ADB

Board of Directors

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(For consideration by the Board on or about 10 December 2018)

R158-18
19 November 2018

Proposed Policy-Based Loan and Grant
Local Health Care for Disadvantaged Areas Sector Development Program
(Viet Nam)

1. The Report and Recommendation of the President (RRP: VIE 50285-002) on the proposed policy-based loan and grant to Viet Nam for the Local Health Care for Disadvantaged Areas Sector Development Program is circulated herewith.

2. This Report and Recommendation should be read with the (i) *Country Partnership Strategy: Viet Nam, 2016–2020: Fostering More Inclusive and Environmentally Sustainable Growth*, which was circulated to the Board on 9 September 2016 (DOC.Sec.M28–16); and (ii) *Country Operations Business Plan: Viet Nam, 2018–2020*, which was circulated to the Board on 16 November 2017 (DOC.IN.421-17).

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Report and Recommendation of the President to the Board of Directors

Project Number: 50285-002
November 2018

Proposed Policy-Based Loan and Grant
Socialist Republic of Viet Nam: Local Health Care for Disadvantaged Areas Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 15 October 2018)

Currency unit	–	dong (D)
D1.00	=	$0.000042
$1.00	=	D23,330

ABBREVIATIONS

ADB	–	Asian Development Bank
CHS	–	commune health stations
EU	–	European Union
GDP	–	gross domestic product
IMF	–	International Monetary Fund
LHC	–	local health care
MOH	–	Ministry of Health
NCD	–	noncommunicable disease
PBL	–	policy-based loan
PFM	–	public financial management
SRH	–	sexual and reproductive health
UHC	–	universal health coverage

NOTE

In this report, "$" refers to United States dollars.

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PROGRAM AT A GLANCE

1. Basic Data

Project Number: 50285-002

Project Name	Local Health Care for Disadvantaged Areas Sector Development Program	**Department/Division**	SERD/SEHS
Country	Viet Nam, Socialist Republic of	**Executing Agency**	Ministry of Health
Borrower	Socialist Republic of Viet Nam		

2. Sector

	Sector	Subsector(s)	ADB Financing ($ million)
✓	**Health**	Health insurance and subsidized health programs	3.00
		Health sector development and reform	97.60
		Total	**100.60**

3. Strategic Agenda

Strategic Agenda	Subcomponents
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive

Climate Change Information

Climate Change impact on the Project	Low

4. Drivers of Change

Drivers of Change	Components
Governance and capacity development (GCD)	Institutional development
Partnerships (PAR)	Official cofinancing Regional organizations

Gender Equity and Mainstreaming

Gender equity (GEN)	✓

5. Poverty and SDG Targeting

Geographic Targeting	Yes
Household Targeting	No
SDG Targeting	Yes
SDG Goals	SDG1, SDG3

Location Impact

Nation-wide	High

6. Risk Categorization: Complex

7. Safeguard Categorization

Environment: C **Involuntary Resettlement:** C **Indigenous Peoples:** B

8. Financing

Modality and Sources	Amount ($ million)
ADB	**100.60**
Sovereign Project grant: Asian Development Fund	12.00
Sovereign SDP - Program (Concessional Loan): Ordinary capital resources	88.60
Cofinancing	**0.00**
None	0.00
Counterpart	**1.60**
Government	1.60
Total	**102.20**

Currency of ADB Financing: USD

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed policy-based loan (PBL) and (ii) a proposed project grant, both to the Socialist Republic of Viet Nam for the Local Health Care for Disadvantaged Areas Sector Development Program.[1]

2. The program is part of a coordinated effort to assist the Government of Viet Nam achieve universal health coverage (UHC), including access to essential health care services. The program is fully aligned with (i) the government's local health care (LHC) system[2] reform agenda, and (ii) the Master Plan on Building and Developing of the LHC Network in New Situation.[3] The program complements the proposed Second Health Human Resources Development Project, which will boost the quality and quantity of health care professionals overall, and provide systematic solutions to build the capacity of health professionals working in rural underserved areas. The PBL will support reforms to strengthen key areas in the LHC system, and improve health service delivery, and the quality of the LHC workforce. The grant will fund the critical investment gaps necessary to translate these reforms into tangible results. These investments will ensure access to quality health services and health security in remote, disadvantaged, and border areas with a strong focus on the health needs of women. Policy reforms will have nationwide impact while the grant will focus on areas with high poverty levels.

II. PROGRAM AND RATIONALE

A. Background and Development Constraints

3. **Development context.** Viet Nam's sustained economic growth has bolstered the country's progress in reducing poverty. Gross domestic product (GDP) grew by an average of 6.5% per year from 1991 to 2017. GDP per capita reached $2,389 in 2017. The poverty rate (i.e., the share of the population living on less than $1.90 per day in 2011 purchasing power parity) fell from 52.9% in 1992 to 2.0% in 2016, while the Gini coefficient decreased slightly from 35.7 to 35.3 over the same period.[4] Poverty incidence varies significantly across regions. Ethnic minorities, who account for 14.5% of the population, make up more than half of the poor.[5] The government has recognized that inclusive growth and public health are intricately linked, as shown by disparities in key health indicators by region. For example, in the impoverished Central Highlands, infant mortality rate was 24.8/1,000 live births in 2015, while in the affluent South East region,[6] it was 8.6/1,000 live births. Similar variations are also found in reproductive health and maternal mortality outcomes.[7]

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[1] The design and monitoring framework is in Appendix 1.

[2] The local health care system is intended to serve as the first point of contact between health services and the population. It encompasses the network of (i) commune health stations, (ii) district health centers providing public health and preventive services, and (iii) district hospitals providing inpatient and outpatient curative services.

[3] Government of Viet Nam, MOH. *Decision No. 2348/QD-TTg (5 December 2016) on the Master plan on building and development of the LHC network in the new situation*. Hanoi.

[4] ADB. 2018. *Asian Development Outlook.* Manila*;* ADB. 2018. Country Information: Socialist Republic of Viet Nam. Information note. 25 October (internal); and World Bank. World Development Indicators. (accessed 2 November 2018).

[5] ADB. 2016. *Country Partnership Strategy: Viet Nam, 2016–2020—Fostering More Inclusive and Environmentally Sustainable Growth*. Manila.

[6] Government of Viet Nam, Ministry of Health (MOH). 2017. Joint Annual Health Review 2016: Towards Healthy Aging in Viet Nam.

[7] For example, in 2016 the national maternal mortality ratio (MMR) was 58 maternal deaths per 100,000 live births. In comparison, the MMR in Dien Bien province (63 maternal deaths per 100,000 live births) and in Lai Chau province (85 maternal deaths per 100,000 live births) were very high.

4. Inequitable access to quality and affordable healthcare services worsens the disparities in health outcomes and perpetuates income inequality. Inclusive growth is further threatened by the growing financial burden associated with the treatment of non-communicable diseases (NCD).[8] In 2015, the proportion of total disease burden attributable to NCD reached 73%, partly due to Viet Nam's aging population.[9] Catastrophic health expenditure is more likely to occur among households with NCD patients.[10] Epidemic prone diseases can also have a significant impact on health and livelihoods, and pose a further risk to inclusive growth, as evidenced by the economic damage caused by the severe acute respiratory syndrome and avian flu epidemics.[11]

5. The LHC system plays a central role in mitigating health-related barriers to sustainable inclusive growth. In Viet Nam, a strong LHC system, consisting primarily of commune health stations (CHS) is critical to ensuring equitable access to health care, especially for low-income and ethnic minority populations. It provides the foundation for effective long-term management of NCDs, as well as early detection of and timely response to health security threats.[12] Local governments manage LHC investments, including budgets allocated by the central government. Health insurance reimbursements finance recurrent costs for LHC, including salaries and equipment operation and maintenance. CHS provide various services: preventive health, basic curative, obstetric, pediatric care, and inpatient treatment.[13] Recognizing the important role of CHS, the Ministry of Health (MOH) is setting policies and standards, including frameworks for CHS financing.

6. However, Viet Nam's LHC system has been unable to deliver health care services adequately, and many CHS are considered substandard. Years of underinvestment in lower level facilities have perpetuated poor service delivery. In 2015, only 66.1% of CHS nationwide met national service standards. The Northern midlands and mountain region, which achieved only 44.6% of standards, was the worst-performing region. Out of 11,000 CHS nationwide, about 1,192 require reconstruction and 1,239 require major renovation. Over 5,000 CHS need better equipment to provide essential health services, including for the timely detection of and response to communicable diseases. CHS lack the capacity for quick and accurate diagnosis of patients because of inadequate equipment and health workforce with an inappropriate skill mix. Patients perceive CHS to be of poor quality and often bypass them for higher-level and more expensive facilities. Many conditions for which higher-level care is sought could be treated at CHS, including NCDs and age-related illnesses.[14] Further, patients using the LHC system receive limited coverage from health insurance. As a result, out-of-pocket health expenditure

[8] An NCD is a medical condition or disease that is not caused by an infectious agent.

[9] Institute for Health Metrics and Evaluation. Global Burden of Disease database. https://vizhub.healthdata.org/gbd-compare/ (accessed 26 April 2018).

[10] Health expenditure is considered catastrophic if a household's financial contributions to health equal or exceed 40% of non-food expenditures. H. Bach and B. Tran. 2012. *Assessing the household financial burden associated with the chronic non-communicable diseases in a rural district of Viet Nam.* https://www.tandfonline.com/doi/full/10.3402/gha.v5i0.18892.

[11] World Health Organization. 2014. A *Brief Guide to Emerging Infectious Diseases and Zoonoses*. New Delhi.

[12] Health security threats encompass infectious disease outbreaks, health hazards caused by natural disasters, chemical emergencies or acute health events traced to environmental, industrial, accidental or deliberate cause/s, which present or could present significant harm to humans. Health security relates to activities required to minimize vulnerability to these threats.

[13] Government of Viet Nam, MOH. *Decision No. 4667/QD-BYT (7 November 2014) on the national standards for CHSs for the period to 2020.*

[14] K. Takashima et al. 2017. *A Review of Viet Nam's Healthcare Reform through the Direction of Healthcare Activities.* http://doi.org/10.1186/s12199-017-0682-z.

has remained high, constituting 43% of total health expenditure in 2015 (footnote 6). Improving access to quality LHC services, particularly in poorer rural areas, will have a positive impact on health outcomes.

7. **Binding constraints.** The government has recognized the following development constraints: (i) an inadequate framework and supporting policies to guide public investment in LHC, (ii) the failure of LHC service delivery to respond to health needs, and (iii) weak LHC workforce management and development.

8. **Inadequate framework and supporting policies to guide public investment in local health care.** The MOH has prepared a comprehensive framework for the development of LHC, including technical standards for facilities, equipment, human resources, and service provision. However, many are outdated and do not address the system's current challenges. Inadequate investment in the LHC system and a lack of financing mechanisms perpetuate system deficiencies. The institutional arrangements for fiscal transfers from central to local governments and the incentives for local governments, to pursue the national health reform agenda are weak. While Viet Nam has a well-established health insurance system, additional reforms are required to increase health insurance revenues and to improve the affordability of health services.

9. **Failure of local health care service delivery to respond to health needs.** Approximately 74% of all outpatients visit hospitals and private facilities, while only 20% visit public CHS due to the limited range of available interventions.[15] CHS do not deliver a comprehensive mix of primary care and curative services, nor do they address the lifelong health needs of women and men in the community. For example, CHSs are not equipped to provide for the effective management of NCD, across a continuum of prevention and early intervention services.[16] Moreover, district health centers and district hospitals operate separately, largely without referral and linkage, causing inefficiencies and service overlaps.

10. **Weak local health care workforce management and development.** The LHC workforce does not have the required skills mix to effectively respond to the evolving health needs of the population, especially women. CHS are staffed with lower-skilled health practitioners, particularly in remote and mountainous regions (footnote 16). They also lack the capacity to provide long-term care for the elderly and patients with chronic diseases. There is a need to enhance their competencies in epidemiology and in responding to health security threats.[17] Moreover, health service providers have not been provided with the training to work in a gender-sensitive and culturally appropriate manner when dealing with female and ethnic minority patients. While ADB has previously supported the MOH's health professional licensing and registration system, service delivery in LHC facilities remains largely unregulated.[18]

B. Policy Reform and ADB's Value Addition

11. **The government's reform agenda.** The government acknowledges that a strong LHC

[15] Government of Viet Nam, Ministry of Planning and Investment, General Statistics Office. 2016. *Results of the Viet Nam Living Standards Survey 2014.* Ha Noi.
[16] World Bank. 2016. *Quality and Equity in Basic Health Care Services in Viet Nam: Findings from the 2015 Viet Nam District and Commune Health Facility Survey.* Washington, DC.
[17] World Health Organization. 2017. *Joint External Evaluation of IHR Core Capacities of Viet Nam*. Geneva.
[18] ADB. Viet Nam: Health Human Resource Sector Development Program.

system is essential for sustainable inclusive development.[19] The health sector 5-year plan, 2016–2020 identifies the LHC network as one of nine key reform areas.[20] Reforms aim to strengthen the grassroots health network by (i) increasing investment in infrastructure and equipment for district and commune health facilities; (ii) restructuring the LHC's organization and operations to be more responsive to epidemiological changes; (iii) reforming finance mechanisms for central and local governments; (iv) improving service delivery by providing integrated services for infectious diseases, NCDs, and injuries; and (v) responding to epidemics through early detection, prevention, and response plans. The National Action Plan for the Implementation of the 2030 Sustainable Development Agenda confirms the government's commitment towards achieving UHC, which includes ensuring access to essential health care services.[21]

12. **Sector development program.** ADB's Country Partnership Strategy for Viet Nam 2016–2020 prioritizes support to UHC as the focus of health sector operations. The program is aligned with the operational priorities of ADB Strategy 2030 (Table 1).[22] A sector development program is appropriate given Viet Nam's limited fiscal space, need for PFM reform, and inclusive growth agenda.[23] The program supports the health sector 5-year plan's objectives to enhance the accessibility, responsiveness, quality, and affordability of LHC, particularly in disadvantaged and remote areas (footnote 20). The PBL will provide budget support and contribute to fiscal consolidation through targeted transfers in the health sector, allowing the government to sustain budget allocations to the MOH while implementing a complex reform program. MOH has demonstrated experience with sector development programs (footnote 18). Specifically, the PBL addresses key reform areas governing public investment, health service delivery, and health workforce quality in the LHC system, through 14 policy actions (all accomplished). The associated project grant will complement the PBL by implementing LHC system reforms including infrastructure and equipment standards, and health insurance benefits. The project grant will pilot health service delivery models and inform institutional arrangements in support of attaining UHC goals. The project grant component supports reforms in 12 pilot districts in six provinces along borders and socioeconomic corridors with high poverty incidence, ethnic minority populations, and susceptibility to health security threats.[24]

Table 1: Alignment with Strategy 2030

Strategy 2030 Priorities	Sector Development Program
1. Addressing remaining poverty and reducing inequalities	Improving quality of and access to local health care services: • Increasing health insurance coverage and benefits for LHC services. • Addressing vulnerability to outbreaks and public health threats in target districts.
2. Strengthening governance and institutional capacity	Supporting governance reforms aimed at LHC services improvement: • Strengthening public investment management for LHC • Improving service delivery models for LHC network • Strengthening LHC workforce development and management

[19] Government of Viet Nam. *Resolution 76/2014/QH13 (24 June 2014) on strengthening the implementation of sustainable poverty reduction targets to 2020*.
[20] Government of Viet Nam, MOH. 2016. *Plan for People's Health Protection, Care and Promotion, 2016–2020*. Ha Noi.
[21] Government of Viet Nam. 2017. *National Action Plan for the Implementation of the 2030 Sustainable Development Agenda.* Prime Minster Decision No. 622/QD-TTg.
[22] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific.* Manila.
[23] International Monetary Fund (IMF). 2018. Viet Nam: 2018 Article IV Consultation. *IMF Country Report.* No. 18/215. Washington, DC.
[24] The six provinces are Dak Nong, Gia Lai, Phu Tho, Quang Nam, Soc Trang, and Tuyen Quang.

Strategy 2030 Priorities	Sector Development Program
3. Accelerating progress in gender equality	Supporting the government policies to improve health services for women and children, particularly for ethnic minorities: • Implementing action plan on gender equality for the health sector including access to capacity building program for health practitioners

LHC = Local Health Care.
Source: Asian Development Bank.

13. **Reform area 1: Public investment management for local health care.** The government established an enabling policy and institutional framework to govern and guide public investments for the delivery of LHC services. A master plan has been approved (footnote 3) which sets the direction of the required policy, regulatory, and institutional reforms of the LHC system.[25] Based on the master plan, the MOH updated architectural, equipment, and human resource standards for CHS and upgraded LHC infrastructure. As a result, 70% of CHS now meet the national service standards (2017). To ensure revenues for LHC services, the MOH has enacted a series of policies defining a list of health services, medical procedures, and drugs covered by health insurance funds to be delivered by CHS. Further, by increasing health insurance coverage to 86.4% of the population (2017), the government has successfully increased health facility revenues from health insurance.

14. The project grant will provide equipment for pilot districts to meet the national service standards, including equipment for (i) diagnosis of infectious diseases, which threaten health security; (ii) NCD detection and management; and (iii) sexual and reproductive health (SRH)-related services. Results from pilot districts will inform necessary adjustments to technical standards for CHS, the financing mechanism, and the benefits provided by health insurance.

15. **Reform area 2: Service delivery models for local health care network.** To meet the challenges of the rising NCD burden and public health threats, and to respond to the specific needs of women, children, and indigenous peoples, the MOH formulated a set of policies aimed at improving health service delivery. An expanded package of health services for curative and preventive services has been adopted, which addresses the increasing needs of the population. SRH services and gender-based violence prevention and response programs have been strengthened. Specific plans for indigenous peoples have been introduced. The MOH has adopted and scaled up the family medicine model, which encompasses the holistic management of an individual's health needs across the continuum of prevention, early intervention, and treatment. To address gaps in long-term care, the MOH has approved the scope, target, and budget for a national program targeting the elderly. The MOH linked individual electronic health records to the communicable diseases information system as a tool for referring patients between different levels of health services, and has implemented health financing through health insurance. Finally, provincial centers for disease control have been established and the functions of health centers and hospitals in 202 districts have been merged to better coordinate outbreak response and mitigate health security threats.

16. The project grant will enhance responsiveness of LHC service delivery through new service delivery model(s) for disease surveillance and response, primary health care, and long-term care using family medicine principles. The grant will equip pilot district health facilities to meet the service delivery requirements of the family medicine model and implement the model

[25] The master plan provides the road map to (i) upgrade and equip all CHS in the country, (ii) improve knowledge and skills of LHC staff, (iii) reform the packages of health services offered by LHC facilities, and (iv) improve health financing mechanisms through health insurance.

in selected CHS.[26] Electronic health records will be linked to the communicable diseases information system in selected health facilities. Gender-sensitive information campaigns on family medicine will be conducted and SRH-related services will be provided. District response units will be equipped to address health security threats (footnote 12). Finally, analytical work will help to optimize operational efficacy of the family medicine model before the nationwide rollout of reforms and health financing through health insurance.

17. **Reform area 3: Local health care workforce development and management.** The MOH has implemented reforms designed to achieve better gender balance in management and leadership roles based on the MOH gender equality action plan, 2016–2020.[27] The MOH increased the proportion of CHS served by a medical doctor to 88% in 2017.[28] Measures were implemented to improve staff knowledge and skills through a training curriculum on family medicine for doctors, nurses, midwives, assistant doctors, and assistant pharmacists.[29] A policy was issued on health facility licensing for family medicine.

18. The project grant will strengthen the quality of the LHC workforce in pilot districts. To complement the health human resources policy, the grant will assess the capacity of LHC facilities for health security functions, family medicine, provision of a basic health service package, and service management. Competencies of CHS staff will be enhanced through the provision of scholarships for a 3-month certificate on family medicine for CHS doctors. Continuing professional education will be provided for assistant doctors, nurses, and midwives. Training on communicable diseases, NCDs, elderly care, SRH, responses to outbreaks, and electronic health records will be conducted.

19. **ADB experience.** Since 1995, ADB assistance to the Viet Nam health sector has focused on improving access to and the quality of health care, especially for the poor and ethnic minorities. From 1995 to 2005, ADB provided support to (i) strengthen primary health care and family planning services in 15 provinces;[30] (ii) improve primary health facilities, management capacity, and human resources in 14 provinces;[31] and (iii) develop hospitals, health service management, health care funds for the poor, and human resources in five mountainous and ethnic minority provinces. During 2006–2016, ADB continued its investment in health services in remote areas,[32] while providing more focused support for health security.[33] ADB operations included (i) upgrading preventive health centers in 15 provinces; and (ii) enhancing regional, national, and subnational systems for prevention, surveillance, and response to health security threats. ADB also focused investment in health human resource development through sector-wide reforms in health professional education, training, and management (footnote 18).

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[26] Family medicine model implementation at CHS includes establishing a personalized electronic health record system; having a family medicine-certified doctor; and having at least a midwife, nurse, or assistant doctor who has attended a short course on family medicine.

[27] Government of Viet Nam, MOH. *Action Plan on Gender Equality of the Health Sector, 2016–2020.* Ha Noi.

[28] Government of Viet Nam, MOH. *Report 1499/BC-BYT (29 December 2017) of the MOH on review of performance in 2017 and the key directions, tasks, and solutions in 2018*.

[29] Selected medical universities (e.g., Hanoi Medical University) support provincial departments of health and medical colleges to deliver the certificate training. Provincial or district hospitals serve as clinical training sites.

[30] ADB. Population and Family Health Project.

[31] ADB. Viet Nam: Rural Health Project.

[32] ADB. Viet Nam Healthcare in the Central Highland Project; ADB. Viet Nam: Second Health Care in the Central Highlands Project; and ADB. Viet Nam: Health Care in the South Central Coast Region Project.

[33] ADB. Viet Nam: Preventive Health System Support Project; ADB. Greater Mekong Subregion Regional Communicable Diseases Control Project; ADB. Second Greater Mekong Subregion Regional Communicable Diseases Control Project; and ADB. Regional: Greater Mekong Subregion Health Security Project.

20. **Lessons learned.** The program design integrates the lessons learned from previous ADB interventions. Institutional reforms require a long-term strategy and policy coherence that build upon prior gains and achievements, thereby creating the desired impact over time. Development effectiveness is enhanced by (i) strengthening development partner coordination, and (ii) sustaining support for institutional development and capacity building. Addressing complex disease patterns, population aging, and entrenched health inequity requires a shift to more responsive and comprehensive health service delivery models. A strong and functioning LHC system supports timely detection of and response to health security threats both at country level and cross-border, the latter through regional cooperation.

21. **ADB's value addition.** ADB's assistance in Viet Nam ensures the required institutional arrangements required for UHC—a strong LHC network, quality health human resources, and universal access to social health insurance. ADB assisted MOH to formulate and implement policy reforms for strengthening LHC, through structured policy dialogue informed by past programming. This includes in the areas of communicable disease control (footnote 33), health service delivery (footnote 32) and health practitioner training and management (footnote 18). ADB's value addition has also been enhanced by maximizing linkages across individual investments, which creates synergies to achieve sector-wide and regional impacts. Linking the program with the ongoing regional effort to strengthen health security in the Greater Mekong Sub-region is illustrative of this (footnote 33).

22. **Post-program partnership framework.** The post-program partnership framework provides a common understanding of subsequent reform areas to be supported by the government, ADB, and development partners (Appendix 4, column 3). The proposed Second Health Human Resources Development Project (2019–2025) will complement the program by increasing the supply of skilled workers to provide quality services, particularly at the LHC level. Subsequent analytical work and policy dialogue for PFM reforms and fiscal consolidation efforts through a national targeted program for health sector investment are required. ADB strengthened its role as knowledge provider by delivering the initial phase of reforms based on analytical work and technical assistance to support health insurance and health information systems development. ADB has ongoing technical assistance to strengthen the institutional capacity of the MOH to deliver its reform agenda and identify subsequent regulatory and institutional reform areas.[34] This coordinated approach sets a solid foundation for ADB's progressive support for health sector reforms aimed at progressing towards UHC (footnote 22).

23. **Development coordination**. The master plan provides the overarching framework for a coordinated and phased development partner response to strengthen the LHC network (footnote 3). ADB, the European Union (EU), and the World Bank coordinate and harmonize investments to achieve system-wide impacts as envisaged under the master plan. The current phase of development partner support to implement the master plan includes (i) the EU's Health Sector Policy Support Programme (Phase 2),[35] (ii) the World Bank's Health Professionals Education and Training for Health Systems Reforms Project (cofinanced by the EU),[36] and (iii) the World Bank's proposed Grassroots Service Delivery Reform Project. ADB maintains close dialogue with the International Monetary Fund on Viet Nam's economic and policy performance.

[34] ADB. Viet Nam: Support to Strengthening Local Health Care Program; ADB. Viet Nam: Strengthening the Policy and Institutional Framework of Social Health Insurance; and ADB. Regional: Results for Malaria Elimination and Control of Communicable Disease Threats in Asia and the Pacific.
[35] European Union. 2010. Viet Nam Health Sector Policy Support Programme HSPSP-2.
[36] World Bank. 2014. Health Professionals Education and Training for Health System Reforms Project.

C. Impacts of the Reform

24. **Economic impact of the program.** The program addresses Viet Nam's need for reforms to improve accessibility, responsiveness, and quality of the LHC system. The program's benefits derive from a reduction in (i) the morbidity and premature mortality among poor, disadvantaged, and ethnic minority populations, and (ii) health expenditures through greater utilization of lower-level health facilities. The program will strengthen capacity to prevent disease outbreaks and pandemics and reduce the associated potential economic losses.[37]

D. Development Financing Needs and Budget Support

25. The program financing amount is $102.2 million. The government has requested (i) a concessional loan of $88.6 million from ADB's ordinary capital resources, and (ii) a grant not exceeding $12.0 million from ADB's Special Funds resources (Asian Development Fund) to help finance the program (Table 2). The loan will have a 25-year term, including a grace period of 5 years, an interest rate of 2.0% per annum during the grace period and thereafter; and such other terms and conditions set forth in the draft loan agreement. The PBL release will be aligned with government's investment and budgeting processes, in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time). The project investment plan is in Table 3. The size of the PBL reflects the government's overall financing needs, the strength of the reforms, and development expenditures arising from the program, such as CHS infrastructure upgrade, capacity building, and incentives for the health workforce. In 2018, the government's budget deficit target is 3.5% of GDP, with a gross financing need of $17.1 billion. To meet the financing demand, the government plans to raise $12.3 billion from the issuance of securities and $4.8 billion from official foreign loans.

Table 2: Summary Financing Plan

Source	**Amount** ($ million)	**Share of Total** (%)
Asian Development Bank		
Ordinary capital resources (concessional policy-based loan)	88.6	86.7
Special Funds resources (Asian Development Fund regional health security grant)	12.0	11.7
Government of Viet Nam[a]	1.6	1.6
Total	**102.2**	**100.0**

[a] Government counterpart funding is estimated at $1.6 million and includes civil servants' salaries, in-kind provision of assets (office space, equipment, recurrent operating costs), or other paid-for costs.
Source: Asian Development Bank estimates.

Table 3: Project Investment Plan
($ million)

Item		**Amount**[b]
A.	**Base Cost**[a]	
	1. Public investment management for LHC	7.7
	2. Service delivery models of LHC network	3.2
	3. LHC workforce development and management	1.6
	Subtotal (A)	**12.5**
B.	**Contingencies**[c]	**1.1**
	Total Project Cost (A+B)	**13.6**

LHC = local health care.

[37] Program Impact Assessment (accessible from the list of linked documents in Appendix 2).

[a] The grant will finance taxes and duties, bank charges, local transport, and insurance costs. Taxes and duties are estimated at $0.81 million. Such amount does not represent an excessive share of the project cost.
[b] In mid-2018 prices.
[c] Physical contingencies computed at 5% of total base cost. Price contingencies computed at an average of 1.6% foreign exchange costs and 5% on local currency costs; includes provision for potential exchange rate fluctuation under the assumption of a purchasing power parity exchange rate.
Source: Asian Development Bank estimates.

E. Implementation Arrangements

26. Implementation arrangements are summarized in Table 4 and described in detail in the project administration manual.[38]

Table 4: Implementation Arrangements

Aspects	**Arrangements**		
	Policy-based loan	Project grant	
Implementation period	January 2016–June 2018	March 2019–March 2025	
Closing date	31 March 2020	30 September 2025	
Management			
(i) Oversight body	MOH, under the guidance of the minister of health		
(ii) Executing agency	MOH (policy-based loan and project)		
(iii) Key implementing agencies	MOH DPF and DOHs of six targeted provinces (project)		
(iv) Implementation units	Central project management unit		
Procurement and Consulting services[a]	OCB (internationally advertised)	TBD	$6.35
	RFQ	2 contracts	$0.13
	OCB-QCBS	7 contracts	$2.36
	OCB-LCS	1 contract	$0.05
	ICS	3 contracts	$0.28
Retroactive financing/ Advance contracting	None		
Disbursement	The policy-based loan and grant proceeds will be disbursed following ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.		

ADB = Asian Development Bank, DOH = Department of Health of Provinces, DPF = Department of Planning and Finance, ICS = individual consultant selection, LCS = least-cost selection, MOH = Ministry of Health, OCB = open competitive bidding, QCBS = quality- and cost-based selection, RFQ = request for quotation, TBD = to be determined, TOR = terms of reference.
[a] Procurement and consulting services will follow the ADB Procurement Policy (2017, as amended from time to time) and Procurement Regulations for ADB Borrowers (2017, as amended from time to time).
Source: ADB.

III. DUE DILIGENCE

27. **Economic and financial.** Economic analysis of pilot provinces suggests that the proposed investments in health services and infrastructure are economically viable. Economic benefits will occur from increased utilization of lower-level LHC facilities and the family medicine services, which will reduce healthcare costs, along with gains in labor productivity because of the population will be healthier. The net present value of estimated benefits less costs is $25.0 million over a 15-year period. The economic analysis has not included benefits arising from the lower risk of economic shocks achieved through greater control of communicable diseases, so the quantified benefits are likely to be conservative estimates. Careful health sector planning will be required to ensure sufficient resources to support recurrent costs and ensure financial

[38] Project Administration Manual (accessible from the list of linked documents in Appendix 2).

sustainability. Recurrent costs represent less than 0.2% of projected annual provincial health expenditure.

28. **Governance.** Financial management assessment found governance risk to be *substantial.* The MOH's experience with externally financed projects, including those of ADB, indicates adequate overall capacity. Project procurement risk is *moderate.* MOH procurement teams are experienced in ADB procurement procedures, and the requirements of the government are broadly aligned with international procurement practices. Advanced training on ADB Procurement Policy (2017, as amended from time to time) and the Procurement Regulation for ADB Borrowers (2017, as amended for time to time) is recommended for the central project management unit of the executing agency and the implementing agencies. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the Government of Viet Nam.

29. **Poverty and social impacts.** The program will help improve access and increase the responsiveness and quality of LHC services for populations in disadvantaged, mountainous, remote, and border areas. The program contributes directly to improved health status, especially for the poor. Further, indirect contributions to poverty reduction will ensue from reductions in catastrophic health expenditure, a result of increasing health insurance coverage, and improvements in people's productivity. The project will benefit populations residing in six provinces with high poverty incidence. Enhanced access to responsive and quality LHC services brings benefits to vulnerable populations in remote and border areas most susceptible to health security threats. These include the poor and minority populations for whom morbidity and mortality attributable to infectious diseases remain high, and vulnerable populations in disadvantaged areas where the NCD burden is highest.

30. **Gender.** The program's gender category is gender equity as a theme. The program is expected to contribute to gender equality and women's empowerment through improved health outcomes for women and girls. Women and girls will have improved access to quality local essential health services through CHS that are well equipped and incorporate gender-friendly design features. Service delivery will accommodate women's social and cultural preferences, including those of ethnic minority women and good-quality services critical to women's health and well-being, including SRH services. The policy-based program supports the launch and implementation of the health sector action plan on gender equality covering 2016–2020 (footnote 27) as well as the adoption of other policies aimed at enhancing access to health services for women, children, and ethnic minorities. The project includes a gender action plan to support implementation of the MOH gender equality action plan and other gender-related policies in areas including SRH, domestic violence, and the provision of gender- and ethnic minority-sensitive health services.

31. **Safeguards.** In accordance with ADB's Safeguard Policy Statement (2009), the program is categorized C for environment because none of the policy reform actions or investments in district hospitals involve civil works, and none are anticipated to result in adverse environmental impacts or increased health and safety risks. The program is categorized C for involuntary resettlement since no land acquisition or involuntary resettlement impacts are expected. A matrix of potential impacts of policy actions has been prepared. The program is expected to bring positive impacts to ethnic minorities such as improving the capacity of ethnic minority health care staff and improving minorities' access to health services and improving the quality of those services, especially in disadvantaged and remote areas. The program is classified category B for indigenous peoples. The ethnic minority development plan will ensure that project grant activities benefit ethnic minorities.

32. **Risks and mitigating measures.** Major risks and mitigating measures are described in detail in the risk assessment and risk management plan.[39] Country risks pertain to macroeconomic instability, a high level of public debt, and a shift in political leadership, which weakens support for LHC. CHS may not receive sufficient budget to finance reform implementation. Country level risks will be mitigated through continuous policy dialogue, support for targeted interventions, and other specific measures to strengthen PFM. Project pre-mitigation risk for PFM is rated *high* because each Department of Health in the six target provinces will manage a subaccount. Project procurement pre-mitigation risk is rated *high*. Mitigation measures include staff capacity building and assistance from experts. The pilot districts will prepare annual plans and budgets to ensure that the equipment will remain operational. The integrated benefits and impacts are expected to outweigh the costs, and fiduciary arrangements are put forward to minimize financial management risks.

IV. ASSURANCES

33. The government and MOH have assured ADB that implementation of the program shall conform to all applicable ADB policies including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the project administration manual and loan documents. The government and MOH have also agreed with ADB on certain covenants for the program, which are set forth in the related legal agreements.

V. RECOMMENDATION

34. I am satisfied that the proposed policy-based loan and grant would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the loan of $88,600,000 to the Socialist Republic of Viet Nam for the Local Health Care for Disadvantaged Areas Sector Development Program, from ADB's ordinary capital resources, in concessional terms, with an interest charge at the rate of 2.0% per year during the grace period and thereafter; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board; and

(ii) the grant not exceeding $12,000,000 to the Socialist Republic of Viet Nam from ADB's Special Funds resources (Asian Development Fund) for the Local Health Care for Disadvantaged Areas Sector Development Program, on terms and conditions that are substantially in accordance with those set forth in the draft grant agreement presented to the Board.

Takehiko Nakao
President

19 November 2018

[39] Risk Assessment and Risk Management Plan (accessible from the list of documents in Appendix 2).

DESIGN AND MONITORING FRAMEWORK

Country's Overarching Development Objective
Universal health coverage for all citizens achieved (National Action Plan for the Implementation of the 2030 Sustainable Development Agenda)[a]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Effects of the Reform Quality of and access to LHC services for women and men, particularly in disadvantaged and remote areas, improved	By 2026, nationwide: a. 90% of CHS meet MOH's 2014 national standards for health service delivery (2017 baseline: 70% as per 2014 standards)[b] b. Proportion of CHS outpatient visits to total outpatient visits in last 12 months increased to at least 25%, with data disaggregated by sex, age, and ethnicity (2014 baseline: 20.0%)[c] c. At least 85% of pregnant women have four antenatal care visits during pregnancy (2017 baseline: national aggregate 61.9%)[d] d. Score on JEE assessment of human resources available to implement IHR core capacity requirements increased to 4 (2016 baseline: JEE indicator D.4.1 score = 3)[e]	a. MOH joint annual health review b. Viet Nam living standards survey c. MOH Maternal and Child Health Department data d. MOH JEE assessment	Shift in political leadership weakens support for investment in the LHC system
Reform Areas 1. Public investment management for LHC	**Program: Key policy actions** By 2018: 1a. National Master Plan for Building and Developing the LHC Network approved by MOH[f] (2016 baseline: not applicable) 1b. Decree defining the list of CHS services and tariffs reimbursable by health insurance issued by MOH (2016 baseline: not applicable) **Project: Outputs** By 2024: 1c. 12 district hospitals in the six target provinces are equipped with essential medical equipment, including equipment for SRH services and outbreak investigation and diagnosis (2018 baseline: 0 hospitals equipped)[g]	1a. MOH decision 1b. MOH Circular 39/2017/TT-BYT 1c. Project annual report	High public debt reaching 65% of GDP limit
2. Service delivery models for LHC network	**Program: Key policy actions** By 2018: 2a. List of LHC services to be delivered under the new model approved[h] (2016 baseline: not applicable) 2b. Implementation plan of the family medicine model approved (2016 baseline: no plan defined) 2c. Implementation plan for electronic health records disaggregated by sex, age, and ethnicity adopted (2016 baseline: no implementation plan defined)	2a. MOH circular 39/2017/TT-BYT 2b. Decision 1568/QD-BYT (2016) 2c. Decision 6111/QD-BYT (2017)	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	Project: Outputs By 2024: 2d. 20% of CHS in six target provinces have implemented the family medicine model (2017 baseline: 0 CHS)[i] 2e. 12 districts in six target provinces are equipped with operational outbreak response units (2017 baseline: 0 districts)[j]	2d–2e MOH project performance monitoring system and MF-MPSLHCS reported in annual project progress report	
3.LHC workforce development and management	**Program: Key policy actions** By 2018: 3a. Training curriculum based on national standards on family medicine and health security for doctors, nurses, midwives, assistant doctors, and assistant pharmacists at the CHS level developed (2016 baseline: not applicable) 3b. Percentage of CHS nationwide served by a medical doctor increased to 88.0% in 2017 (2014 baseline: 78.5%) 3c. Action Plan on Gender Equality of the Health Sector, 2016–2020, including national standard targets to promote gender equality in the health workforce, issued (2016 baseline: not applicable)	3a. Decision 55/QD-K2DT(2017) 3b. MOH 2017 annual report (Report 1499/BC-BYT) 3c. Decision 822/QD-BYT (2016)	
	Project: Outputs By 2024: 3d. 100 doctors (at least 38% women) awarded a certificate in family medicine (data disaggregated by sex and ethnicity) (2018 baseline: 0) 3e. In the six targeted provinces, at least 1,000 assistant doctors, nurses, midwives (of which 65% are women) successfully pass the 3-day training program on principles of family medicine (2018 baseline: 0)[k]	3d–3e. Project annual progress report	

Key Activities with Milestones

1. Public investment management for LHC (Project)

1.1 Assess district-level equipment inventories (including diagnostic equipment for noncommunicable and communicable diseases) (December 2019)
1.2 Supply equipment for district hospitals (December 2020)
1.3 Conduct review of the guidelines and norms for infrastructure and equipment at LHC facilities (2021)
1.4 Review health insurance benefit packages for LHC (2021)

2. Service delivery models of LHC network (Project)

2.1 Assess the equipment inventories in 12 pilot districts to implement the family medicine model (including SRH) and response capacity to HSTs (December 2019)
2.2 Assess human resource capacity and training needs for the family medicine model (including SRH) and response capacity to HSTs (December 2019)
2.3 Assess needs for EHR implementation (that include information on sex, age, and ethnicity, as well as on gender-specific health issues such as domestic violence) (October 2019)
2.4 Review existing IEC materials for family medicine models (December 2019)
2.5 Prepare new gender-sensitive and culturally appropriate IEC materials (August 2020)
2.6 Provide family model, SHR, HST response, and IT equipment (December 2020)
2.7 Introduce and monitor family medicine model (including SRH), EHRs, and HST response (December 2020)

2.8 Implement IEC campaigns in selected provinces (January 2020–December 2023) 2.9 Monitor and evaluate implementation of the family medicine model (including SRH), EHRs, and HST response (December 2023) 2.10 Disseminate lessons learned and policy recommendations (June 2023) **3. LHC workforce development and management (Project)** 3.1 Train health staff on use and preventive maintenance of diagnostic equipment (December 2020) 3.2 Implement training programs on family medicine (including SHR and domestic violence), HST response, and EHRs (September 2019–2022)
Project Management Activities • Advertise the recruitment of experts in health care, IT, gender and safeguards, project implementation, procurement, and financial management by April 2019. • Identify and track parameters of effectiveness, efficiency, integration, sustainability, and other qualities for results-based project management by October 2019. • Train implementing agencies in procurement, disbursement, and annual plans by November 2019. • Commence baseline evaluation of reforms in 12 pilot districts with sex-disaggregated indicators in July 2019, with midterm and final evaluations by 2023.
Inputs Asian Development Bank: $88,600,000 (loan) $12,000,000 Asian Development Fund (grant) Government of Viet Nam: $1,600,000
Assumptions for Partner Financing Not applicable

CHS = commune health stations; EHR = electronic health record; HST = health security threat; IEC = information, education, and communication; IHR = International Health Regulations; IT = information and technology; JEE = joint external evaluation; LHC = local health care; MF-MPSLHCS = Monitoring Framework—Master Plan for Strengthening Local Health Care Services; MOH = Ministry of Health; SRH = sexual and reproductive health.

[a] Government of Viet Nam, MOH. 2017. *National Action Plan for the Implementation of the 2030 Sustainable Development Agenda.* Prime Minster Decision No. 622/QD-TTg.

[b] Government of Viet Nam, MOH. *Decision 4667/QD-BYT (7 November 2014) on the national standards for CHS for the period to 2020.*

[c] 21.1% male; 19.3% female.

[d] MOH Maternal and Child Health Department data for the first 9 months of 2017.

[e] The MOH conducted a JEE in 2016 in collaboration with the World Health Organization and other development partners. The JEE evaluated Viet Nam's capacities to prevent and respond to acute public health risks that have the potential to cross borders and to threaten regional health security.

[f] As per the master plan, normal delivery services, obstetric techniques, and provision of family planning services are included in the mandatory tasks that CHS are requested to perform.

[g] The list of the essential medical equipment is included in the Project Administration Manual (accessible from the list of linked documents in Appendix 2).

[h] Technical services to be performed at CHS include several techniques related to obstetrics, gynecology, neonatology, family planning, and abortion. Child health and health care promotion is also included in the services to be provided at LHC level.

[i] Family medicine model implementation at a CHS includes establishing a personalized electronic health record system; having a family medicine-certified doctor; and having at least a midwife, nurse, or assistant doctor who has attended a short course on family medicine. It also means LHC services become more responsive to the needs of the people in the communities (women, men, children, the elderly, and ethnic minorities).

[j] An outbreak response unit should meet four criteria: (i) pickup vehicle available, (ii) at least five staff trained, (iii) budget available for 2018, and (iv) equipment for vector control.

[k] The baseline value of each indicator will be updated based on findings from the assessment of inventories that the project will undertake.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS
http://www.adb.org/Documents/RRPs/?id=50285-002-3

1. Loan Agreement
2. Grant Agreement
3. Sector Assessment (Summary): Health
4. Project Administration Manual
5. Contribution to the ADB Results Framework
6. Development Coordination
7. Economic and Financial Analysis
8. Country Economic Indicators
9. International Monetary Fund Assessment Letter: IMF Executive Board Concludes the 2018 Article IV Consultation with Vietnam[1]
10. Summary Poverty Reduction and Social Strategy
11. Risk Assessment and Risk Management Plan
12. Gender Action Plan
13. List of Ineligible Items

Supplementary Documents:

14. Ethnic Minority Development Plan
15. Program Impact Assessment
16. Environmental and Social Impact Assessment of the Policy Matrix and Project Grant

[1] The IMF confirmed on 11 July 2018 that the attached IMF Country Report No. 18/215: Viet Nam 2018 Article IV Consultation-Press Release and Staff Report may serve as the IMF assessment letter. The staff report is accessible at https://www.imf.org/en/Publications/CR/Issues/2018/07/10/Vietnam-2018-Article-IV-Consultation-Press-Release-and-Staff-Report-46064.

DEVELOPMENT POLICY LETTER

MINISTRY OF HEALTH
SOCIALIST REPUBLIC OF VIETNAM

Ha Noi, 14 November 2018

DEVELOPMENT POLICY LETTER

Mr. Takehiko Nakao
President
Asian Development Bank
Manila, Philippines

Subject: DEVELOPMENT POLICY LETTER AND POLICY MATRIX
Local Health Care for Disadvantaged Areas Sector Development Program (LHCSDP)

Dear President Nakao,

The Government of Viet Nam has made substantial progress in improving the health status of its citizens. Average life expectancy has increased from 72.9 years in 2010 to 73.5 years in 2017 (70.9 in males and 76.2 in females) and U5MR declined from 58.0 child deaths per 1000 live births in 1990 to 21.5 in 2017. Despite these improvements, key challenges remain in providing equitable access to high quality health services and to further improve health outcomes in all regions and segments of the population. Disparities in basic health indicators between regions and between various population groups have not declined as much as hoped. Several remote and mountainous areas have inadequate primary health care (PHC) services and the health outcome indicators in these areas are significantly lower than the national average level. The responsiveness of the grass roots health network to Viet Nam's changing epidemiological profile needs to be enhanced. Many patients are referred to hospitals, for communicable diseases, along with non-communicable disease management and aging-related illnesses, which could have been treated in primary care facilities.

Policies and the legislative framework for the health sector are being refined to address these issues. The Central Executives Committee of the Communist Party of Vietnam has issued Resolution No.20/NQ-TW dated October 25th 2017, and the government issued the National Strategy on the Protection, Care and Promotion of the People's Health for the period 2011–2020, with a vision to 2030 (Decision No. 122/QD-TTg dated 10/01/2013). The resolution and strategy set out a vision for consolidating and renovating the grassroots health system. In December 2016, the government enacted the National Master Plan for Building and Developing the LHC Network in the New Situation. The Master Plan seeks to (i) renovate the organization, operating mechanism, financing mechanism, and health human resource development to improve delivery capacity for quality grassroots health services; (ii) ensure adequacy of PHC services, examination, and treatment for each citizen in the locality; (iii) provide health services towards comprehensiveness and continuity, and establish linkages between preventive care and

medical treatment, and between the local health care networks in the locality and higher levels; (iv) contribute to reduce overcrowding in hospitals at the upper level; and (v) ensure fairness and efficiency in the protection, care and enhancement of people's health.

We are grateful to the Asian Development Bank and other development partners for their assistance to the Vietnamese health sector. Recently this has involved support in preparing the Local Health Care for Disadvantaged Areas Sector Development Program (LHCSDP) which will accelerate the attainment of improved health care in line with the local health care (LHC) Master Plan through the development of a network of local health facilities to ensure responsive PHC leading to improved quality of and access to LHC services for people in disadvantaged and remote areas. The program has established policies that ensure responsive commune health stations (CHS) service delivery through reforms such as implementing a package of health services that are paid by health insurance and strengthening the preventive health functions of the LHC system; and strengthened the LHC workforce through enhanced competency standards for health professionals and by addressing incentive structures. With the support of LHCSDP the Government agrees to fulfill the conditions described in the policy matrix accompanying this Development Policy Letter. Key reform areas and policy actions in the matrix include the following:

Public investment management for local health care strengthened. An enabling policy and institutional framework has been established to enhance the delivery of local health care services. The Prime Minister enacted the National Master Plan for Strengthening Local Health Care Network in the New Situation (Prime Minister Decision No. 2348/QD-TTg dated 05/12/2016), which defines the required policy, regulatory, and institutional reforms to improve local health care system in the country. MOH has updated the architectural, equipment and human resources standards for communal health stations (CHS) and upgraded LHC based on the Master Plan. As a result, the proportion of CHS meeting national service standards reached 70% in 2017.

The Government has adopted measures to improve health financial risk protection from health care costs and tap sustainable sources of health financing through social health insurance. MOH issued a series of policies defining the fee of services, list of medical supplies including the rate and conditions for payment, and the basic health care service package covered by health insurance (Circular Nos. 04/2017/TT-BYT dated 18/10/2017 and 39/2017/TT-BYT dated 14/4/2017).

The Government has set the 2016–2020 health insurance coverage target to support its goal for achieving universal health insurance coverage in Decision No. 1167/QD-TTg dated 28 December 2016. As a result, the number of health insurance beneficiaries increased from 76.5% of the population in 2015 to 86.4% in 2017. As a medium-term objective, coverage of essential health services under indicator 3.8.1 of the sustainable development goals (SDGs)–defined as the average coverage of essential services based on interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service access, among the general and the most disadvantaged population–will further be increased.

To counter hospital over-crowding, the Government is pursuing a family medicine model of LHC service delivery. The Government is also investigating new methods to improve access to quality health care, contain costs, and increase efficiency. This includes prioritizing state budget allocation for preventive medicine (at least 30% of state health budget), grassroots healthcare, PHC, service delivery in mountainous and remote areas and implementation of basic social policies on health.

Service models of LHC network improved. The Government has established a comprehensive service package delivered at local health care to meet the challenges of epidemiologic transition, aging and public health threats, and respond to the needs of women, children and indigenous people. MOH has structured the package health services for PHC, preventive and curative services, comprising essential services to delivered at the CHS. The Government implemented policies that prioritize health services for women and children, particularly for ethnic minorities including policies related to sexual and reproductive health services and gender-based violence prevention and response.

The government developed new service delivery models appropriate to the shift in epidemiologic profile and population aging (Decision 1568 QD-BYT dated 27/01/2016, Decision 7618/QD-BYT dated 30/12/2016). MOH developed and undertook a phased implementation of family medicine model aimed at providing comprehensive health care for individuals, families and communities. The family medicine model aims to improve patient retention at the primary care level through improved referral, record management capacity and improved service quality. MOH established individual electronic health records for primary health care, which includes information on sex, age, and ethnicity (Decision No. 5004/QD-BYT dated 19/09/2016, Decision 831/QD-BYT dated 11/03/2017, Decision 4210/QD-BYT dated 20/09/2017, Decision 6111/QD-BYT dated 29/12/2017).

The government improved the management and the coordination of measures aimed at improving health security. MOH established Provincial Centers for Disease Control aimed at strengthening health security and outbreak control through Circular No. 26/2017/TT-BYT. It merged the functions of district health centers and district hospitals to improve coordination between curative and preventative services (Circular No. 37/2016/TT-BYT dated 25/10/2016). By 2017, the functions of district hospital and district health center have been merged in 202 out of 420 districts.

Systems for LHC workforce development and management strengthened. The government intensified efforts to ensure adequate staffing with appropriate skills in the CHS. MOH is committed to develop a comprehensive policy framework and long-term plan to improve the quality of health workforce capacity development, as called for in the Government's Master Plan for Health System Development in Viet Nam 2010 and Vision to 2020. Health human resources deployment and rotation at LHC facilities are being pursued, which include incentive structures as well as gender and ethnic representation. MOH issued the Action Plan on Gender Equality of the Health Sector (2016–2020) with objectives, targets and strategies to promote gender equality, including in the health workforce. MOH has developed training curriculum on family medicine and health security for doctors, nurses, midwives, assistant doctors and assistant pharmacists at the CHS level, based on national standards (Decision No. 55/QD-K2DT dated 08/05/2017, Decision No.4667/QD-BYT dated 14/08/2017). MOH implemented policies to increase the proportion of CHS 2017 served by a medical doctor to reach 88% in 2017, and to regulate the health facility licensing for family medicine model (Decree 109/2016/ND-CP dated 01/07/2016).

In conclusion, the Government of Vietnam appreciates ADB's efforts to support our initiatives to conduct health care reforms. We further appreciate ADB's commitment to work with the Government over the medium-term in further reforming the health sector. We thus request favorable consideration of the proposed $88.6 million policy-based loan of the Local Health Care for Disadvantaged Areas Sector Development Program. We would also like to provide our assurances that the Government will follow up these reforms under the ensuing post program partnership framework.

Dedication of Counterpart Funds. The Government will dedicate counterpart funds generated from LHCSDP loan to ensure that policy conditions underpinning the Program are fully

implemented. The counterpart funds generated from the proceeds of LHCSDP loan will (i) supplement the Government's health budget in support of the LHCSDP policy actions, and (ii) be part of the Government's contribution to ADB-funded health sector activities within the scope of LHCSDP. The Government wishes to reaffirm its commitment to continue the partnership with ADB for the sustainable economic and social development of Viet Nam through improved effectiveness, efficiency, and equity of access to health care services.

Sincerely yours,

Assoc.Prof. Nguyen Thi Kim Tien, MD, Ph.D
Minister of Health
Socialist Republic of Vietnam

POLICY MATRIX

Reform area	Policy Actions accomplished (January 2016 to June 2018)	Post-program partnership framework: 2018 to 2025
Reform area 1: Public investment management for local health care		
1.1 Establishing an enabling policy and institutional framework to enhance the delivery of LHC services	The government formulated policies to strengthen LHC infrastructure. Policy Action 1: Government enacted the National Master Plan for Strengthening LHC Network,[a] which defines the required policy, regulatory, and institutional reforms of the LHC system. Policy Action 2: MOH updated the architectural, equipment, and human resources standards for CHS and upgraded LHC infrastructure based on the Master Plan. As a result, in 2017 70% of the CHS meet the national service standards.	ADB will continue providing technical assistance to the implementation of the National Master Plan for Strengthening LHC Network 2016–2025.
1.2 Improving financial risk protection at LHC level.	The government adopted measures to tap sustainable sources of financing through social health insurance system. Policy Action 3: MOH adopted a series of policies defining tariff of services, and list of health services, medical procedures and drugs covered by health insurance funds to be delivered by the CHS. Policy Action 4: Government subsidized health insurance premiums for poor and other targeted groups to increase health insurance coverage. As a result, the number of health insurance beneficiaries increased from 76.5% in 2015 to 86.4% of the population in 2017.	The government will increase health insurance coverage, develop insurance benefit packages for local health care and increase the budget allocated to local health care health insurance benefits. ADB's technical assistance (TA) for Strengthening the Policy and Institutional Framework of Social Health Insurance[b] (2017–2019) will support the MOH review of the Health Insurance Law and develop a Master plan for the implementation of Universal Health Coverage (UHC) for 2020–2025.
Reform area 2: Service delivery models of LHC network		
2.1. Enhancing responsiveness of LHC system through a comprehensive package for LHC services	The government established a comprehensive package of health services to be delivered at LHC level. Policy Action 5: MOH expanded the range of core services for primary health care, preventive and curative care guaranteed to be delivered at CHS. Policy Action 6: Government implemented policies that prioritize health services for women and children, particularly for ethnic minorities including policies related to sexual and reproductive health services and gender-based violence prevention and response.	MOH will continue the progressive nationwide roll out of the restructured health service package. The government will further develop policies aimed at reducing maternal mortality ratio and targets an increase in the proportion of pregnant women attending at least four antenatal care visits to 85% by 2025
2.2. Developing family medicine model, long-term health care and electronic health	The government developed new service models appropriate to the shift in epidemiologic profile and population aging. Policy Action 7: MOH developed and undertook a phased implementation of family medicine model aimed at providing comprehensive health care for	The MOH will roll out nationwide the family medicine model and introduce the electronic health records in all commune health stations. This will enable the provision of long-term health care through recording of the health history of individual patients

Reform area	Policy Actions accomplished (January 2016 to June 2018)	Post-program partnership framework: 2018 to 2025
records	individuals, families and communities.[c] Policy Action 8: MOH established individual electronic health records for primary health care (which includes information on sex, age, and ethnicity).	LHCSDP project grant component (2019–2025) will pilot the family medicine model and electronic health records to inform national roll out, guidelines and future policy actions. ADB's TA for Support to Strengthening Local Health Care Program[d] will help MOH in (i) introducing health financing mechanisms for local health care delivery, and (ii) preparing for an ICT roadmap to improve health service delivery. ADB's TA for Strengthening the Policy and Institutional Framework of Social Health Insurance[b] (2017–2019) will develop innovative solutions to address long-term health care needs and design and pilot a basic health service package for the elderly to be covered by social health insurance.
2.3. Pursuing measures to strengthen health security	The government improved the management and the coordination of measures aimed at improving health security. Policy Action 9: MOH established Provincial Centers for Disease Control aimed at strengthening health security and outbreak control. Policy Action 10: MOH merged the functions of district health centers and district hospitals to improve coordination between curative and preventative services. By 2017, the functions of district hospital and district health center have been merged in 202 out of 420 districts.	LHCSDP project grant component (2019–2025) will strengthen health security of pilot districts in disadvantaged and remote areas to address public health threats. ADB's GMS Health Security Project[e] will strengthen disease surveillance and rapid response teams in 36 provinces.
Reform area 3: LHC workforce development and management		
3.1. Improving deployment and quality of staff in the CHS	The government intensified efforts to ensure adequate staffing with appropriate skills in the CHS. Policy Action 11: MOH implemented the Action Plan on Gender Equality of the Health Sector (2016–2020) with objectives, targets and strategies to promote gender equality, including in the health workforce. Policy Action 12: MOH developed training curriculum on family medicine and health security for doctors, nurses, midwives, assistant doctors and assistant pharmacists at the CHS level, based on national standards. Policy Action 13: MOH increased the proportion of CHS 2017 served by a medical doctor to reach 88% in 2017.	MOH will further deploy health staff in CHSs and provide family medicine training and accreditation for doctors, nurses, midwives, and assistant doctors. LHCSDP grant component (2019–2025) will implement capacity building and training for health practitioners in pilot districts. ADB's grant component of the proposed Second Health Human Resources Development Project[f] (2019–2023) will strengthen the competency of graduates to respond to community health needs; and enhance the quality of health workforce in disadvantaged communities. It will

Reform area	Policy Actions accomplished (January 2016 to June 2018)	Post-program partnership framework: 2018 to 2025
	Policy Action 14: MOH issued health facility licensing for family medicine.	introduce a IT based innovative approach for health workforce continuing medical education (CME) and provide equitable access to professional development in disadvantaged and remote areas. Other areas for technical assistance and development coordination include establishing the regulatory framework for health practitioner licensing, adopting of model for professional standards of medical graduates and guidelines for knowledge and skills transfers, and accreditation of continuous medical education courses.

CHS = commune health station, EHR=electronic health record, GMS = Greater Mekong Subregion, HHRSDP = Health Human Resource Sector Development Program, LHC = local health care, LHCSDP = Local Health Care for Disadvantaged Areas Sector Development Program, MOH = Ministry of Health, TA = technical assistance.

Note: In Viet Nam, the official policies and regulations promulgated by the government and the ministries are classified as follow: (i) “Decrees”/ “Resolutions” promulgated by the government; (ii) “Circulars”/ “Joint Circulars” contain the highest level of policies that can be promulgated by line ministries; (iii) “Decisions” promulgated by the Prime Minister or the ministers for occasional events; and (iv) “Official Letters” issued by the government or ministry.

[a] Per the Master Plan, normal delivery services, obstetric techniques, and provision of family planning services are included in the mandatory tasks that CHS are requested to perform.

[b] ADB. Viet Nam: Strengthening the Policy and Institutional Framework of Social Health Insurance.

[c] Family medicine model implementation at a CHS includes establishment of personalized electronic health record system, having a family medicine certified doctor and at least a midwife, nurse or assistant doctor having attended family medicine short course training). It also means local health care services becoming more responsive to the needs of the people in the communities (women, men, children, the elderly and ethnic minorities).

[d] ADB. Viet Nam: Support to Strengthening Local Health Care Program.

[e] ADB. Regional: Greater Mekong Subregion Health Security Project.

[f] ADB. Viet Nam: Second Health Human Resource Development Project (SHHRDP).