cost-benefit analysis, the economic analysis sought to establish the economic case for the project's investments by presenting the mechanisms through which cost savings will be achieved, and by setting out the potential benefits in terms of improved health outcomes and equity.

44. The project is expected to result in cost savings in the health sector because it will address inefficiencies both in the production and consumption of health services. In turn, the cost savings will generate additional resources for the sector as a whole. The economic justification for the program is also driven by public finance criteria for public investments. Government involvement in public financing of services is typically justified when market failures exist. A primary objective of the Project is to reduce the referral and self-referral rates (due to increased trust) to higher level facilities when it is unnecessary which adds cost to the system, to the patient as well as the opportunity cost in terms of the use of the resources. The project, by improving access through health insurance is improving equity through significantly improving the risk-pooling among the near poor.

45. The fiscal impact of the specific activities included in the project hinge largely on the costs arising from them to the government. There are two types of government expenditures that will be incurred during the lifetime of the project: direct government outlays towards subsidizing health insurance for the near poor and providing funds for catastrophic cases; and the incremental recurrent costs arising out of the project's investments. The analysis of the fiscal impact shows that the incremental recurrent costs of the project are relatively low at around 3.5 percent of the total health budget of the NE and RRD Regions. An upper bound estimate is 5 percent.

46. The fiscal impact of the government subsidy accounting for 70 percent of the health insurance premiums, which the Project will leverage, is much greater under the high take-up scenario whereby 95 percent of the near poor are covered by 2018. Under this scenario, up to 10.55 percent of the NE and RRD Provinces budget will be spent on this subsidy. Under the government's more conservative scenario of 50 percent coverage, up to 5.5 percent of the region's budget will be spent on subsidy. Under the fiscal space projections and given the social protection benefit, this is considered acceptable to the government which is willing to consider expansion of its support 100 percent of the premium according to the UHC Masterplan within the lifetime of the Project.

B. Technical

47. The project seeks to achieve its objectives by a combination of demand and supply side measures in order to ensure a balanced approach by increasing the capacity and providing a means for greater access to those who might not otherwise be able to afford the service. The project fits well with the government's strategy: (a) to address central hospital overcrowding

through building the capacity of lower level health services to provide quality care; (b) to prioritize the expansion of coverage and in particular targeting the near poor; (c) to strengthen provincial health systems through regionally targeted programs; (d) to address those basic supply side-constraints, i.e. quality of care and competency of the doctor, that also have impact on the demand of health services thereby creating a synergistic effect; and (e) specifically, to address priority services to reduce the referral rates to the central hospitals in Hanoi.

48. The project's focus on near poor is warranted by the fact that this group of economically disadvantaged population seems to be under the greatest risk. Women and children are a focus through the medical services that are identified as being supported (obstetrics/gynecology, pediatrics at both the provincial and district level) and through the requirement that the near poor insurance premium subsidy be extended to the entire household that will bring in the spouses and school-age children.

49. The project's design builds on the lessons learned in other regional operations in Vietnam (Mekong, Northern Uplands, Central North, Hospital Waste Management, etc.) and also on international experience. This reduces the technical risks associated with the project design and increases the effectiveness of proposed mitigation measures.

50. The PDO and results indicators are focused on one facet of the complex issue of hospital overcrowding. It is recognized that additional measures are necessary outside of this Project intervention to materially address the rates of hospital occupancy, include payment reform, hospital autonomy and governance incentives, and rebalance the supply of health services towards a more comprehensive and quality primary health care system. The Bank has a program of support addressing these other priority areas.

C. Financial Management

51. The CPMU established by MoH will play the leading role on Financial Management (FM). The FM function in provinces will be performed by the existing FM units of the provincial Departments of Health (DoH). These existing FM units will form part of the Provincial Project Management Units (PPMUs) to be established. As the CPMU was not established until shortly before negotiations and the PPMUs have not yet been established, the Bank carried out the FM Capacity and Risk assessment based on the capacity assessment of the MoH and related DoH[18]. The FM functions of the MoH/DPF and the DoH meet the Bank's

[18] Since the provinces have not previously been involved in a Bank supported operation, a capacity assessment of the DoHs was conducted based on the information provided on the FM questionnaires completed from a sample of five DoHs of Nam Dinh, Ninh Binh, Yen Bai, Bac Giang, Hung Yen and Lang Son, and field visits to Nam Dinh, Ninh Binh, Yen Bai and Lang Son. The centralized health system provides similar institutional and financial management arrangments among all the provincial DoH's.

minimum FM requirements. The action plan agreed with MoH to strengthen both central and provincial levels includes: (i) financial management section of the Project Operations Manual; (ii) qualified staff with adequate training on Bank's procedures; and (iii) internal audit function.

52. Funds will be channeled through the Designated Account (DA) and provincial project accounts opened at commercial banks. This design was agreed with MoH and the provinces to overcome the current limitations of the country system fund flow. There would be one segregated DA denominated in US dollars maintained by CPMU for the whole project. Each of the 13 provinces and Thai Nguyen Central Hospital will maintain a project account in VND at a commercial bank in the province to receive funds from the DA for the activities to be implemented by each Province.

53. All provinces would have to prepare project financial statements on an annual basis. There will be a single auditor, hired by MoH CPMU. MoH CPMU will consolidate all provincial financial statements with the CPMU's to be one project financial statements, to be audited and submitted to the Bank annually within 6 months after the year end. Interim Financial Reporting (IFR) would be done on a quarterly basis. Because of the high decentralization of the Project and weak capacity of the implementing agencies, internal audit function is required at both central and provincial level. The readiness of MoH for this function is low; therefore an outsourced internal audit function has been agreed. More details on FM capacity and arrangements are available in Annex 3.

D. Procurement

54. The CPMU, the PPMUs to be established under DoHs of 13 participating provinces and the PPMU of Thai Nguyen Central Hospital will be responsible for procurement under the proposed project. The MoH is familiar with the Bank's procurement rules and procedures. The large risks come from the newness of the provincial DoHs. As CPMU was established prior to negotiations and PPMUs will only be established following Board approval; therefore, the Bank carried out procurement capacity and risk assessment (PCRA) based on capacity assessment of related provincial DoHs. The PCRA revealed that the procurement management capability at the local levels is relatively weak as the majority of provinces lack prior experience in implementing Bank-financed projects and are unfamiliar with the Bank's procurement rules and procedures. The assessment identified some risks that may cause procurement delays or inappropriate procurement decisions. These risks and the recommended mitigation measures are presented in Annex 3.

55. Procurement for the proposed project will be carried out in accordance with the Bank's "Guidelines: Procurement of Goods and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 ("Procurement Guidelines"), and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 ("Consultant Guidelines"). The

draft Procurement Plan for the first 18 months implementing the proposed project was agreed during negotiations.

E. Social (including Safeguards)

56. The Bank's safeguard policy on Indigenous Peoples (OP 4.10) is triggered because of the presence of ethnic minority groups in the project area. The percentage of ethnic minority people in total population is different across project provinces, ranging from 2.6 percent in Ninh Binh to 83.1 percent in Lang Son. The main and largest ethnic groups living in the project provinces include: Thai, Tay, Muong, Nung, Hmong, Dao, San Chay and San Diu. It is expected that the project will help to reduce the financial barriers to access by the economically vulnerable with a focus (including ethnic minority groups) on (i) administering the subsidy for the near poor health insurance premium subject to family enrollment (the subsidy payment) and (ii) the information and education communication activities related to the health insurance, calling on the uncovered to seek health insurance coverage and providing relevant benefits information to those who are covered.

57. In line with OP 4.10, a Social Assessment was done to identify and characterize key stakeholders in terms of their importance to and influence over the project objectives and implementation; to identify potential barriers (cultural, institutional, financial, language etc.) for ethnic minority communities in the project area to access the project benefits and services; and to document the 'broad community support' toward the project's activities and define the processes for ensuring the consultation and participation of these stakeholders (especially ethnic minority communities) in project design, implementation, and monitoring and feedback.

58. Based on the findings of social assessment, an Ethnic Minority Development Plan (EMDP) was developed for the project. The EMDP was disclosed in Vietnamese at the Vietnamese Development Information Center (VDIC) and at the MoH website on January 2, 2013 and disclosed in English at the VDIC and the Bank's Infoshop on January 22, 2013. The mechanisms for ensuring culturally appropriate intervention and equal access to project benefits are addressed in the operational manual and in the EMDP.

59. The Bank's policy on Involuntary Resettlement (OP 4.12) is not triggered because the project will not result in any land acquisition and physical or economic displacement of people. All minor civil works (under Component One) will take place within the existing land boundaries.

60. Due attention was paid to the health concerns and the health seeking behavior of women. A summary of key information is presented in Box 1. The ways in which the project addresses these issue include the specialty areas covered by the project (including obstetrics/gynecology and pediatrics), the aim of the project to bring health services closer to the community and home, and the explict approach of expanding to health insurance to the near poor on the basis of

household enrollment that would, in particular, bring more women and school age children into the system. Where possible the project results would be disaggregated by gender as well as ethnic minority status; however, there are limitations with respect to the ability to do this when using administrative data that does not collect this information.

Box 1: Health status and health care seeking behavior and gender

Available data in Vietnam showed that women tend to have higher self-reported illness than the men do, thus may have higher needs for health care. When measuring other health outcomes in children, i.e. morbidity, mortality, and nutrition status, no significant difference between male and female is found.

However, there is an emerging serious imbalance of sex ratio at birth, which is now 110.6/100 for male and female, far above the natural ratio of 106/100.This is a possible consequence of the prenatal sex selection of the family stemming from a combination of the Confucius custom of boy preference and the advancement of high technology of fetus screening. The government has strong policy which places prenatal sex selection as an illegal behavior for both health workers and families. In practice, however, there is no clear mechanism effectively identify and fine the behavior, and the imbalance keeps increasing in recent years, especially in the Red River Delta Region.

There is no gender difference on health insurance coverage in Vietnam with equal share of 49% and 51% for men and women, respectively (VHLSS 2010). In terms of health care service utilization, women had higher mean of utilization during the last 12 months than men did (1.47 vs. 1.06), as a proper reflection of higher reported needs of health care among women (VHLSS 2010).

Maternal mortality ratio (MMR) is the most important indicator for measuring the impact of interventions in achieving MDG5. The target for Vietnam is to reduce the maternal mortality ratio (MMR) from 233/100,000 in 1990 to 58.3/100,000 in 2015 and the country has shown some progress in achieving this target. The 2009 Census showed that the MMR was 69/100,000 in 2009, so in order to achieve the MDG5 target, the average annual decline of MMR between 2009 and 2015 should be 1.7/100,000. However, there was barely any change in MMR during 2006–2009, thereby suggesting that Viet Nam will need to exert greater efforts for ensuring quality services, including family planning and prevention of unwanted pregnancies, improved quality of obstetrics and gynecology services in order to achieve MDG5 by 2015. More importantly, the inequality of MMR is evident; available data showed that MMR was twice the national average in the 225 difficult districts (104/100,000) and 5 times the national average in the 62 poorest districts (157/100,000); and the disparity between urban and rural areas was from 2.5 to 3 times. Further analyses by other attributes showed disparity of MMR by education level, ethnicity and occupation. The MMR among illiterate people was 4–6 times higher than that among literate people. The MMR among ethnic minorities (H'Mong, Thai, Ba Na, Tay, Dao and Nung) is 4 times higher than that for the Kinh group. The MMR among farmers and agricultural workers is 4–6 times higher than that among civil workers.

F. Environment (including Safeguards)

61. The project triggers the Bank's safeguard policy on Environmental Assessment (OP/BP 4.01) due to the potential adverse environmental impacts associated with the activities of medical equipment purchase and minor civil work for provincial/district level hospitals under the project subcomponent 1a. These activities are included in the subprojects of participating provinces. The key negative potential impacts during rehabilitation of district/provincial hospitals include the generation of dust, noise, solid waste, wastewater, local flooding and safety issues at a low level and in short-term period. The generation of healthcare/hospital waste is the main, long-term impact during the operation of beneficiary hospitals. So far, the project support for radiation therapy equipment is still being considered until such time as the MoH has issued guidelines to pilot the provision of radiation therapy treatment on a primarily outpatient, as opposed to inpatient, basis. In the case that the radiation therapy equipment is financed, there will be a potentially significant health risk relating to the exposure to ionizing radiation during the operation of this equipment. Currently, the project's potential adverse environmental impacts are expected to be localized, able to be mitigated and manageable through good design, good management practices and close monitoring during implementation and operation. Therefore, the project is not expected to have significant adverse environmental impacts and is classified as a category B project.

62. As part of the project preparation, an Environmental and Social Management Framework (ESMF) has been developed by the MoH to ensure that the project activities shall be in compliance with the World Bank's safeguard policies and national regulations on environmental assessment and management. The ESMF is in accordance with the national environmental management regulations as well as the Bank's safeguards policies and requirements on public consultation and information disclosure. The ESMF was disclosed in Vietnamese at the Vietnam Development Information Center (VDIC) and at the MoH website on January 21, 2013 and disclosed in English at the VDIC and the Bank's Infoshop on January 23, 2013. The project Central PMU (CPMU) under MoH, provincial PMUs (PPMUs) under DoH of participating provinces and beneficiary hospitals are the key actors responsible for safeguard implementation of the project. More details on environmental assessment, ESMF content, public consultation and information disclosure are described in Annex 3.

ANNEX 1: RESULTS FRAMEWORK AND MONITORING

Vietnam: North East and Red River Delta Regions Health System Support Project (P122629)

Project Development Objective

The Project Development Objective is to increase the efficiency and equity in the use of hospital services in selected provinces of the North East and Red River Delta Regions.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline 2012	Cumulative Target Values						Frequency	Data Source/ Metho-dology	Responsibility for Data Collection
				YR1 2014	YR2 2015	YR3 2016	YR4 2017	YR5 2018	End Target 2019			
Twenty percent reduction in the percent of patients referred from provincial to central level hospitals in five intervention areas.	☐	Percentage	64.80			58.00			52.00	Annually and progress expected starting from 2016 (year 3)	VSS statistics	Central Project Management Unit responsible for collection and verification of information.
Ten percent reduction in the percent of patients referred for deliveries, child pneumonia and appendicitis from district hospitals to provincial hospitals	☐	Percentage	6.00*			5.5			4.00	Annually and progress expected starting in 2016 (year 3)	VSS and provincial VSS statistics	PPMUs - primary responsibility; CPMU - collection, summary analysis and quality assurance

Ten percent improvement in the self-referral rate by insured patients from the participating project provinces to Central Hospitals in five intervention areas	☐	Percentage	10.00			9.40			8.00	Annually and progress expected starting in Year 4 (2017) of the Project	VSS statistics	Central Project Management Unit responsible for collection and verification of information.
At least fifteen percent increase in the use of inpatient (IP) and outpatient (OP) health services by the poor and insured near poor in the local hospitals.	☐	Text	0.08 (IP) 0.94 (OP)			0.09 (IP) 1.00 (OP)			0.10 (IP) 1.12 (OP)	Annually and from Year 3	VSS statistics	Central Project Management Unit responsible for collection and verification of information

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline 2012	Cumulative Target Values						Frequency	Data Source/ Metho-dology	Responsibility for Data Collection
				YR1 2014	YR2 2015	YR3 2016	YR4 2017	YR5 2018	End Target 2019			
Number of new technical services is transferred from central to provincial hospitals and district hospitals	☐	Number	0.00			440.0			2200.00	Annually starting in Year 3 of the Project	Hospital reports	PPMUs - primary responsible for collecting information and quality assurance from the hospitals; CPMU - responsible for collecting information from

												Provinces, analyzing information and quality assurance.
Increase in the percent of project hospitals implementing Continuous Quality Improvement (CQI) program	☐	Percentage	0.00			25.0			75.00	Annually starting from Year 2	PPMU and CPMU reporting	PPMU is responsible for collecting from the hospitals; and CPMU is responsibility collecting and preparing summary analysis from PPMUs.
Health facilities constructed, renovated, and/or equipped (number)	☒	Number	0.00			15.0			57.00	Annually starting from Year 2	PPMU and CPMU reporting	PPMU is responsible for collecting from the hospitals; and CPMU is responsible for collecting and preparing summary analysis from PPMUs
Health personnel receiving training (number)	☒	Number	0.00			800			4050.00	Annually	Project Progress Reporting broken down by type of training,	PPMUs by Province and CPMU at the Center and in Aggregate

											gender, EM status, and province	
At least seventy percent near poor have health insurance	☐	Percentage	3.50			35.0			70.00	Annually	VSS/Health Insurance Department	PPMU by Province and CPMU coordinating with the PPMU, VSS and HID and providing summary analysis
Increase of patient satisfied with (a) the overall quality of care, (b) reduction of waiting time, and (c) availability of services and diagnostic facilities at provincial and district hospitals	☐	Percentage	(a)-(c) 50.00*						(a)-(c) 63.00	Reported annually beginning in Year 3 of the Project	Hospitals administered patient exit surveys	PPMUs for ensuring that hospitals administer the standardized patient surveys timely basis and in an appropriate methodology
People with access to a basic package of health, nutrition, or reproductive health services (number)	☒	Number	9,969,522			10,395,472			10,882,272	Annually	VSS, Provincial VSS reports. The data refers to the Health insurance	PPMUs, CPMU

											coverage in the project provinces.	
Increase in the knowledge on health insurance (a) benefit package; (b) rights and responsibility; and (c) operation mechanism among near poor people	☐	Percentage	15.00 (a) – (c)*			At least 25.00 (a) – (c)			At least 50.00 (a) – (c)	Baseline, mid-term and end-project	Household survey	Consultants hired by CPMU
Complete and Timely Project reporting, including Progress Reports, Monitoring and Evaluation Updates, Year 1, Midterm and End of Project surveys, Annual Plans	☐	Text	Not applicable			Satisfactory Assessment			Satisfactory assessment	Each semester	Project Reports	by Province by PPMU and centrally and consolidated by CPMU

*baseline established based on value in different, but similar regions. Baseline to be updated during Year 1 of the operation specific for the 13 participating provinces. The percentage change will remain valid. Therefore, the end target may be adjusted accordingly.

Results Framework Definitions

Project Development Objective Indicators	
Indicator Name	Description (indicator definition etc.)
Twenty percent reduction in the percent of patients referred from provincial to central level hospitals in five intervention areas.	# of referred cases /# of total cases. The indicator will be reported by Province and then weighted average by the Project territory
Ten percent reduction in the percent of patients referred for deliveries, child pneumonia and appendicitis from district hospitals to provincial hospitals	# of referred cases /#of total cases referred by district to provincial hospitals in one year. The indicator will be reported by Province and then weighted average by the Project territory
Ten percent improvement in the self-referral rate by insured patients from the participating project provinces to Central Hospitals in the five intervention areas	# of patients by-passing provincial hospitals in five intervention areas / # of total cases in the five intervention areas
At least fifteen percent increase in the use of inpatient and outpatient health services by the poor and insured near poor in the local hospitals.	# insured inpatient (and outpatient) poor (and near poor)/total number of insured poor (and near poor) in the provincial and district hospitals. Data will be collected from VSS.

Intermediate Results Indicators	
Indicator Name	Description (indicator definition etc.)
Number of new technical services is transferred from central to provincial hospitals and district hospitals	Number of new technical services successfully transferred from central to provincial levels and from provincial to district levels. The successful service is identified as being approved by the higher technical level and provincial Health Bureau, and certified by the provincial VSS for reimbursement
Increase in the percent of project hospitals implementing Continuous Quality Improvement (CQI) program	# of hospitals implementing CQI program/total number of project hospitals
Health facilities constructed, renovated, and/or equipped (number)	This indicator measures the cumulative number of health facilities constructed, renovated and/or equipped through a Bank-financed project.
Health personnel receiving training (number)	This indicator measures the cumulative number of health personnel receiving training through a Bank-financed project.

At least seventy percent near poor have health insurance	Number of the near poor having HI/total number of near poor
Increase of patient satisfied with (a) the overall quality of care, (b) reduction of waiting time, and (c) availability of services and diagnostic facilities at provincial and district hospitals	Percentage of patient reported satisfactory with (a) overall quality of care; (b) waiting time; and (c) availability of diagnostic and curative services rated as good or very good (or equivalent) in the 5-degree scale in patient exit survey
People with access to a basic package of health, nutrition, or reproductive health services (number)	Defined as the number of people enrolled in the Social Health Insurance System.
Increase in the knowledge on health insurance (a) benefit package; (b) rights and responsibility; and (c) operation mechanism among near poor people	Percentage of the near poor people have good understanding on the areas of health insurance (a) benefit package; (b) rights and responsibility; and (c) operation mechanism. The data will be collected at the baseline and end-project through household surveys.
Complete and Timely Project reporting, including Progress Reports, Monitoring and Evaluation Updates, Year 1, Midterm and End of Project surveys, Annual Plans	As described.

ANNEX 2: DETAILED PROJECT DESCRIPTION

Vietnam: North East and Red River Delta Regions Health System Support Project

1. The Project will be implemented in thirteen selected Provinces of the NE and RRD Regions. From the descriptive statistics shown, it is easy to see that the two regions are quite different. The provinces included in the Project in the RRD Region are on average almost five times as densely populated as the NE provinces and almost half as poor. The different types of conditions that are found in the Provinces would indicate that the Project cannot necessarily have a uniform approach and implementation will have to factor in the need for flexibility based on the capacity, and the needs and priorities of the provinces.

Table 3: Descriptive Statistics of the Selected Provinces

		Region	Population *(Thous. pers.)*	Population density *(Person/km^2)*	Avg. Per capita income (thousand VND, GSO)	GSO poverty rate (%)	% of Pop Insured (2011 Estimated from Form 02/BHYT)	Health budget per capita ('000 VND, HSY)
1	Hải Dương	RRD	1712.8	1038	15463.3	11.04	58.1%	155.3
2	Hưng Yên	RRD	1132.3	1226	15125.9	10.94	52.50%	163.6
3	Thái Bình	RRD	1786.3	1140	13927.6	9.16	62.10%	149.1
4	Hà Nam	RRD	786.3	914	14219.4	12.82	51.90%	117.2
5	Nam Định	RRD	1830.0	1107	13750.7	9.95	42.70%	197.5
6	Ninh Bình	RRD	900.6	648	13943.4	12.4	60.60%	214.8
7	Tuyên Quang	NE	728.9	124	10628.2	33.5	83.70%	259.5
8	Yên Bái	NE	746.4	108	9993.3	24.23	44.90%	248.4
9	Thái Nguyên	NE	1131.3	321	13798.5	20.57	77.70%	179.8
10	Lạng Sơn	NE	735.6	88	9432.5	29.23	86.70%	284.9
11	Bắc Giang	NE	1560.3	408	12401.4	19.61	57.10%	175.3
12	Phú Thọ	NE	1322.1	374	13495.8	20.34	69.50%	181.6
13	Hoà Bình*	NW	793.5	173	9877.0	31.51	79.7%	184.4

	AVG ALL		1166.6	590	12773.6	18.9	63.6%	193.18
	AVG RRD		1358.1	1012	14405.1	11.1	54.7%	166.25
	AVG NE		1002.6	228	11375.2	25.6	71.3%	216.27
	SUM		15166.4					

* Hoa Binh is included because it was the only province in the North West that had not been included in another regional health support project and that it was adjacent to the other provinces.
Sources: GSO Website, Health Statistics Yearbook (2010) and the VSS

Component One: Strengthening the capacity of lower level hospitals to deliver quality services (estimated US$118.0 million of which US$116.0 million IDA)

2. This component would support the implementation of the government's "Easing Hospital Overcrowding" Masterplan approved by the Prime Minister in January 2013. The Masterplan has several components, including building new hospital infrastructure. NORRED would selectively support parts of the Masterplan implementation by: (i) extending new services to provincial hospitals through a version of the Ministry's strategy to set up "satellite" departments at certain provincial hospitals through 'sponsorship' by Central Hospitals and generally transferring of services from higher level facilities to lower level health facilities (central hospitals to provincial hospitals and central and provincial hospitals to district hospitals); (ii) improving the quality and management of health services in participating provincial hospitals; and (iii) developing the capacity of the MoH in these areas, including development of policies, research and participating in learning and knowledge exchange activities. The outcome of the component would be an increased capacity of the health system to deliver more priority services and to improve the quality of the health services and management generally in selected hospitals of the Project provinces, thus contributing to the PDO. This would be achieved through two subcomponents.

3. *Subcomponent 1a - Provincial Subprojects for the Development of Medical Services and Quality Improvement (estimated US$109.0 million of which US$107.0 million IDA).* This subcomponent would provide technical and financial support directly to the Provinces to increase their capacity to deliver quality health services at their general provincial hospitals or specialized pediatric or obstetrics and gynecology hospitals as well as at least three district hospitals. This would be implemented as a virtual "fund". The resources would not ex-ante be specifically allocated to the Provinces. Provinces would apply to receive these funds to support their "subproject" through the development of a Provincial proposal. Once subprojects are approved by the MoH and the Bank and their feasibility reports are approved by the People's Provincial Committee, then the Credit funds would be allocated to the Province. The funds would not be on-lent nor would any specific sub-grant agreement be signed. The funds would be allocated for the purposes of implementing the subproject proposal which would be translated to the annual workplans of the Provinces and part of the consolidated annual

workplans prepared by the CPMU. The allocation to a province based on its implementation performance would be reviewed annually. In case of poor implementation by the Provinces including improper management and significant delays, the subproject can be reduced or cancelled in order to reallocate the funds to well-performing provinces. In the case of good performance and subject to the availability of funds, the Provinces may submit a supplemental subproject proposal in which it may expand upon the number of services to be supported and/or include additional district hospitals. The MoH will provide technical support, under subcomponent 1b, to Provinces with less capacity for the design and implementation performance of the subprojects.

4. This first part of a provincial subproject proposal would report on the needs analysis undertaken by the Province based on the needs of the population, the health services that are under-provided by the hospital and those services which the hospitals prioritized for development building on the existing capacity of the hospital in terms of human resources and physical infrastructure. The proposal would also confirm that the subproject does not duplicate other sources of financing such as government bonds or other donor assistance project. It would define exactly which medical services (procedures, tests) the hospitals would be able to perform after the assistance with support from the Project and the sponsorship of the central level hospitals which would provide training and technical support in the development of the services. Eligible health services to be supported by the Project would be five specialty areas (obstetrics/gynecology, pediatrics, cardiology, oncology, and trauma) at the provincial hospital level and three specialty areas at the district hospital level (obstetrics/gynecology, pediatrics, and trauma) as well as the auxiliary services at the hospitals in support of these services (laboratory, intensive care). The exact services would be in accordance with the needs of the population, the inability to provide the required service currently (or provide it with sufficient quantity) and would be in accordance with the MoH guidelines (MoH Decision 23) on the services to be provided according to the hospital technical level. Technical levels of hospitals are as follows: Level I -- a tertiary facility and usually a Central Hospital, but some Provincial Hospitals are designated as Level I facilities; Level II -- and usually denoted as a Provincial Hospital; and Level III -- a basic secondary facility with a more limited scope of services and usually denoted as a District Hospital. The second part of the provincial subproject proposals would define specific measurements of quality or management improvement that they want to implement in certain defined areas (at least 5 percent of subproject cost).

5. The provincial service areas were defined as priority in the MoH's Masterplan based on the overcrowded conditions at the central level hospital as well as based on the health demands of the population. After assessing overcrowding conditions in specialist hospitals, it was seen that 100 percent of all specialist cancer, cardiology, and trauma and orthopedics hospitals were overcrowded; and 70 percent of specialist obstetrics and pediatrics hospitals were overcrowded. The service areas of district hospitals were defined based on their core functions to provide

basic secondary care for deliveries, children and accidents. The MoH also wanted to concentrate on fewer services than the entire functions of the hospital in order to realize more concrete results. The inventory of the hospitals potentially supported by the Project shows the ten leading causes of death were: injuries (especially road traffic-related injuries, including cerebral injury), cancers, cardiovascular diseases, acute respiratory infection, cerebral hemorrhage, myocardial infarction, other heart conditions, respiratory tuberculosis, pregnancy-related deaths, and perinatal diseases.

6. It is recognized that radiation therapy is one important service area under oncology where there is a bottleneck in the service delivery system due to too few active treatment units. It is also agreed that following international standards of practice radiation therapy should, for the most part, be provided on an outpatient basis. Currently, radiation therapy is largely provided and financed as an inpatient service in Vietnam. Not only is this a less efficient use of resources, but it is can also be less safe for patients. In some cases, patients do go home for the day, but the system is still set up to register and finance them as an inpatient. Generally, Vietnam needs to develop the appropriate conditions to not only provide radiation therapy treatment as an outpatient service, but many other specialist services as well. Radiation therapy treatment appears to be a good place to start with piloting these arrangements. The project will support the MoH to develop a feasibility report and the appropriate guidelines for piloting this service**.** It was discussed and agreed that radiation therapy equipment would not be an eligible expenditure under subcomponent 1a until such time as the guidelines have been issued and the ESMF, acceptable to the Bank, has been updated to reflect this support.

7. Based on the defined service areas, it has been determined that 23 provincial hospitals would be eligible under the Project. Specifically, they are:

Table 4: Provincial Hospitals Eligible to Apply[19]

NO	Hospital Name	Catchment population	Licensed beds (actual)	Hospital class	Total # of staff
1	Tuyen Quang General Hospital	730,800	500(500)	II	585
2	Phu Tho General Hospital	1,329,300	1150	I	919
3	Hai Duong General Hospital	1,800,000	700(826)	I	803
4	Hai Duong Obstetric Hospital	1,800,000	150(220)	II	200

[19] This list is subject to change if the configuration of hospitals in the participating project provinces changes during the course of project implementation.

NO	Hospital Name	Catchment population	Licensed beds (actual)	Hospital class	Total # of staff
5	Yen Bai General Hospital	790,000	390(420)	II	446
6	Ha Nam General Hospital	785,057	550(638)	II	647
7	Nam Dinh General Hospital	1,833,500	600	I	606
8	Nam Dinh Obstetric Hospital	1,833,500	190(250)	II	216
9	Nam Dinh Pediatric Hospital	1,833,500	120(85)	III	223
10	Hai Duong Pediatric Hospital	1,800,000	230(312)	II	269
11	Ha Duong TB & Lung Hospital (Oncology Department)	1,800,000	150(150)	II	120
12	Hung Yen General Hospital	1,097,000	500(610)	II	603
13	Hung Yen Obstetric-Pediatric Hospital	1,097,000	200(180)	III	170
14	Lang Son General Hospital	800,000	550(630)	II	637
15	Bac Giang* General Hospital	1,574,300	500(600)	II	678
16	Bac Giang Obstetric-Pediatric Hospital	1,574,300	350	II	346
17	Thai Binh General Hospital	1,786,000	650(1135)	I	712
18	Thai Binh Pediatric Hospital	1,786,000	200(250)	II	197
19	A Thai Nguyen General Hospital	1,300,000	380(590)	II	388
20	Thai Nguyen Central Hospital	7,800,000	950 (950)	I	1100
21	Ninh Binh General Hospital	907,800	600(738)	II	614
22	Ninh Binh Obstetric-Pediatric Hospital	898,500	300(450)	II	289
23	Hoa Binh General Hospital	800,000	520(744)	I	592

8. As mentioned, the Provinces would submit a proposal for a “subproject” to be financed. The proposal would indicate explicitly: (a) the provincial hospital(s) which would be key recipient; (b) services that they want to develop at that provincial hospital (which is on the long-list of eligible services and depending on their current technical level); (c) the central level hospital or hospitals from which they would seek ‘sponsorship’; (d) the investment needs for those services (within the definition of eligible investments); (e) the training needs (the clinical and para-clinical short-term training for the staff either in country or abroad, and any needed preparatory courses such as foreign language training); (f) the selection of at least 3 district

hospitals in rural areas to be supported and for which the provincial hospital offers its sponsorship; (g) the identification of services to be developed in those district hospitals (which is on the long-list of eligible services and within their current technical level); and (h) the investment needs for the district hospitals (in accordance with the list of eligible investments). The province and district hospitals would have to indicate that they have the necessary minimum conditions for receipt of the services and investments including the staff with the necessary basic qualifications and the hospital infrastructure. The endorsement of the one or more central level hospitals that would be designated as the teaching center would be required. As long as the services are within the define list, it has been determined that the VSS would contract the hospital for those services under the insurance program. Any need for significant additional staffing or major infrastructure investments would indicate that the hospital was not ready for investments in those services. All provinces are expected to have prepared and submitted their applications for subprojects before or during the first year of Project implementation. However, not all of the services included in the proposals would be transferred at the same, due to capacity constraints of both the receiving and the training hospitals. The proposals would be implemented through annual plans and subject to detailed training plans prepared by the training hospitals.

9. Each participating hospital would include in its proposal at least 5 percent of the total (IDA) investment costs for the purposes of quality and management improvement. The hospitals would determine specifically one or more supplementary areas that they want to work on during each year of the project. All participating hospitals would be involved in: (i) the measurement of patient satisfaction; (ii) in the assessment of quality according to the Continuous Quality Improvement methodology; and (iii) improved management through better budgeting and planning for facilities (including equipment) maintenance. These areas are chosen as they are directly related to the project interventions and in order to initiate quality improvement process. In addition to these activities, the hospitals would select at least one additional activity that it wants to work on as part of the annual workplan. Similar to the technical transfer, the hospitals would actually select which specific indicator that it would commit to achieving. Technical support would be provided from the MoH and its CPMU in the form of TA from national and international experts in the planning and implementation of the quality and management improvement activities. Additionally, there are organizations like the International Hospital Federation and others who are interested in facilitating peer learning between some of the key provincial hospitals supported by the project and hospitals in other countries with more developed quality assurance systems. The advantage of providing this support under the Project is that the project could finance the incremental travel and related expenditures as well as provide the provinces with resources to implement the activities. Funding this support through a type of memorandum of understanding and reimbursing the incremental expenditures for the exchange is included as an eligible expenditure under the component.

10. The specific areas of Quality and Management Improvement may be changed from time to time as agreed between the Bank and the MoH. At present, they are as shown in Table 5:

Table 5: Quality and Management Improvement Area

Quality and Management Improvement Area	Indicators
1. **Continuous Quality Improvement (CQI)**	1. Evidence of implementation of gap analysis and quality improvement plan in the clinical departments in the project hospitals, which includes measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services required as part of the quality program. 2. Checklists are applied in project hospitals to prevent adverse events identified by hospital staff such as central line infections, catheter-related infections, medication reactions, patient falls, pressure ulcers, etc. 3. Percent increase (between baseline and end line) in quality assessment scores in project hospitals implementing CQI program. 4. Surgical checklist applied to all surgeries conducted in operating theaters in project hospitals.
2. **Quality Measurement and Monitoring**	1. Project hospitals effectively monitor clinical indicators in the clinical departments: (i) inpatient quality indicators; and (ii) and patient safety indicators. Effectiveness of monitoring will be measured by evidence of definition of a subset indicators (per department), use and timing of measurement instruments, existence of databases, preparation of monitoring reports and follow-up actions by relevant hospital personnel. 2. Project hospitals effectively monitor a set of patient experience/satisfaction indicators in clinical or non-clinical departments as measured by evidence of definition of subset indicators (per department), use and timing of measurement instruments, existence of databases, preparation of monitoring reports and follow-up actions by relevant hospital personnel.
3**. Improving Patient Experience and Satisfaction**	1. Percent increase over baseline of patient satisfaction for specific patient experience interventions as measured by standardized patient surveys applied with sound methodologies measurement and monitoring required as part of the quality program. 2. Hygiene and cleanliness checklists applied to major patient flow areas (such as wards and outpatient waiting areas) in project hospitals.
4. **Non-clinical Services Quality Management**	1. Project hospitals effectively have introduced Standard Operating Procedures (SOPs) and monitor at least one set of quality indicators in at least three non-clinical service lines. Effectiveness of implementation will be measured by evidence of definition of approved and enacted SOPs, registration of quality indicators and reports on corrective

	measures. 2. Project hospitals effectively use non-clinical service quality indicators in management decision making process in at least three non-clinical departments as measured by evidence of definition of subset indicators (per service line), use and timing of measurement instruments, existence of databases on the indicators, preparation of performance reports and follow-up actions by relevant hospital personnel. 3. Facility maintenance plans and budgets are prepared and implemented required as part of the quality program.
5. **Clinical pathways**	1. Project hospital has developed and introduced at least one clinical pathway in the most common therapeutic area in their day-to-day clinical practice, while effectively establishing baseline and follow-up measurement tools and indicators to analyze the effect of the intervention. 2. Project hospitals have successfully entered the process of clinical pathways. 3. Project hospitals effectively monitor a set of quality indicators relevant to the enacted pathway and have routine reporting and analyzing practice with functioning system of feedback and corrective actions in place.
6. **Day Hospitals**	1. Project hospitals have analyzed and developed a list of potential services, in which outpatient or day hospital modality can be considered as priority. Target hospitals have effectively implemented at least on day hospital modality in service provision. 2. Radiotherapy patients are treated largely on an outpatient basis.

11. The provincial proposals will be approved by the MoH and by the Bank. The MoH and the Bank will not have any other explicit criteria than meeting the requirements as described herein which are translated into the OM. The MoH has an interest in and will provide support to each of the Project provinces to develop and approve a subproject proposal. Once the subproject proposal is approved, the provinces will use the subprojects to develop their investment project feasibility study as required by normal government procedures. In addition to the content of the subproject proposal, the feasibility study would include the implementation plan, financing plan, and proposed procurement plan as well as the Environmental Management Plan//Hospital Waste Management Plans as outlined by the ESMF. The financing plan will, in particular, note any proposal from the province with respect to counterpart funding. The CPMU may provide support to the provinces in the preparation of their feasibility reports, particularly with the provinces of less capacity.

12. The provincial subprojects are to be implemented over a 3-5 year period depending on their complexity with a minimum subproject cost of about US$5 million equivalent and a

maximum subproject about US$12 million equivalent. The exact amount will vary and will depend on the size and capacity of the provinces. These are not fixed thresholds and are subject to consideration during the review and approval of each subproject proposals. The overall objective is to ensure that the proposals are large enough to have a significant impact while also not too large to ensure that all provinces have a chance to seek financing at the beginning of the project. While it is planned that all provinces would have developed their subproject proposals during the first year of project implementation, initial subproject proposals would be considered up to and during year three of the project after which no new proposals would be considered. This will ensure that the allocation of funds under component 1a would be known by the time of the mid-term review. Small (even less than US$5.0 million) supplemental proposals may be considered based on the provincial performance and availability of funds up to 18 months before the closing date of the Credit. All subproject activities would need to be completed prior to the closing date of the project as set out in the Financing Agreement.

13. The Procurement, Disbursement and FM of the subproject funds would be delegated from the CPMU to the PPMU to the extent possible. For certain, high value and highly specialized equipment it may be agreed for the MoH to procure the items on behalf of the provinces. The procedures followed will be in accordance with the Bank guidelines established in the Financing Agreement. The details of the subproject preparation, approval, implementation and assessment process will be detailed in the OM.

14. *Subcomponent 1b - National Policy and Central Level Technical Support for Reducing Hospital Overcrowding and Quality Improvement (estimated US$9.0million of which US$9.0 million IDA).* This subcomponent would support the MoH and the other national level stakeholders to provide quality technical support to the provinces to achieve the components goals. This component would be implemented by the MoH and its CPMU. This would include two TAGs (teams of national experts, including from national institutions and hospitals).The first TAG would support the provinces in the preparation and implementation of the plan for the technical transfer of the knowledge and skills for certain performing medical services and conducting certain medical procedures from the central hospitals to the hospitals in the provinces; the second TAG would support the provinces in the preparation and implementation of a hospital quality and management improvement plan. The component would also support the MoH in defining national level strategies and sector policies which may be piloted in the participating provincial and district hospitals as well as conducting research on the hospital overcrowding issue. The subcomponent would also include direct support to the central hospitals, but only in development of their training capacity and the training programs and not towards generally enhancing the central hospitals' clinical capacity. The direct support would include medical equipment, technical assistance, participation in international education, training and study visits, as well as teaching material.

15. **Eligible expenditures for Component One would include but not necessarily be limited to**: (a) medical equipment; (b) office equipment and off-the-shelf software; (b) minor civil works; (c) consulting services (local and foreign); (d) ambulances and vehicles; (e) training/tuition fee in relation to short-term and long-term training or any preparatory courses for such training (both in-country and abroad), including training fees to hospitals and their staff; (f) per-diem, transportation and living expenses related to training; (g) consulting services (local and foreign); (h) incremental travel costs (airfare, per diem, travel insurance, hotel) of organizations providing technical support on a no-fee basis; (i) operating costs necessary for conducting training activities (renting facility, providing stationary and teaching equipment, food catering, translation and interpretation); (j) professional fees, transportation and accommodation costs of trainers including from public hospitals providing technical transfer training and technical supervision; (k) teaching equipment, instructional materials and aids, including audio-visual equipment, IT equipment, books, stationary, medial simulators, laboratory equipment; (l) books; (m) accommodation and per-diem costs for medical personnel supporting the technical transfer of services; and (n) study tours for building capacity in improved hospital quality and management.

Component Two: Reducing the financial barriers to access health services by the economically vulnerable (estimated US$29.0 million of which US$29.0 million IDA).

16. The objective of this component is to support the implementation of the government's UHC Masterplan through direct support for rolling out additional State subsidy for the coverage of the near poor. The project will support provinces in the region to expand their health insurance coverage and increase access to health care services for disadvantaged and vulnerable groups. This will contribute to the government's efforts towards universal health insurance coverage for Vietnam population by 2020. In the Masterplan, three dimensions of universal coverage were mentioned, including: (i) expand the breadth coverage; (ii) improve the quality of care; and (iii) reduce out of pocket payment. However, due to capacity and resources constraints, much of the effort will be to increase the coverage of the rest of more than 30 percent of the population, those were defined as the most difficult to reach groups, such as the near poor and informal sector.

17. By end of 2012, the overall Health Insurance (HI) coverage was about 64 percent of the total population. Importantly, Vietnam has reached full coverage for some specific vulnerable groups, such as children under six, the poor and ethnic minorities, with premiums fully subsidized by the government. However, other groups are still far from the target, notably the coverage is only 10 percent, 25 percent and 30 percent for farmers, informal sector and the near poor, respectively.

18. The near poor are defined as those having an average income between 100 percent and 130 percent of the official poverty line. The number of the near poor ranges from 10 percent to

30 percent of the population, with big variation across provinces in the region. Even with the defined threshold between the poor and near poor, the discrepancy is quite small, and the near poor are as high risk of falling into poverty with payment of medical expenses. While the poor received full support from the government, the near poor still have to pay 30 percent of the premium from out of pocket (the government has just increased the premium support of the near poor from 50 percent to 70 percent from 2012), thus the enrollment is limited and mainly among those at high risk or having chronic conditions. In the UHC Master Plan, the government indicated that the premium support to the near poor group will increase up to 100 percent along with the country economic development. In the meantime, the roadmap is to gradually increase the support from the government budget and mobilize other resources to cover the remaining. Some well off provinces already covered the remaining 30 percent of the premium from their provincial budget. However, not many provinces can do so when they still have budget deficits.

19. In this region, the average general coverage of the HI was 66.6 percent of the total population, similar to national data. However, the coverage is not equal across provinces, ranging from Lang Son with almost 87 percent to as low as Nam Dinh at 42 percent. In fact, the NE provinces include poor provinces with high share of the poor and ethnic minority people, who already receive the government subsidy of the HI, while provinces in the RRD Region have a larger share of those who have to pay themselves to get the HI (Table 3).

20. The HI coverage for the near poor is also varied among provinces depending on the locally additional support to the premium and the efforts and commitment of the local authorities on expanding health insurance. Ninh Binh, a better-off RRD province, has the policy to support the rest of 30 percent of the HI premium for all the near poor in the province since 2012. Other provinces with similar or even higher GDP capita like Ninh Binh still have low share of HI for the near poor and general population like Nam Dinh, Ha Nam, and Hung Yen. Overall, only about 3.5 percent of the near poor currently have health insurance of provinces participating in NORRED.

21. In the past years, supporting the near poor to join health insurance scheme is a priority in several World Bank lending operations (See Box 2).The proposed support is seen as important towards contributing the PDO by reducing financial difficulties in health service utilization among vulnerable groups. It will directly help to reduce out-of-pocket payment and reduce the risk of catastrophic health care expenditure and impoverishment in the project beneficiaries.

22. *Sub-component 2a - Direct subsidy to support purchase of health insurance card by the near poor (estimated US$23.0 million of which US$23.0 million IDA):*Similar to other regional health support projects, the NORRED project will provide the top up subsidy of 20 percent of the premium, but only for the whole family enrollment. Those who enroll individually will not receive any support from the project. The support to household enrollment will help to increase

the coverage more quickly than individual enrollment, improve risk sharing between the sick and the healthy and reduce adverse selection when only the sick near poor join the health insurance sytem. The support will provide good experience and lesson learned for the MoH to later expand to a national policy.

Box 2: Health Insurance support to the near poor in WB Regional Health Support Projects

Mekong Regional Health Support Project (2006 – 2012)

The project provided the top up of 30 percent of the premium to the near poor, while the government supported 50 percent and the near poor paid the rest of 20 percent. The project reached 70 percent coverage by the midterm in 2010 (while the nationwide coverage was less than 10 percent) and some provinces even covered all the rest 50 percent of the premium to reach 100 percent HI coverage. By end of the project, 50 percent of the near poor population was covered (*Due to budget constraint, the project stopped the support by July 2011, and the near poor had to pay the rest of 50 percent of the premium from 2012*).

The project also supported poor and near poor patients with high medical expenditure at provincial hospitals (during 2007 – 6/2009) and congenital heart diseases operations (during 7/2009-7/2011). More than 2,000 patients received financial support to overcome their catastrophic payment at provincial hospitals and about 800 cases of heart surgery in poor patients were covered.

Traditional means of IEC (leaflets, brochures, mass media, and direct communication) for HI was supported in project provinces. This support has been also implemented in all other regional projects.

Central North Region Health Support Project (2009 – 2016)

The project takes initiative of encouraging household enrollment by giving 40 percent support of the premium for near poor households and 30 percent for individuals (during 2009 – 2011) and 10 percent and 5 percent for households and individual enrollment, respectively from 2012 onwards while the government increased the support from 50 percent to 70 percent of the premium in 2012. After 2 years, the project over achieved the original target of 40 percent by end of project. The current coverage is 60 percent with some provinces even reached almost 90 percent. Among enrollees, 90 percent enrolled under household scheme.

Northern Upland Health Support Project (2008 – 2014)

Since the region covers mountainous and remote areas, where most of residents are poor or ethnic minorities, who already have subsidized HI cards, the project provided additional transportation and meals support to beneficiaries in cash. The payment is made through district hospital. However, this support is already covered in the newly issued policy by the government (Decision 14/2012/QD-TTg).

23. This support is in line with the government's policy of gradually increasing the support to the near poor conditioning to the country's economic development. The household then will pay the rest of only 10 percent of the premium (the government supports 70 percent of the premium already), discounting every 10 percent from the second member enrolled as defined in the policy.

24. In line with the government procedures for identifying beneficiaries of social programs, the list of near poor people, who want to purchase health insurance, will be identified each year by the provincial VSS and certified by the provincial Department of Labor, Invalids and Social Affairs. The project will not finance implementation of any new survey, and will instead build on the existing mechanism used by the government to identify and register poor and near poor households. Since the official list includes all near poor in the locality, the project will provide some technical support to refine the list for the specific project beneficiaries, i.e only those who have not yet had HI supported by other programs (children under 6, elderly of 85+, merit people, etc). During the first year, the project will support the development of detailed support schemes, financial mechanism, refinement of the beneficiaries list, and mechanism for issuing health insurance cards. Actual enrollment of the near poor household will begin from the second year.

25. The PPMU will reimburse the provincial VSS for the top-up support of the premium on a quarterly basis. Supporting document for payments would include: list of near poor certified by local authorities, and the health insurance card number signed for and issued. The CPMU will also transfer funds to the PPMUs upon their quarterly request.

26. As the project will encourage household enrollments, monitoring the progress in enrolling the whole family and evaluating the impact of the intervention will be carried out in order to inform government policy as requiring family as opposed to individual enrollment as part of Component Three. The government's policy has already provided incentives to more than one member of the family joining HI at the same time (reduction of 10 percent of the premium form the second enrollee), however, no statistics or evaluation have been done to prove the effect. In this project, enrollment data will be regularly collected from the local VSS offices with clear distinction between family and individual enrollments.

27. The social health insurance policy of the government is dynamic and there is regular advancement of the policy, primarily to include more of the vulnerable population in the national health insurance system through subsidized (partial or full) state support. The definition of the target beneficiaries supported by the Project may be amended during the implementation of the Project to ensure that the Project is used to advance the implementation of government policy and would not be duplicating or in contradiction with government strategy. For example, the government has a policy to support 30 percent of the HI premium for

farmers with below average income; however, the implementation is still pending due to unclear definition and identification of the target group. This group will be considered to include in the project support during project implementation when clear identification criteria are available in order to meet actual demand by provinces.

28. This support has proved successful in other projects by quickly increasing the coverage rate. Because the policy is fully in line with the government strategy towards expanding universal health insurance coverage by 2020 -- particularly targetting the near poor as a priority vulnerable group -- it is expected that before the end of the Project, the government will adopt a policy to expand its support to the Near Poor. When the government adopts this policy and it is implemented, the Bank and government will discuss the options for cancellation and/or reallocation of any funds remaining under this subcomponent. The funds could potentially be reallocated to another beneficiary group if properly identified and in line with the government strategy. Alternatively, the funds could be reallocated to Component One depending on its satisfactory performance.

29. *Sub-component 2b –Supporting catastrophic health care expenditure at provincial hospitals (estimated US$2.0 million of which US$2.0 million IDA).* As a mitigation measure against the risk that the vulnerable would have difficulty in accessing some of the services supported under Component One which may be of high cost, the subcomponent would reimburse the health care expenditures above the insurance cap for the eligible beneficiaries for acute health treatment costs until such time as the government program "Health Care Funds for the Poor" effectively provides the same support. The eligible beneficiaries would be the poor, ethnic minority living in difficult communes and the insured near poor. The government has issued Decision 14 revising the Decree 139 re-establishing health care funds for the poor; however, the guiding circular for implementation is still under development. Among other things, Decision 14 indicates that the government will support the catastrophic health expenditures experienced by vulnerable groups[20]. Each province will eventually establish its own fund with government budget support and possible mobilization of funds from other sources. This is expected to take more time in the poorer provinces on the NE and Hoa Binh. In the meantime, the program will be managed by the PPMU/DoH to support the high out-of-pocket payment by the poor, ethnic minority living in difficult communes and near poor patients up to a cap to be defined as part of the OM. Each case will be reviewed and endorsed by the hospital management board of the provincial Hospital based on eligibility criteria. The PPMU will provide the reimbursement to the patient directly.

[20] The vulnerable groups defined by Decision 14 is expansive including the poor, ethnic minorities, social assistance beneficiaries, and patients with cancer, dialysis, heart operation and other high cost treatment without ability to pay.

30. This program will be managed by the PPMU/DoH to support the high out-of-pocket payment by the poor and near poor patients. The support will cover high out of pocket expenditures incurred by the eligible beneficiaries through high co-payments and the co-insurance required for the treatment cost exceeding 40-month basic salary (about US$2,000) in the provincial hospitals. The project will set up a cap for the support to reasonably manage the flow of funds, based on the price of the high cost procedures, and to mitigate against abuse. Each case will be technically reviewed and endorsed by the hospital management boards of the provincial hospitals based on eligible criteria. The PPMU will provide the reimbursement to the provincial or central hospital (for patients with referral) directly on behalf of the patients. Supporting document include detailed hospital expenses indicating different financial resources (payment from VSS, the out-of-pocket payment, and the amount eligible for project support).

31. *Sub-component 2c -- IEC support towards increased and effective health insurance (estimated US$4.0 million of which US$4.0 million IDA).*This sub-component will support IEC activities in the project provinces in order to: (i) promote the awareness of and enrolment in health insurance by the near poor, including the additional insurance premium subsidy benefit under the Project; (ii) raise the understanding of all health insurance enrollees, but particularly the poor and near poor, about their rights and responsibilities under the insurance system; and (iii) target information to the providers to reduce institutional barriers of access for insured, such as how insured patients are received, medical staff attitudes, etc. Information would be made available on the support of covering catastrophic health care expenditure to ensure that the poor and insured near poor have information on available financial support. Innovative IEC measures are encouraged to effectively target beneficiaries, particularly ethnic minority population.TA would be provided in the effective design and implementation of communication activities. The TA would be mobilized by the CPMU. The IEC activities would be implemented directly by the PPMU on behalf of the DoH or through the VSS and the Health IEC Centers (reimbursing the eligible expenditures).

32. Activities to be financed through the subcomponent include behavior change communication, such as the preparation and printing of promotional material, mass media campaigns, and direct communication. The subcomponent will encourage innovative communication measures and support non-financial reward system for the commune or village that are able to significantly increase enrollment rate.

33. The support will be provided through the MoH's and the Provincial Health IEC Centers in project provinces and local VSSs. Some TA, training and capacity building will be provided to local VSS and Health IEC Centers to strengthen and update their knowledge and skills as well as to support the design and implementation of the communication activities.

34. In the region, there are nine ethnic minority groups living in 8 out of 13 provinces, with about 2.7 million people. Considering the fact that many ethnic minorities do not speak Vietnamese, and most health workers are from the Kinh majority, this makes communication between them difficult. Also with the lower literacy rates, this makes them less likely to benefit from most of the health IEC messages. It is very important for the project to make sure that communication messages are translated to local language and can properly reach ethnic minorities.

35. **Eligible expenditures for Component Two would include but not necessarily be limited to**: (a) partial costs of health insurance premiums for the near poor (20 percent of the premium of each near poor household family member subject to family enrollment in addition to the direct government subsidy); (b) partial reimbursement of high medical costs incurred by the insured poor, ethnic minority living in difficult communes, near poor according to the procedures to be defined in the OM; (c) TA (foreign and local consulting services); (d) social marketing, health information and education campaign, which operating costs for conducting the campaign (e.g., workshops, print materials, translation and interpretation, media promotions, etc.); (e) workshops; and (f) study tours and related training fees, travel cost and per-diem.

Component Three: Project management, monitoring and evaluation (estimated US$7.0 million of which US$5.0 million IDA)

36. The aim of this component is to ensure adequate management structure, processes and human resource capacities for the project, and to set up mechanisms for effective monitoring of activities and evaluation of results. The component is not intended for the purposes of building management capacity generally. It will, however, ensure adequate support to the Project provinces in project management, and, therefore, will provide some related project management, fiduciary and safeguard management training. The overall structure of the Project management arrangements are will be detailed in the OM.

37. The component would: (i) establish and execute the project management and coordination functions at both the national and PPMU levels; (ii) provide for sufficient resources for effective implementation support; (iii) ensure the effective and proper management in the use of the resources, including financial management and procurement; (iv) contract with internal and external auditors for the provision of their services; (v) provide for timely planning, budgeting and reporting; (vi) monitor and ensure compliance with the safeguards; and (vii) provide for appropriate M&E of the project progress and results, including fielding of necessary surveys.

38. **Eligible expenditures for Component Three would include but not necessarily be limited to**: (a) local and foreign consultants; (b) audit services; (c) minor office repairs; (d) office equipment and IT technologies; (e) two 7-seat vehicles for the CPMU for project monitoring purposes; (f) operating costs (such as office rent, costs of conducting workshops, meetings, translations/interpretation, telecommunication, fuel and other transportation related costs, per-diem for CPMU and PPMU when travelling for business, costs for any project related advertisement or programming on Vietnam Television and its associated firms; (g) participation in project management related training and CPMU/PPMU staff participation in the technical study tours; and (h) costs related to monitoring, data collection and auditing

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ANNEX 3: IMPLEMENTATION ARRANGEMENTS

Vietnam: North East and Red River Delta Regions Health System Support Project

Project Institutional and Implementation Arrangements

1. **Management Structure.** The MoH will be responsible for the overall execution of the project. A CPMU in MoH has been established under Planning and Finance Department (DPF) to be in charge of the implementation and coordination of the project. The Medical Services Administration (MSA) would be responsible for technical oversight of Component 1 and the Health Insurance Department (HID) would be responsible for providing oversight of Component Two. The departments will have representatives of their staff seconded to work at least part time in the project management structure. A PPMU in each project province under the DoH will be responsible for the day-to-day operation of the project activities.

2. **Project Steering Committee.** As per the MoH's common procedure, a PSC will be established with a decision of the Minister of Health. The PSC will be chaired by the Minister or a designated Vice Minister of Health who will provide regular project oversight and who will authorize the approval of the annual work, financing and procurement plans. The PSC will be a consultation body during project implementation; the PSC will be composed of various senior managers of the relevant departments of MoH including, but not limited to the Medical Service Administration, HID and the project provinces. It may also include representatives of concerned ministries such as Ministry of Finance (MOF), Ministry of Planning and Investment (MPI), State Bank of Vietnam (SBV), and the VSS.

3. **Central Project Management Unit.** A CPMU has been established by MoH and led by Department of Planning and Finance (DPF). The standing deputy director will be in charge of the core coordination, fiduciary, M&E functions of the CPMU. The second deputy director, coming from the Medical Services Administration, would be responsible for the coordination and technical aspects of Component 1. The core teams for procurement, financial management, administration, M&E and safeguards will be headed by a MoH-seconded staff (full time or part time) and supported by contracted national consultants. Two TAGs consisting of national experts hired on framework contracts will be an extension of the CPMU structure, including one for supporting the technical transfer for the medical services. This team would consist of medical specialists in the areas supported by the project. A second team consisting of quality and management specialists would support the provinces in planning and implementing the quality measures. In addition to the Deputy Director from MSA, a second MSA staff member working on quality would be seconded to work at least part time in developing the quality improvement activities. If needed, an international technical advisor will be recruited to support the implementation of the overall project with focus to highly technical issues such as satellite hospitals, at least for the first two years of implementation.

4. The role of CPMU will be:

(a) coordination with the World Bank, MoH management and concerned departments, PPCs, the provincial DoH, Provincial Hospitals, the PPMUs and other Ministries and agencies at the national level for overall implementation guidance, institutional arrangements and technical guidance/support;

(b) implementation of the CPMU activities, including, but not limited to, major TA contracts, trainings, procurement of goods at central level;

(c) management of the Designated account at central level and fiduciary duties including annual financial audits and monitoring of the PPMU's project accounts;

(d) preparation of overall workplan, annual workplan, procurement, financial plans, regular and progress and thematic reports MoH;

(e) implementation of the M&E of the project activities, impact evaluation against the project result framework and performance indicators; and

(f) organization of the routine semi-annual supervision mission, mid-term review and final review.

5. **Memorandum of Understanding (MOU).** The MoH and each of the Provincial Peoples' Committees will enter into an MOU describing the roles and responsibilities of various stakeholders involved in implementation in line with the institutional, financial management, and procurement arrangements of the Project.

6. **Provincial Project Management Unit (PPMU).** A PPMU will be established by each Provincial People's Committee with the PPMU Director from the Provincial DoH as well as by the management structure of the Thai Nguyen Central hospital located in Thai Nguyen Province for the purposes of implementing the provincial subproject in that specific beneficiary. The structure of the Provincial PPMU will be like that of the CPMU with the core teams and 2 technical teams. The implementation of the Provincial subproject will include team members from the hospitals included in the proposal.

7. The role of the PPMU will be:

(a) Coordination with CPMU, PPCs, provincial hospital, district hospitals and health center, and other relevant provincial departments for institutional arrangement and technical support/guidance within the province;

(b) coordination and implementation of activities at the provincial level and supervision of activities in the project districts of the respective province including, but not limited to, the procurement, training, consulting services, technology transfers, small civil works for sub-national levels (province, district and commune);

(c) management of project account at provincial level and fiduciary duties; and

(d) preparation of provincial overall workplan, annual workplan, procurement, financial plans, regular and progress and thematic reports at PPC's and CPMU's request.

8. The MoH/DPF will consider various options of integrating the institutional arrangements into the existing CPMUs/PPMUs or mobilize available human resources that have good experience in implementing Bank-financed projects to: (i) minimize the establishment of new PMUs; and (ii) make use of the available resources to speed up the project readiness and implementation. We will likely see an absorption of some of the staff from the Northern Uplands Region Health System Support Project in mid- to late-2014 upon the completion of that Project.

9. **Reporting Arrangements and Supervision.** The PPMUs will report to CPMU, which in turn will report to the MoH. To ensure that the project is implemented with the full participation of and close coordination between the CPMU and PPMUs, regular field visits and workshops will be conducted by the CPMU/PPMU managers, staff and consultants throughout the year. The Bank will conduct it formal supervision mission at least every six months with more frequent on the ground support from the field based project team. The project mid-term review will be conducted about 3.5 years following the start of project implementation.

10. **Staff composition of CPMU and the PPMUs.**The detailed staff plan for the CPMU and PPMUs would be outlined in the OM. As per this plan, each unit would be headed by a full time or part time director seconded from the health administration and have at least a standing Deputy Director that works almost full time; core service teams that include the FM and accounting teams, a procurement coordinator and procurement staff; M&E; Planning; Training coordinator; and Administration. Technical teams will be required for each of the two subcomponents. A full time international senior consultant is planned to be recruited at the beginning phase of the project to support the management team in setting up the administrative and reporting structures. The technical teams would include one focused on hospital satellite/technical transfer and quality improvement (HS) team and one focused on the health insurance component. The CPMU would also engage in establishing a network of consultant that can support the provinces in: (i) the satellite model/technical transfer; and (ii) quality and management improvement.

11. **Operations Manual (OM).** A well developed draft of the OM of the project was received in order to provide the MoH with time to consult on the OM with the project provinces. The OM will be maintained and updated from time to time thereafter. It will detail the project management, financial management, procurement and disbursement arrangements. It would include the specific details of the provincial subproject cycle including the subproject development, review, approval, implementaiton, monitoring and reporting as well as the respective roles of the Bank, MoH, PPMU and beneficiary in that process. It would also include the details of the Insurance Subsidies and Catastrophic Payment supports be defining the level of support, the eligible beneficiaries and the financial management arrangements.

Financial Management, Disbursements and Procurement

Financial Management

12. The inherent risk to project financial management is assessed as High and the project control risk is assessed as Substantial after mitigation measures are taken. The overall financial management risk is assessed as High. The key risks identified were: (i) project management personnel, including financial management personnel at central and provincial level were not yet appointed, leading to lack of responsibility in project design and budgeting; (ii) non-existence of internal audit function, which may not allow to detect misuse of Project fund; and (iii) weak financial reporting capacity of spending units which may result in inaccurate and delayed financial information for project management decision making.

13. The proposed Financial Management Action Plan is as follows:

Table 6: Financial Management Action Plan

	Actions on Financial Management	**Expected Date of Completion**	**Responsibility**
1	Appointment of adequate qualified experienced officers to be in charge of financial management of the Project at MoH CPMU and provincial implementing agencies	CPMU personnel appointed. PPMU personnel appointed prior to submission of subproject proposals pursuant to subcomponent 1a and the implementation of the Insurance Subsidies and/or Catastrophic Payments pursuant to subcomponents 2a and 2b respectively.	MoH CPMU, provincial implementing agencies
2	Approval and Maintenance of the Project Operations Manual	About September 30, 2013	MoH CPMU, MoH
3	Training on project financial management to personnel of MoH CPMU and provincial implementing entities	After effectiveness	MoH CPMU, WB, provincial implementing agencies
4	TOR of internal audit is approved by the Bank. Recruitment of outsourced internal auditor is included in the Project procurement plan	About 6 months after effectiveness	MOH CPMU, WB. Managed by Bank task team.

14. MOH will be the implementing agency at central level, with the set-up of a CPMU through its Department of Planning and Finance (DPF) to perform the daily project management function. The DPF of the MoH, including its FM team, have several years experience working with a number of World Bank financed operations. Implementing agencies at provincial level are the provincial Departments of Health ("DoHs"). The CPMU to be established by MoH and will play the leading role on FM. The FM function in provinces will be performed by the existing FM units of the provincial DoH's. These existing FM units will form part of the Provincial Project Management Units (PPMU's) to be established. The Bank carried out the FM

Capacity and Risk assessment based on the capacity assessment of the MoH and related provincial DoH's[21].The FM function of the MoH/DPF and the DoHs meet the Bank's minimum financial management requirements. Areas of weakness that need to be addressed during the project preparation and implementation are: i) lack of internal audit function; ii) lack of formalized internal reporting system for management purposes and iii) lack of experience in managing large donors funded projects. The Bank will formally review/evaluate the capacity of each of the DoH's during the review of the staff experience and capacity of the PPMU teams once they are formally appointed/established.

15. **Quarterly Interim Financial Reports (IFRs).** PPMUs, who are the ultimate spending units at provincial level, will prepare financial reports for all project expenditures incurred at the province and submit to CPMU quarterly. MoH CPMU will prepare IFRs based on the information provided by PPMUs and submit to the Bank within 45 days of the end of the quarter. The IFRs, which are unaudited, will cover all project activities.

16. The IFRs include the following forms:

IFR1: Sources and Uses of Funds;
IFR2: Disbursement by component and by province;
IFR3: Statement of Designated Accounts Reconciliation

17. **External Audit.** Project financial statements will be prepared by each of the provinces and MoH CPMU for their own components, and then submitted to MoH CPMU for consolidation and audit. The project's annual financial statements will be audited in accordance with international auditing standards and in compliance with the independent auditing regulations of Vietnam. MoH CPMU will be responsible for the appointment of the auditor for the entire project in accordance with the Bank's guidelines.

18. **Internal audit.** The assignment and TOR of the internal auditors is included in the first procurement plan of the first 18 months of the project and included in the OM. The internal auditor, selected as an independent consultant, is expected to be hired about 6 months after Project effectiveness.

[21]Since the provinces have not previously been involved in a Bank supported operation, a capacity assessment of the DoHs was conducted based on the information provided on the FM questionnaires completed from a sample of five DoHs of Nam Dinh, Ninh Binh, Yen Bai, Bac Giang, Hung Yen and Lang Son, and field visits to Nam Dinh, Ninh Binh, Yen Bai and Lang Son. The centralized health system provides similar institutional and financial management arrangments among all the provincial DoH's.

19. **Governance and Anti-corruption.** To strengthen the financial management arrangements for the project and to help reduce the risk of fraud and corruption, particular emphasis is needed in the following areas: (i) clear FM responsibilities without gaps and overlaps in the duties to be performed in the Financial Management (FM) manual; (ii) internal audit function with comprehensive TOR approved by the Bank; (iii) authorization by Expenditures Verification Agencies (State Treasury and VDB) prior to payments, following the procedures in the country.

Disbursements

20. **Funds Flow.** The primary disbursement method will be Advances. One segregated US$ denominated Designated Account (DA) will be set up and managed by the MoH CPMU at a bank acceptable to IDA with a fixed ceiling of US$15,000,000. Supporting documentation required for documenting eligible expenditures paid from the DA are Statement of Expenditures and Records. The frequency for reporting eligible expenditures paid from the DA is quarterly. The Reimbursement, Special Commitment, and Direct Payment disbursement methods will also be available. Reimbursements would also be documented by Statement of Expenditures and Records. Direct payments will be documented by Records. The Minimum Application Size for Reimbursement, Special Commitment and Direct Payments will be US$3,000,000 equivalent.

21. Provincial project accounts in VND will be opened by provincial departments of health at the provincial level to receive advances from MoH CPMU. The CPMU will evaluate the amount of the request of the advance to each of the provincial project accounts and the subsequent use of the funds so far advanced[22] to ensure that if funds are not being used by the provinces, that they are refunded to the DA (these accounts will also be reflected on the DA Reconciliation Statement). Provincial departments of health (PPMUs) are the ultimate spending units at provincial level. The provincial departments of health will pay the contractors and suppliers for the goods and services provided, and pay the provincial Vietnam Social Insurance entity (PSS) for the health insurance cards purchased for the near poor, and report eligible expenditures to MoH CPMU for replenishment to the provincial project account. The Project will use the existing country system in management of the near poor health insurance cards to ensure project support is consistent with the management of the national health insurance system. The proposed ceiling of each of the project accounts is US$300,000 in VND although the actual amount will vary depending on the province and its implementation progress.

[22] The CPMU will need to keep track of all the advances made to the VND denominated Provincial project accounts from the US$ denominated Designated Account and the subsequent reporting of the use thereof so as to avoid any exchange rate issues, when reporting back to the Bank on the use of advances in US$.

22. The project will have a disbursement deadline date (final date on which the Bank will accept applications for withdrawal from the Recipient or documentation on the use of Credit proceeds already advanced by the Bank) four months after the closing date. This "Grace Period" is granted in order to permit the orderly project completion and closure of the Credit accounts via the submission of applications and supporting documentation for expenditures incurred on or before the closing date. Expenditures incurred between the closing date and the disbursement deadline date are not eligible for disbursement, except as otherwise agreed with the Bank.

23. **Proposed Disbursement Schedule.** Disbursement will be made against eligible expenditures for each of the Project components. See more detail in the table below. It is expected that the proceeds of the Credit will be disbursed over a period of six years from 2014 to 2020, including grace period.

Table 7: Proposed Disbursement Schedule

	Disbursement by Components	*US$ equiv. (million)*	*SDR Amount (million)*	*% Financing*
1.	Goods, works, non-consulting services, consultants' services, Incremental Operating costs, and Workshops & Training for Part 1 of the Project	116.0	77.4	100
2.	Insurance Subsidies, Catastrophic Payments, goods, non-consulting services, consultants' services, Incremental Operating Costs and Workshops & Training for Part 2 of the Project	29.0	19.35	100
3.	Goods, non-consulting services, consultants' services, Incremental Operating costs, and Workshops &Training for Part 3 of the Project	5.0	3.35	100
	TOTAL	150.0	100.1	

24. **Retroactive Financing.** Upon request from the government, the Financing Agreement will allow for retroactive financing in the amount of about SDR 1 million (US$1.5 million equivalent) for eligible expenditures under Components (1), (2), and (3) paid on or after September 2, 2012 but before the Signing Date of the Financing Agreement.

Procurement

25. **Procurement Capacity and Risk Assessment.** The CPMU to be established under MoH and the PPMUs to be established under the DoHs of the 13 participating provinces will be responsible for procurement under the proposed project. The MoH is familiar with the Bank's procurement rules and procedures, as the proposed project would be the fourth regional health support project in close succession. The large risks come from the newness of the provinces which, for the most part, have not previously been involved with the Bank. The Bank conducted the procurement capacity and risk assessment (PCRA) based on capacity assessment of related provincial DoH. The PCRA revealed that the procurement management capability at the local levels is weak. Although the participating Provincial DoHs have certain experience in conducting procurement in accordance with Vietnam public procurement law and regulations, the majority of them have no experience in management of Bank-financed project. Given the decentralization nature of the project where procurement implementation will be largely delegated to provincial level, the large number of implementing agencies with low capacity is expected to pose a major challenge to project procurement performance. Major risks include: (i) lack of knowledge and experience in Bank's procurement rules and procedures by PMU staff; (ii) possible confusion at provincial level on internal mechanism for approval of procurement decisions; (iii) possible delays due to untimely preparation of bidding documents and lengthy bid evaluation especially for large packages; and (iv) vulnerability to vague or bias/restrictive technical specifications favoring certain suppliers. The project procurement risk rating is therefore assessed as High.

26. **Risk Mitigation Measures.** To mitigate the identified risks, the following actions are recommended to be taken by CPMU and PPMUs. It is expected that after these measures are implemented, the Residual Risk would become Substantial.

Table 8: Procurement Risk Mitigation

	Actions	**Expected Date of Completion**	**Responsibility by**
1	Appointment of adequate qualified experienced officers to be in charge of procurement of the Project at MoH CPMU and provincial implementing agencies. Qualified procurement consultants, preferably having experience in Bank financed projects, will be mobilized if needed.	April 18, 2013. Additional consultants selected, if needed, and addressed by letter.	CPMU PPMUs
2	Prepare and enforce a hands-on procurement manual (covering rules, procedures, sample bidding documents evaluation report, etc.) as part of the Operations Manual (OM). The use of sample bidding documents indicated in the OM shall be mandatory.	Draft received on April 18, 2013. Adoption by or about September 30, 2013 and maintenance thereafter.	MoH
3	Provinces delegate the responsibilities for approval of bidding document and bid evaluation results to the Employer's level (e.g., the DoHs). The internal procedures and division of responsibilities should be clearly presented in the OM.	December 2013.	PPCs
4	CPMU provides coordinating role and help desk support to PPMUs in procurement implementation.	During implementation.	CPMU
5	Provide procurement training for PMU staff on the January 2011 Procurement and Consultant Guidelines, on routine and/or ad hoc basis.	During implementation.	WB, CPMU
6	Involve senior technical staffs and users or hire competent consultants to draft technical specifications.	During implementation.	CPMU, PPMUs

7	MoH develops standardized technical specifications for major equipment by involving senior technical specialists or competent consultants, and share with provinces for common use. Compulsory use of the above mentioned standardized specifications shall be clearly indicated in the OM.	Within 3 months after approval of the annual procurement plan for the respective equipment. During implementation.	MoH, CPMU
8	MoH/WB facilitates the exchange of experiences between the provinces that have longer experience in working with the Bank-funded operations and new provinces with less experience.	During implementation.	MoH,WB
9	Regularly monitor the performance of provincial subprojects. In case of poor performance including improper management or significant delay, reallocation of funds among provinces could be made through updates of Annual Work Plan.	During implementation.	MoH, CPMUs,PPMUs
10	Engage the internal and external auditor(s) to do procurement audits.	During implementation.	CPMU, PPMUs

27. **Procurement Arrangements.** Procurement for the proposed project will be carried out in accordance with the Bank's "Guidelines: Procurement of Goods and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 ("Procurement Guidelines"), and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 ("Consultant Guidelines"), as well as the relevant provisions in the Financing Agreement. The specific procurement methods, their application thresholds, and the thresholds for the Bank's Prior Review to be applied for these Components of the proposed project are indicated in the Table below:

Table 9: Summary of Procurement Arrangements

Category	**Procurement Method Thresholds**	**Bank's Prior Review Thresholds***
Works	ICB**: >=US$10,000,000/contract NCB***: <US$10,000,000/contract Shopping: <US$200,000/contract Direct Contracting (DC): exceptional circumstances	ICB: All NCB: first three contracts for CPMU and each PPMU Shopping: N/A DC: All
Goods and Non-Consulting Services	ICB: >=US$1,000,000/contract NCB***: <US$1,000,000/contract Shopping: <US$100,000 /contract Direct Contracting (DC): exceptional circumstances	ICB: All NCB: first three contracts for CPMU and each PPMU Shopping: N/A DC: All

Consulting Services****	QCBS: preferred method QBS: by nature & complexity LCS: by nature & complexity CQS: <US$300,000/contract SSS: exceptional circumstances Individual Consultant (IC): by nature & complexity	• Firms: - For competitive selection: >=US$300,000/contract, plus the first contract for CPMU and each PPMU regardless of value - For SSS: >=US$50,000/contract • Individual: - For competitive selection: only in exceptional cases - For SSS: >=US$20,000/contract • Auditing services: All

* Contracts below these Prior Review thresholds shall be subject to Post Review. The rate of post review will be initially 20 percent. This rate may be adjusted during project implementation based on the procurement performance.

** The applicability of ICB for Works has not been identified

*** The applicability of NCB for Works has been not been identified

The NCB procedures shall be those set forth in Vietnam's procurement laws and regulations, but subject to modifications, waivers, and exceptions as set forth in the "NCB Annex" to the Financing Agreement

**** Shortlists for contracts below US$0.3 million/contract may comprise entirely national consultants.

28. With regard to Subcomponent 1a (Provincial Subprojects for the Development of Medical Services and Quality Improvement), it is expected that procurement implementation will be largely delegated to the provincial level except for large ICB packages. In case of poor implementation by the provinces including improper management and significant delays, the subprojects may be reduced or cancelled in order to reallocate the funds to well-performing provinces. This would be addressed through the development and approval of the Annual Work Plan and Procurement Plan. The procurement arrangements are described in the OM.

29. **Procurement Plan.** The Procurement Plan for the first 18 months implementing the proposed project was prepared by the MoH and submitted to the World Bank dated April 18, 2013 and approved.

30. The above mentioned Procurement Plan shall be updated throughout the duration of the project as needed or at least annually. The updated Procurement Plan should retain all the contracts previously awarded to present a full picture on procurement under the project. All

procurement plans, their updates or modifications shall be subject to Bank's prior review and no-objection. The Bank shall arrange after project negotiations the publication on the Bank's external website of the agreed initial procurement plan and all subsequent updates.

31. **Engagement of government owned research institutes.** It is envisaged that the Information Center of VSS, a government owned research institute under the VSS, would be engaged in a consulting services contract under the project for monitoring and reporting of the patient flows in the project provinces and according to the specific specialties supported by the Project. This is the only institution in Vietnam that would have direct access to VSS data and would be able to manipulate it in the format and time required for proper project monitoring; hence, the VSS Information Center is considered to be uniquely qualified (as per para. 1.13 (c) of the Guidelines for selection and Employment of Consultants) for the proposed assignment. Another assignment for which hiring a government owned research institute is envisaged is the provision of policy relevant research on hospital overcrowding. The Health Strategy and Policy Institute (HSPI),which is a research institute under the MoH, is considered to be the key technical institute with experience in this area. Both the VSS Information Center and HSPI would carry out tasks that are incremental to their statutory activities. Any other request by the MoH for hiring a government owned research institute would be justified and reviewed on a case-by-case basis in accordance with the provision of the Guidelines especially in respect of paras. 1.9 and 1.11-1.13 of the Guidelines for selection and Employment of Consultants; if found justified, the institution would be hired on a single source basis. In each case, the Bank team would ensure that the tasks would not be covered by the usual activities of the institute concerned for which it was already receiving financing from other sources.

Environmental and Social (including safeguards)

Environment

32. The project was classified as category B as its potential environmental and social impacts are assessed to be localized and manageable through good design and management practices. The project may cause adverse environmental impacts related to the medical equipment purchase and upgrading provincial/district level hospitals activities under the project subcomponent 1a. These activities are included in the subprojects of participating provinces. So far, the detailed activities of these subprojects have not yet been fully identified.

33. The key adverse environmental potential impacts of the project during implementation include the generation of dust, noise, solid waste, wastewater, local flooding and safety issues at a low level and in short-term period. The generation of hospital/healthcare waste is the main, long-term environmental issue during the operation of beneficiary hospitals.

34. The development of oncology services will be supported by the project. It is agreed with the Borrower that the project would not specifically invest in radiation therapy equipment until such time as the MoH has issued guidelines to pilot the provision of radiation therapy treatment on a primarily outpatient as opposed to inpatient basis. In the case that the radiation therapy equipment is financed, there will be a potential significant health risk relating to the exposure to ionizing radiation during the operation of this equipment.

35. **Environmental and Social Management Framework.** As part of preparation, an ESMF was developed by MoH. The ESMF is in accordance with the Bank's safeguards policies and national regulations on environmental management. It will be approved by MoH and included in the OM to ensure that environmental and social issues will be considered together with other requirements during project implementation. It includes: (i) a screening mechanism to exclude ineligible activities; (ii) identification of potential impacts and development of mitigation measures during subproject design, construction and operation including the Environmental Codes of Practice for minor construction/rehabilitation activities; (iii) preparation and clearance of safeguard documents for participating subprojects and hospitals which include the development of an Environmental Management Plan (EMP) and Hospital Waste Management Plan as a part of the EMP; (iv) safeguard implementation, supervision, monitoring and reporting; (vi) institutional arrangements and budget for safeguard implementation; and (vii) institutional capacity building program for the CPMU and other relevant safeguard implementing entities.

36. So far, the project support for radiation therapy equipment is still being considered. However, the ESMF also covers health risk relating to the exposure to ionizing radiation associated with the operation of radiation therapy equipment. Additionally, it was agreed that the ESMF will be reviewed, updated and re-disclosed as necessary to take into account the potential environmental impact and mitigation measures necessary as a byproduct of this service.

37. **Public consultation.** During preparation of the ESMF, meaningful consultation was conducted with participating provinces and MoH staff. Thirteen provinces conducted rapid assessments on healthcare waste management in their province based on self-administered questionnaires. The ESMF was disseminated to relevant agencies within MoH including Vietnam Health Environment Management Agency for review. The concerns and feedback during consultation were taken into account and reflected in the final draft ESMF.

38. **Information Disclosure.** The final ESMF has been disclosed locally at the MoH office and website and Vietnam Development Information Center (VDIC) in Vietnamese language on January 21, 2013. In addition, it has been disclosed in WB InfoShop in Washington DC in English language on January 23, 2013.

39. **Safeguard implementation and capacity building.** The project CPMU under MoH, PPMUs under Provincial DoH of participating provinces and beneficiary hospitals are the key actors responsible for safeguard implementation. The CPMU will have the overall responsibility for safeguard implementation including providing guidance on safeguard requirements and carry out environmental monitoring to ensure provincial subprojects and their hospitals adequately implement safeguard compliance. The PPMUs is responsible for ensuring safeguard compliance of its subproject at provincial level. The beneficiary hospitals under each province will be accountable for implementing safeguard requirements of financed activities. The project will require the allocation of qualified environmental staff/consultant under CPMU to oversee environment and social safeguard issues and necessary training will be carried out to strengthen capacity of CPMU, PPMUs and hospitals in implementing safeguard requirements.

Social

40. **The Bank's safeguard policy on Indigenous People (OP4.10) is triggered.** The Project is not expected to have any adverse impacts on ethnic minority groups. The percentage of ethnic minority people in total population is different across project provinces, ranging from 2.6 percent in Ninh Binh to 83.1 percent in Lang Son. The main and largest ethnic groups living in the project provinces include: Thai, Tay, Muong, Nung, Hmong, Dao, San Chay and San Diu. It is expected that the project will help to reduce the financial barriers to access by the economically vulnerable with focus (including ethnic minority groups) by: (i) administering the subsidy for the near poor health insurance premium subject to family enrollment (the subsidy payment); and (ii) providing IEC activities related to the health insurance benefits targeted at those who do not yet have insurance as well informing those who already insured about their benefits.

41. In line with OP 4.10, a Social Assessment was done to identify and characterize key stakeholders in terms of their importance to and influence over the project objectives and implementation; to identify potential barriers (cultural, institutional, financial, language etc.) for ethnic minority communities in the project area to access the project benefits and services; and to document the 'broad community support' toward the project's activities and define the processes for best ensuring the consultation and participation of these stakeholders (especially ethnic minority communities) in project implementation, design, implementation, and monitoring and feedback.

42. Key constraints affecting the access to health care service include: (i) long distance from the communities to the health service clinics, lack and of transport and poor quality of roads; (ii) indigenous knowledge system, traditions and practices; (iii) language barriers; (iv) low level of educational attainment; (v) low economic status and income; and (vi) high rate of acute and chronic diseases. These factors will be factored into all IEC activities supported by the project.

43. As a result of the consultation, it was shown that Project stakeholders including beneficiaries and local health staff/authorities at different levels fully supported the Project. All trusted that the Project would not create any negative impacts on the disadvantaged and ethnic minority people but bring about the better access to health services.

44. Based on the findings of social assessment, an EMDP was developed for the project. The mechanisms for ensuring culturally appropriate intervention and equal access to project benefits are addressed in the OM and in the EMDP. The compliance with the EMDP will be monitored by the CPMU safeguard team and regularly supervised by the Bank team during supervision missions.

45. **Information Disclosure.** The final EMDP was disclosed locally at the MoH office and website and Vietnam Development Information Center (VDIC) in Vietnamese language on January 21, 2013. In addition, it has been disclosed in WB InfoShop in Washington DC in English language on January 22, 2013.

Monitoring & Evaluation

46. The project outcomes and results indicators will be measured regularly throughout the project implementation with reference to the baseline values. To the extent possible, the project will rely on existing health information systems and data collection mechanism in the MoH and in provinces in order not to create any unnecessary burden to the current system. The project will also utilize national representative surveys, i.e Vietnam Household Living Standard Survey, which is implemented every two years, for the regional aggregated data, especially for socio-economic related indicators. Data on health insurance coverage and health service utilizations will be collected from the routine reporting system by VSS and health facilities.

47. However, for certain statistics related to specific project interventions, it will be necessary to design specific data collection tools and conduct independent data collection (e.g., household surveys, patient exit surveys, health facility surveys). It is also expected that with project interventions on improving health service quality in hospitals, the information system of the hospital will also be improved thus can help to produce better quality of data.

48. The Project Management Unit at both central and provincial levels will be responsible for monitoring of project implementation and project results. The CPMU and each PPMU shall assign a qualified M&E staff. For baseline, mid-term and end-project surveys, consulting firms shall be hired to complete the task with technical oversight by CPMU and Bank Task Team.

49. The monitoring of the PDO results indicators would be contracted to the Information Center of the VSS Institute which has ready access to the confidential patient data. The Institute will also be able to target the data for the specific provinces and intervention areas supported by the Provinces. A contract will be arranged between the MoH and the VSS Information Center to provide quarterly reporting in an agreed format. To increase the accuracy of the hospital reporting, training of the hospitals on complete reporting and coding will be provided, including the use of VSS personnel as trainers in accordance with government norms on civil servants providing training in addition to their regular duties.

50. The project will carry out a baseline survey during the first year of the project to gather baseline information with respect to patient satisfaction as well as well public understanding of the health insurance system. The MoH should report on the results of the baseline survey by December 31, 2014. All results indicators will be updated by mid-term and end-project with respective surveys, while some indicators will be collected at more routine basis. The Project Mid-Term Review should take place by June 30, 2017, about 3.5 years after the start of implementation and with the availability of the end of year 2016 information. The CPMU shall collect necessary information from provinces and report to the Bank two weeks prior to the implementation support mission, which will be formally scheduled twice a year. Details on result indicators were shown in Annex 1.

ANNEX 4: OPERATIONAL RISK ASSESSMENT FRAMEWORK (ORAF)

Vietnam: North East and Red River Delta Regional Health System Support Project (P122629)

Project Stakeholder Risks						
Stakeholder Risk	Rating	Low				
Description: 1. Risk of poor coordination among government agencies at central and local levels could impact the efficiency of the project preparation and implementation	**Risk Management:** The provincial proposals will be endorsed by the Provincial People's Committees with the detailed commitment on local resources and sound coordination mechanism among concerned agencies; while the number of agencies involved at the center will be minimized during implementation (concentrating at the MoH among a few key departments).					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
2. Risk of lack of ownership	**Risk Management:** The Project directly responds to the highest priority of the Ministry -- hospital overcrowding and universal health coverage -- for which there is also national pressure from the National Assembly and the Party. The provinces will carry out need assessments and will own the subproject proposals, within the framework outlined by the Ministry.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
3. Stakeholder interests could run contrary to the Project and they would undermine project implementation	**Risk Management:** The project design does not take on major reform challenges and instead support strategy implementation; no major stakeholder interests are threatened.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due	Frequency: Yearly	Status: In

				Date:		Progress

Implementing Agency (IA) Risks (including Fiduciary Risks)						
Capacity	Rating	Substantial				
Description: The DoHs in the project provinces will, most likely, be involved for the first time in implementing a Bank-financed project. Therefore, they will not be familiar with the Bank procedures. Risks of insufficient capacity could cause delays in development of provincial application/proposals (for the 2nd and following rounds); preparation and approval of implementation plan, procurement plans, bidding documents, bid evaluation reports and contract management actions; in compliance with the Bank's FM requirement. Project management capacity at the central and local levels is relatively weak. The project implementation team in MoH comprises key members and directors from three departments (DPF, MSA, HID) of which two will be implementing a Bank supported project for the first time. There will be a learning curve for implementation. Participating provinces and hospitals will use their own structures for implementing grants under the Component 1 that may be a capacity constraint for managing investment	**Risk Management:** Qualified consultants will be recruited to assist the provinces in the implementation.					
	Resp: Client	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: The Bank will facilitate the exchange of experiences between the provinces that have longer experience in working with the Bank-funded operations and new provinces with less experience.					
	Resp: Client & Bank	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: Intensive procurement training (on routine and/or ad-hoc basis) would be done for the participating provinces.					
	Resp: Client & Bank	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Project documents have been prepared to facilitate the implementation including, but not limited to, (i) agreed templates and guidelines for provincial proposals; (ii) guidelines for appropriate technology and equipment selection; (iii) guidelines with standardized grant costing; (iv) appraisal of provincial proposals by MoH (initially jointly with IDA).					
	Resp: Client & Bank	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress

projects. Differences between the Bank's Guidelines and government regulations on procurement and tendency to follow government procurement regulations by project staff at both central and local levels. Borrower's unfamiliarity with procurement policies and procedures set out in the Bank's Procurement & Consultant Guidelines. Capacity of the central and provincial level hospitals may be limited to provide technical transfer and support as much as that which be demanded during peak periods. High level of decentralization of procurement responsibility to provincial DoHs and hospitals. Bureaucracy in review/appraisal/approval procedures by MoH, PPCs for procurement decisions that potentially delay the procurement process.	**Risk Management:** Publication of sample bidding documents and evaluation reports in the project OM. Use of the sample bidding documents indicated in the OM is mandatory. The OM shall be updated when needed.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Standardized technical specifications for major equipment will be developed and shared with provinces for use by involving senior technical staff of MoH/provincial DoHs and users or hiring competent consultants.					
	Resp: Client	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: Project has a rolling design that allows for clustered implementation of proposals. The rolling design also implies that any time new proposals are launched/ approved, there will be proposals that are under implementation; lessons can be shared thus reducing the risk. TAG functioning as help-desk support mechanisms is also expected to lower the risk.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: The technology transfer and support will be directly supported by the project.					
	Resp: Client & Bank	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: The Central Hospitals and the MoH have an existing model of technical transfer support that will be used as a model.					
	Resp: Client &	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress

	Bank					
	Risk Management: The active involvement of the large central hospitals in the project design and since they get something out of implementation, they should lend their support and pressure on the MoH for implementation.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
Governance	Rating	Substantial				
Description: Project addresses two key areas among highest priorities of health sector in Vietnam - reduction of hospital overcrowding and increase of universal coverage. The political mandate for the project implementation will certainly be there. The day to day management, however, could be encumbered from a lack of coordination and cooperation among the key stakeholders. The coordination includes within the MoH (three departments involved), at the central level including the MoH, VSS and central hospitals, between the center and provinces, and within the provinces (between the PPCs, provincial and district hospitals). The decentralization diversifies and spreads the potential procurement risks.	**Risk Management:** Government: the master plans for overcrowding reduction and increase of universal health have been developed and are submitted to Prime Minister for approval. Such approvals will create the favorable environment and mechanism for stakeholders to be accountable.					
	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Consultation and training workshops on the project designed and implementation have been and will be conducted with the mandatory participation of all stakeholders and provide changes for them to contribute the project design and address implementation issues.					
	Resp: Client & Bank	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Internal auditor(s) is mobilized to do the procurement audit.					
	Resp: Client	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: Several power stakeholders (central level hospitals and provincial hospitals) would have incentive for project implementation to proceed.					

	Resp: Client	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Training on Bank's procedures will be provided by the Bank team, followed by the CPMU, throughout the implementation period.					
	Resp: Client & Bank	Stage: Both	Recurrent:	Due Date:	Frequency: Yearly	Status: In Progress
	Risk Management: Post procurement review will be conducted routinely and by qualified staff.					
	Resp: Client & Bank	Stage: Implementation	Recurrent:	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: FM and Procurement procedures will be clearly defined in details in operational manual on which the intensive training will be conducted as soon as possible.					
	Resp: Client & Bank	Stage: Both	Recurrent:	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: Semi-annual FM reviews for all implementing agencies will be conducted by qualified FMSs. Annual external financial audit is required					
	Resp: Client & Bank	Stage: Both	Recurrent:	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management: Provide and be prepared to reduce and/cancel a project's initial proposal if the project province shows sign of the downturn.					
	Resp:	Stage:	Recurrent:	Due Date:	Frequency: Yearly	Status:
Project Risks						
Design	Rating	Substantial				
Description:	**Risk Management:**					

Capacity constraint for developing quality provincial and hospital proposals and selection of appropriate host central hospitals and technology-transfer mechanism in decentralized implementation arrangement. Vulnerability to special interest to develop narrow/bias/restrictive technical specifications favoring some bidders, suppliers and lead to corruptive practices. MoH ability to coordinate and provide oversight/support to highly decentralized project implementation arrangements. Large number of implementing agencies and low capacity in implementing procurement at participating province and hospital level. Risks of implementing the health insurance support to the near poor will be delayed due to the delay in identifying the beneficiaries according to the newly issued decision to support the near poor from the government budget for those who graduate from the poor less than 5 years.	Template has been designed and tested in the first groups of provinces with the intensive support from CPMU and Bank staff.					
	Resp: Client	Stage: Both	Recurrent:	Due Date:	Frequency:	Status: In Progress
	Risk Management: Diligent review of technical specifications will be done before provinces issue the bid doc					
	Resp: Client & Bank	Stage: Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Not Yet Due
	Risk Management: Technical teams consisting of qualified seconded MoH staff and consultants will provide support to provinces and hospitals throughout the project preparation and implementation. Hand-on training will also be conducted as needed.					
	Resp: Client	Stage: Both	Recurrent: ☐	Due Date:	Frequency:	Status: Not Yet Due
	Risk Management: TA is included as project activities to support the identification of the near poor beneficiaries					
	Resp: Client & Bank	Stage: Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: In Progress
	Risk Management: The first and largest component is designed as "Fund" type of mechanism where provinces have to demand the use of the funds. All provinces have to apply for the fund and it is subject to reallocate if not applied and used.					
	Resp: Client & Bank	Stage: Both	Recurrent: ☐	Due Date:	Frequency:	Status: In Progress
Social and Environmental	Rating	Moderate				

<table>
<tr><td rowspan="4">Description:

There is a minor risk that some ethnic minorities living in the project provinces may not benefit from the project to the same extent as other population groups. However the share of the ethnic minorities in the involved provinces is smaller than in other Bank operations and they are more blended into the general population, which decreases the risk of them being excluded from the project benefits. The project is not going to worsen in any possible way access to health services for ethnic minorities. It is most likely that all population groups and especially the disadvantaged ones will benefit from the project.

Renovation of existing facilities generates dust, noise, vibration, and construction waste, potentially causing minor impacts to patients, their relatives and hospital staff.

There are potential environmental and health risk from improper disposal/management of hazardous healthcare waste during the operation of invested hospital.</td><td colspan="6">Risk Management:
Environmental Codes of Practice are developed and incorporated into the Environmental and Social Management Framework (ESMF).
The Contractor shall throughout the contract comply with Environmental Codes of Practices under supervision of investor and hospital managers.
The ESMF includes establishment or improvement of hospital waste management system; Each project hospital shall have a hospital waste management plan prepared and approved by local authority.</td></tr>
<tr><td>Resp: Client</td><td>Stage: Both</td><td>Recurrent: ☑</td><td>Due Date:</td><td>Frequency: Yearly</td><td>Status: Not Yet Due</td></tr>
<tr><td colspan="6">Risk Management:
The project hospitals and investors at provincial level will be provided with TA such as training, guidance, supervision in preparation and implementation of hospital waste management plans.
The project hospitals are eligible to receive sub-grants for investment in solid waste and wastewater treatment system from Hospital waste management improvement facility which are being managed by MoH and financed by the World Bank.
Financing for hospital waste management equipment and facilities in the second stage of implementation will be determined based on demand from project hospitals and local authorities in accordance with their needs and priorities.</td></tr>
<tr><td>Resp: Client</td><td>Stage: Both</td><td>Recurrent: ☑</td><td>Due Date:</td><td>Frequency: Yearly</td><td>Status: In Progress</td></tr>
<tr><td>Program and Donor</td><td>Rating</td><td colspan="5">Low</td></tr>
<tr><td rowspan="2">Description:

Risks is low as the project support to address two key issues of health sector for which national strategies were developed</td><td colspan="6">Risk Management:</td></tr>
<tr><td>Resp:</td><td>Stage:</td><td>Recurrent: ☐</td><td>Due Date:</td><td>Frequency:</td><td>Status:</td></tr>
</table>

and are awaiting approval from Prime Minister.						

Delivery Monitoring and Sustainability	Rating	Moderate

Description:	**Risk Management:**					
Sustainability is high due to the project is in line with government and MoH's strategic developments in the coming years. The project is not supporting the procurement of complex equipment or construction of facilities. Therefore the risk is low.	Clear and measurable result framework and agreed performance indicators are developed. Dedicated and qualified full time staff at CPMU and provinces are hired to perform this M&E responsibilities.					
	Resp: Client & Bank	Stage: Both	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: In Progress
Considerably weak capacity for monitoring the project implementation and performance indicators given the highly decentralized nature of project design	**Risk Management:**					
	Additional health procedures and equipment to be provided will be revenue enhancing for the facilities as they are able to do more advanced services than currently capable.					
	Resp: Client	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due
	Risk Management:					
	The coverage of the Near Poor under the national health insurance system is included in the Road Map for UHC and given the trajectory of state support for vulnerable groups is likely to become national policy.					
	Resp: Client	Stage: Implementation	Recurrent: ☑	Due Date:	Frequency: Yearly	Status: Not Yet Due

Overall Risk
Implementation Risk Rating: Substantial
Description: Overall, the risk is rated as substantial. The MoH is familiar with implementing this kind of operation. At least initially, this project will implement concurrently with two other regional health support operations. Less than a year after implementation begins, the experienced team from the Northern Uplands Regional Health Support Project will be available. The potential risk remains while current CPMU and PPMU staff as well as standard operating procedures are not yet available. The project will be implementing in several and diverse regions. The tasks will for the

large part be decentralized which increases the opportunity for moving faster in some places while others may lag behind. However, the decentralization also includes an increased risk that will have to be mitigated during implementation with both internal controls, monitoring and supervision.

ANNEX 5: ECONOMIC AND FINANCIAL ANALYSIS[23]

Vietnam: North East and Red River Delta Regions Health System Support Project

Economic and Sector context

1. In recent years, Vietnam has encountered economic difficulties. In the context of an economy suffering from the negative impacts of the sovereign debt crisis in the European Union and the reverberating consequences of the 2008 global crisis, loose domestic macroeconomic policies were largely responsible for the record high rates of inflation in 2011. A once-booming property market has come down, leaving the banking industry weak and vulnerable. In response, the government has implemented tightened macroeconomic policies and managed to bring inflation back down. The economic situation has become more stable and confidence in the currency has increased. However, both output and credit growth have slowed, and vulnerabilities in the financial sector are still a major concern. Percent change in real GDP has declined from 2010 and although projections for the following years are positive (Table 10), the earlier period of stunning fast growth is now gone, opening a new phase of economic growth that necessitates more cautious moves. Furthermore, these recent challenges have also exerted downward pressures on public spending.

Table 10: Vietnam's GDP growth rates and estimated projections

Output				**Estimated projections**		
	2008	2009	2010	2011	2012	2013
Real GDP (Percent change)	6.3	5.3	6.8	5.9	6.0	6.3

Source: IMF 2012 Article IV Consultation.

2. The government has earlier set itself the goal of achieving universal health coverage by 2014. However, up to now, only over 60 percent of the population has health insurance (Table 11), which calls for more effective measures. On November 22, 2012, the Party issued its Resolution No. 21-NQ/TW for the period of 2012-2020, setting a more realistic goal of having 80 percent of the population insured by 2020.

[23]The Project appraisal was completed prior to April 8, 2013 when the new Economic Analysis Guidelines are to be applied.

Table 11: Health insurance participation over the years

Year	No. of health insured people (millions)	Percentage of health insured population (percent)
1998	9.74	12.70
2000	10.62	13.40
2002	13.03	16.50
2004	18.39	21.10
2006	36.87	43.90
2008	37.70	43.76
2010	52.41	60.92

Source: Health Statistics Yearbook 2010.

3. At the same time, the near poor population has come to the center of attention after various policy dialogues on ways to expand health coverage. As a result, the government's phased approach has shifted to near poor households. On June 26, 2012, the Prime Minister signed Decision No. 797/QD-TTg to increase the level of subsidy of health insurance premium for the near poor from 50 percent to 70 percent. In December 2012, the Ministry of Finance submitted to the government a policy draft to extend full health insurance subsidy to the near poor in certain categories.[24] The near poor group is also the target group of this project.

4. There are a number of key health system features that pose problems to the equity and efficiency of health spending.

5. **Low levels of public spending on health.** Vietnam's government health spending has improved in the last few years thanks to the commitment to expanding social protection for vulnerable groups. The level of government health expenditure as a share of total government expenditure has increased from 8.7 percent in 2008 to 11.28 percent in 2009 and 12.38 percent in 2010,[25] the average of which is now close to the average among South East Asian countries.[26]

[24] Vietnam government Web Portal News. http://baodientu.chinhphu.vn/Home/Mot-so-doi-tuong-ho-can-ngheo-se-duoc-ho-tro-100-dong-BHYT/201212/156077.vgp.

[25] Ministry of Health, 2010. Health Statistics Yearbook.

[26] World Health Organization.Global Health Expenditure Database.

6. Public spending on health as part of total health spending has increased in the last few years, from 20 percent in 2008 to 24.2 percent in 2010. However, this portion remains low while household direct out-of-pocket health expenditure still makes up for nearly 60 percent of total health spending (Table 12).

Table 12: Sources of health financing in Vietnam

Source of health financing	Spending as percentage of total health expenditure		
	2008	2009	2010
Government health expenditure	23.2	21.8	24.2
Household out-of-pocket payments	54.3	50.7	57.6
Insurance contributions	15.2	20.6	13.6

Source: World Bank and National Health Accounts.

7. Vietnam's public spending on health as part of total health spending is also low compared to most other countries in the region (Table 13) where this figure ranges from 30 percent to 86 percent.

Table 13: Government health spending as part of total health expenditure in some Asian countries (%)

Country	Government health expenditure as percentage of total health expenditure		
	2008	2009	2010
Bangladesh	32	33	34
Bhutan	86	86	87
India	28	30	29
Indonesia	46	46	49
Nepal	37	38	35
Sri Lanka	47	46	45
Thailand	76	75	75
Timor Leste	70	66	56
Vietnam	23	22	24

Source: National Health Accounts and Global Health Expenditure Database.

8. Although government health expenditure in Vietnam has increased at a faster rate than GDP,[27] this has happened without commensurate improvements in the quality and depth of health insurance coverage due to systemic problems that make it difficult to control the growth of out-of-pocket spending. In order to expand and deepen health insurance coverage, Vietnam will need to increase government spending on health and/or significantly increase the effectiveness of current spending, which would demand substantial efficiency gains so as to lower health-related out-of-pocket expenditure and improve access to and quality of health services in the nation.

9. **Regional disparities in public spending.** While the distribution of public spending between provinces has been ameliorated, thanks to improvements in the inter-governmental transfer mechanisms, the allocation of public spending within provinces continues to be a source of inequality. Under the highly decentralized health system, local government health finances still account for the largest component of government spending. The strengthened inter-governmental transfer mechanisms have increased the amount of subsidy for the poorest provinces. Nevertheless, less poor provinces with limited local revenues are at a disadvantage. Moreover, there still exist within-province inequalities in spending.

10. **Socio-economic disparities in public spending.** While the incidence of public health spending remains pro-rich, there have been improvements in equity in public spending. According to the HSPI, in the period of 2006-2010, the poorest 20 percent of the population only received 17 percent of total inpatient subsidy and 14 percent of total outpatient subsidy for use of hospital facilities. Meanwhile, the rich accounted for 22 percent and 29 percent respectively of total inpatient and outpatient subsidies (Table 14). The main reason for this unequal pattern is that wealthier patients make up a disproportionately large share of use of urban hospitals, which receive a very large share of total government health spending.[28] However, the findings of HSPI's study have also revealed that equity in public spending has actually improved from 2006 to 2010, and this improvement appears to be linked to the increase in health insurance coverage.

[27] Fleisher L. and Tandon A. (2012). The Macro-Fiscal Context of Universal Coverage in Vietnam. *Policy Note*. World Bank.

[28] World Health Organization, 2009. National Health Accounts Vietnam.

Table 14: Incidence of public subsidies for health 2010 (%)

Income-based quintile	Hospital facilities	
	Inpatient (episodes)	Outpatient (visits)
Poorest quintile	17.78	14.36
2nd	19.62	15.36
3rd	20.12	17.43
4th	20.38	23.59
Richest quintile	22.11	29.27

Source: Health Strategy and Policy Institute, 2012. Benefit Incidence Analysis, 2006-2010.

11. **Low levels of financial protection.** The level of health insurance coverage for the poor has increased substantially due to the government's initiative to sponsor 100 percent of their health insurance costs. Since 2009, the near poor received 50 percent of sponsorship for health insurance premium from the government. However, up to now, only about 25 percent of the near poor population has health insurance, which necessitates more initiatives and investments to increase the level of financial protection for the near poor.[29]

12. Moreover, as mentioned above, out-of-pocket payments still stay at high levels due to the inadequate structure of health insurance: the insurer only reimburses a part of the provider's costs, with the rest covered by supply side subsidies and out-of-pocket payments. Nearly 15 percent of Vietnamese households incurred out-of-pocket payments that exceed 20 percent of their non-food discretionary consumption.[30] The poverty headcount in Vietnam would have been 1.1 percent lower in the absence of out-of-pocket payment.[31] Moreover, insurance does not cover over-the-counter drugs, which are a major source of out-of-pocket spending.

[29] Vietnam Social Security. http://baohiemxahoi.gov.vn/index.aspx?u=nws&su=d&cid=384&id=5036.

[30] Van Doorslaer E. et al. (2007)Catastrophic Payments for Healthcare in Asia. *Health Economics*, *16*, 1159-1184.

[31] Van Doorslaer E. et al. (2006). Effects of Payments for Healthcare on Poverty Estimates in 11 Countries in Asia: An Analysis of Household Survey Data. *Lancet*, *368*, 1357-1364.

13. **Allocative inefficiencies in public sector delivery.** Supply-side subsidies, which are based on staffing levels and bed-norms, encourage providers to maintain high hospital occupancy rates. As such, providers and patients do not have the incentives to shift their demand towards lower level health facilities. At the same time, since out-of-pocket payments incurred at low- and high-level facilities are not very different, there is no incentive for uninsured patients to get medical attention from lower level health facilities, especially given the perception that the quality of care is superior at the higher level.

14. **Technical inefficiencies in public sector delivery.** The annual increase in hospital costs is significant. However, it does not come with increases in throughput or more complex case-mix. This cost increase correlates with an increasingly sophisticated style of care, without corresponding improvements in health outcomes.

15. Such problems necessitate increased financing to strengthen health system performance and system level reforms to improve equity and reduce allocative and technical inefficiencies. Institutional reforms also play an important role in improving governance and stewardship.

16. The premise of the project is to support the government in dealing with several of these challenges in the NE and RRD region. The project will take advantage of lessons learned from similar reforms implemented in other regions, including the Central North and Northern Uplands and Mekong regions, as well as international experience.

Economic analysis

17. Due to difficulties in assigning a monetary value to expected improvements in health outcomes, the economic analysis has made no attempt to quantitatively estimate the net present value of benefits from the project through cost-benefit analysis. The main objectives of the project are to improve quality of services provided at provincial and district hospitals, ease hospital overcrowding, increase access to healthcare and reduce financial risk for economically vulnerable groups. Therefore, the analysis will instead establish an economic case for the project's investments by presenting the mechanisms through which cost savings will be achieved, including: (1) increased efficiencies in both the production and consumption of health services, leading to cost savings that will generate additional resources for the sector as a whole; and (2) correcting market failures: addressing the failure of insurance markets to provide adequate protection for households against catastrophic costs associated with acute curative care.

18. The main sources of inefficiencies in the production of services are poor quality of medical equipment, inadequate training and lack of incentives for efficient performance. Under Components One and Three of the project, investments in medical equipment, training and TA to improve performance of the service delivery system in district hospitals will help decrease the cost of wasteful and unnecessary treatments that generally result from inaccurate diagnosis.

Moreover, project's investments in an enhanced system of telemedicine for both provincial and district hospitals will help provide quality diagnosis from a distance, consequently improving health outcomes and reducing transport costs for patients in seeking care.

19. With a better-trained workforce through "satellite" department initiatives, together with good quality equipment, the input mix will become more optimal, hence increasing technical efficiencies in production. For example, project investments to increase the skill level of pediatricians will change the skill mix in the region into a more efficient one. Finally, the throughput of district hospitals will increase significantly due to insurance on the demand side, and improved quality of services on the supply side. The increase in throughput will be achieved without substantial increases in the hospital budget, at least in the short to medium term. The decline in unit costs will be an improvement in efficiency in itself.

20. The inefficiencies in the consumption of services are associated with households bypassing commune and district level services in favor of provincial and central level facilities. In Vietnam, lower level services are perceived to be of poor quality because they are traditionally associated with shortages of staff, poor quality equipment and supplies. As a result, households choose provincial and central level hospitals and end up paying higher user fees and transport costs. The project's investments in improving the quality and availability of personnel and equipment at district level facilities will help reduce this bypassing and strengthen the referral system. Moreover, for insured individuals, the co-payment for use of higher level hospitals is substantially higher. If the insured seek care at a higher level (Level 1 or 2) hospital, only 30-50 percent of their expenditures are reimbursed. However, they receive 70 percent reimbursement for expenses paid at a lower level (Level 3) hospital. The near poor who become insured through the project will thus have a greater incentive to use district hospitals than if they were uninsured.

21. By both improving the quality of care at the district level and prioritizing district hospitals that are farther away from provincial centers where provincial hospitals typically are located, the project will help ease hospital overcrowding (Table 15) as demand will be shifted to district hospitals. This mechanism rests on the rationale that residents of more remote areas will have a greater incentive to use district level health facilities (once these facilities are improved) than those who live closer to provincial and central hospitals due to factors like transport costs and the need for timely treatment.

Table 15: Bed occupancy rates at hospitals are consistently over 100%

	Total			Central hospitals			Local hospitals		
	2008	2009	2010	2008	2009	2010	2008	2009	2010
Bed occupancy rate (%)	125.62	127.32	116.60	128.52	127.56	124.03	126.66	128.10	117.16

Source: Health Statistics Yearbooks 2008, 2009 and 2010.

22. Moreover, the project targets five priority curative areas (obstetrics/gynecology, pediatrics, traumatology/orthopedics, cardiology, and oncology) that are associated with leading causes of morbidity and death nationwide as well as in the NE and RRD region. For example, transport or work-related accidents and heart failure result in the highest death rates in the country, while these same conditions together with other cardiology and obstetrics-related diseases are among the leading causes of death in the region (Table 16). The region also accounts for over 35 percent of total cases of hemorrhage nationwide, the most common obstetric complication out of the five listed in the Health Statistics Yearbook 2010. Thai Binh, one of the 13 provinces covered by the project, has the single highest number of hemorrhage cases in the country with 224 cases, accounting for nearly 10 percent of the total number. Meanwhile, neoplasm is among disease chapters associated with high rates of death nationwide – 2 percent of cases and 1 percent of deaths.[32] The project will help increase access to these critical curative services and better reduce the death and morbidity rates in the region.

[32] Ministry of Health, 2010. Health Statistics Yearbook.

Table 16: Leading causes of mortality for the Red River Delta and North East region

Region	Code report	Name of diseases	Deaths (Per 100 000 inhabitants)
Red River Delta	039	Human immuno-deficiency virus disease	0.66
	295	Contact with heat and hot substances	0.35
	290	Transport accidents	0.34
	278	Intracranial injury	0.31
	281	Other injuries of specified, unspecified and multiple body regions	0.22
	169	Pneumonia	0.12
	147	Heart failure	0.10
	153	Intracerebral hemorrhage	0.10
	150	Conduction disorders and cardiac arrhythmia	0.05
Northern midlands and mountain areas	169	Pneumonia	1.90
	278	Intracranial injury	0.80
	249	Other respiratory disorders originating in the perinatal period	0.71
	150	Conduction disorders and cardiac arrhythmias	0.69
	153	Intracerebral haemorrhage	0.61
	039	Human immuno deficiency virus disease	0.59
	155	Stroke, not specified as haemorrhage or infraction	0.54
	151	Transport accidents	0.47
	179	Other diseases of respiratory system	0.39
	246	Slow fetal growth, fetal malnutrition and disorders related to short gestation and low birth weight	0.39

Source: Health Statistics Yearbook 2010.

23. The project is also expected to have a positive impact on health equity and poverty reduction in the region. Quantitative evaluations of health insurance expansions in Vietnam have shown that increased health insurance coverage has had positive impacts on health outcomes and access to care, while reducing the out-of-pocket burden on poor households.[33]Some authors have also pointed out two factors that tend to limit the impact of health insurance expansion: the poor quality of care, especially in poor areas, and the fact that health insurance contributions are too low to cover the cost of the package of services promised to the insured.[34] The project, by improving access to health insurance on the one hand, and on the other hand tackling two of the main factors that have undermined earlier health insurance reforms, is likely to help improve equity and reduce poverty. A study conducted on the financial burden of household out-of-pocket health expenditure by Minh et al. (2012)[35]shows that the shares of out-of-pocket spending to both household's capacity to pay and household expenditure are higher among households that have no health insurance enrollee, indicating that insured households are less likely to face catastrophic payments and impoverishment (Table 17). By increasing access to health care for the near poor and reducing the out-of-pocket costs of treatment and catastrophic payments they encounter, Component Two will have a direct impact on equity and the poverty situation.

[33] Lieberman S. and Wagstaff A. (2008). *Health Financing and Delivery in Vietnam: The Short and Medium-Term Policy Agenda*. Hanoi: World Bank; Wagstaff A. (2007). Health Insurance for the Poor: Initial Impacts of Vietnam's Health Care Fund for the Poor. *Policy Research Working Paper* # WPS 4134. Washington DC: World Bank; Wagstaff A. and Pradhan M. (2005). Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country. *Policy Research Working Paper* # WPS 3563. Washington DC: World Bank.

[34] Lieberman S. and Wagstaff A. (2008). Health Financing and Delivery in Vietnam: The Short and Medium-Term Policy Agenda. Hanoi: World Bank.

[35] Van Minh H. et al. (2012). Financial Burden of Household Out-Of-Pocket Health Expenditure in Vietnam: Findings from the National Living Standard Survey 2002-2010. *Social Science & Medicine*.

Table 17: Out-of-pocket payment (OOP) as a share of household capacity to pay (CTP) total household expenditure (EXP)

Households with at least one insurance enrollee	2004		2006		2008		2010	
	OOP/ CTP(%)	OOP/ EXP(%)	OOP/ CTP(%)	OOP/ EXP(%)	OOP/ CTP(%)	OOP/ EXP(%)	OOP/ CTP(%)	OOP/ EXP(%)
No	13.4	7.1	12.6	6.8	11.5	5.9	9.8	5.2
Yes	9.8	5.4	9.2	5.1	10.3	5.5	8.0	4.4

Source: Minh et al., 2012. Financial Burden of Household Out-Of-Pocket Health Expenditure in Vietnam: Findings from the National Living Standard Survey 2002-2010.

24. By encouraging the near poor to participate in the health insurance system, Component Two will substantially increasing risk-pooling among the near-poor. Furthermore, the premium subsidy (20 percent) provided through this Component will raise the revenues collected through contributions. Meanwhile, the project's supply-side investments under Components One and Three will directly improve the quality of services at the provincial and district levels, where the majority of the poor and near poor seeks health care.

25. The economic justification for the proposed program is also derived from public finance principles for public investments. The case for government interventions in public financing and provision of services arises where market failures exist. In the health sector, these include externalities, public goods, failures in the insurance markets and equity issues. In Vietnam, household direct out-of-pocket health expenditure has always accounted for a large proportion of total health spending (Table 12), partially as a result of the hospital fee policy introduced in 1989 following the Decision No. 45/HDBT by the government, which enabled hospitals to recover costs through user fees. As analyzed above, Minh et al.'s study has pointed this out as a serious problem in health care financing in Vietnam: many households face catastrophic health expenditure and/or fell into poverty due to health care payments. This problem represents the failure of Vietnam's insurance markets to provide adequate protection for households against catastrophic costs associated with acute curative care. Moreover, Minh et al. suggest that out-of-pocket expenditure is likely to remain a major source of financing health care in Vietnam in the future, which indicates a persistent lack of financial protection for households. The project's focus on strengthening catastrophic coverage for the economically vulnerable will help deepen financial protection and hence address this market failure.

26. One risk that would compromise the sustainability of the project is the failure of provinces to retain trained staff beyond the committed three years after training. In order to prevent this from happening, effective monitoring mechanisms and/or an incentive structure need to be preemptively put in place at an early stage of the program.

Fiscal analysis

27. In this fiscal environment, the rate of increase in public spending will not accelerate significantly in the next few years. However, at current growth projections, and if income elasticity stays at post-2006 levels, Vietnam could expect additional funding for health of about 0.8 percent of GDP by 2015. Assuming that government health expenditure follows the same rising pattern as they have in the period post-2006, Vietnam could expect public health spending to be about 2.8 percent of GDP by 2015.36 In other words, there are good prospects of fiscal space for increases in government health spending in Vietnam.

28. Incremental recurrent costs arising from project's activities are the main type of government expenditure that will be incurred by the project. Incremental recurrent costs include the increase in utilization due to increased health insurance coverage, maintenance costs of equipment, and the increase in the salary budget for the newly trained staff. Since the government now subsidizes 70 percent of the cost of health insurance cards for all the near poor,37direct government outlays towards subsidizing health insurance for the near poor in the project's provinces are not considered costs arising from the project. However, this analysis still calculates these health insurance subsidy costs in different scenarios to gauge the level of financial preparedness that the government will need in order to meet its social protection objectives through the project.

29. The increase in utilization as a result of greater insurance coverage and improved health services is a potential source of incremental recurrent costs. However, it is not clear whether there will be significant incremental costs associated with increased utilization. Although it is likely that improved access to health insurance (Component Two) and improvements in quality (Component One) will increase use of government health services, costs to government also depend on (1) the commitment of VSS to paying for new services developed through the project, especially those provided at the district level and strengthened outpatient services, for example, radiation therapy in oncology, and (2) the structure of payment made to providers: if the payment is below the marginal cost of the service, providers may restrain supply or pass on

[36] Fleisher L. and Tandon A. (2012). The Macro-Fiscal Context of Universal Coverage in Vietnam. *Policy Note*. World Bank.

[37]Decision No. 797/QD-TTg by the Prime Minister on June 26, 2012.

the cost to the patient, which will restrict utilization. On the other hand, increased pressure on service may actually increase the productivity of providers, so that the increased throughput is obtained with little increase in recurrent costs. It is hence important for the project to obtain necessary support from the MoH in creating a suitable legal environment for its implementation. Moreover, it is not possible to estimate what the counterfactual increase in utilization would have been without the project due to various health financing reforms alongside the project. Given these factors, a conservative estimate and an upper-bound estimate of the likely increase in costs due to increased utilization are made here.

30. Another source of incremental recurrent costs is the maintenance need of new equipment provided through the project. The expenditure for this category is estimated at 4 percent of the total value of the equipment, based on estimates from other health projects.

31. The last source of incremental recurrent costs to government arising from this project comes from investments in training, which will result in the intake of new graduates by the health system and improvements to current staff's technical skills. Both will require increases in the salary budget. The fiscal impact of training investments will depend on how easily the increased salary budget can be absorbed. Based on the experience of previous World Bank-financed health support projects for other regions, this figure was estimated at 1 percent of the region's health budget.

32. Table 18 below presents the results of the analysis, which shows that the incremental recurrent costs of the project, or government expenditure arising from the project, are relatively low at around 3.5 percent of the total health budget of the region. An upper bound estimate is around 5 percent.

33. Direct government outlays on health insurance subsidy are comprised of a 70 percent government subsidy for the price of the premium that the near poor pay for health insurance. The project will subsidize a further 20 percent (subject to family enrollment) and near poor households will pay the remainder out-of-pocket. The price of the health card is VND 567,000 per year, which is 4.5 percent of the minimum wage of VND 1,050,000 per month (from May 2012). Currently, the proportion of near poor population having insurance is estimated at 25 percent by VSS.38 Therefore, this fiscal analysis uses 25 percent as the base health insurance coverage rate for the near poor in 2012. The coverage rate is conservatively kept at 25 percent for 2013, the first year of project implementation. From 2014 on, the coverage rates will increase, depending on the effectiveness of the social marketing efforts by the project, in three different scenarios: conservative scenario (low take-up), medium take-up, and high take-up,

[38] Vietnam Social Security. http://baohiemxahoi.gov.vn/index.aspx?u=nws&su=d&cid=384&id=5036.

which is also the project's set goal of covering 95 percent of near poor population. Table 9 presents all three sets of estimates.

34. The fiscal analysis also takes into account the likely impacts of the policy draft in December 2012 by the Ministry of Finance to increase insurance coverage for the near poor, which will take effect from 2013 if approved. Specifically, under this new initiative, the government will subsidize 100 percent of the costs of health insurance cards for two near poor groups: (1) those who just get out of poverty and become near poor (full health insurance subsidy will be extended to this group for a period of five years), and (2) the near poor population of 62 poor districts in the country. For the first group, given that the rate of increase in the near poor population of the region from year to year in this analysis is already very small as it is based on the national population growth rate of only about 1 percent per annum, the impact of the new policy regarding this new near poor group on government expenditure will be quite small, and hence no adjustment was made to account for this change. For the second group, since four districts from three of the 13 provinces of the project are in the list of 62 poor districts, the near poor in these districts will be fully supported by the government. Therefore, the base number of near poor population for those provinces have been subtracted by the total number of the near poor in these four districts to reflect the lower costs of insurance subsidy to the government during the life of the project under this new policy.

35. It is important to note that the calculations in this fiscal analysis do not take into account the family enrollment incentive (the price of health insurance premium is reduced by 10 percent for each next person in the family), which lowers the actual cost for the government to subsidize for each poor household. Therefore, the actual government outlays are likely to turn out to be lower than these estimates.

36. Under the more conservative scenario, about 5.5 percent of the region's health budget will be spent on subsidy for health insurance premium. Since the cost will be shared between the local and central governments, even under the high take-up scenario of coverage of 95 percent of the near poor by 2018, an outlay equivalent to 10.55 percent of the region's health budget will be feasible given good prospects of fiscal space and the remarkable social protection objectives that will be achieved.

Table 18: Fiscal impact of the project

	2008	'09	'10	'11	'12	'13	'14	'15	'16	'17	2018
In trillions of VND											
GDP[1]	1485	1658	1981	2535	2927	3336	3743	4178	4654	5176	5564
Total government expenditure	495	533	582	631	685	743	806	874	948	1029	1116
Total government expenditure on health [2]	43	60	72	68	74	80	87	94	102	111	120
Total government health expenditure NORRED Region	2.1	2.4	2.8	2.7	2.9	3.1	3.4	3.7	4.0	4.3	4.7
As a share of GDP											
Total government expenditure	33.3%	32.1%	29.4%	24.9%	23.4%	22.3%	21.5%	20.9%	20.4%	19.9%	20.1%
Total government health expenditure	2.9%	3.6%	3.6%	2.7%	2.5%	2.4%	2.3%	2.3%	2.2%	2.1%	2.2%
Total government health expenditure NORRED Region	0.14%	0.15%	0.14%	0.10%	0.10%	0.09%	0.09%	0.09%	0.09%	0.08%	0.08%
Government outlays on 70% subsidy for health insurance cards (% of region's health budget)											
Subsidies for health insurance card (conservative scenario)[4]					0.00%	3.95%	4.42%	4.80%	5.11%	5.36%	5.55%
Subsidies for health insurance card (medium take up scenario)[5]					0.00%	3.95%	5.15%	6.17%	7.03%	7.15%	7.77%
Subsidies for health insurance card (high take up scenario)[6]					0.00%	3.95%	6.62%	8.23%	9.59%	10.13%	10.55%
Incremental recurrent costs associated with NORRED Project (government expenditure arising from the project, expressed as % of the region's health budget)											
Recurrent curative care costs due to increased health insurance coverage											
Inpatient admissions - conservative scenario [7]					0.00%	0.14%	0.26%	0.37%	0.45%	0.53%	0.58%
Outpatient visits - conservative scenario [8]					0.00%	0.23%	0.43%	0.60%	0.75%	0.88%	0.98%
Inpatient admissions - upper-bound scenario [9]					0.00%	0.28%	0.53%	0.73%	0.91%	1.06%	1.18%
Outpatient visits - upper-bound scenario [10]					0.00%	0.46%	0.87%	1.21%	1.52%	1.77%	1.99%
Maintenance costs of new equipment [11]					0.00%	0.00%	0.00%	0.00%	0.28%	0.51%	0.91%
Salary costs of newly trained staff[12]					0.00%	0.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Total - lower bound estimate [13]					0.0%	0.4%	1.7%	2.0%	2.5%	2.9%	3.5%
Total - upper bound estimate [13]					0.0%	0.7%	2.4%	2.9%	3.7%	4.3%	5.1%

Table Notes:

(1) GDP actuals and 2011-2017 estimates from IMF Article IV Report 2012
(2) Government health expenditures from 2008 to 2010 from Health Statistics Yearbook. Estimates for 2011-2017 assume that the health share of total government expenditure remains at 10.79%, the average share for 2008-2010
(3) GDP and government expenditures estimates for 2011-2018 based on average annual growth rate 2008-2010
(4) Assumes the following coverage rates for health insurance for the near poor: 2013 = 25%; 2014 = 30%; 2015=35%; 2016=40%; 2017=45%; 2018=50%.
(5) Assumes the following coverage rates for health insurance for the near poor: 2013=25%; 2014=35%; 2015= 45%; 2016=55%; 2017=60%; 2018=70%.
(6) Assumes the following coverage rates for health insurance for the near poor: 2013= 25%; 2014= 45%; 2015=60%; 2016=75%; 2017=85%; 2018=95%.
(7) Assumes 0.75% increase per year in inpatient visits between 2012 and 2018, compared to a counterfactual increase of 0.5% per year
(8) Assumes 1.5% increase per year in outpatient visits between 2012 and 2018, compared to a counterfactual increase of 1% per year
(9) Assumes 1% increase per year in inpatient visits between 2012 and 2016, compared to a counterfactual increase of 0.5% per year
(10) Assumes a 2% increase per year in outpatient visits between 2012 and 2018 compared to a counterfactual increase of 1% per year
(11) Estimated as 4% of the cost of the equipment, based on the usual proportion allocated for maintenance in the government budget. Since the purchase of new equipment is spread over 5 years (from 2014) and maintenance costs do not start until 2 years after the purchase (and the warranty is over), the value of maintenance costs in the first 3 years of the project is 0.
(12) Estimated as 1% of the North East and Red River Delta region's annual budget
(13) The conservative estimate of total incremental costs uses the conservative estimates of the increase in inpatient and outpatient utilization; the upper bound estimate uses the upper-bound estimates of the increase in inpatient and outpatient utilization

ANNEX 6: IMPLEMENTATION SUPPORT PLAN

Vietnam: North East and Red River Delta Regions Health System Support Project

Strategy and Approach for Implementation Support

Project Implementation Approach

1. The Bank's implementation support strategy for the project is aligned with implementation risks identified in the ORAF, and builds on implementation experience of the completed and ongoing Health projects including Regional Health Support Projects and Hospital Waste Management Treatment Project. Implementing agency risks, social and environment safeguard risks, and financial management and procurement risks are considered moderate to substantial, based on fiduciary and safeguards assessments conducted during the preparation. While the CPMU members are familiar with the IDA projects, the lack of human resources due to overload of the assigned staff for other responsibilities at the same time, the decentralized nature of project design to the DoHs and Hospitals that have not implemented any IDA projects make the project risks higher. To address the shortcomings, lessons from other completed and on-going projects in health and other sectors have been learnt and reflected in the design to ensure the readiness of the implementing agencies for the project execution and to avoid at the extent possible for inefficiency and delays during the implementation stage. Risks are identified in detail and the specific mitigation measures have been included in ORAF. TA supporting project implementation will be actively and intensively provided by both CPMU and Bank team. These include the organization of multiple training courses on Bank procedures for all project provinces, a good number of qualified international and national consultants being recruited, development of standard template for provincial applications/proposals, technical specifications of key medical equipment, full set of standard procurement documents, internal and external auditors.

2. Given the complexity of Component One on "Strengthening the capacity of lower level health services to deliver quality services", it will be implemented in rolling design that allows for clustered implementation of proposals. The rolling design also implies that any time new proposals are launched, there will be proposals that are under implementation; lessons can be shared, thus reducing the risks. However, the central hospitals and the MoH have an existing model of technical transfer support that will be used. Further, the active involvement of the large central hospitals in project design and possible benefits out of the project, they will lend their support and pressure on the MoH for implementation.

Task Team Project Supervision Approach

3. Close project supervision will be undertaken by a multi-disciplinary team consisting of safeguards, fiduciary and technical specialists based in Washington and Hanoi offices. Most of the team members have been involved in supervision of regional health projects. Project supervision will continue emphasis on foreseeing future issues and realistic action plans. For the first two years of the project, beside routine semi-annual supervision missions, interim missions will be conducted to address newly arising issues. The task team leader will be based in Vietnam, at least for the first two years, to be fully on board of the daily project implementation.

Implementation Support Plan

4. The Implementation Support Plan highlights the Bank's support to implement the risk mitigation measures in the ORAF and to ensure achieving the PDOs. The Bank's implementation support plan consists of scheduled full supervision missions every six to twelve months, and short review missions focusing on problem solving and timely follow-up monitoring. A Mid-Term Review conducted after about 3.5 years of implementation will identify and implement any structural changes. Enhanced fiduciary supervision is foreseen given the complexity of the operation, particularly at the start of the operation. Normal attention to safeguard compliance and implementation is foreseen.

5. Technical expertise will be maintained throughout project implementation and increased as needed during critical implementation periods to review and provide recommendations. Active involvement of the task team members and CPMU in daily work will help reduce design and implementation risk. The table below sets out approximate technical inputs required, which will vary in specific expertise as the project moves from design through procurement to implementation.

Table 19: Project Implementation Support Plan

Focus	**Skills Needed**	**Resource Estimate (Staff-weeks/year)**
Team Leadership	Sr. Operations Officer/Health Specialist	10
Technical Review – provincial proposals, procurement documents and technology transfer planning and procedures	Health Specialist (Local and Intl), Procurement officer, Hospital Management Specialist	24
Health Service Delivery Expert	Health Service Planning Expertise	2
Health Service Financing Expert	Health financing expertise	2
Institutional oversight – TA and capacity building activities	Institutional and Health specialist	4
Ethnic Minority Development Plan monitoring	Social Development Specialist	2
Environmental Monitoring	Environmental Specialist	2
Procurement Review of Bidding Documents and Training (as needed), and procurement review thereafter.	Procurement Specialist/Medical Equipment Specialist	8
FM and disbursement training and monitoring	FM Specialist/Disbursement Officer	5

VIETNAM

NORTH EAST AND RED RIVER DELTA REGIONS HEALTH SYSTEM SUPPORT PROJECT

- PROJECT PROVINCES
- PROVINCE CAPITALS
- NATIONAL CAPITAL
- PROVINCE BOUNDARIES
- INTERNATIONAL BOUNDARIES

PROVINCES:

1	Lai Chau	32	Da Nang
2	Dien Bien	33	Quang Nam
3	Lao Cai	34	Quang Ngai
4	Ha Giang	35	Kon Tum
5	Cao Bang	36	Gia Lai
6	Son La	37	Binh Dinh
7	Yen Bai	38	Phu Yen
8	Tu Yen Quang	39	Dac Lac
9	Bac Can	40	Dac Nong
10	Lang Son	41	Khanh Hoa
11	Phu Tho	42	Binh Phuoc
12	Vinh Phuc	43	Lam Dong
13	Thai Nguyen	44	Ninh Thuan
14	Bac Giang	45	Tay Ninh
15	Quang Ninh	46	Binh Duong
16	Ha Noi	47	Dong Nai
17	Bac Ninh	48	Binh Thuan
18	Hung Yen	49	T.P. Ho Chi Minh
19	Hai Duong	50	Ba Ria-Vung Tau
20	Hai Phong	51	Long An
21	Hoa Binh	52	Tien Giang
22	Ha Nam	53	Dong Thap
23	Thai Binh	54	Ben Tre
24	Ninh Binh	55	An Giang
25	Nam Dinh	56	Vinh Long
26	Thanh Hoa	57	Tra Vinh
27	Nghe An	58	Kien Giang
28	Ha Tinh	59	Can Tho
29	Quang Binh	60	Hau Giang
30	Quang Tri	61	Soc Trang
31	Thua Thien Hue	62	Bac Lieu
		63	Ca Mau

GSDPM Map Design Unit