ADB

Report and Recommendation of the President to the Board of Directors

Project Number: 40354
May 2010

Proposed Loans and Administration of Grant Socialist Republic of Viet Nam: Health Human Resources Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS

(17 May 2010)

Currency Unit	–	dong (D)
D1.00	=	$0.000052
$1.00	=	D19,025

ABBREVIATIONS

ADB	–	Asian Development Bank
HHR	–	health human resources
LET	–	Law on Examination and Treatment
MDG	–	Millennium Development Goal
MOH	–	Ministry of Health
PMU	–	project management unit

NOTE

In this report, "$" refers to US dollars.

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CONTENTS

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed program loan, (ii) a proposed project loan, and (iii) proposed administration of a grant to be provided by the Government of Australia, all to the Socialist Republic of Viet Nam for the Health Human Resources Sector Development Program.

2. The program loan will support key policy reform actions in health workforce management and financing; and the project loan will finance investments directly linked to and supportive of the policy actions. The program will support the development and implementation of the new Law on Examination and Treatment (LET) governing health facilities and the registration and practice of health professionals, a new comprehensive plan to upgrade teaching institutions, and the adoption of new models for costing and managing service delivery in district hospitals.[1]

II. THE SECTOR DEVELOPMENT PROGRAM

A. Rationale

3. Viet Nam has made notable progress in reducing poverty and improving the health status of its citizens. The country is on track to achieve most of its health-related Millennium Development Goals (MDGs) by 2015.[2] Key challenges still confront Viet Nam in its effort to provide equitable access to high-quality health services and to further improve health outcomes across the different regions and segments of the population. Much of the improvement in national health indicators has been driven by gains in the heavily populated regions around Ha Noi and Ho Chi Minh City. Remote and rural provinces lag significantly; if measured alone, they would not meet the MDGs. The demand for higher-quality health services has increased as a result of growing prosperity and the emerging middle class, particularly in urban areas.

4. To continue improvements in health status and extend the benefits more broadly and equitably, the government has set out an ambitious plan to address an array of continuing problems in the health sector. The *Master Plan: Vietnam Health Systems Development to 2010 and the Vision to 2020* calls for making access and use of health services more equitable and effective to protect and promote people's health.[3] It aims to improve the quality of health care at all levels, with attention to the poor, women, minority groups, and those living in remote areas.

5. **Recognized need for reform.** While the needs for policy development and investment are diverse, complex, and intricately interwoven, the government has identified areas for policy reform in the short to medium term to achieve the overarching sector goals of equity, efficiency, and development. They include strengthening the policies that underpin service delivery, especially the management of human and financial resources and the training of health workers. The government's legislative and policy reform agenda provides opportunities to introduce critical reforms that will lead to significant advances in the management and training of health workers and integration of that workforce into an improved setting for health service delivery. The reforms include the passage of the LET, a master plan to upgrade teaching institutions, and the adoption of new models for budgeting and managing service delivery in district hospitals.[4]

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[1] ADB. 2007. *Technical Assistance to the Socialist Republic of Viet Nam for Preparing the Support for Health Systems Development Program.* Manila (TA 7029-VIE); Design and Monitoring Framework (Appendix 1); Project Classification Summary (Appendix 2).

[2] Government of Viet Nam, Ministry of Health. *Health Statistics Yearbook 2007.* Ha Noi: Government of Viet Nam.

[3] Government of Viet Nam. 2005. *Master Plan: Vietnam Health Systems Development to 2010 and the Vision to 2020.* Ha Noi: Government of Viet Nam.

[4] Another new law on "public service providers"—which is currently under preparation for enactment in late 2010—will complement the LET through improved general management of health sector personnel.

6. **Licensing of health facilities.** Viet Nam has no system for licensing and registering health facilities, from local doctors' clinics to large hospitals. The rapid growth of private facilities has increased the need for such a system. A licensing system should apply to public and private facilities, and will be useful in gradually improving standards in the public system while protecting the public from inferior private providers. Licensing guidelines relate to the physical qualities of the facility, available medical equipment, and the qualifications and registration status of professionals working within the facility.

7. **Health workforce registration.** Viet Nam is one of the few countries in Asia that does not have a functioning system for regulating and managing the registration of its health workforce. This constraints quality and management in a number of areas, including regulation of professional qualifications and skill standards, quality monitoring of individual performance, taking disciplinary action when problems arise, and enforcing ongoing skills development. Given Viet Nam's commitments under the Mutual Recognition Arrangement on Nursing Services adopted by the Association of South East Asian Nations in 2006, the government recognizes the urgent need to establish a registration system to better serve consumers and to meet its regional obligations.

8. **Human resource constraints.** Viet Nam has a large number of health workers, but improvements in health services and outcomes are constrained by the workers' skill levels, distribution, management, and financing. There are insufficient medical specialists, nurses, college-trained pharmacists, public health workers, and specialist managers, particularly for hospitals and in the poor and remote areas with the greatest needs. Urban areas are also facing the growing loss of highly skilled health professionals to the rapidly emerging private sector. The variable and at times poor performance of health workers can be attributed to a lack of knowledge and skills, limited supplies and equipment, low motivation, and weak human resource management.

9. **Health workforce capacity building.** Health personnel are trained in universities, colleges, and secondary medical colleges. There is an urgent need for an increase in the number of health graduates to meet the growing demands of the expanding population. It is estimated that the number of health graduates (doctors, nurses, pharmacists, technicians) has to double every 6 years, or grow by 18% per year, to maintain current ratios. The quality of these institutions also needs to improve as they have been affected by a weak and incomplete policy framework, fragmented array of organizational structures, and limited funding.

10. **Low government spending on health.** Government expenditures on health have not kept pace with economic growth. Low health spending underlies many of the remaining and persistent problems in the sector. While annual health expenditures have risen substantially—from as low as $28 per capita in 2000 to $46 in 2006—the government's share has increased only slightly, from 30.1% of total health spending in 2000 to 32.3% in 2006.[5] Private out-of-pocket payments account for the major share of health spending (these accounted for 62.2% of spending in 2006, which is one of the highest levels worldwide). Low public spending on health (particularly on health workers' wages and other incentives) combined with the widening wage disparity between public and private sector workers exacerbate the chronic problems of recruiting and retaining qualified health workers.

11. **Quality, management, and financing of health services.** The systems and guidelines for internal quality control in hospitals are weak, and the regulatory frameworks are not well developed. A lack of policy direction and financial incentives has frustrated efforts to address

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[5] World Health Organization. 2009. *World Health Statistics 2009*. Geneva: WHO.

these challenges, especially for hospitals. Hospital financing is currently supply-driven, based primarily on staff levels and number of beds, which encourages overuse and inefficiency. The use of per-case payment methods (supported by "care pathways") offers a promising alternative to current payment methods. Care pathways are written protocols that describe integrated care strategies for selected conditions and serve as a basis for budgeting the per-case payments and monitoring the quality of care.

12. **Lessons.** The Asian Development Bank (ADB) has financed six health projects in Viet Nam and is one of the key development partners in the health sector. An important lesson from this experience is that human resource constraints need to be addressed more comprehensively, with support integrated into existing systems rather than in the form of project-based training. While sector development programs are new to the health sector in Viet Nam, lessons from similar loans in other sectors highlight the need to target a small, timely, and influential set of policy actions with regular and meaningful dialogue.[6]

13. **Sector development program approach.** A roadmap has been prepared to support a coordinated and comprehensive program of reform and investment that addresses human resource constraints in the health sector. A sector development program approach provides a suitable mechanism for initiating a transition in the delivery of official development assistance in the sector, as well as offering the opportunity to support a combination of system-focused policy reforms with accompanying investments to address critical needs with respect to the quality, efficiency, and capacity of health human resources. The program was developed through extensive consultation that included intensive technical inputs on the development of the workforce registration system and legislation on medical practice from ADB and a small group of development partners[7] with long-term experience in the sector.

14. The proposed program is included in ADB's country operations business plan, 2010–2012[8] and is consistent with Viet Nam's 5-year socioeconomic development plan.[9] The program covers both education and health sectors in line with Strategy 2020[10] and the operational plan for health,[11] as it supports health training institutions and health workforce development, and strengthens the planning and governance of health public expenditure. The proposed investment addresses a binding constraint to achieving the MDGs across all segments of the population and geographic areas. This is not currently addressed by development partners in the same comprehensive manner.

B. Impact and Outcome

15. The impact of the program will be improved health status and progress toward meeting the health-related MDG targets, especially in the remote and poor provinces. The outcome will be better quality, efficiency, and equity in the health workforce and health service delivery.

C. Outputs

16. The outputs will support the government's ongoing reform agenda for the health sector, specifically relating to health human resources (HHR). It includes (i) better planning and

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[6] Development Coordination (Appendix 2).
[7] Australian Agency for International Development, Pathfinder International, World Bank, and World Health Organization.
[8] ADB. Forthcoming. *Country Operations Business Plan: Viet Nam, 2010–2012.* Manila.
[9] Government of Viet Nam, Ministry of Planning and Investment. 2006. *The Five-Year Socio-Economic Development Plan, 2006–2010.* Ha Noi.
[10] ADB. 2008. *The Long-Term Strategic Framework of the Asian Development Bank, 2008–2020.* Manila
[11] ADB. 2008. *An Operational Plan for Improving Health Access and Outcomes under Strategy 2020.* Manila.

management of human resources; (ii) higher-quality human resources training; and (iii) improved management systems in health service delivery. The accompanying project loan supports investments directly linked to implementation of the policy actions in key institutions, including the Ministry of Health (MOH) and a select number of teaching institutions.

1. Program Outputs

17. Key policy actions supported under the program loan are described in paragraphs 18–24; details are in the development policy letter (Appendix 3) and policy matrix (Appendix 4).

a. Better Planning and Management of Human Resources

18. **Joint committee on health human resources.** MOH approved a decision on 21 April 2010 to establish a joint committee on HHR to address fragmentation of HHR policy and program implementation. Within 2 years, the committee will submit a report to MOH defining workforce needs and targets, and recommending policy measures and plans, including recommendations on expanding the health workforce, incentives for working conditions in rural and remote areas, and improving the gender balance at senior levels of MOH and provincial health departments.

19. **Law on Examination and Treatment.** Approved by the National Assembly in November 2009, the LET is an omnibus law that covers a wide area of health care practice including (i) the rights and responsibilities of patients, medical practitioners, and health care facilities; (ii) the classification, accreditation, and licensing of health professionals and health care facilities; (iii) operational procedures in health services; and (iv) the recording and remedying of medical malpractice. The LET and the subsequent implementation decrees and circulars are critical to establishing the institutions and systems necessary for long-term, sustained improvements in HHR. It will also set the standards and regulate the quality and safety of medical examination and treatment provided within health facilities and by health professionals. The program recognizes the adoption of the LET, provides incentives for the efficient implementation of the policy actions, and contributes to the costs associated with LET implementation.

b. Higher Quality Human Resources Training

20. **HHR training network master plan.** In February 2010, MOH submitted to the Prime Minister a master plan that addresses the acute staff shortages and recognizes the need to rapidly increase the number of graduates, expand coverage, and improve training quality. The plan includes proposals to upgrade medical colleges to universities and some secondary medical schools to medical colleges in underserved areas. It outlines a comprehensive approach to increasing investment in staffing, curriculum development, and equipment in training institutions. The policy matrix recognizes the development of this plan and the significant work that follows the passage of the LET.

21. **Rotation of medical specialists to lower-level hospitals.** MOH approved (i) Circular 09 (2008), which requires health training institutions to assign faculty and medical specialists to work with provincial and district hospitals; and (ii) Circular 1816 (2009), which imposes the same requirement on high-level hospitals. The rotation of specialist medical staff through lower-level hospitals and commune health centers will boost the availability and quality of local health care, especially in remote and mountainous areas, and support skills transfer to local health care staff. A comprehensive policy review of the implementation of Circulars 09 and 1816 will be undertaken after about 2 years to consider their impact and make recommendations for further policy development or modifications to improve policy outcomes.

22. **Increasing access to training and education.** Decision 134 (2006) and Circular 13 (2008) of MOH outline measures to increase access to training and education for health workers from ethnic minority communities. These include waiver of tuition fees, lower entrance requirements, and bridging and preparatory courses. Within 2 years of program loan effectiveness, MOH will complete a policy impact review on increasing the enrollment and completion rates of ethnic minority students, especially women, in health training, including the implementation of Decree 134 and Circular 13.

c. Improved Management Systems in Health Service Delivery

23. **Increased government spending on health.** In May 2008, the National Assembly adopted a resolution to increase the share of annual state budget spending for health care, ensuring that health spending will grow faster than overall state budget spending. The resolution recognizes that health spending has not kept pace with economic growth. This resolution is an important measure to ensure the budget level does not continue to decline, and to maintain real budget growth.

24. **Innovative clinical management procedures and health services financing.** MOH issued a *De An* (project plan) in November 2009 to support further piloting and adoption of the care pathway delivery mechanism, and authorized the health insurance fund and the provincial health authorities to pilot the case-based payment system in hub and cluster hospitals. Policy actions under the second tranche requires 20 care pathways to be developed, benchmarked, and budgeted in at least six hospitals, including at least three pathways that directly relate to medical care for women and/or at the primary level. Guidelines for financing reforms associated with care pathways are to be submitted to MOH and the Ministry of Finance.

2. Project Outputs

25. The project loan supports a set of linked and coordinated actions that are closely aligned with the policy actions and are designed to support their implementation at national and sub-national levels. The key project outputs are described in paragraphs. 26–32.

a. Better Planning and Management of Human Resources

26. **Stronger human resources policy, planning, and implementation.** This output will focus on building the capacity and systems for planning and managing HHR at the central level. The project will support the establishment and operation of the joint committee on HHR by providing (i) capacity-building inputs to establish the committee; identifying appropriate representation (including district and community representatives, while taking into account the need for a gender balance, and ethnic minority representation); (ii) terms of reference; and (iii) a secretariat with appropriate equipment, facilities, and operating budget.

27. **Established systems for the registration and licensure of health professionals.** This output will support technical inputs to guide the legal and administrative arrangements to establish and oversee the registration of health professionals, as provided in the LET. It will also support the establishment and operation of the health professional registration system at the provincial and national level. Support will be provided for the development of a standardized database system, the procurement of computer equipment, database software, training of central and provincial staff in certification of health professionals, and development of an effective accountability mechanism to implement the system at the different regional, provincial, and institutional levels in the health sector.

b. Higher Quality Human Resources Training

28. **Stronger capacity of teaching institutions.** The project will strengthen the universities, colleges, and schools responsible for training the health workforce, including pre-service and post-graduate training and continuing education. Support will be provided for the procurement and maintenance of prioritized teaching equipment and training laboratories to facilitate the application of modern teaching and learning methods in key training institutions in each part of the country. Expert inputs will support the development of minimum standards for equipment maintenance schedules. The targeted institutions will become teaching and learning resources or "hubs" for the other institutions in the region. Teachers in targeted institutions will be trained to improve skills and teaching methods. Selection of trainees will include targets for women and ethnic minorities.

29. **Stronger mechanisms for quality improvement and assurance.** The project will help MOH pilot an accreditation system for training institutions based on the requirements established in the LET. The supervisory system for training institutions will be strengthened at the national and regional levels. Criteria for accreditation and tools for internal and external evaluation will be developed, staff will be trained, and accreditation processes supported. The project will also support the implementation of Circular 07 on continuing medical education.

30. **Stronger staff training and utilization in remote areas.** The project will help MOH and selected training institutions serving remote communities increase the number of ethnic minority and female students from remote areas who complete health worker training and return to work in their local health facilities. The project will support and strengthen some pre-existing special entry programs that are not being utilized efficiently. It will also provide improved support to ethnic minority candidates and women for pre-service and in-service training, including scholarships to participate in health worker training.

c. Improved Management Systems in Health Service Delivery

31. **Piloting care pathways to organize clinical work.** This output will support the further development and expansion of the pilot care pathways mechanism for organizing clinical work linked to the provider payment mechanism. Six "hub" hospitals will be selected to become resource transfer centers for development and implementation of 20 care pathways for high-volume conditions within the capability of district hospitals. Project activities will comprise (i) piloting care pathways for organizing clinical work; (ii) introducing product-focused management methods and structures; (iii) introducing and testing case-based funding mechanisms; and (iv) strengthening the policy framework and human resource capacities to implement case-based provider payment linked to care pathways.

32. **Introducing and testing case-based funding mechanisms.** The project will support the development, training, testing, and evaluation of a case-based payment system associated with the care pathways pilot. The health insurance fund will be supported to (i) develop and implement case-based pricing and to negotiate and monitor volume and/or price contracts with hospitals, and (ii) institute performance monitoring that includes cost and fraud control.

D. Financing Plan

33. The overall sector development program financing is estimated at $76.3 million (Table 1). The government has requested loans from ADB's Special Funds resources as indicated below.

Table 1: Sector Development Program Financing Plan

Source	Amount ($ million)	Share of Total (%)
Asian Development Bank (program loan)	30.0	32.5
Asian Development Bank (project loan)	30.0	32.5
Government of Australia	11.0	24.0
Government of Viet Nam	5.3	11.0
Total	**76.3**	**100.0**

Source: Asian Development Bank estimates.

34. **Program financing plan.** ADB will provide a program loan in various currencies equivalent to SDR 20,086,000 from ADB's Special Funds resources. The loan will have a 24-year term, including a grace period of 8 years, an interest rate of 1.0% per annum during the grace period and 1.5% per annum thereafter and such other terms and conditions set forth in the draft loan agreement.

35. In determining the amount of the program loan, the following factors were considered: (i) the scope and strength of the proposed policy actions; (ii) the relative importance of the health sector in terms of public spending and recent budget growth trends; and (iii) the short- and medium-term costs of the proposed policy actions and the associated financing gap. The loan amount covers part of the adjustment costs[12] for the measures in the policy matrix. A large portion of the program loan will be used to implement the master plan for upgrading health teaching institutions. Loan proceeds will also contribute to costs incurred in implementing the institutional reforms initiated by the LET, such as the establishment of a registration system for the health workers and a system for licensing health facilities.

36. The program loan will be released in two equal tranches. The first will be released upon loan effectiveness on completion of all first-tranche policy actions; the second after 24 months when the remaining policy actions are expected to have been completed.

37. **Project investment plan.** The project is estimated to cost $46.33 million (Table 2). The government requested a loan in various currencies equivalent to SDR 20,086,000 from ADB's Special Funds resources to help finance the project. The loan will have a 32-year term, including a grace period of 8 years, an interest rate of 1.0% per annum during the grace period and 1.5% per annum thereafter, and such other terms and conditions set forth in the draft project agreement. The Government of Australia will provide an untied grant of $11 million to be administered by ADB as joint financing. The Government of Viet Nam will contribute $5.3 million, including local taxes and duties of $3.16 million.

Table 2: Project Investment Cost

Item		Amount ($ million)[a]
A.	**Base Cost**[b]	
	1. Better planning and management of human resources	9.17
	2. Higher quality training of human resources	25.13
	3. Improved management systems in health service delivery	3.80
	Subtotal (A)	38.10
B.	**Contingencies**[c]	7.48
C.	**Financing Charges During Implementation**[d]	0.74
	Total (A+B+C)	46.32

[a] Includes taxes and duties of $3.16 million. [b] In December 2008 prices, including bank charges (e.g., bank transfer fees) to be financed from the fund resource. [c] Physical contingencies computed at 0% for civil works and goods; 5% for training, surveys, and studies; and 0% for consulting services. Price contingencies computed at 0.7% on foreign exchange costs and 5.6% on local currency costs; includes provision for potential exchange rate fluctuation under the assumption of a purchasing power parity exchange rate. [d] Includes interest rate of 1.0% for ADB loan funds. Source: Asian Development Bank estimates.

[12] Implementation of the master plan for upgrading teaching institutions is estimated to cost $260 million and the initial costs of setting up the LET registrations system is estimated at $26 million annually.

E. Implementation Arrangements

38. **Program management.** MOH will be the executing agency for the program. A project management unit (PMU) will be set up in the Department of Science and Training. The PMU will be responsible for program management and ensuring implementation of the policy actions and will include science and training, medical services, and planning and budgeting departments. Table 3 summarizes the implementation arrangements.[13]

Table 3: Implementation Arrangements

Aspects	Arrangements		
Implementation period	1 January 2008–30 June 2015		
Estimated project completion date	31 December 2015		
Project management			
(i) Oversight body	Minister of Health		
(ii) Executing agency	MOH		
(iii) Key implementing agencies	Department of Science and Training, MOH, selected training institutions		
(iv) Project management unit	Department of Science and Training, MOH; there will be 25 staff from different departments of the MOH as well as contracted staff.		
Procurement	International competitive bidding	4 contracts	$15.3 million
	National competitive bidding	14 contracts	$4.74 million
	Shopping	Multiple	$8.72 million
Consulting services	Quality- and cost- based selection	5 firm contracts	$6.42 million
	Consultants' qualifications selection	5 firm contracts	$0.23 million
	Individual consultant selection	Multiple	$3.29 million
Retroactive financing	First tranche release upon loan effectiveness		
Disbursement	The loans and grant proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2007, as amended from time to time) and detailed arrangements agreed upon between the government and ADB. The $30 million program loan will be disbursed in two tranches: Tranche 1: $15 million (upon loan effectiveness) Tranche 2: $15 million (24 months after loan effectiveness)		

ADB = Asian Development Bank, MOH = Ministry of Health.
Source: ADB.2007. *Technical Assistance to Viet Nam for Preparing the Support for the Health Systems Development Program. Manila (TA 7029-VIE, $500,000, approved on 11 December, financed by the Japan Special Fund).*

III. DUE DILIGENCE

A. Economic and Financial

39. **Economic benefits.** The program will improve the effectiveness and efficiency of the health workforce through passage of the LET and improvements in training quality. This may improve standards of health care and ultimately improve overall population health outcomes. At the sector level, economic benefits will accrue from efficiency gains resulting from upgraded training facilities; better training and financing methods; and improved clinical, administrative, and human resources management. This will lead to more cost-effective use of health resources, making the sector more financially sustainable. Improving access to, and quality of, health care will increase economic productivity by helping to reduce morbidity in the workforce. Better diagnosis and reduced treatment cost will reduce people's out-of-pocket costs, especially among the poor.

40. **Financial sustainability.** The government has committed to increasing the health budget faster than the average annual increase in the government budget. A modest increment of 0.05% (estimated to cover the project investment recurrent costs) would result in an annual cost to the government of $4.2 million. The recurrent costs associated with the licensing of

[13] Project Administration Manual (Appendix 2).

health facilities and the health workforce will be increasingly financed by licensing and registration fees.

B. Governance

41. **Financial management.** MOH has extensive experience with projects and ADB procedures, and should be able to use its experience to facilitate effective and efficient financial management of loan funds and project activities. PMU staff with relevant experience will be sought, and the PMU will work closely with existing ADB-supported PMUs. Project consultants will train staff in financial planning, accounting, reporting, auditing, and control. The consultants will implement a performance-based planning and budgeting system based on established national and project-specific cost norms.

42. **Anticorruption measures.** ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the Government of Viet Nam. In November 2009, an anticorruption dialogue focusing on the health sector was held between the government and development partners. Further, ADB conducted governance risk assessments that also highlighted fiduciary risks in the health sector.[14] The specific policy requirements and supplementary measures are described in the project administration manual.

C. Poverty and Social

43. **Poverty.** The program will improve health care services for the poor in remote communities by strengthening the capacity of health facilities and teaching institutions to serve their special needs. The strengthened teaching institutions will ensure that there are more graduates available to work in these areas, and will also improve their training. Quality control mechanisms for health professionals and facilities, particularly registration and licensing, should disproportionately benefit those with the poorest quality services and health workers. Better access to quality health services and lower health care costs will benefit the poor.

44. **Gender.** Women and adolescent girls in poor, remote, and ethnic minority communities are particularly affected by the limited access to quality health services. Design measures are included to promote improved access and equity, and targets are set for training of female health workers and provision of scholarships in all training programs. While most health care workers are women, most of them are concentrated in lower-level positions. MOH aims to increase the proportion of women in higher-level positions and ensure all program activities are consistent with the Gender Equality Law.[15]

D. Safeguards

45. **Ethnic minorities.** Poverty rates and health indicators lag substantially among marginalized ethnic groups. It is estimated that nearly half of poor women and more than 70% of women in mountainous areas gave birth at home, compared with about 5% of well-off women.[16] Poor, rural, and ethnic minority groups, especially women, are discouraged from seeking health care by the distance to the nearest health facility, the absence of staff in local health facilities, and the lack of qualified staff and ethnic minority health workers. The program supports measures to address these inequities, particularly through training of health workers from ethnic minority communities, and incentives and support for health workers in rural and remote areas.

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[14] ADB governance risk assessments conducted in 2009 for education, energy, and transport sectors.
[15] Summary Gender and Ethnic Minority Strategy (Appendix 2).
[16] Ministry of Health. 2007. *Vietnam Health Report 2006.* Ha Noi: Medical Publishing House (p. 130).

E. Risks and Mitigating Measures

46. The potential risks identified include a reduced pace and momentum for policy reforms, financial risks associated with counterpart funds, and a lack of funds for operation and maintenance of new equipment. These risks are mitigated by the two-tranche program loan design, which will help maintain momentum for the policy reform agenda, enable regular policy dialogue, and help MOH leverage support needed to facilitate policy reforms in several areas. Substantial consultant assistance will contribute to sustained impetus for reforms. The increased government budget for the health sector is expected to mitigate the risks related to timely provision of counterpart funds. The benefits and impacts resulting from the sector development program—through support to high-quality policy processes, along with investments that will support the full realization of policy impacts—are assessed as outweighing the identified risks.[17]

IV. ASSURANCES

47. The government and MOH have assured ADB that implementation of the sector development 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 sector development program, which are set forth in the related legal agreements.

V. RECOMMENDATION

48. I am satisfied that the proposed loans and grant would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

(i) the loan in various currencies equivalent to SDR 20,086,000 to the Socialist Republic of Viet Nam for the Health Human Resources Sector Development Program from ADB's Special Funds resources, with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 24 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the related draft loan agreement presented to the Board;

(ii) the loan in various currencies equivalent to SDR 20,086,000 to the Socialist Republic of Viet Nam for the Health Human Resources Sector Development Project from ADB's Special Funds resources, with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 32 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the related draft loan agreement presented to the Board; and

(iii) the administration by ADB of the grant not exceeding the equivalent of $11,000,000 to the Socialist Republic of Viet Nam for the Health Human Resources Sector Development Project, to be provided by the Government of Australia.

Haruhiko Kuroda
President

Date

[17] Risk Assessment and Risk Management Plan (Appendix 2).

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions And Risks
Impact Improved health status and progress toward the health-related MDGs and Viet Nam Development Goals	The 35 poorest provinces have achieved the Vietnam Development Goals for reducing infant and maternal mortality by 2020. Life expectancy figures for the poor and ethnic minorities in 20 poorest provinces have increased by at least 2 years by 2020.	Viet Nam Development Report Joint annual health review	**Assumptions** - Strengthened health systems and human resources improve health status. - Government gives priority to health care for the poor. - Population expectations and health service usage patterns influenced by improved quality of care at the community level. **Risks** - Reduced pace for policy reforms - Financial risks associated with counterpart funds and budget for operation and maintenance of new equipment
Outcome Improved quality, efficiency, and equity in health workforce and health service delivery	By project completion: - At least 50% of doctors and nurses practicing in public facilities registered and licensed and participating in accredited continuing education programs (50% women) - At least 500 health professionals per year from central and provincial institutions have done 3-year placements in rural and underserved areas - 10% increase in number of ethnic minority students graduating from six prioritized medical universities over baseline level[a] - 20 hospitals have improved efficiency and quality services through adoption of policies for use-of-care pathways and case-based payments.	Joint annual health review Viet Nam Development Report Provincial health services and hospital statistics	**Assumptions** Government and National Assembly continue to give priority to enactment of health care legislation **Risks** Enacting ordinances are ambiguous, or implementation is delayed
Outputs 1. Better planning and management of human resources	**Program** - By April 2010, MOH decision established joint committee on human resource planning and management - By November 2009, the LET approved by the National Assembly with provisions for establishing a system to register and license medical workforce and facilities. **Project,** by project completion: - At least 50 public hospitals licensed under new accreditation system - A health professional registration system established with all new graduating doctors and nurses registered in that year - Minimum of 10% increase in the number of women holding senior positions in MOH	Signed development policy letter from MOH Joint HHR committee progress reports Joint annual health review Health Statistics Yearbook PMU reports	**Assumption** Continued government priority given to health human resource strengthening **Risks** Weak links with provincial, district, and community plans Adoption of LET implementing ordinances delayed
2. Higher quality of human resources training	**Program** - By February 2010, the master plan for teaching institutions submitted to the MoH - By November 2009, the LET approved by the National Assembly with provisions for accreditation of training institutions and CME -By December 2012, MOH has adopted a set of standards for equipment in medical colleges - By December 2012, MOH has completed policy	Signed development policy letter from MOH Staffing lists (gender-disaggregated), including	**Assumptions** - Staff able to participate in training - Training institutions willing to participate and commit resources and capacity - Supervisory system supports quality improvement, not simply documenting strengths and weaknesses - Rural workforce interested in strengthening professional identity

[a] Baseline figures to be established at the beginning of the program.

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions And Risks
	impact review on increasing enrollment of ethnic minority students in health training **Project**, by project completion: - Six medical teaching institutions with upgraded teaching laboratories and equipment - 600 university teachers (40% women) trained in modern teaching methods - At least six prioritized universities have met national teaching accreditation standards - Three courses in each prioritized training institution accredited under CME - Special entry programs for ethnic minority students strengthened and operational - 80 scholarships for in and pre-service for EM students (50% women) delivered - 40% of attendees in all study tours and teacher exchange programs are women - 50% of scholarships reserved for women in pre-service and in-service training - Association of Rural Health Workers established and two meetings held by 2014	qualifications at selected institutions Reports on accreditation activities Student and graduate data (disaggregated by gender and ethnicity) from selected institutions	**Risks** - Participation of women and ethnic minority candidates in training limited by lack of prerequisites - Gap between strong and weaker training institutions widens - Supervision and accreditation activities constrained by lack of capable staff - Institutions cannot release staff to participate in activities - Incentives or support insufficient to ensure participation of ethnic minority students in training - Ethnic minority graduates do not return to work in rural areas
3. Improved management systems in health service delivery	**Program** - A *De An* (project plan) authorizing pilot study on case-based provider payment linked to care pathways issued in November 2009 - 20 care pathways developed and used in six hospitals by December 2012 - Guidelines for financing reform associated with care pathways submitted to MOF and MOH by December 2012 **Project** - By 2013, pilot study commences of extending care pathways and case-based payments to at least 20 poor/remote district hospitals - Policy framework and human resource capacity for innovative clinical service delivery strengthened By project completion: - Management and finance systems operational in all pilot hospitals - Pilot hospital records show reduced average length of stay for all inpatients - Payment mechanism based on care pathways developed in pilot hospitals	Signed development policy letter from MOH MOH reports Hospital service and financial records Health insurance agency records	**Assumptions** Managers of pilot hospitals willing to participate Health insurance authorities become active participants Pilot study demonstrates improvements in hospital efficiency and service delivery costing **Risks** Managers and systems of district hospitals are not strong enough to support new methods Case-based payment system provides inadequate revenue to pilot hospitals Care pathways and case-based payments have no impact on affordability of health care for the poor

Activities	**Inputs** ($ million)
1. Better planning and management of human resources **Program Activities** (with milestones) – Decision adopted by MOH to establish joint committee on human resources planning and management (Apr 2010) – LET submitted to government (Nov 2009) with provisions for: registration and licensing of health facilities in public and private sectors; a certification system for health professionals; and a consumer rights standard and a complaints mechanism – Socioeconomic impacts analysis of LET completed (Nov 2009) – Report of joint committee on workforce planning targets and policies (Dec 2012) – Licensing standards for facilities adopted and operational (Dec 2012) – National health professional registration system established and tested (Dec 2012) – Registration of professionals initiated (Dec 2012)	**Program: 30.0** **Project: 46.3** ADB: 30.0 Government of Viet Nam: 5.3 Government of Australia: 11.0 **Base Cost** Civil works: 1.23 Equipment and vehicles: 18.11 Workshops and studies: 3.87 Education and training: 3.77

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions And Risks

Project (with year of activity)
1.a. Strengthened coordination, planning, and implementation of HR policy in the health sector
1.a.i Establish joint committee on human resource planning and management (year 1)
1.a.ii Provide operational support for task force and secretariat (year 2)
1.b. Strengthened mechanisms for the registration of health professionals, and system of CME
1.b.i Complete LET decrees and circulars and enactment (by year 2)
1.b.ii Establish a health professional registration system and authority (by year 3)
1.b.iii Initiate registration and licensing of all new graduates (by year 3)
1.b.iv Transition to re-registration and re-licensing (by year 4)
1.b.v Transition to self-sufficient funding of registration of health professionals (by year 5)

Consulting services: 3.84
Health professional registration system: 3.81
Project management: 1.65

Recurrent Costs: 1.82
Contingencies: 7.48
Financing Charges: 0.74

2. Higher quality of human resource training

Program Activities (with milestones)
- Submit master plan for teaching institutions (Feb 2010)
- LET submitted with provision for training institution accreditation and continuing education (Nov 2009)
- Develop and approve decision on teaching institution accreditation (Dec 2012)
- Develop and approve regulation on CME (Dec 2012)
- Decision on accreditation of health workforce teaching institutions (Dec 2012)
- Upgrade Circ. 7 on accrediting CME courses (Dec 2012)
- Decision 1816 requiring rotation of high-level staff through lower-level hospitals (Aug 2009)
- Equipment standards available in medical colleges (Dec 2012)
- Review on implementation of Circ. 09 and Dec. 1816 (Dec 2012)
- Policy impact review on increasing enrollment of ethnic minority students in health training (Dec 2012)

Project (with year of activity)
2.a. Strengthen capacity and effectiveness of training institutions
2.a.i Train teachers and managers (continuing through project)
2.a.ii Orientate students toward active learning (by year 3)
2.a.iii Procure equipment, for science laboratories (by year 3)
2.a.iv Upgrade and renovate skills labs for teaching (by year 3)
2.a.v Improve e-learning capacity and resources (by year 4)
2.a.vi Improve practical training capacity in hospitals (by year 5)
2.a.vii Improve institutions to support practical training (by year 4)
2.a.viii Strengthen cooperation between hospitals and training institutions (by year 5)
2.b. Strengthened networking for institutional development
2.b.i Build capacity for collaboration of teaching institutions and students (continuing)
2.b.ii Establish regional training resource centers (by year 4)
2.c. Strengthened effectiveness of mechanisms for quality improvement and quality assurance and supervision of training institutions
2.c.i Pilot accreditation system for training institutions (by year 3)
2.c.ii Develop methods for student evaluation (by year 3)
2.c.iii Develop mechanisms for consumer feedback to education providers (by year 3)
2.c.iv Strengthen quality of in-service training (by year 3)
2.d. Improved mechanisms for utilization of staff in remote areas
2.d.i Strengthen entry system for EM students (by year 3)
2.d.ii Improve mechanisms for support of rural health workforce (by year 4)
2.d.iii Develop mechanisms for rotation of quality staff through remote areas (by year 4)

3. Improved management systems in health service delivery

Program Activities (with milestones)
- National Assembly passes resolution to increase annual budget spending for health at rate higher than the annual rate of increase of the gross domestic product (Aug 2008)
- Approve a *De An* authorizing pilot study on care pathways (November 2009)
- Develop 20 care pathways in six hospitals (Dec 2012)
- Develop three pathways for medical conditions for women or primary care focused (Dec 2012)
- Develop guidelines for financing reform based on care pathways and submit to MOF and MOH (Dec 2012)

Project (with year of activity)
3.a. Improved method of organizing clinical work in hospitals
3.a.i Establish inter-ministerial task force (in year 1)
3.a.ii Establish clinical management reform unit (in year 1)
3.a.iii Conduct workshops for benchmarking and costing of care pathways (years 1–2)
3.b. Improved management in hospitals
3.b.i Procure equipment and software for hospital management information systems (by year 2)
3.b.ii Provide support to implementation of MIS (by year 2)
3.b.iii Provide training to improve management (years 1–3)
3.c. Improved funding mechanisms in hospitals
3.c.i Procure equipment for financing mechanisms in province and insurance agency (by year 3)
3.c.ii Implement alternative payment (by year 3)
3.c.iii Provide training for capacity building (years 1–3)
3.d. Strengthened policy framework and HR capacity needed to implement pathway-based approaches
3.d.i Examine policies and make recommendations (by year 2)
3.d.ii Provide training, workshops, and study tours to build capacity of policy makers, provincial health authorities, and health insurance agency managers (years 2–4)
3.d.iii Facilitate development and dissemination of materials that document methods and systems and related curricula for training clinicians and managers (by year 4)

ADB = Asian Development Bank, Circ. = circular, CME = Continuing Medical Education, Dec. = decision, EM = Ethnic Minority, HR = Human Resources, LET = Law on Examination and Treatment, MDG = Millennium Development Goal, MIS = management information system, MOF = Ministry of Finance, MOH = Ministry of Health, PMU = project management unit.

LIST OF LINKED DOCUMENTS

http://lnadbg4.adb.org/sec0066p.nsf/RRPs/40354-01-3?OpenDocument

1. Agreements
   - Loan Agreement
   - Project Agreements
2. Summary Sector Assessment
   - Health and Social Protection
3. Project Administration Manual
4. Project Classification Summary
5. Contribution to the ADB Results Framework
6. Development Coordination
7. Economic Analysis
8. Financial Analysis
9. Country Economic Indicators
10. International Monetary Fund Assessment Letter
11. Summary Poverty Reduction and Social Strategy
12. Gender Action Plan
    - Summary Gender and Ethnic Minority Strategy
13. Risk Assessment and Risk Management Plan
14. List of Ineligible Items
15. Others
    - List of Supported Training Institutions

DEVELOPMENT POLICY LETTER

Ministry of Health
Socialist Republic of Viet Nam
Hanoi: 10 May 2010

Mr. Haruhiko Kuroda
President
Asian Development Bank
Manila, Philippines

Dear Mr. Kuroda,

Subject: Health Human Resources Sector Development Program

1. The Government of Viet Nam has made notable progress in reducing poverty and improving the health status of its citizens. Poverty has been reduced as a result of several years of strong economic growth. From 2001 through 2006, annual economic growth averaged over 7 percent, while average per capita income grew by 60 percent, from $400 to $720 per year, and is expected to grow as high as $1,100 per year by 2010. As a result, poverty levels have dropped from over 58 percent in 1993 to less than 20 percent today.

2. For most of our 85 million people, health status has also shown remarkable improvements and we are on track to achieve most of our health-related Millennium Development Goals by 2015. Since 1990, life expectancy has increased from 65 years to over 71 years, the maternal mortality ratio has dropped from nearly 250 deaths per 100,000 live births to under 75, and the under-5 mortality rate has declined from 58 per 1,000 live births to under 26. The Infant Mortality Rate (IMR), declined from 54.8 in 1979-1983, to 36.7 in 2000, followed by a dramatic drop to 17.8 in 2005. The percentage of low-weight newborns (under 2500 grams) has dropped progressively from 7.3 percent in 1998 to 5.1 percent in 2005. In 2005, 97.8 percent of children under one year of age had been fully immunized. Malnutrition among children under five has steadily declined from 43.9 percent in 1996, to 33.1 percent in 2000, to 25.2 percent in 2005. Polio and newborn tetanus have been eradicated.

3. Despite these gains, we must address key challenges in our efforts to provide equitable access to high quality health services and to further improve health outcomes in all regions and segments of the population. Much of the improvement in national health indicators is driven by gains in the heavily populated regions around Hanoi and Ho Chi Minh City while remote and rural provinces lag behind. Moreover, while there have been steady improvements in the quality of health services, the Government is concerned by indications that the quality of services does not meet the expectations and needs of the urbanizing and increasingly prosperous population.

4. To continue the advancements in health status, and to extend those gains more broadly, the Government's *Master Plan for Health System Development in Viet Nam by 2010 and Vision to 2020* calls for making access and use of health services more equitable and effective to protect and promote people's health. The plan also aims to improve the quality of health care at all levels, with attention to the poor, women, children, handicapped, minority groups, and those living in remote and disadvantaged areas.

5. The *Master Plan* provides the foundation for developing the policy framework, program strategies, and investments that are required if the overarching goals of equity, efficiency and development are to be achieved. Key among the issues to be addressed - as documented in the *Joint Annual Health Review 2009*, developed by the Ministry of Health and the Health Partnership Group - are health workforce training, development, management, and financing. The Government's legislative and policy agenda for the next 1-3 years provides important opportunities for introducing critical reforms and other measures that will lead to significant advances in the training and management of the health workforce and the integration of that workforce into a strengthened health service delivery setting.

6. We are grateful to the Asian Development Bank, the Government of Australia and other development partners for their assistance in supporting numerous health projects and programs over the years that have advanced the development of the health sector. We are particularly grateful to ADB and the Government of Australia for their assistance in preparing the *Health Human Resources Sector Development Program* which will accelerate the attainment of improved health care for all through improved effectiveness, efficiency, and equity of access to health services. The outcome of the program will be stronger policies and institutions that guide and support human resources development for the health sector. The program supports the development and implementation of the new Law on Examination and Treatment (LET) governing health facilities and the registration and practice of health professionals, a new comprehensive plan to upgrade teaching institutions, and the adoption of new models for costing and managing service delivery in district hospitals.

7. With the support of the *Health Human Resources Sector Development Program*, the Government agrees to fulfill the conditions described in the policy matrix accompanying this Development Policy Letter.

8. **Better Planning and Management of Human Resources.** In the *Five-Year Socio-Economic Development Plan for 2006–2010*, the Government of Viet Nam commits to "reduce morbidity rate; improve physical *health, and life expectancy. And, provide all peo*ple with basic medical services and access to quality medical service." With regard to the health workforce, the Government will, "Develop medical staff based on the requirements of improved professional skills, responsibilities and ethics."

9. Despite our commitment to strengthening human resources for health, significant policy challenges remain in the area of human resources (HR). There is currently no comprehensive policy document on human resources in the health sector to guide efforts by stakeholders in addressing current and anticipated HR problems. Although many policies exist, they are spread across a wide range of documents, contributing to fragmentation and confusion on priorities for action. There is no long-term HR Plan for the health sector, which would allow the MOH to reflect on the current situation and trends, project health workforce needs for the next 10 years, and plan for training and management of health professionals to achieve targets. Although much of the responsibility for HR management, including recruitment and distribution of staff, has been decentralized to the Province level, the Provinces require strong support from the national level to address "big picture" HR issues, such as regulation, production, salaries and allowances, registration and licensing.

10. A number of national level policy developments related to health human resources are in development. In November 2009, the National Assembly approved the LET (Quoc Hoi Khoa XII – 23/11/2009). This new law includes provisions for the registration, certification and licensing of health professionals and health facilities in both the public and private sectors. While proceeds

of the HHRSDP project loan will be used to support the development and implementation of the LET, the MOH intends to use proceeds of the Program loan to support the establishment and initial operation of the health professional and facilities registration system until regular budget support is provided.

11. To these ends, at Program inception, the Ministry of Health has established a Joint Committee on Human Resources Planning and Management (1304/QD-BYT -21/4/2010). The Joint Committee will coordinate with, and complement the activities of, the Health Partnership Group and the Joint Annual Health Review. Its key functions will be to coordinate HHR strengthening activities within the MOH and between the MOH, other relevant jurisdictions, and development partners; to share information, to gain agreement on what should be done to implement agreed HHR development recommendations developed in other forums, to assign responsibility for action, and to monitor results. The Joint Committee will submit an annual report of its activities and progress to the Program Management Unit, the MOH, other Governmental departments and agencies, and the National Assembly.

12. **Higher Quality of Human Resources Training.** The MOH is committed to developing a comprehensive policy framework and long term plan that address the issue of improving the quality of health workforce training, as called for in the Government's *Master Plan for Health System Development in Viet Nam by 2010 and Vision to 2020*. At present, in the absence of a comprehensive national plan, training is guided by a number of Government and Ministerial level policies, regulations and plans by both the MoH and the Ministry of Education and Training (MOET).

13. In February 2010, MOH submitted to the Prime Minister a master plan (616/TTr-BYT – 7/7/2009) that addresses the acute staff shortages and recognizes the need to rapidly increase the number of graduates, expand coverage, and improve training quality. The plan includes proposals to upgrade medical colleges to universities and some secondary medical schools to medical colleges in underserved areas. It outlines a comprehensive approach to increasing investment in staffing, curriculum development, and equipment in training institutions. The policy matrix recognizes the development of this plan and the significant work that follows the passage of the LET.

14. The MOH approved Circular 09 (09/2008/TT-BYT – 1/8/2009) and Decision 1816 (1816/QD-BYT – 26/5/2008), which require health training institutions and high-level hospitals respectively to assign faculty and medical specialists to work with provincial and district hospitals. The rotation of specialist medical staff through lower-level hospitals and commune health centers will boost availability and quality of local health care, especially in remote and mountainous areas, and support skills transfer to local health care staff. A comprehensive policy review of the implementation of Circular 09 and Decision 1816 will be undertaken after about 2 years to consider their impact and make recommendations for further policy development or modifications to improve policy outcomes.

15. Decree 134 (ND-CP-14/11/2006) and Circular 13 (TTLT-BLDTBXH-BTC-BNV-UBDT – 07/04/2008) of the MOH outline measures to increase access to training and education for health workers from ethnic minority communities. These include waiver of tuition fees, lower entrance requirements, and bridging and preparatory courses. Within 2 years of program loan effectiveness, the MOH will complete a policy impact review on increasing enrollment and completion of ethnic minority students, especially women, in health training, including the implementation of Decree 134 and Circular 13.

16. **Improved Management Systems in Health Service Delivery.** The Government recognizes that further improvements in the performance of the health system will require a greater financial investment at the highest level. In 2008 the National Assembly adopted a resolution (18/2008/QH - 3/6/2008) that a greater portion of annual state budget should be allocated to health care. Each budget year, increases will be implemented at rates greater than the rate of increase of overall government expenditure.

17. The Government is also seeking new methods to improve access to quality health care, contain costs, and increase efficiency. At present, Government guidelines for clinical care are prescriptive and often outmoded, with few rewards in the system that encourage good quality of care. In addition, the predominance of fee-for-service payments – both consumer out-of-pocket and third party payments - provides incentives that encourage inequities, inefficiencies, and over-utilization. These problems are exacerbated in hospitals that receive part of their funding as budget support from government, based on bed-count and staffing levels, which encourages over-building and inefficient use of personnel.

18. The Government is committed to exploring alternative methods of organizing and funding clinical work in hospitals. The aim is to improve the quality of care provided by hospitals, their operational efficiency and financial viability, and their utilization and retention of human resources. By program inception, the Ministry of Health will have issued a *De An* (project plan: 4340/QD-BYT – 9/11/2009) authorizing the organization and operation of a pilot to test case-based provider payment linked to care pathways in Hanoi province, and establishing an Inter-Ministerial Task Force to guide the effort. It will also establish a Unit for Clinical Management Reform to provide and coordinate technical support and training. With assistance from the program the government aims to develop, test and cost 20 *care pathways* in at least six hospitals, including at least three pathways that directly relate to medical care for women and/or at primary level. Further, guidelines for financing reforms associated with *care pathways* are to be submitted to the MOH and Ministry of Finance.

19. **Dedication of Counterpart Funds.** The Government will dedicate counterpart funds generated from the Sector Development Program (SDP) loan to ensure that policy conditions underpinning the Program are fully implemented. The counterpart funds generated from the proceeds of the SDP program loan will (i) supplement the Government's health budget in support of the SDP policy actions, and (ii) be part of the Government's contribution to ADB-funded health sector activities within the scope of the Sector Development Program.

20. As ADB continues to support the Socialist Republic of Viet Nam in developing the country's health care system, we would like to confirm our commitment to further policy and strategic dialogue. 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

Yours sincerely,

Nguyen Quoc Trieu
Minister of Health

Attached: Policy Matrix

POLICY MATRIX

Tranche 1 Policy Actions (at loan effectiveness - $15 million)	Tranche 2 Policy Actions (24 months post effectiveness - $15 million)
Output 1. Improved Planning and Management of Human Resources.	
• Ministry of Health has issued a Decision (1304/QD-BYT dated 21/4/2010) to establish a, Joint Committee for Human Resources Development for Health. • The Law on Examination and Treatment (Quoc Hoi Khoa XII dated 23/11/2009) approved by the National Assembly with provisions for - registration and licensure of health facilities in both the public and private sectors; - certification of health professionals working in both the public and private sectors, including those currently practicing; - a disciplinary process for health professionals; - consumer rights and the establishment of a complaints mechanism. • The socio-economic analysis of the draft Law on Examination and Treatment has been completed and submitted to the Prime Minister.	• The Joint Committee has submitted a report to the Minister of Health on reform, planning, and management of the health workforce. • Standards for licensing of health facilities are adopted and institutional systems are established and operational. • The health professional certification system has been established, including: - Issuance of the decree on the detailed provisions and guidelines for the implementation of the LET that contains provisions for the certification of health professionals; - A decree and/or circulars are issued specifying the handling of ethical, technical and administrative violations by health professionals regarding examination and treatment ; - A circular is issued to ensure that health professionals meet the requirement of continuing medical education and that this can be monitored regularly; - the MOH-level Advisory Council is operational; - a national unit within the Ministry of Health with responsibility for the health professional certification system; - a national health professional certification database has been developed and tested; - a national training plan is submitted to the Minister of Health for training provincial staff involved in health professional certification.
Output 2: Strengthened Quality of Training of Human Resources.	
• Ministry of Health has submitted to the Prime Minister a Master Plan (616/TTr-BYT dated 7/7/2009) for the upgrade of teaching institutions for the health workforce. • Ministry of Health has issued a Circular (09/2008/TT-BYT dated 1/8/2009) requiring each health training institution to submit an annual plan to assign their faculty and students to provincial and district hospitals for training, research, and health care delivery. • Ministry of Health has issued a Decision (1816/QD-BYT dated 26/5/2008) requiring high level medical centers to rotate their staff through lower level hospitals to help improve the quality of health care available at the grass roots level.	• Ministry of Health has issued a guideline for the accreditation of pre-service and post graduate health professional training programmes in health within recognized educational institutions. • Ministry of Health has issued a regulation (an upgrade of Circular 07/2008/TT-BYT dated 28/05/2008) on a system for accrediting continuing education courses and a secretariat for implementing this system is established in the Ministry. • The Ministry of health has formally issued a set of minimum standards for equipment available in Medical Colleges, based on courses provided and students enrolled. • The MOH completed a policy review on the implementation of Circular 09 of 2008 and Decision 1816 of 2008, reporting on policy outcomes for improved service quality and recommendations on constraints and impact. • The MOH has completed a policy impact review on increasing enrollment of ethnic minority students in health training, including the implementation of Decree 134/2006/ND-CP dated14/11/2006 and Circular 13/2008/TTLT-BGDDT-LDTBXH-BTC-BNV-UBDT dated 07/04/2008) with recommendations to address constraints.

Output 3: Improved Management Systems in Health Service Delivery.	
• National Assembly has passed a resolution (18/2008/QH dated 3/6/2008) increasing the annual state budget spending for health care at a rate higher than the annual rate of increase of government expenditure. • Ministry of Health has issued a *De An* (project plan: 4340/QD-BYT dated 9/11/2009) authorizing a pilot study on hospital provider payment linked to care pathways. • Health Insurance Law (25/2008/QH12 dated 14/11/2008) passed allowing use of case-based provider payment. • Circular 09 (09/2009/TTLT-BYT-BTC dated 14/8/2009) of the MOH including the provisions on the implementation of case-based provider payment submitted to the Minister of Health.	• Twenty care pathways have been developed, benchmarked, and budgeted in six hospitals. At least three pathways are for medical conditions that primarily affect women or are primary care focused and delivered. • Guidelines for management and financing reform associated with the introduction of case-based provider payment linked to care pathways have been submitted to the Minister of Health and Minister of Finance.

Annex B

ALLOCATION AND WITHDRAWAL OF GRANT PROCEEDS (Health Human Resources Sector Development Project)			
CATEGORY			AusAID FINANCING
Number	Item	Total Amount Allocated for AusAID Financing $ Category	Percentage and Basis for Withdrawal from the Grant Account
1	Consulting Services	3,840,000	100 percent of total expenditure*
2	Health Professional Registration System Establishment – Capacity and System Development	2,760,000	100 percent of total expenditure*
3	Office Equipment and Project Management Unit (PMU) Vehicle	50,000	100 percent of total expenditure*
4	Project Management for Care Pathway Pilot	270,000	100 percent of total expenditure*
5	Capacity Building for Care Pathway Pilot	300,000	100 percent of total expenditure*
6	Unallocated	3,780,000	
	Total	**11,000,000**	

*Exclusive of taxes and duties imposed within the territory of the Recipient.