Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 02-Mar-2020 | Report No: PIDA27524

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
China	P171064	Hainan Health Sector Reform Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	02-Mar-2020	28-May-2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	People's Republic of China	Hainan Provincial Health Commission	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to contribute to improving the quality of primary health care services and efficiency of the health system in Hainan.

Components

Reforming Institutions and Strengthening Stewardship for People Centered Integrated Care
Strengthening Primary Health Service Delivery
Strengthening Healthcare Information System
Strategic purchasing for quality services
Technical Assistance and Project Management :

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	220.00
Total Financing	220.00
of which IBRD/IDA	200.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	200.00
Non-World Bank Group Financing	
Counterpart Funding	20.00
Local Govts. (Prov., District, City) of Borrowing Country	20.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **China has made remarkable gains in reducing poverty and enhancing overall health outcomes in the last three decades, fueled by consistently high rates of growth**. However, China's economy has slowed more recently, reinforcing the push towards building human capital especially by supporting population health and productivity. While earlier health reforms have resulted in greater utilization of health services, a fall in the share of out-of-pocket expenditures and greater access to drugs, yet more needs to be done, particularly in the context of escalating health costs.

2. **China health system challenges lie in the low value care emanating from a hospital-centric, fragmented and volume-driven health system.** An aging population, growing prevalence of smoking and alcohol consumption (particularly among men), and environmental factors such as air pollution have contributed to a high and increasing burden of non-communicable disease (NCD). The government recognizes that this calls for a strategic shift, to achieve universal health care by focusing resources on lower levels of care and ensuring that services are 'safe, effective, accessible and affordable'.[1] To achieve and sustain the goal of a 'Healthy China', there is a need to strengthen a people-centered integrated care (PCIC) based system, supporting timely access to high-quality outpatient care and primary services.

Sectoral and Institutional Context

3. **Hainan, with a population of 9.25 million, is one of the smallest and newer Provinces in China**. Over 18 percent of the population belong to minority groups, with the Li Minority Group accounting for around 16 percent. 4 Counties are on the Government's list of Counties suffering extreme poverty, and half of the Minority Autonomous Counties are on the list. 8.14 percent of the residents are aged 65 and above, more than 3 percent lower than that of the national average. In 2017, Hainan's GDP per capita was

[1] China Joint Study Partnership (2016). Deepening Health Reform in China; p ix.

RMB 48,430 (RMB 1 = US$0.15), compared to the national average of RMB 59,660. Hainan's special status and greater freedom for innovations, however, could make it a front runner in demonstrating how reforms can be deepened and leap frogged.

4. **People in Hainan have good access to primary health care facilities.** In general, people in Hainan have good access to primary care facilities with over 4000 clinics and over 400 township/community health centers (THCs/CHCs). Over half of the population have access to township/community health centers within 15 minutes, and over 80 percent within 30 minutes. At the grassroot level, the mainstay of China's health reform efforts is the Family Doctor Team (FDT)whose main tasks are to deliver the Basic Public Health Services (BPHS), basic medical care services for common diseases, and health management services, in particular for high-risk populations including pregnant women, children, the elderly, the disabled, and NCD patients.

5. **However, health outcomes in Hainan rank in the middle range among the Provinces**. Data from 2017 indicate that the maternal mortality ratio was higher than the national average, whereas under-five, infant and neonatal mortality rates were lower than the national average. The prevalence of NCDs as well as the disease burden in Hainan, similar to other parts of China, has been rising rather fast, particularly diabetes; however, the burden of cardiovascular disease and cerebrovascular disease was relatively low when compared to other Provinces.

6. **Yet, Hainan spends more on health than the national average.** Total health expenditure in Hainan was RMB 30.3 billion in 2016, accounting for 7.48 percent of its GDP, over 1 percent higher than the national average. Compared to other Provinces, a larger portion of total health expenditure was financed by the Government, whereas a smaller portion was paid by individuals' out-of-pocket (OOP). Rising health care costs, poor quality of services, low returns in terms of health outcomes remain major hurdles to economic growth and well-being.

Health Sector Challenges

7. ***First, skewed development of the health system has disrupted the continuum of care***. This is evident in the functioning of the health system:

i. **Despite improved access there has not really been a shift to the use of primary care, and case detection, care and outcomes at this level continue to be poor**. This is largely because FDTs have consistently suffered from low quality of services, lack of motivation and poor care coordination. Not surprisingly, communities bypass primary care leading to gross inefficiencies. Only around 54 percent of outpatient services were provided by primary care providers.

ii. **The health service delivery system is increasingly hospital-centric.** To operationalize tiered delivery, the government encouraged the development of medical alliances. While the growth of medical alliances has helped link hospitals and PHC, without a functioning PHC system these mechanisms potentially become feeders for more hospital admissions as well for hospitals to capture market share, rather than providing integrated care for patients. Hainan has been exploring the development of medical alliances following national guidelines and early pilots have been initiated in Changjiang and Sanya.

8. ***Second, the health system is ill-equipped to provide comprehensive primary care, particularly for the growing burden of NCDs and other emerging health challenges***.

i. **Institutional barriers exacerbate the fragmentation of delivery of primary healthcare services**, leading to gaps in care and overall low utilization of primary care services. Key challenges include: a) the BPHS is limited to case identification and provides only basic screening services, falling short of linking high-risk patients with curative services at secondary or tertiary facilities; b) specialized public health agencies, such as the Centers for Disease Control (CDCs) are increasingly marginalized in primary care management and delivery; c) front line PHC staff are burdened with multiple reporting and recording requirements, taking away valuable time from real service delivery and community outreach.

ii. **While the burden of disease due to NCDs was slightly lower in Hainan than the rest of China, it still accounted for 77.6 percent of all DALYs in 2017**. [2] Among around 7 million adults in Hainan, it is estimated that 1.62 million and 2.89 million had hypertension and pre-hypertension, respectively, and only 0.24 million had achieved control; and 0.76 million and 2.50 million had diabetes and pre-diabetes, respectively, and only 0.12 million had achieved control. Clearly, there are substantial gaps in the diagnosis, treatment and management of both diabetes and hypertension.

iii. **Hainan as an island province is also vulnerable to natural disasters and climate change significantly contributes to these risks**. By 2050, most areas in Hainan province are projected to convert from non-endemic dengue into endemic dengue areas. Further climate change will place increased stress on everyone, but disproportionately on the most vulnerable populations, especially the old and those with chronic illness.

9. ***Third, there are rising concerns over the appropriateness of care***. This is largely because:

i. **Hainan performs poorly in Quality of Care rankings in comparison to other provinces**. Among the 31 provinces, Hainan fell to the last position in the national performance ranking of the BPHS Program in 2016, with an average score of only 57 (out of 100). Further, the patients were often not diagnosed correctly, and providers ordered a large number of unnecessary tests.

ii. **Human resources for PHC face multiple constraints**. The health system is facing a severe shortage of qualified health professionals at the grassroot level. This seriously affects quality of care and inhibits use of primary care services. Specific problems are: a) recruitment and retention of the primary care workforce has been a challenge as most of the better-quality human resources flow into urban hospitals, leaving the primary care workforce weak; b) doctors working at primary care facilities vary greatly in terms of education, training, licensure and competency leading to heterogeneity in care provision; c) there is little in-service training, poor supervision and performance management leading to a low skilled and poorly motivated workforce.

[2] Zeng, et al. Disease burden by provinces in China between 1990 to 2016. Chinese Circulation Journal. December 2018, Vol. 33 No.12 (Serial No.246)

10. ***Fourth, the current health financing system is not contributing to the sector's efficiency and equity goals***:

i. **The fee-for-service (FFS) model is leading to supplier-induced demand for unnecessary or inappropriate care and cost inflation**. Most of the social health insurance funds at present are spent on inpatient services. The benefit package of outpatient services is limited, and does not leverage utilization at the primary health care level nor promote the early diagnosis and treatment for hypertensive and diabetic patients. Improving the generosity of the benefit package for outpatient services, at the primary level, will incentivize patients to seek care when diseases are minor and can be better managed and prevented, and avoid shifting outpatient care to inpatient care.

ii. **Inefficiencies in financing disproportionately impact access to healthcare for the poor**. Despite the weaknesses of PHC services, they remain an important source of healthcare for the poor. However, on average, the poor in Hainan had relatively poorer health status, used proportionately less health services (while using more primary care) and suffered greater financial burden.

iii. **Women need greater support against long-term degenerative and chronic conditions.** Women used PHC slightly more than men, which means they are less likely than men to receive proper healthcare due to weak capacity at the primary level. Almost 40 percent of healthcare costs incurred by women were out-of-pocket (as compared to about 30 percent for men); and more women were likely to forgo hospitalization when needed due to financial constraints.

iv. **Gaps in cancer screening for women**: The Central Government launched a nationwide cervical cancer and breast cancer screening programs in 2009, providing free screening to rural women between 35-64 years. Hainan exceeded the 2018 targets; however, women did not have access to screening services at local primary care providers due to lack of capacity. This led to increased workload at the prefectural/county level hospitals and low willingness to participate by the target population.

C. Relevance to Higher Level Objectives

11. **The proposed Project will contribute to the twin goals that anchor the World Bank's overarching mission**, and to galvanize international and national efforts in this endeavor, namely to: a) end extreme poverty at the global level within a generation; and b) promote shared prosperity (defined as a sustainable increase in the wellbeing of the poorer segments of the society). This Project will do so by improving health service delivery with a focus at the primary care level. This will directly benefit vulnerable groups with improved access to affordable and high quality of care, and will eventually improve people's health, financial protection, and satisfaction.

12. **The proposed Hainan Health Reform Project is closely aligned with the World Bank Group (WBG) Country Partnership Framework (CPF) for China (FY 2020 – 2025)**, by addressing some of China's key development and institutional challenges. The proposed Project falls under the third engagement area of the CPF, which aims to share the benefits of growth, and contributes to the CPF objective to ensure quality health and aged care services. The Project is in line with several of the CPF's selectivity criteria, namely strengthening policies and institutions, supporting critical services in lagging regions, addressing

regional and global public goods, and strategic piloting of approaches that address key development priorities (see Box 1).

Box 1. Alignment of the Hainan Health Reform Project with the selectivity criteria of the China CPF (FY20-25)

- **Strengthening primary health care institutions and policies**, the foundation for people centered integrated care. The Project aims to support a broad-based health system reform in Hainan, which requires significant institutional adjustments. It will do this by a) strengthening the capacity of front-line service delivery through rigorous measurement of performance outputs and outcomes, supportive supervision and targeted incentives; b) deeper institutional, human resources, health financing and information technology reforms within the HPHC and the HPHSA to create a sustainable and efficient service delivery system.
- **Improving service delivery in lagging regions**: The project will support improved health services delivery in Hainan. Hainan ranks in the middle of China's provinces in economic performance, with rural Hainan lagging further behind. Over 18 percent of the population belong to minority groups, with the Li Minority Group accounting for around 16 percent. 4 Counties are on the Government's list of Counties suffering extreme poverty, and half of the Minority Autonomous Counties are on the list. Hainan performed poorly on the national performance ranking of the BPHS Program in 2016 and a rapid assessment conducted in preparation of this project showed major gaps in quality of care at the primary care level.
- **Delivering regional and global public goods.** The project will cover activities to improve surveillance systems to prevent and manage emerging infectious diseases, reduce antibiotic resistance and mitigate climate change, which contribute to regional and global public goods.
- **Strategic piloting of approaches that address key development priorities.** The Project will pilot innovative solutions in measurement of quality and purchasing of services through insurance programs to improve quality of primary care and efficiency of the health system. At the individual provider level, the Project will leverage incentives to change provider-level behavior and improve care for the growing burden of NCDs. The generated technical and financial knowledge will be highly valuable for other provinces in China, and the Subcomponent 5.2 will support the dissemination of the lessons both nationally and internationally.

13. **The proposed Project builds on the solid analytical work undertaken by the World Bank and partners and complements Hainan's own investments through the ongoing Primary Health Care Standardization Project (PHCSP).** The proposed Project addresses four of the six actions identified in the in the analytical study report, 'Deepening Health Sector Reform in China' (2016) namely: a) scaling up of people-centered integrated care (PCIC); b) realigning financing incentives; c) improving quality and strengthening patient engagement; and d) human resource strengthening. Further it builds on Hainan's RMB 2.6 Billion investment through the PHCSP aims to upgrade PHC infrastructure and introduce related policy reforms to improve the quantity and quality of health professionals working at the primary level.

D. Proposed Development Objective(s)

Development Objective(s) (From PAD)

14. The Project Development Objective (PDO) is to contribute to improving the quality of primary health care services and efficiency of the health system in Hainan.

Key Results

15. **PDO Level Indicators:** The PDO will be achieved by strengthening the health system of Hainan with a combination of institutional reforms, enhanced service delivery, improved quality of care and appropriate incentivization of primary care providers. The outcome indicators in the table below will measure progress towards achievement of the PDO.

Table – PDO-Level Results Indicators

PDO-level Results Indicator	Quality of PHC Services	Efficiency of Health System
Increase in the number of Type II diabetic patients who are under optimal blood glucose control in the past three months	X	
Increase in the number of hypertensive patients who are under optimal blood pressure control in the past three months	X	
Increase in the number of outpatient care delivered by primary care providers		X
Reduction in the proportion of prescriptions with antibiotics for outpatient care at the primary level	X	

E. Project Description

16. The overall goal of the Hainan Health Sector Reform Project (HHSRP) is to strengthen the quality of PHC services and efficiency of the health system. The Project does this by:

i. **Strengthening of the primary care delivery system:** The central focus for PHC strengthening will be to improve the performance of Family Doctor Teams (FDTs) operating in Town Hospitals/Community Health Centers (THCs/CHCs) and Village Clinics (VCs) through targeted strengthening of front-line service delivery, rigorous measurement of performance outputs and outcomes, supportive supervision and targeted incentives; and to build health sector stewardship of People Centered Integrated Care (PCIC) through better integration of different levels of care and alignment of public health functions such as disease surveillance and emergency response with PHC service delivery.

ii. **This is supported with deeper institutional, human resources, health financing and information technology reforms to create a sustainable and efficient service delivery system**. At the operational level this will mean providing technical and financial support for strategic and results-oriented planning and management, evidence-based decision-making and adoption of e-governance platforms for greater coordination and efficiency. The Project will also strengthen strategic purchasing of services through insurance programs in order to drive the system towards the Project goals of improving quality of primary care and efficiency

iii. of the health system. At the individual provider level, the Project will leverage incentives to change provider-level behavior and improve care for the growing burden of NCDs.

F. Project Components

Component 1: Reforming Provincial Institutions and Strengthening Stewardship for People-Centered Integrated Care (US$21.15M)

17. This component will focus on institutional reform of the health system to deliver people-centered integrated care by: a) strengthening leadership and stewardship for primary care at the provincial level through technical support and additional resources; and b) reducing institutional fragmentation and promoting multi-party engagement. Key project activities will include:

18. ***Subcomponent 1.1. Enhancing and strengthening technical capacity, professional management and leadership*** in the multiple divisions of the provincial health authorities responsible for primary health service delivery. The Project would augment and improve existing capacity while paying special attention to building additional institutions/functions that are currently missing in the systems. Specific areas of focus include: i) Building leadership for quality and outcomes in primary care services; ii) Addressing human resource gaps in placement and retention; iii) Promoting care integration iv) Strengthen disease surveillance and outbreak response and v) Engaging more closely with citizens to promote healthy behaviors and their trust in PHC services.

19. ***Subcomponent 1.2 Reducing institutional fragmentation and promoting multi-party engagement*** by: i) Streamlining primary health service; ii) Increasing coordination between the HPHC and the HPHSA iii) Improving public finance management (PFM) for health.

Component 2: Strengthening Primary Health Service Provision (US$82.55M)

20. This component aims to strengthen the quality of PHS provided by FDTs. It consists of (a) addressing equipment and human resources gaps at the primary level; and (b) introducing FDT Performance Management Program (PMP) to improve process and outcome quality.

21. ***Subcomponent 2.1: Closing gaps in PHC equipment and tools***: Under this component, the Bank will close any remaining gaps in PHC equipment and tools. The Project will support minor equipment for efficient functioning and delivery of primary care services. To ensure efficiency, equipment procurement activities will be managed by the Provincial PMO.

22. ***Subcomponent 2.2: Strengthening human resources for PHC*** : The Project will strengthen human resources for PHC by addressing the following gaps: First, the Project will support the design of policy innovations to address chronic human resource issues such as head counts, salaries and benefits, filling vacancies among the primary care workforce; second, the Project will support a series of training programs led by HPHC and conducted by the Prefecture and County Health Commissions; third, the Project will also support activities to strengthen institutional capacity for training, such as curriculum optimization, training of trainers, and upgrading of Continuing Medical Education Schools (CMES).

23. ***Subcomponent 2.3: FDT performance management***: County/Prefecture Health Commissions will lead a Performance Management Program (PMP) to improve process and outcome quality of FDT services. Under the PMP, a Tripartite Service Agreement will be signed between County/Prefecture Health Commission, County/Prefecture Social Security Bureau and T/CHCs for a set of key services and activities

to be delivered by FDTs. FDT performance on the agreed parameters will be measured and reviewed semiannually. County/ Prefecture Health Commissions will carry out training of front-line providers, supervise the performance of FDTs, provide periodic feedback, and support community mobilization.

Component 3: Strengthening Healthcare Information Systems (US$59.23M)

24. **The objective of this component is to support improvement in the quality of PHC services and health outcomes** by integrating each person's health and medical data. Information collected, shared and used at the PHC level will be collated into one comprehensive digital information space ensuring PCIC and continuity of care throughout the tiered health care delivery system. A key goal of the project is to dovetail the information systems development at the HPHC and HPHSA and streamline information collection, thereby facilitating its use in evidence-based management and decision making. Specific investments include:

25. ***Subcomponent 3.1: Provincial Health Commission Capacity Building by:*** *i) building an Interconnected Provincial Health Information System* that provides desktop applications; integrates PHC information systems; creates local Clinical Guidelines and Digital Decision Support Systems; and builds a hospital performance management system; and ii) *Strengthening IT Governance and Stewardship* by building management capacity; and supporting development of public health information systems and e-services for PHCs.

26. ***Subcomponent 3.2: Supporting Provincial Healthcare Security Agency IT Capacity*** by i) improving management and upgrading of current HPHSA IS; ii) participating in data security and privacy subsystem development; and iii) enhancing operational efficiency by, for example, integrating PHC patient information and insurance fee receipt information with e-medical insurance platform through issuing devices and desktop solutions.

Component 4: Strategic purchasing for quality health services (US$43.07M)

27. **The Project will support HPHSA to become a strategic purchaser by introducing performance-based payment to FDTs**.

28. **Subcomponent 4.1 Performance-based payment to FDTs:** The Project will introduce performance-based payment to FDTs to incentivize them to improve service quality and coordination of care. The performance-based payment per empaneled individual per year will cover the costs of additional human resources, medical consumables and operating cost, part of which will be channeled from the World Bank loan.

29. **Subcomponent 4.2 Capacity building and operational research:** The Project will simultaneously support capacity building activities and operational research within the Project scope to ensure a successful implementation and cover the cost of counter verification and PIU operation.

Component 5: Technical Assistance and Project Management (US$14M)

30. Enhanced technical support will be needed to support research, development, design and monitoring and implementation. Specific areas prioritized for technical assistance (TA) include:

31. ***Subcomponent 5.1. TA for program implementation and research*****:** Key areas for TA include: i) Design and implementation support for a Performance Management Program for FDT; ii) Strengthening health financing and resource allocation through the Medical Alliance Strategy and reform of financing and management of primary care services; iii) Evaluation and operations research support for a sample-based Cascade Analysis of Hypertensives and Diabetics and identification of health risk management and behavior change strategies; and iv) Support for strengthening the stewardship role of the HPHC and HPHSA.

32. ***Subcomponent 5.2 Support for project management*** through specific activities, including implementation coordination, technical support, ensuring safeguard commitments, day-to-day management of the project, and annual reporting. The Project will also finance learning and knowledge dissemination and exchange.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

33. The Project will only support equipment procurement, capacity building and technical assistance activities without involving any civil works and thus will not result in any direct and significant environmental impact. However, with the operation of reoptimized PHC services/associated facilities, there will be some downstream environmental issues to be considered, including use and disposal of hazardous chemicals, increased production of wastewater and medical waste, Occupational, Health and Safety risk of healthcare workforce in the primary health care system. Given the limited information currently available and lack of institutional capacity at the provincial and local levels on environmental and social risk management, the overall environmental risk is rated substantial at this stage and this rating will be further checked during Appraisal. The Project recognizes these potential risks and has incorporated several safeguards into Project design such as more modern technology, more efficient processes, more targeted awareness campaigns and better management systems to minimize waste streams and OHS risks and to secure safe handling and disposal of hazmat.

34. The Project is not expected to have any physical investments in civil works. Thus, no sensitive locations will be considered, and no land take is expected to be required. Therefore, there is no displacement impact and no significant adverse impact on local communities and ethnic minorities. No community workers will be used and no significant risks on labor and working conditions are envisaged due

to the nature of the project.

35. Some concerns were identified during this stage with regard to effective and appropriate stakeholder engagement to support equity in access for the most poor and ethnic minorities groups. The number and diversity of stakeholders and agencies to be involved in Project implementation, as well as the complexity of the required engagement process, are dependent on specific Project activities yet to be defined. This may affect the potential risk level if the Project fails to deliver improved healthcare services to vulnerable groups. Further technical design, a rapid poverty and social impact assessment to be undertaken during the project preparation, as part of the ESMF development, and the initial stakeholder engagement would contribute to confirm the Project complexity and its risk level.

36. Regarding borrower capacity and commitment, although lacking previous experience of working with Bank policies, the Hainan PMO and implementation agencies have experienced health reform challenges in the past few years, which have contributed to their management capacity development. In addition to that, it is important to consider the current context of a strong national and provincial government commitment and support for Project. For these reasons, the overall social risk rating is considered substantial at this stage.

G. Implementation

Institutional and Implementation Arrangements

37. **Oversight, implementation guidance and support**: Stewardship for the Project will be provided by a Project Steering Committee (PSC)/Project Guidance Leading Group under the leadership of Vice Governor (in charge of health), and Deputy Secretary-General of the provincial government, and will consist of the Provincial Development and Reform Commission (DRC), Provincial Department of Finance (DOF), HPHC and HPHSA. The PSC will also include representatives from the National Development and Reform Commission, Ministry of Finance, National Health Commission and the National Healthcare Security Administration. The PSC will meet every six months and review progress of the project, provide guidance on implementation and support management of implementation risks.

38. **HPHC will be the lead implementation agency supported closely by the HPHSA.** Drawing on representation from both these entities a Project Management Office (PMO) will be established within the HPHC. The PMO will be headed by the Deputy Director-General of the HPHC, with the Director for Health Reform and the Director of the HPHSA as the two Executive Deputy Directors of PMO. The PMO will be responsible for day-to-day management of Project activities, including carrying out regular supervision missions, monitoring progress on the results framework and preparing progress reports. Expert panels will be constituted as necessary to support the PMO on technical issues cutting across key areas such as institutional issues, health financing, human resources in health and health information technology. The PMO will also have specialist skills on project management, safeguards and financing.

39. **The key Project Implementing Units (PIU)** will include the HPHC (together with the centers responsible for specific activities) at the provincial level and prefectural/county levels, the HPHSA and the Social Security Bureaus in the prefectures and counties. The PMO and the PIUs will include a mix of

technical, project management and implementation specialists including those skilled in procurement, financial management and safeguards. Some of the key mandates of the three units are outlined below:

- **Project Management Office/HPHC PIU** will provide overall leadership for Project implementation and tracking of Project results and six-monthly reporting, provide technical support and advice for the various Project components and carry out, as needed, the procurement tasks as related to Component 1, 2 and Component 5.

- **Provincial Center PIU** will lead the implementation of Components 1, 2 and 3.1 including technical design, planning, implementation, procurement and reporting for these components. Each PIU will develop clear annual task plans, implement the corresponding social and environmental safeguards plans, and at their very core ensure sound finance management and procurement activities where mandated.

- **Prefecture/County Health Commission PIU**: As the frontline agency, the Prefecture/County Health Commission will be responsible for the implementation of Component 2. It will lead the hiring of technical support, capacity building activities, supervision, behavior change and community mobilization and periodic reporting on performance. It will sign a tripartite "service agreement" along with Prefectural/County Social Security Bureaus PIU and THC/CHCs for a set of key priority services and activities to be delivered through FDTs, the service standards expected and supervision arrangements.

- **The HPHSA PIU** will lead the design, planning and rollout out of performance-based payment of the project, overall strategic purchasing capacity building and the advancement of IT linkages (component 3.2) between the HPHSA and HPHC.

- **Prefectural/County Social Security Bureaus PIU** will sign the tripartite service agreements along with the Prefecture County Health Commission PIU and THCs/CHCs for a set of key priority services and activities to be delivered through FDTs, the service standards expected and the performance payments that will be triggered when the results are achieved and results counter-verified by HPHSA.

40. The overall risk of this operation is high as the technical and institutional capacity for implementation in the province is untested. The main sources of the technical and institutional capacity risks stem from the comprehensiveness and complexity of reforms being proposed in the Project. These reforms involve strengthening existing institutions, creating new rules for accountability and good governance, and a provider payment mechanism reform with value-based payments for public and private front-line PHC providers. Interwoven in this health sector reform is a profound change of the health information management infrastructure with an e-health platform which communicates across existing platforms, and an e-health record system for frontline health providers. Implementing these reforms will require the participation and reform of multiple technical divisions and county/prefecture health commissions. Mitigation measures have been inbuilt into the project design and implementation strategies. Designed as a six-year project, significant resources have been allocated in the first year for start-up activities and phased roll out. Substantial technical assistance for strategic and operational support has been factored in at the provincial and prefecture to ensure skilled experts within the country

and internationally can be mobilized. Implementation arrangements mitigate these risks to an extent through high level coordinating mechanisms like the steering committee, day to day coordination through the PMO as well as using the regular system of reporting for Project implementation. The World Bank task team will also continue to actively coordinate and provide close supportive supervision support especially in the initial years of implementation.

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