

Strategy for Vietnamese-German Development Cooperation in the Priority Area “Health”

I. Summary

Vietnam is still one of the poorest countries in the world. However, its key health indicators are more like those of a middle-income country, albeit with considerable regional variations. This comparatively good starting position must be stabilised and developed in line with the challenges of transition to a market-based economic system. Persistent insufficient state financing of the health sector is its key and critical weakness. This results in substantial absorption of health costs by the people which in the absence of adequate health insurance coverage leads to inappropriate access to essential health services by the poor and disadvantaged in particular.

The government has taken the first steps away from a centrally planned health care system towards a demand-oriented one (decentralisation, health insurance), but must now carry out its steering function in terms of regulating and monitoring the health service more effectively which entails the creation of the necessary framework conditions for this. At the local level (provinces/districts, communes), health providers must adjust the services they offer to the changed medical requirements (increase in non-communicable diseases, in (traffic) accidents and in “new” diseases such as HIV/AIDS, etc.) and develop preventive and curative health services further.

The overarching goal of Vietnamese-German development cooperation in the health sector is to improve the health of the population, especially of the poor and disadvantaged. This cooperation is conceptualised for and implemented at the decentral level in selected poor provinces and embraces the whole system. Experiences and best practices will be fed back at the national level. Institutions at central level with regulatory and supporting function will be supported.

The German contribution focuses on the following aspects:

- **Strengthening provincial health systems**
- **Feedback from experiences between provincial and national level**

German development cooperation participates in the discussion about a sector-wide approach (SWAp) in the long term, whereby under the leadership of the Vietnamese Government and, in collaboration with other bilateral and multilateral donors a coherent strategy for the health sector, is elaborated.

II. Scenario in the priority area

II. 1 General situation in the health sector¹

Health situation of the population: Vietnam’s key health indicators are comparable to those of middle-income countries. Average life expectancy is 71.3 years in 2005. Infant mortality Rate (IMR) is 17.8/1000 (2004-05). This IMR is slightly lower than Indonesia and Thailand. The demographic situation is characterised by a growing population, a falling infant mortality rate (IMR) and an almost stable total fertility rate of 2.11. The contraceptive prevalence rate (modern methods) among married women was 65% in 2004. High abortion rates show insufficient access to and/or a low acceptance of family planning (FP) methods.

¹ Data sources: Health Statistic Yearbook 2004, Socio-economic Development Plan 2006-2010, UNFPA-Hanoi 2006

The WHO describes the constraints and challenges of the health situation as follows:

- (i) persistent high prevalence of chronic malnutrition among the under-fives and children of low birth weight;
- (ii) relatively high maternal mortality, mainly among ethnic minorities and in remote areas; high rate of induced abortion;
- (iii) an unfinished agenda in infectious and communicable diseases (although they now represent less than 25% of the causes of mortality);
- (iv) a steady increase in non-communicable diseases (cardiovascular diseases, diabetes, cancers);
- (v) new or re-emerging diseases such as tuberculosis, HIV/AIDS, dengue fever, Japanese encephalitis and bird flu in humans are increasing;
- (vi) increasing importance of life-style-related diseases (tobacco, alcohol and drug abuse, injuries from road accidents, violence, suicide attempts, mental health problems accounting for more than 20% of total mortality);
- (vii) increasing levels of resistance to common antibiotics.

The main challenge for the Vietnamese health system is to ensure equitable access to quality health services in all regions of the country and for all income brackets. Thus, strengthening decentralized health sector support systems will lead to quality improvement of service provision and an increased demand for health care that has to be covered by appropriate financing mechanisms (Communist Party's Resolution 46/NQ/TW 2/25/2005 on people's health protection, care and promotion). A particular challenge is the high proportion of children (11%) and people in need of special social privileges (9-10%) such as ethnic minorities and people with disabilities as a result of the war and birth defects.

Poverty, ethnic minorities and health: Vietnam's Health Policy aims at creating an equitable health system. Decentralized health services delivery centres are developed in relevant catchment areas to ensure access to quality assured basic health care services for all. Substantial progress has been made over the last decade. However, some significant differences between the various regions and population groups remain; these disparities are increasing rapidly in the wake of the advancing economic development of some regions and population groups ("two-speed country"). In the poor regions (incl. Central Highlands and Northern Mountains) the health indicators are worse than in the rest of the country, partly due to difficult access and low coverage with health facilities. For example, maternal and infant mortality rates are higher among the members of ethnic minorities than the national average (e.g. infant mortality: Northwest mountains 34.1/1000 versus 18.1/1000 nationwide in 2004). One reason for this great variation is the far higher incidence of poverty within the minority population (55% versus 23% in 2004). Furthermore, members of ethnic minorities are on average less educated than the Kinh majority (illiteracy rates of 27% versus 10%; school enrolment rates among minorities in some cases only 41% compared with 93% among ethnic Vietnamese).

The government is actively seeking to further improve the social situation of members of ethnic minorities by means of specific programs. There is clear evidence that these efforts have contributed to a reduction of the development gaps between the mountainous and urban and low land regions.

Health sector funding: In particular among the non-insured, substantial private spending, mainly on drugs (high level of self medication) and private health provider amounts to 54% of total health expenditures. Some insufficiencies and weaknesses of the public health sector contribute to a lucrative private health sector, which is still largely unregulated.

Treatment and preventive care in hospitals absorbs more than 80% of total public spending on health. This does not match with an efficient and equitable distribution of funds because:

- a) basic preventive measures should have priority, to avert external effects and because, people tend to spend less private money for such care
- b) hospitals are used proportionately more by wealthier people.
- c) Vietnam has more hospital beds than other countries with comparable or higher incomes.²

Public spending on health is relatively low, but has risen in the last 10 years from about 1% of GDP to 1.92% in 2004. International comparisons show Vietnam still behind low- and middle-income countries such as Cambodia, Thailand, Malaysia or China. As a result of major decentralisation efforts, the level of public spending on health within the overall public budget has fluctuated between 4.9% and 7.1% during the past 15 years. Only about 25% of the funds are from the national budget, the rest is from the budgets of the provincial governments. This large share of local funding is one reason why public health care in poorer provinces is much less satisfactory than the care in well-to-do provinces.

State health policy: The government strove to provide universal care for people of all classes also during the economically difficult 1970s and 1980s. Nationwide campaigns against diseases such as malaria and TBC were carried out during that time with considerable success.

The challenge now is to sustain the population's relatively good state of health and to provide – in the challenging circumstances of the country's transition to a market economy – poor and disadvantaged people in particular with appropriate access to health services.

In addition, state health facilities are often inadequately equipped. Because many health care workers move (de facto) to the private sector, qualified staff is continually being lost. The reasons for this are insufficient remuneration, inadequate supervision and insufficient opportunities for further training. Furthermore, the capacities and medical knowledge in the existing system are not yet attuned to the growing complexity of the health situation in Vietnam (e.g. sharp increases in the number of accidents and non-communicable diseases, appearance of new diseases such as SARS, bird flu and similar).

The government has set itself ambitious goals in various central strategies (cf. III.1), incl. improving the country's position on the Human Development Index (HDI), providing prevention and treatment for the entire population and raising the average life expectancy to 70-75 years. The WHO considers these state strategies to be a good foundation for the development of the health sector. However, the strategies do not yet adequately show how the goals that have been defined are to be achieved.

The focus of the national strategies has been for many years on a) preventing illness and b) access to appropriate treatment (especially for poor people, members of ethnic minorities, children, etc.). The considerable growth momentum in the private health sector, growing costs as a result of new treatment methods, and above all the government's policy of decentralisation change the practical scope of central government institutions to influence and regulate the health system consistent with health goals and priorities. The key to achieving the national goals is to be found above all at the provincial level (provincial health administration, management of hospitals and health services). The task for central government is, increasingly, to regulate and monitor the quality of agreed standards and – as a new task – to establish a sustainable financing system.

Institutional framework: Until the mid-80s, Vietnam had a functioning, socialist, state health system for the broad masses of the population. Preventive and curative health care was organised via local health centres throughout the country. Although these centres still exist, in practice they no longer function adequately, since their medical equipment is largely out-dated due to shortage of funds. Also funds to deploy qualified staff are often lacking. Well-trained health workers are increasingly moving to private companies and practices, since they offer much higher salaries.

² WB-Report Growing Healthy, 2001.

Today the health system is divided into three levels of care (national, provincial, and communal) and two administrative levels, with the Ministry of Health (MoH) at the head of the system (Decrees 171/2004 and 172/2004). The MoH formulates strategies and programs and implements them together with the People's Committees at the provincial, district and municipal levels. The Provincial Health Bureaus at the second level are formally subordinated to the Provincial People's Committee in terms of organization, operational implementation and human resources management. These "Departments of Health" operate under close technical and strategic guidance as well as supervision of the Ministry of Health at the first level.

Health service funding from the patient's point of view: The purely state health system of the past was basically free. Fees were first introduced in the wake of the economic reforms carried out in 1989. Private health providers were allowed from 1993 onwards. In 2002, the government set up a Health Care Fund for the Poor (targeted demand-side financing; Decision 139) for poor and disadvantaged people. Basic medical care is meant to be provided via health insurance cards or direct reimbursement for services (Decree 63/2005 on Health Insurance). The (state) health insurance only covers about 36% of the population. Those covered are, in particular, public sector workers (who have compulsory insurance), students and school-children. Coverage of the private salaried sector is very low at less than 15% of active workers. Many of the uninsured and even many of the recipients of free insurance cards through the HCFP, either do not know what health insurance is or do not know exactly how and where to get health insurance or how to use the service which are covered. Moreover, the chronic underfunding of the system and imprecise implementing regulations entail inappropriate care for the poor or oblige them to pay out of pocket expenditure. However, the Vietnamese government's declared goal is to set up a general health insurance system for all population groups by 2010. The GOV has invested large sums in this HCFP in 2005. Some private services are now eligible for reimbursement by the Health Insurance. No sound projections exist how strong the costs will rise when not only full coverage is reached but when the beneficiaries all do change their health care seeking behaviour. Sustained public financing of the expected growing demand will pose a major challenge for the state budget of Vietnam.

II.2 Core problem – causes, potential

The provinces are gradually becoming responsible for health care (decentralisation), but without adequate funding, know-how and supervision and guidance from the central government level being provided. The core problem identified is, therefore that **appropriate access to health services (prevention and treatment) for the population and especially for poor and disadvantaged people is not secured, above all at the decentral level.** (Core problem).

The main **causes** are:

- Limited capacity in the Ministry of Health (MoH), which is responsible for overall planning, regulation and quality control in the health sector and for supporting local health structures (e.g. training and quality control).
- Deficits in the referral system.
- Not enough funding allocated to the health sector, both from the national budget and – in addition – by the provinces.
- Lack of knowledge about optimum allocation of funding in the health sector, above all at the local level.
- Fragmentary health insurance system and a Health Care Fund for the Poor that does not function satisfactorily.
- Low level of knowledge among the population about modern preventive health care and treatment.
- Poverty as a main health hazard.

The main areas of **potential** are:

- Remarkable level of performance. Vietnam has already made great achievements with regard to numerous health indicators, so that these developmental achievements just need to be secured and taken further.
- Political will to improve the legal framework in the health sector, including the development of a national health insurance system.
- Differentiated and universal system based on planned economy structures, with health centres, district, provincial and city hospitals.
- Successful implementation of health campaigns (malaria, TBC), which can be a basis to address other health problems.
- Dynamic economic development leading to gradual eradication of the health hazard "poverty".

II.3 Assessment of the German contribution so far

Areas in which Vietnamese-German development cooperation has had successes since 1993 are, above all, malaria prevention, the rehabilitation and integration of disabled people (key: orthopaedic technology), reproductive health/family planning, combating HIV/AIDS and supporting hospitals.

A fundamental re-orientation of the cooperation portfolio is needed. The situation with regard to malaria, orthopaedic technology and family planning in particular has improved so much that there is good reason to end the German support in these areas. In addition, family planning/reproductive health is an area with such a high density of donor support that it is becoming increasingly difficult to make contributions with added value.

HIV/AIDS prevention is also an area where Vietnamese-German development cooperation has developed models which show the way ahead for the future and which are making a significant contribution towards supporting national efforts in the field of HIV/AIDS prevention. However, the potential for further conceptual contributions is largely exhausted. Since the BMZ Health Sector Strategy recommends the mainstreaming of Anti-HIV/Aids support, the topic has to be handled as a cross-cutting issue. Moreover, Vietnam now has considerable funding from other donors for dealing with HIV/AIDS. For example, the World Bank is providing a grant of US \$35 million (2005) for HIV/AIDS prevention and the US committed additional funding of US \$34 million in June 2006. Further support is being mobilized through the Global Fund and through more than 50 individual projects with bi-lateral and multilateral donors. Recent volumes of ODA-support to the Vietnamese health sector can be read off the regularly updated Development Assistance Database, DAD (<http://dad.mpi.gov.vn>).

German involvement in the hospital sector is still relatively recent (currently two projects), so that it is not yet possible to make any reliable assessments here. In the case of hospital equipment

- a) sustainable solutions need to be sought involving integrated measures aimed at further system development (avoidance of isolated solutions) , and
- b) contributions need to be significant and visible.

II.4 Other donors

Altogether more than 40 donors and international NGOs are active in the Vietnamese health sector with nearly 320 ODA-financed health projects (end of 2003). By comparison, in 1998, there were just 180 projects with a much smaller total volume of funds. The largest donor is the World Bank, followed by Japan, the ADB and the EU Commission. Germany is among the bigger bilateral donors. Although the positive impacts of the projects are undeniable, the large number of projects means a high administrative burden for the Ministry of Health. Initiatives have been developed to improve the coordination of the activities of the donor community. The

feasibility of a so-called sector-wide approach (SWAp) is presently studied and Germany is actively involved in the consultations.

The four **areas that receive the majority of commitments in the health sector** are:

1. Reproductive Health (by far the biggest)
2. Hospitals (national and provincial levels)
3. Primary Health Care (community/district level)
4. Prevention and monitoring of infectious diseases (HIV/AIDS, TBC, malaria, etc.)

German development cooperation has so far been a prominent player in the field of HIV/AIDS prevention and in the field of “Reproductive Health”. The volume of funds provided by the donor community for the sub-sectors “Hospitals” and “Primary Health Care” is roughly the same, with **considerably more projects at the grassroots level and fewer at the provincial level.**

The World Bank expressed criticism in 2003 about the fact that the regional distribution of projects had little to do with the needs (poverty situation) of the provinces. For example, it is noticeable that the project density in the wealthier provinces around Hanoi and Ho Chi Minh City – with 23 and 16 donors (and 78 and 56 projects) respectively – is much higher than in the rest of the country.

III. Aims and strategies

III.1 Vietnam’s strategies

Two major strategic plans govern the health sector of Vietnam to date.

The five-year Socio-Economic Development Plan (SEDP) is a central government planning and strategy instrument. Recently the Vietnamese poverty strategy (Comprehensive Poverty Reduction Growth Strategy, CPRGS) has been integrated into the SEDP 2006-2010. The new SEDP lists the following goal for the health sector:

“Reduce morbidity rate; improve physical health, life expectancy and quality of life. Provide all people with basic medical services and access to quality medical services. All people can live in a safe community and develop both physically and mentally.”

The following priorities are emphasised:

- 1. improving health care at the grassroots level, and**
- 2. preventive health care at the provincial level.**

State investments are to be made above all in local clinics (district/provincial level).

Besides improving essential health indicators (raising life expectancy to 72 years, reducing maternal mortality to 70/100,000 live births, reducing under-1 infant mortality to 16%) additional targets are:

- increase the number of hospital beds from the current 16.5 to 25 per 10,000 inhabitants,
- provide all communal health centres with sufficient medical equipment,
- increase deployment rate of doctors to communal and mountainous medical stations, and
- ensure an immunisation coverage rate of 95 % of under-one infants with essential vaccines.

The five-year plan thus complements and defines the so-called Vietnam Development Goals, which in turn place the Millennium Development Goals (MDGs) of 2000 in a Vietnamese context.

On 30 June 2006 the Government of Vietnam endorsed (153/2006/QD-TTg) the **“Comprehensive Development Design of the Health System in Vietnam to 2010 and Vision by 2020”**. This inclusive plan offers ample opportunities for the development partners of Vietnam in the health sector to coordinate and harmonise their contributions. He defines one general objective that corresponds to the above mentioned goal in the SEDP and four specific objectives:

1. **Invest in the development of a preventive network which enables forecasting, surveillance, detection & control of diseases and food safety control**
2. **Invest in and reorganize the network for health consultations, curative and rehabilitative care**
3. **Consolidate and finalize the local health care network to improve access of people to essential health care services of good quality**
4. **Develop the pharmaceutical sector into a key industry.**

Referring to the SEDP and the recently endorsed Health Sector Strategy the development of the Vietnamese health system rests on **four pillars**:

1. **a preventive medicine network for health promotion ,**
2. **a system for consultative, curative and rehabilitative care**
3. **a scheme for traditional medicine and pharmacy**
4. **a grass root health network**

In order to support the development of poor and remote regions, communal health care has been singled out as of particular importance.

III.2 Aims of German development cooperation

The following overarching goals characterise Germany's involvement:

a) Achieving the Millennium Development Goals:

The top priority for German development cooperation is the sustainable achievement of the Millennium Development Goals (MDGs). Relevant for the health sector are in particular the following goals:

- MDG 1, since poverty is the greatest health hazard,
- MDG 4 (“Reduce child mortality”),
- MDG 5 (“Improve maternal health”) and
- MDG 6 (“Combat HIV/AIDS, malaria and other major diseases”).

b) Programme of Action 2015:

The German contribution to achieving the MDGs is described in the German government's Programme of Action 2015. Under the heading “Guaranteeing Basic Social Services” the main fields of action in this area are:

- Supporting social sector reform programmes in Germany's partner countries
- Supporting basic social services
- Combating HIV/AIDS
- Supporting access to Family Planning services
- Supporting activities to enhance the performance of informal social security systems
- Supporting reforms of public social insurance

c) BMZ Health Sector Strategy:

The German government's efforts to provide support in the health sector are extensively guided by the WHO's and UNICEF's **Comprehensive Primary Health Care Concept. Eligible for support are measures that:**

- **are based on an integrated, multi-sector approach**
- **focus on disease prevention in particular**
- **are oriented towards basic needs and poverty reduction, and**
- **seek to strengthen the health system.**

The financing of medical infrastructure aims at improved access to health services in under-served areas. Even where the measures are limited to a particular location, an impact on the system must be achieved in order to ensure sustainability (**systemic approach**).

Germany's development cooperation addresses these objectives and links with them the following concrete expectations:

- **The entire portfolio of bilateral development cooperation must reflect that a) Vietnam is developing in the direction of a middle-income country, but b) the disparities within the country are growing and in some regions significant poverty still exists.**
- **A decentralised approach by the donor only makes sense and can be justified if there is feedback of all experience to the national level or if other mechanisms for disseminating jointly developed models are secured**
- **The design of bilateral development cooperation in the health sector is guided by the Paris Declaration and the Hanoi Core Statement: accordingly and above all, no parallel structures are to be established and alignment with comprehensive (whole sector) programmes is preferred.**

III.3 Definition of a shared strategy

Starting from a basis of:

- **shared views regarding goals and strategies;** especially the shared conviction that forward-looking cooperation in the health sector must be directed towards the greatest possible poverty relevance,
- **broad support in the sector from bilateral and multilateral donors,**
- **the findings and experience of cooperation to date,** and
- **the challenges and potential on the partner side,**

the two sides agreed on the following strategy for the health sector:

Strategy for 2006-2010:

The joint wish for bilateral development cooperation in the health sector is, to have an optimum, direct impact for the benefit of the poor people in Vietnam. Improved health care through decentralisation of the national health system is only going to succeed if the respective administrative levels are allowed extensive autonomy and if the necessary capacities for planning and implementation and for efficient resource management are in place at the provincial and district levels.

The focus of bilateral development cooperation is on improving decentralised health care in poor provinces of Vietnam and on feedback from lessons learned to the national level. To this end, the institutions responsible for the health sector will receive assistance for the regulatory and support functions that they perform for the local level. At the heart of these efforts is improved access, above all for poor and disadvantaged people, to preventive and curative medical services whose quality is assured. This is a question of both overcoming financial barriers to access on the demand side and increasing the quality and efficiency of the services on offer.

Important areas of action for improving performance are:

- sector reform and policy advice – in consultation with other donors (division of tasks between state and private sector, financing solidarity)
- infrastructure and equipment (suitable procurement, standardisation of equipment/ maintenance requirements)
- training and staff (basic and advanced training)

Reproductive Health/Family Planning and HIV/AIDS will be addressed as cross-cutting issues but will no longer be supported through separate projects.

Since it is not possible for German development cooperation to achieve improved health services throughout the entire country, German cooperation – apart from policy advice at the central level – will concentrate on a number of provinces and their downstream administrative levels.

In 2006/07, criteria for selecting the project provinces will be elaborated jointly. Attention has to be given to Vietnam's poor provinces in particular. The provinces thus selected will receive support in the form of advisory services and capacity building (Technical Cooperation) and investments (Financial Cooperation). For the advice and capacity building (TC) the question of efficient and pro-poor allocation of funds (budget funds and ODA) will be a priority and this will also be discussed with other donors. The Kreditanstalt für Wiederaufbau (KfW) will hold discussions with the health authorities and the People's Committees of the provinces to be supported and consult with donors active in the field, in order to determine which of the levels of health care in the provincial health system need special investment. Assuming that the findings of the project appraisal are positive, the demand for funds thus determined can be covered by Financial Cooperation funds.

A planning process to coordinate the deployment and timing of the various development co-operation instruments is envisaged in order to achieve efficient use of funds in future. All the implementing organisations of German development cooperation will – where necessary – speedily redesign their existing project portfolios to bring them into line with this strategy.

At the provincial level, a division of labour with other donors is being sought. The intention is that Germany will participate actively in the health partnership group and in the EU health group, so that adequate coordination and coherence with the contributions of other donors is ensured. What is more, the German side will continue to take part in the discussion about the development of a sector-wide approach (SWAp) in Vietnam.

III.4 Target groups

The target group is the population of provinces that are still to be selected and, in particular, poor and disadvantaged people from these provinces. Criteria such as the proportion of people living in absolute poverty or ethnic diversity will play a part in the selection of the provinces. In the spirit of the Hanoi Core Statement (HCS) and by taking into account the activities of the local donor community, the Ministry of Planning and Investment (MPI) and German development cooperation will jointly assess the feasibility of support to provinces proposed by MPI.

The central Ministry of Health, national institutions for referrals and training, senior executives from health, health insurance and hospital institutions at the provincial level and health service providers and representatives from People's Committees (provincial, district and commune) will act as intermediaries.

III.5 Shared development cooperation targets and time estimates

Overarching goal:

The population in selected Vietnamese provinces has better access to and makes greater use of quality-controlled health services.

Results:

- Between 2006 and 2010, the quality of health services at the local level (provincial/district and communal) has improved in the project provinces.

Indicators:

- Perinatal and Infant mortality
 - Maternal Mortality
 - Outcome of acute diagnostics and treatment of trauma
- The demand from the poor population groups (per capita income < 1 USD) for health services has risen in the project provinces

Indicators:

- Number of poor patients using health services
- Number of patients treated under the HCFP-scheme

The indicators will be quantified in the process of project definition on the basis of existing data or baseline studies.

III.6 Complementarity with other donors

Germany will close an important gap in the donor activities in the field of health with the integrated approach that has been chosen here: all the other donors have so far addressed a particular level of health care provision with their projects or have focused on a particular disease or diseases. By contrast, bilateral Vietnamese-German development cooperation will attempt to address health system deficits, particularly at the local level, in an integrated way (taking account of all the levels of care). Division of labour will be agreed with other donors who already have health projects in the project provinces. The concrete coordination of the donor activities will take place at the national level, also within the framework of the consultation mechanisms for establishing a sector-wide approach (SWAp).

IV. Significance of the German contribution

The German contribution tackles the **core problem** – the lack of appropriate preventive and curative health care at the local level, especially for poor people: the still too small amounts of state funding that are available are not being used in an optimum, efficient and pro-poor way. The aim is to improve this situation with an integrated approach (advice and capacity building for provincial authorities and managing executives of local health institutions and use of additional funding under Financial Cooperation and feedback to the national level).

It is expected that within this cooperation jointly developed models will be replicated in some other provinces and/or are useful to shape national policies (**broad impact**). This will mean a structural impact, which will extend beyond the German development cooperation contribution. One **comparative advantage** of German development cooperation is the experience that has been gathered in the health sector. Although Germany's current contribution is only of a medium size compared with the contributions of other donors, both sides consider that it is necessary and makes good sense to continue this cooperation in the health sector in order to achieve **sustainable, broad-impact poverty alleviation**.

By focusing on this priority area, an important contribution is also being made to reducing poverty in Vietnam, and towards gender equality, in line with the German government's Programme of Action 2015.

V. Instruments and procedures

V.1 German development cooperation instruments to be used

All the instruments of official German development cooperation – Technical Cooperation: GTZ, CIM, DED, InWEnt; Financial Cooperation: KfW – are to be used, i.e. the above institutions will coordinate their activities in terms of content and organisation and will align them with this strategy. Besides the contribution of the DED, which will continue its involvement in the health sector to promote the integration of disabled people through community-based rehabilitation and Inclusive Education, InWEnt will need to interlock its contribution towards training with existing or future Financial and Technical Cooperation projects. The division of labour approach is meant to reduce overlaps in terms of content, reduce transaction costs, ensure a coherent approach and also mobilise additional synergies and impacts. The BMZ will steer and actively attend to the policy and content of this process, with a view to achieving “joined-up development cooperation”.

V.2 Levels of intervention

The levels of intervention are all levels of the health system (integrated approach), with the focus on advice, capacity building and investment at the local level (cf. targets, III.5).

V.3 Preconditions for cooperation

The political will of the Vietnamese government to initiate and implement reforms in the health sector is a precondition for cooperation. This willingness will be expressed by, among other things, an increase in the amount of the national budget spent on health and a sustainable arrangement for health funding (which shows solidarity).

VI. Topics for the dialogue on the priority area

- Financing models for the health sector (orientation towards the development of an integrated approach showing solidarity for health funding).
- Increasing the share within the national budget for the health sector.
- Defining priorities and a strategy for possible implementation within the framework of the five-year plan and other relevant strategies; orientation of health policy towards the needs of the poor.
- What consequences does decentralisation of the health system have for the quality of health care in poorer provinces in particular those which are not able to contribute high levels of own funding? Can something be done to counteract this problem?
- Developing clear goals: What should the Vietnamese health system look like in 5, 10 years? What role should private providers of health services play (promotion and regulation)?
- Further development of the national health insurance scheme (including workers in the informal sector) and how to link it with to the Health Care Fund for the Poor (HCFP); strengthening the management capacities of the HCFP.
- Role of the Ministry of Health in regulating and monitoring the quality of the private sector and the free sale of drugs.
- Inefficient duplication of basic services (community-based advisors from the Ministry of Health and the Vietnam Commission for Population, Family and Children, VCPFC).