MINISTRY OF HEALTH HEALTH PARTNERSHIP GROUP

JOINT ANNUAL HEALTH REVIEW 2012

Improving quality of health care services

Executive summary

The Joint Annual Health Review 2012 (JAHR 2012) is the sixth annual health sector review jointly conducted by the Ministry of Health and the Health Partnership Group (HPG), aimed at supporting Ministry of Health in health planning for the year 2013, and laying a foundation for selection of key issues for cooperation and dialogue between the Vietnamese health sector and international partners. The JAHR 2012 covers updates on the current situation of the health system, including health status and determinants; assessment of performance towards goals of the 5-year health sector plan 2011–2015; and inquiry into "improving quality of health care". Below is a summary version of the report.

All previous JAHR reports are available at the website http://jahr.org.vn .

PART I: UPDATES ON THE HEALTH CARE SYSTEM

1. Health status and determinants

Health status: Health status of the Vietnamese people has continuously improved over the past few years. Almost all basic health indicators set in the 5-year health sector plan have seen improvement: Average life expectancy of the Vietnamese people has increased slightly; in 2011 it was estimated at 73.0 years (male 70.4 years; female 75.8 years). The infant mortality rate (IMR) has tended to fall, in 2011 reaching 15.5 deaths per 1000 live births; the under-five child mortality rate has dropped considerably to 23.3 per 1000 live births in 2011. The maternal mortality ratio has seen a considerable decline over the past two decades, from 233 cases per 100 000 live births (in 1990) to 67 cases (in 2011). However, there remain disparities in health status of the people across regions and rural and urban locations; the neonatal mortality rate remains a serious problem, accounting for 60% of infant mortality and 40% of under-five mortality with large differentials across regions. The economically disadvantaged regions of the Central Highlands and Northern Midlands and Mountains have the highest rate of under-five child mortality. Child malnutrition in the form of stunting remains a persistent problem in need of greater effort. The decline in the maternal mortality ratio has decelerated in recent years.

There is a striking change in morbidity patterns from 1986 to 2010. The proportion of health care visits for non-communicable diseases is continuously rising and accounts for a high share of all visits. The opposite trend is seen with communicable disease which has seen a sharp decline in its share of all health care visits. The proportion of health care visits for accidents, injuries, poisoning has stabilized. Indeed, the disease burden has strongly shifted to non-communicable diseases. For mortality patterns, based on hospital statistics, there is a rapid change in patterns over time as the share of deaths in hospitals due to non-communicable diseases has risen considerably in recent years.

Some communicable diseases and new unidentified diseases have shown unpredictable trends and a risk of death including from dengue fever, hand-foot-mouth disease, inflammatory palhoplantar hyperkeratosis syndrome, etc.

With regard to health determinants: Besides positive impacts of improving economic conditions, rising investments in social sectors including education and health, and improved living standards of the people in all regions, health status and health care for the people is heavily influenced by risk factors.

The lives of some segments of the population living in the mountainous, remote areas face many difficulties. There is a rising rich-poor gap and high population density putting pressure on the economy, society and living conditions of the people. The social infrastructure is failing to keep pace with population growth in urban areas and areas with spontaneous in-migration.

Accompanying the ongoing industrialization and urbanization, the problems of urban environmental pollution, air and water pollution in residential areas are becoming increasingly serious, and causing a number of health problems related to acute and chronic diseases linked to short-term and long-term exposure to air and water pollution. For small enterprises, private enterprises and traditional handicraft enterprises, working conditions are rarely if ever monitored, and there are many risk factors for health and disease. Use of illegal chemicals and food additives during cultivation, and food processing remains fairly common.

Rising temperature due to climate change combined with urban heat island effects and air pollution have caused negative impacts on human health. Climate change accelerates the likelihood of emergence and re-emergence of some tropical diseases such as malaria, dengue fever, Japanese encephalitis. Rising sea level poses great threats to the production, life and health for the people living along coastal areas.

The rising intensity of life and changing lifestyles has created risk factors for mental diseases, cardio-vascular disease and other non-communicable diseases. Use of tobacco and alcohol tends to increase in some communities, especially among young adults and self-employed laborers. The number of illegal drug users is large and no decline is imminent. It is estimated that 41% of HIV/AIDS infections are due to injecting drug use.

- Construct and apply care pathways for common disease groups, diseases with high volume of service utilization and diseases accounting for a high proportion of total health care costs.
- Strengthen the Steering Committee and Technical Group on Transforming Payment Methods to the study, pilot and scale-up of various forms of incentives for performance and quality care.

6.4. Enhance consistency, standardization and quality of service databases

- Implement programs on improving quality of data and statistics to meet requirements for monitoring, oversight and evaluation of various forms of incentives to encourage service quality.
- Develop the information component to classify case types and service types (clinical information according to the international disease classification - ICD9-CM and ICD10). Construct and develop the HMIS as a management model suitable for result-based management mechanism.

6.5. Strengthen supervision, and audit of service quality

- The supervision of service quality of the payer (Vietnam Social Securities), and encourage independent participation of social and professional organizations
- Provide practical training on supervision of service quality for managerial staff, staff of the VSS and managers of hospitals/health facilities.
- Study and propose penalties, fines – bonuses mechanism based on ex post verification of performance
- Gradually consolidate the supervision, accreditation system (internal - external), to enhance quality verification work of independent supervision and accreditation agencies.

- Develop curriculum for continuous medical education in patient safety. Strengthen inspection of regulations on safe blood transfusion. Apply granting of certificate for intravenous therapy. Apply quality standards for patient care. Develop the national action program for hospital nutrition.

5. Promote the role of patient and community in service quality improvement

- Review and supplement the Hospital Regulation rules on implementing the rights and obligations of patients.
- Organize information provision and improve necessary knowledge and skills for patients.
- Recommend to supplement regulations on the right of patients to participate in monitoring and improving service quality and disclosure of information on hospital quality in the Law on examination and Treatment.

6. Payment methods and quality of health care

6.1. Review and supplement regulations on payment for health services and budget allocation

- Promote the process of updating service prices for the entire list of services on the basis of full cost information.
- Adjust budget the allocation mechanisms for different professional areas/specialties, taking into account adjustments to reduce differences and increase equity in income between disciplines.

6.2. Adjust and monitor strictly implementation of regulations on the allocation and use of surplus from service revenues

- Implement “transparency in public and private activities" in public hospitals.
- Continue to study and propose salary and remuneration policies for health workers.
- Study and propose policies to better orient the health delivery system to ensure that hospitals move toward social goals rather than pure economic successes.

6.3. Promote studies on application of more progressive payment methods

- Study and pilot feasible result-based payment methods; performance-based payment toward universal coverage of health care, *with appropriate and basic health care packages of disease prevention, treatment and rehabilitation at affordable costs*.
- Design the quality-based payment in the process of developing package payment or capitation-based payment which is under implementation and replication.

2. Updates on the current health care system

2.1 Implementation of the 5-year plan and previous JAHR recommendations

Provision of health care services

Primary health care, preventive medicine and national target programs for health

The basic health care network continues to be upgraded. The Ministry of Health has conducted a review of 10 years of implementation of the Directive 06-CT/TW on consolidating and strengthening the grassroots health care network. The proportion of commune health stations reaching the national benchmark standards for the period 2001–2010 is over 80%. The national benchmark standards for communal health for the period 2011–2020 have been issued and are being applied. Health education and communication work has received more attention. Primary health care has gradually been renewed with expanded health services at the communal level, including pilots in community-based disease management of chronic disease such as asthma, hypertension and diabetes…

Epidemic control has been strengthened and contained some outbreaks such as the hand, foot, and mouth epidemic, meningococcal infection, *dengue* hemorrhagic fever, and influenza type A (H5N1), HIV/AIDS. The proportion of children under age 1 who are fully immunized stayed above 95% for 7 to 8 vaccines.

In 2012, several legal documents were promulgated in food safety including: the National Strategy for Food Safety; the Master Plan for Food Safety; the National Target Program for Food Safety 2012–2015; sublegal documents stipulating details and enforcement of some articles in the Law on Food Safety. Activities such as food poisoning prevention, surveillance of food contamination risk and surveillance of food poisoning have been implemented nationwide. The food poisoning situation has dropped remarkably compared to 2010.

The Prime Minister has approved four National target programs for the period 2012–2015: Health; Population and Family Planning; Food Safety and Hygiene; HIV/AIDS prevention and control, and continues investment in addressing priority health problems.

Medical examination and treatment

The Ministry of Health has been directing implementation of measures to overcome overcrowding in hospitals, namely: strengthened investment in improving quality of care at the grassroots level; adjusted fee schedule of a large number of basic health services in state health care facilities; continued technical mentoring by health professionals from higher levels to improve capacity at the lower level; improved physical infrastructure in some hospitals, etc... Currently, hospital overcrowding hospitals is very serious at all levels, especially at the central level with persistent bed occupancy rates over 100%, and some reaching almost 200%.

A circular to instruct hospital quality management is being developed in order to gradually improve medical service quality.

Consolidation of the organizational structure at the district level, and hospital network planning are receiving substantial attention. By the end of 2011, 91.3% of district hospitals had been allocated capital from government bonds. Among these, 147 district hospitals and 46 regional hospitals have completed construction and new infrastructure put into operation; construction in 275 hospitals and 60 regional hospitals is expected to be completed in 2012; 51 provincial general hospitals, 48 tuberculosis hospitals, 35 mental health hospitals, 23 obstetric/pediatric hospitals, and 5 oncology hospitals and centers received investment under Decision No. 930/QD-TTg. In 2011, there were 133 private hospitals (31 more hospitals), with a total capacity of over 6,000 beds.

Registration, licensing, granting of license for medicine practice has gradually been done under Decree No. 87/2011/ND-CP and Circular No.41/2011/TT-BYT. Series of technical guidelines for inpatient hospitals have been supplemented, updated and promulgated.

Population, family planning and reproductive health care

A steady reduction in fertility has been maintained, with replacement level fertility achieved every year since 2005 (total fertility rate in 2011 was 1.99 children per woman compared to 2.72 children per woman in 1999).

The Prime Minister has approved the National Strategy for Nutrition during 2011–2020 and vision to 2030. Child malnutrition prevention work continues to be implemented in a consistent and comprehensive manner. In 2011, under-five child malnutrition (underweight) dropped by 0.7 percent points compared to 2010, to 16.8% and evenly in all 6 regions. In 2011, the child stunting rate was 27.5%, declining by 1.8 percent points since 2010.

The network to provide reproductive health care services continues to be consolidated. Safe motherhood services are widely provided. Some 95% of pregnant women received antenatal care management (2010) - a 0.4% increase over 2009. In 2010, the proportion of deliveries with assistance from trained attendants reached 95.7%, higher than that in 2009.

Difficulties, limitations: Supervision in preventive care has not yet been done regularly. Prevention and management of non-communicable diseases is not yet extended to the whole country and to all levels. Intersectoral cooperation in formulating policies and implementing preventive health activities remains loose. Investment in health care facilities remains limited both in operational budget, human resources and equipment...

Hospital quality assessment indicators have not yet been developed. The process of updating and supplementing treatment guidelines, technical protocols, and division of technical care by level is very slow … Classification (rating) of hospital has not

- Establish an independent accreditation organization in Vietnam. Study to establish one single Quality Management Council. Conduct systematic assessment of patient satisfaction at the national and institutional level.

4.2. Promote application of information technology in health care quality management

- Develop a master plan for information technology application in health care; Develop information technology standards in the health sector; Study and design training program on applied computer science in health care
- Develop incentives and a legal basis for electronic medical records.
- Implement projects on information technology application in hospital management, electronic medical records, telemedicine and smartcards. Apply software supporting rational drug use: electronic prescription, drug interaction notification software.

4.3. Strengthen hospital management information

- Establish a national and institutional voluntary errors/incident reporting system; Set up a hospital infection surveillance system at national, provincial and hospital level.
- Develop a set of national indicators on hospital quality as a basis for assessing and implementing quality improvement projects.
- Measure hospital quality indicators; develop a set of quality indicators for other health facilities.

4.4. Adequate implementation of quality management regulations and methods

- Conduct expansion of patient safety programs, apply widely the surgical safety checklist; amend and supplement the blood transfusion regulation; implement Circular 18 on infection control.
- Refine the regulation on management of lab test quality. Strengthen the operation of three centers for standardization and quality control of laboratory testing, develop a project on reference laboratories.
- Strengthen supervision on safe and rational use of drugs; Develop programs, materials and training curricula on injection.
- Strengthen equipment and instruments for patient care, and replicate group-based, team-based care models. Strengthen education on professional ethics for health workers. Guide the implementation of the code of conduct and communication skills.

- Refine the health care network. Effectively use resources at all levels of care and improve continuity of healthcare.
- Strengthen capacity in management of health service quality.

3.2. Macro level management for health care practitioners

- Develop and issue standards for core competencies for most health worker categories.
- Implement quality accreditation of medical workforce training programs.
- Supplement and amend the circular on continuous medical education.
- Promote the role of professional associations. Strengthen scientific research on service quality.

3.3. Macro level management of pharmaceuticals, medical equipment, technology and infrastructure

Pharmaceuticals and biologicals

- Improve implementation of existing legal documents.
- Improve drug quality control.
- Strengthen supervision and monitoring of rational and safe use of drugs.

Medical equipment and infrastructures

- Improve medical equipment and infrastructure management systems.
- Regulate medical equipment and infrastructures in hospitals and market
- Enhance effectiveness of investment in medical equipment and infrastructure

4. Management of service quality at health facilities

4.1. Develop mechanisms, arrangements and resources for hospital quality management

- Develop comprehensive programs/plans/projects on quality improvement in hospitals. Prepare a proposal to set up an accreditation agency; issue a circular on quality management in hospitals; pilot a project on management methods and quality improvement.
- Provide quality management training for managers, nursing management and full-time staff for infection control.
- Develop and update treatment protocols, clinical guidelines.

been done system wide. No assessment on implementing Circular No. 03 on district health structure model has been conducted. Imbalance in the sex ratio at birth is rising, creating important threats to social welfare in the next 10–20 years. The risk of population rising remains very high. Unsafe abortion remains prevalent, especially among adolescents. There remain large regional disparities in the health status of women and children. The quality of antenatal care remains limited. Obstetric complication incidence increased from 2.2‰ in 2009 to 2.8‰ in 2010, particularly infections and eclampsia.

Health financing

On 15 October, 2012, the Government issued Decree No.85/2012/ND-CP on reforming the operational and financial mechanism and medical service prices for state health care providers. This is an important document for continued implementation of medical facility autonomization. In 2012, the revised price schedule for medical services in state health facilities was issued (Circular No. 04/2012/TTLT-BYT-BTC, dated 29 February 2012), stipulating the maximum official price for 447 medical services, and replacing the fee schedule issued under Circular No. 14/1995 and 80 service fees in Circular No. 03/2006.

Health insurance coverage reached 64.9% in 2011, a 4.9 percentage point increase over 2010. Contributions to this achievement included: Decree No. 92/2011/ND-CP on penalties for administrative violations in health insurance; Decision No. 797/2012/QD-TTg raising government subsidies to 70% of the health insurance premium for the near poor; addition of target groups to the list of beneficiaries supported by the state budget such as patients facing financial difficulties due to high medical costs; Ministry of Health direction of provinces to review, and jointly work with other sectors to provide insurance cards for 100% of children under age six.

On 22 November 2012, the Politburo issued Resolution No. 21-NQ/TW on strengthening leadership of the Communist Party in the area of social insurance and health insurance for the period 2012–2020. In September 2012, the Ministry of Health submitted to the Government the draft proposal on a roadmap toward universal health insurance during 2012–2015 and to 2020.

The share of government recurrent spending on health has increased: from 8.7% in 2010 to 9.1% in 2011 and expected to reach 9.4% in 2012. State health spending in 2011 was 33.2% higher than in 2010, an increase compared to the increase between 2009 and 2010 of 27.6%. The share of government health spending on preventive medicine and public health reached 38.6% (56.7% at the central level and 34.2% in localities). As of June, 2012, 592 hospitals had been allocated investment capital from government bonds.

Activities to reform payment methods are being implemented and receiving strong support from international organizations. e.g., the World Bank, the Asian Development Bank, AusAID, Rockefeller Foundation,… In 2011, 59 out of 63 provinces were

implementing capitation-based payment in a total 786 out of 1951 health facilities (40.3%). At the district level 51.9% of state facilities implemented capitation payments compared to 14% of provincial level facilities. Case mix payment method continues to be piloted, and expanded to 24 cases within the Health Systems Strengthening Project funded by ADB and AusAID. Result-based financing is being piloted in some provinces supported by the World Bank loan for the North Central Coast health support Project.

Difficulties, limitations: In 2012, Vietnam faced major macro-economic difficulties. The Government relied on fiscal austerity measures to realize its objective of reducing the budget deficit to below 4.8% of GDP. The state budget for health in 2012 was cut, and announcement of funding for 2012 was delayed making it difficult to budget and implement planned tasks. Investment from government bond capital also faced dilemmas as many hospitals were not provided adequate funding, thus reducing investment efficiency and performance.

The recently revised medical service price schedule is still based on partial cost recovery (only including 3 out of 7 cost components). In addition, it still does not cover all services provided by hospitals. The fee-for-service payment method remains widely used despite its inherent incentive for overprovision of services.

Health insurance coverage in 2011 increased only by 4.9 percent points compared to 2010. Expansion of health insurance coverage faces huge impediments. Strengthening the scope and quality of services, and reducing out-of-pocket payments for insurance enrollees remain a big challenge.

There is not yet a comprehensive master plan or project for reforming payment methods. The basis for calculating the capitation payment amounts does not yet ensure cost recovery for providers. Design of the capitation is not yet appropriate, and no evaluation of its impact on quality has yet been implemented. Conditions needed for implementing case mix payments are still lacking, including a minimum essential data set on clinical and financial issues for inpatient care.

There are limitations in monitoring and evaluation of performance of state-funded programs such as investment using capital from government bonds, subsidies to pay insurance premium for the poor, the near poor and children under age six.

Health workforce

The number and quality of health workers continues to improve. The ratio of doctors to 10 000 people increased from 6.59 in 2009 to 7.20 in 2010. In 2011, the proportion of commune health stations having a doctor was 72%; the proportion of commune health stations having a midwife or obstetric-pediatric assistant doctor was over 95%. Regulations revising the salary supplement for medical professionals and other special salary supplements for state sector health workers have been issued.

Quality of medical education has received more attention through implementing the measures indicated in the Prime Ministerial Decision No. 579/QD-TTg, dated 19

- Strengthen the medical equipment workforce.
- Strengthen capacity in health technology assessment.
- Strengthen capacity in standardization and quality assurance of medical equipment.
- Strengthen the servicing, maintenance and repair of medical equipment.

2.5. Health information

- Refine the policies and plans for health information system development.
- Strengthen the ability to meet the demand for use of information and data.
- Develop a monitoring system for priority issues in health care.
- Gradually apply information technology in health information systems.

2.6. Governance

- Continue to refine the health legislation system.
- Complete and stabilize the health network organization at all levels.
- Strengthen capacity and effectiveness in monitoring and supervision of health policy enforcement.
- Strengthen participation of stakeholders in the policy-making process, develop and implement the health sector plan.
- Strengthen inspection and verification.
- Strengthen continuity of care across levels of the system.
- Encourage integration, linkage between preventive care, curative care and rehabilitation in developing a basic health care package paid through health insurance.
- Effectively implement the EU-WHO funded policy dialogue program for Vietnam with a view to strengthening capacity and plan implementation, administration and governance in health care.

3. Macro level management of health service quality

3.1. Macro level management of health care facilities

- Move toward granting time-limited licenses for health care facilities.
- Supplement specific tools/indicators of health facility quality.
- Develop mechanisms to encourage voluntary registration for accreditation.

2. Solutions to carrying on key tasks of the 5-year health plan

2.1. Provision of health services

- Refine policies, supervision mechanism and implementation arrangements for primary health care, preventive medicine and national health target programs, and make progress towards universal healthcare.
- Solve overcrowding in hospitals, and improve quality of care.
- Strengthen management and reform of hospital financing towards greater autonomy, transparency and openness.
- Refine policies, supervision mechanisms and implementation arrangements for population-family planning and reproductive health care.

2.2. Health financing

- Reform the operational and financing mechanisms in public health service facilities.
- Implement the roadmap towards universal coverage.
- Ensure state budget for approved health programs.
- Reform provider payment methods.

2.3. Human resources for health

- Strengthen the health workforce information reporting system to facilitate planning for health human resources. Develop projects to implement the master plan for health human resources development. Develop standards and procedures for evaluating staff performance.
- Improve quality of training, and reform training programs.
- Appropriate deployment and remuneration for health workers in disadvantaged areas.

2.4. Pharmaceuticals and medical equipment

- Refine the legal system and policies.
- Ensure drug prices at a reasonable level.
- Strengthen quality of drugs and vaccines.
- Strengthen rational use of antibiotics.
- Assess the current situation and need for medical equipment in health facilities at all levels.

April 2011 as well as the Master Plan for Human Resource Development for the period 2012–2020.

Difficulties, limitations: Expansion of training modalities and evaluation of effectiveness of training delivery methods, especially human resource training for the mountainous, remote and isolated areas has not received adequate attention. There remains insufficient remuneration to attract and maintain health workers in the grassroots level, in disadvantaged areas and in some specialties.

Training quality is incommensurate with advanced technology development and people's needs for health care. Practice skills of fresh graduates remain fairly poor. Continuing medical education has received insufficient attention. There is no quality accreditation system in medical education establishments. The state budget for human resource training is very limited. There is no overall and long-term plan for a comprehensive reform of human resource training for health.

Pharmaceuticals and medical equipment

Current domestic drug production can only meet 47% of people's needs for drugs (in terms of value of drugs used). The network of pharmaceutical dispensing units is widespread with an average of one drug outlet per 2000 people. Demand for vaccines is met through both domestic production and imports. The 6th version of the essential drug list is being developed. The draft master plan for pharmaceutical industry development in Vietnam for the period 2020 and vision to 2030 has been completed and awaits approval from the Prime Minister.

Development of traditional herbal and pharmaceutical ingredients is being promoted. A list of 40 pharmaceutical ingredients with potential and market development has been issued by the Ministry of Health. The Health Minister has issued Directive No. 03/CT-BYT dated 24 February 2012 on strengthening supply management, use of medicinal materials, traditional medicines and finished herbal products in traditional medicine facilities. Twelve projects to implement the government action plan for development of traditional medicine and pharmaceuticals in Vietnam to 2020 have been developed. The Ministry of Health is directing inspection of medicinal material quality in some localities.

The Ministry of Health has worked in collaboration with the Ministry of Finance to study and propose some preferential tax measures to encourage domestic production of medical equipment, and regulation for licensing and granting certificate of free sale (CFS) for medical equipment products made in Vietnam.

Difficulties, limitations: Capacity for domestic production of specialized drugs is weak. Regulation of competitive bidding for drug procurement in hospitals still includes some inappropriate measures. Verification of sources and quality of medicinal materials and finished herbal products is facing substantial difficulties. The proportion of patients using antibiotics remains high (50% of outpatient prescriptions, and up to 60% at the district level); sale of prescription drugs without a prescription remains prevalent (40%). State control and regulation on procurement and use of

medical equipment in public facilities remains limited. Management of medical equipment prices lacks specific regulations. Health technology assessment has not yet been implemented.

Health information

The National Statistical Strategy for the period 2011–2020 has been approved and issued by the Prime Minister. The Ministry of Health has conducted a health statistical workforce assessment, and action plans for its health statistics development strategy. Basic indicators of medical examination and treatment, preventive medicine, national target programs... have been reviewed, to feed into development of a system of basic health indicators to submit to the Ministry leadership for approval. The Vietnam Administration of Medical Services has issued instructions to fill in data collection forms for private facilities. Currently, the Ministry of Health is collecting approximately 127 indicators, including indicators of people's health status and health sector performance. A review of registers and reporting forms of relevant departments, administrations, national programs and localities has been conducted to propose collaboration, integration, provision and exchange of information within the health agencies and between the health sector and other relevant ministries and sectors. The Ministry of Health has been assigned by the Prime Minister to take the lead in conducting some statistical surveys, including: Survey of medical facilities and manpower; HIV/AIDS survey; Nutrition survey; National health survey; Demographic and health survey.

The usual mode of health information dissemination is publication of the health statistical yearbook. Information on public services and health is widely disseminated. The Joint Annual Health Review is also a comprehensive health information product.

Difficulties, limitations: There is no comprehensive master plan for health information system development. The development of health information databases at various levels remains limited. The basic dataset using the international classification of diseases ICD10 and procedures code ICD9-CM has not been implemented consistently at all health facilities. Data from the national target programs and preventive medicine are not regularly disseminated and are difficult to access. Data from private facilities is not yet available, and there is no feedback system for health information quality improvement.

Governance

Attention has been paid to improve capacity in strategy, policy-making, planning and master planning. Some orientation policies for sector development and governance (master plans, strategies, etc...) have been issued. The national strategy for the protection, care and improvement of people's health has been submitted to the Prime Minister. The Prime Minister has issued Government Decree No.63/ND-CP on the functions, tasks and authority and organizational structure of the Ministry of Health.

- The current financing mechanism has not yet generated motivation for effective performance among health workers.
- Lack of consistent and effective payment methods to promote service quality while study on application of appropriate payment method is facing huge impediments.
- Management and monitoring of service costs and quality remain limited, yet they are an important requirement for operational and financing reform to improve performance and quality of the entire health system.

RECOMMENDATIONS

1. General policy orientations related to health status and health determinants

1.1. Prevention and control of non-communicable diseases

- Develop and enforce national policies and plans for the prevention and control of non-communicable diseases.
- Strengthen interventions to reduce preventable risk factors of non-communicable diseases.

1.2. Improve health status for the people in disadvantaged areas

- Address health problems for the poor and ethnic minorities.
- Strengthen ability to provide basic health care services to the poor and ethnic minorities.
- Reduce burden of health care costs for the poor and ethnic minorities.

1.3. Improve health and respond to changing disease patterns and emerging diseases

- Give priority to preventive medicine and health promotion.
- Strengthen intersectoral and transnational collaboration to develop and implement long-term comprehensive, multisectoral public health strategies.
- Continue to strengthen investment and implement national target programs for 2011–2015, especially programs and interventions on reproductive health to reduce maternal mortality, neonatal mortality, child malnutrition (especially stunting rate) and safe water, environmental sanitation in rural areas.

There is an absence of specific regulations on measurement, management, monitoring, evaluation and payment for service quality. In public health facilities, input-based and budget-line budgeting still predominate.

Third party payer management and supervision of expenditure and quality of hospital services remains very limited, due to shortcomings in personnel, techniques and supporting information systems.

Compensation for health workers

Policies for salary supplements for state health workers and officials working in disadvantaged areas and the policy of financial autonomy have gradually helped overcome the low incentives of egalitarianism in the remuneration regime, contributing to encouraging better performance from health workers

The current mechanism to create "additional incomes" does not yet encourage health workers to work effectively towards better quality. Various forms of income generation through staff capital contributions and profit sharing or directly charging for services provided on a private basis in public facilities are contributing to overprovision of health services, and are contrary to criteria of ensuring efficiency in use of resources and cost effectiveness that are important criteria for quality services

The current health financing mechanisms have not yet created effective motivation for health staff in some aspects. Compensation for health workers is considered low for the professional skill requirements and occupational accident risks. The salary supplements and other incentives stipulated in legal documents, despite recent improvements, are still less than additional income obtained from activities implemented as part of social mobilization policy, thus reducing their incentive effects.

Reform of service prices and payment methods

Efforts to adjust hospital service prices to encourage the seeking of medical examination and treatment services at the appropriate technical level of clinical care are expected to help health facilities have better conditions to improve quality of care. Initial results from application of capitation and case mix payments are considered as prerequisites for implementing performance and quality based payments.

Relationship between costs and service prices are still inappropriate. When the prices are not based on a careful cost estimation at hospitals, then the problem of paying for service quality performance cannot be resolved effectively.

Payment with current capitation payment rate does not provide appropriate incentives for quality improvement since fund deficit is common in many service facilities, and hospitals.

Priority issues related to quality and payment method to be addressed include:

- Incentive payment policies to improve service quality remain very limited.

The Ministry of Health has organized some training courses to improve management and planning capacity (Flagship course) funded by the World Bank, Atlantic Philanthropies and Rockefeller Foundation for managers and leaders of the Ministry of Health and some provinces. Attention has been paid to strengthen participation of stakeholders in policy-making, development and implementation of health plans through holding workshops, consultative meetings, posting the draft documents on the web page of the Ministry of Health...

The Ministry of Health has issued national guidelines for diagnosis and treatment of some diseases; 44 sets of national technical standards for food products. Health inspection, checking and surveillance has been strengthened. The Ministry of Health has health inspectors specialized in the areas of population, pharmaceuticals, food safety and hygiene, preventive medicine, medical examination and treatment, and environmental sanitation.

Difficulties, limitations: The quality of some strategic documents and policies remains poor, or including inconsistencies, and some stipulations that don't fit with reality. Some reasons for this include: weak health information systems; limited management and planning capacity, especially in performance monitoring and assessment; ineffective intersectoral collaboration in policy-making. There remain shortcomings in service quality management. Participation of professional associations in standardization of quality of medical care has not yet occurred. Continuity of care across levels of the system remains inadequate. There is still no incentive for integration and linking between preventive medicine, treatment and rehabilitation. Social mobilization of resources is related to many problems including overprescription of unnecessary tests to maximize revenue when private capital is invested in medical equipment at state facilities. Growth of the private sector involves a number of negative effects. The organizational apparatus and personnel for specialist health inspectorate have not yet met the need. Lack of an inspection system with preventive approach, so inspection usually occurs after adverse events have already occurred.

2.2 Key tasks of the health sector for 2012

To effectively implement Government Resolution No.01/NQ-CP dated 3 January 2012, the health sector needs to accomplish the following key tasks in 2012.

- Strengthen and consolidate the grassroots healthcare and preventive medicine networks and effectively implement the national target programs related to health. Implement the project on rural health development and apply the 2011–2020 national benchmark standards for commune health..
- Implement strong measures to gradually ease hospital overcrowding**.** Improve quality of care, rational use of drugs and high-tech equipment, integrating traditional medicine into treatment. Study, update and organize implementation of master planning for the hospital and health facility network.

- Implement the Decree on reforming the operational and financial mechanism and medical service prices for state health care providers linked to the roadmap toward universal health insurance. Adjust the hospital price schedule in line with improving quality of care, and raising subsidies for health insurance enrollees. Mobilize social resources to participate in the people's healthcare.
- Strengthen investment in upgrading public health workforce training institutions and expanding training modalities, continue expansion of secondment of professional staff from higher levels to mentor clinical staff at lower levels.
- Ensure adequate supply of essential drugs for treatment. Ensure transparent and effective management of drug prices.
- Embark on consistent measures to manage the population growth rate, reduce imbalance in the sex ratio at birth and improve quality of the population
- Strengthen medical ethics education, promoting the movement of learning and following the moral example of Ho Chi Minh alongside refinement of remuneration and conditions of employment for public and civil servants in the health sector.

PART II: IMPROVEMENT OF HEALTH SERVICE QUALITY

3. Overview assessment of health care quality

Based on quality assurance measures recommended for developing countries, the JAHR 2012 has made a general assessment of health service quality in Vietnam with the following observations.

Technical competence has seen much progress, but remains limited at lower level health facilities. This is one of the causes of hospital overcrowding at higher levels in some specialties.

Access to services: People's access to services has been remarkably improved through such policies as health insurance, health care support for the poor and development of the grassroots health care network.

Effectiveness in health service provision: Thousands of technical standards and hundreds of treatment protocols have been developed. However, few of these guidelines have been kept up-to-date. There is no mechanism in place to inspect and assess compliance to guidelines by external audit agencies. Over servicing of drugs, laboratory tests, and medical technology remains an issue of concern.

Professional ethics: The Ministry of Health has issued 12 principles of medical ethics and a code of conduct. The mass media and social commentary often criticize and report incidents, images and violations of medical ethics and misconduct of health workers. No assessment of observation of rights and obligations of the patients has been undertaken.

regulation, hospitals are to carry out assessment of patient satisfaction of service attitude, waiting time, administrative procedures and instructions for drug use.

Although there are specific regulations, there is no legislation and effective mechanism to monitor enforcement and compliance with these regulations. Monitoring, synthesis of feedback and use for service quality improvement has not been assessed.

Supervision, collection and measurement of information, experience of services from patient perspective

The health information management system in hospitals mainly focuses on financial and human resource management. There is a lack of patient level information. There is no study on procedures for collecting and processing reports on adverse drug reactions (ADR). Besides mandatory statistical reporting on ADR, there are also regulations requiring reporting of deaths, complications in blood transfusion, surgery, procedures undertaken in hospitals. However, information is not yet sufficient and rarely used by the health sector to draw lessons and improve patient safety.

Information on service quality to facilitate patient choice of providers

In Vietnam, there is no specific regulation on assessment and dissemination of quality information about health facilities. Meanwhile the press (including also radio and television) can advertise for health facilities, even those that have not met any quality accreditation, causing confusion to the public.

Priority issues in promoting the role of community and patient in improving health service quality include:

- Unable to ensure patient rights to full information about their disease, about safety and treatment method.
- The mechanism for collecting patient feedback is ineffective.
- Patient feedback has not yet been fully analyzed and used for service quality improvement.
- Information on quality of health facilities has not yet been widely disseminated as a basis for patients to choose service providers.

7. Provider payment methods and quality of health services

Health financing reform

An important result of the health financing reform process in Vietnam is the separation of health care providers from payers. This is an important pre-requisite for the payer to apply incentive mechanisms when contracting with the service providers.

integrated design of information technology in health facilities is inadequate or of low quality.

Administrative reform in hospitals has been implemented, contributing to revised procedures, reducing hassles and inconvenience at admission and care for patients. However, the reform is still inadequate as some administrative procedures are still troublesome to patients.

Establish local project team in quality problems

In hospitals, there are drug and therapy committees, infection control committees, and nursing committees. However, no unit is officially responsibility for patient safety issues and implementation of hospital quality improvement. Few hospitals have established hospital quality management committees, hospital quality management divisions, and risk management units but there is no legal basis for these units.

Priority issues in management of service quality in health facilities include:

- The mechanism, organization and resources for implementation of hospital quality management remain incomplete.
- Application of information technology is slow and inadequate.
- The current hospital information system fails to support effective quality management. There is no reporting system for errors or adverse incidents. There is no hospital infection supervision system and no supervision mechanism for prescription. There is no quality standard to measure quality improvement.
- Regulations, methods for quality management are not fully implemented.

6. Promote the role of community and patients in improving health care services

Regulations on the rights and obligations of patients

There exist some documents stipulating roles and types of patient and community participation for service quality improvement such as the Hospital Regulation (1997); Official Letter No. 4969/YT-DTr (2004) guiding the setting up of hotlines in hospital; Regulations on complaint handling in health care facilities that requires patient satisfaction surveys in the annual hospital inventory; Code of conduct for health workers and officials in state health service provision facilities; Rights and obligations of patients stipulated in the Law on Health Examination and Treatment (2009).

Mechanisms to help patients to participate in assessing health services

Patient feedback in hospitals can be collected through either the patient committee, hotlines established by some hospitals, or suggestion boxes. In the

Efficiency: Overcrowding at high level facilities, including mild cases that can be treated at lower facilities, resulting from overprovision of technical services and lack of mutual recognition of lab tests across hospitals result in high medical costs and waste for both patients and society, and thus affects quality of care.

Continuity of care: Some projects under the national target programs for health such as the target project for diabetes prevention and the project on chronic obstructive pulmonary disease and bronchial asthma prevention has created linkages between levels of care in diagnosis, treatment, counseling and follow-up of patients, thus strengthening continuity of care, reducing associated costs for patients and strengthening clinical capacity for lower level facilities.

However, continuity of care across levels and coordination between curative and preventive care has been strongly affected by autonomy under Decree 43 and recent changes in organizational structure at the district level. Some vertical programs on prevention of non-communicable diseases have been implemented since 2002, and adopted as national target programs since 2007 and 2008, but remain restricted to a small-scale due to limited resources.

Safety in health care has been covered in many legal documents but there is no comprehensive and overall guidance. Application of WHO's surgical safety checklist is only in a pilot stage. Apart from the current reporting and monitoring system for adverse drug reaction (ADR), there is no voluntary medical error, incident reporting system in place. There is no continuing medical education program on patient safety.

Amenities for patients: Little attention has been paid to ensuring basic amenities for patients, especially at state medical facilities. Amenities at patient bedside and sanitary conditions in many hospitals are inadequate, negatively affecting patient service quality.

4. Macro management of health care service quality

External regulation and assessment, or *macro management of service quality,* is one of four groups of measures to ensure service quality. It includes legislation on and regulation of professional norms and standards, and monitoring and evaluation by state management agencies and relevant non-governmental organizations covering three inputs to health service quality, namely: i) Organizations/service providers; ii) Professionals/practitioners and medical education; iii) Pharmaceuticals, medical equipment, technology and infrastructure.

Legislation on administration and management of service quality is under development. The Law on Examination and Treatment (2009), provided the first set of regulations on quality assurance in Vietnam including regulations on conditions for licensing practitioners and health facilities; technical requirements in health examination and treatment; application of new technologies and methods in examination and treatment; regulations about medical errors and handling complaints, denouncement and disputes in medical care; conditions for ensuring medical

examination and treatment. The Government has issued Decree No.87/2011/ND-CP stipulating details and guidance for implementation of the Law on Examination and Treatment.

4.1. Macro level management of organizations/service providers

Licensing

The system of legal documents for granting licenses to operate health care facilities has been enacted. However, the Law on Examination and Treatment and guidance for implementation of the law do not include a time limit for the licenses. Another shortcoming is that the national technical regulation framework (NTRF) has not yet been issued. It is necessary to have strict and transparent implementation to avoid the risk of superficial licensing that leads to waste of effort and time.

Technical regulations for services with high risk to health

Radiation safety in health: Legislation on radiation safety in health care is fairly adequately. However, oversight and enforcement of legislation on radiation safety in health care remains limited.

Hospital waste management and environmental safety in health facilities: Legislation on hospital waste management and environmental safety in health facilities is fairly adequate and for implementation the Ministry of Health has established the Vietnam Health Environment Management Agency. Hospital waste management is overseen by the Ministry of Health, Provincial health bureaus and involves annual intersectoral (health, environment, public security) verification.

The current practice of waste management and health environmental safety is inadequate. Only 50% of hospitals ensure compliance with regulations on separation, collection and transport of medical solid waste. Some 35% of hospitals have incinerators for medical waste, but with low capacity and inappropriate technology.

Accreditation

Accreditation is a measure to encourage health facilities to maintain and improve health care services. The Law on Examination and Treatment has stipulated contents related to accreditation for health care facilities and accreditation agencies for health care facilities.

However, accreditation for health facilities has not yet been implemented, mainly due to lack of quality management standards; lack of independent accreditation agencies; lack of incentives to encourage health facilities to voluntarily accept the onerous procedures to meet and verify accreditation standards.

Measuring quality and assessment of health facility quality indicators

Annually, assessment of hospital quality is conducted throughout the country through the *Hospital inventory checklist.* The Ministry of Health has regulations on use of international disease classification and some hospitals have used the ICD

- Oversight and monitoring of rational use of drug has not been effective.
- The management system for medical equipment and infrastructure in the market and at health facilities is incomplete in terms of legal documents such as Law and strategy for medical equipment.
- No comprehensive health technology assessment has been conducted and there is no database for medical equipment and infrastructure.

5. Management of service quality at health facilities

Management of service quality at health facilities, or local quality management is assessed below.

Compliance with regulations and guidance for patient safety and care

The report has assessed compliance with regulations and guidance for *surgical safety*; *safe blood transfusion, safe injection; safe drug use*; *infection control* in hospital and health facilities; *quality of laboratories and testing;* implementation of *code of conduct and medical ethics of health professionals;* nursing care*; nutritional care in* hospital.

Application of methods and tools for service quality management and improvement

Some hospitals have applied quality methods in service quality improvement such as Total Quality Management - TQM, the PDCA (Plan-Do-Check-Act), and development of a quality system under ISO 9001. According to 2012 survey, 37.7% of hospitals have staff in charge of quality management; some hospitals have quality management units in place; but very few hospitals have full-time staff for hospital management. Over many years, the health sector has launched campaigns and activities to raise the spirit of responsibility of physicians and health care facilities, based on valuing culture and ethics such as the propaganda for compliance with 12 medical ethic codes; implementation of the "Code of conduct of health workers and officials state medical service facilities", reducing some negative behavior contributing to improving quality of care. The lack of consistency or misconceptions of quality values creates a barrier for developing a true quality culture in hospitals. For the sake of immediate financial benefits, many hospitals have not prioritized service quality. The culture of "learning from errors" is one of the ways to ensure safety for patients but health facilities often focus more on blame throwing than problem solving.

Most health care facilities have introduced and put in use management software for human resources, supplies, financial and administrative record keeping. However, very few facilities have applied information technology in clinical management. Investment in health information technology remains fragmented; comprehensive and

meet the needs of the drug distribution network. Safe blood transfusion activities are under-resourced.

Medical equipment and infrastructure

The list of sectoral and national standards for medical equipment has been issued, meeting requirements for manufacture, trade and investment for use and management. A list of essential medical equipment to serve the project on renovation, upgrading district general hospitals and regional hospitals, inter-district hospitals has been issued.

Three centers for standardization and quality control of laboratory testing located in Hanoi Medical University, HCMC Medical and Pharmaceutical University and HCMC Health bureau have been established.

Sectoral and national standards for infrastructure in health care, and procedures for management of medical facility construction projects using the state budget have been issued.

Difficulties, limitations. The system of legal documents for medical equipment and infrastructure is incomplete. There is no unit responsible for regulating/managing medical equipment and infrastructure within health facilities. Many hospitals don't have a dedicated medical supplies and equipment management unit. The collaboration of technical administrators such as Vietnam Administration of Medical Services, Preventive Medicine Department in medical equipment management at the macro level is weak. Efficiency in investment and use of medical equipment and infrastructure is low, and lacks regular monitoring and systematic evaluation. Joint-ventures, business partnership investing in medical equipment in hospitals may induce overprovision of services unless an effective control mechanism is in place. Some facilities have invested in modern equipment but lack staff to operate and maintain it, or don't use the full capacity of the equipment. There is no monitoring and evaluation statistics on sectoral and Vietnam standards for medical equipment and infrastructure.

Medical equipment of new district hospitals has reached only 30–50%, even as low as 20% of the amount on the Ministry of Health's standard list. Most medical equipment in use at health facilities has not been regularly calibrated, maintained or repaired. Effective application of medical technology has not been scientifically assessed. Infrastructure in many places is of poor quality, run down and unable to meet technical requirements. There is no strategy for evidence-based medical equipment and infrastructure development.

Priority problems in macro management and regulations for medical equipment and infrastructure include:

- Inability to implement and supervise enforcement of the legal regulations on management of drug quality, pharmaceutical production and distribution.
- Counterfeit and sub-standard drugs are circulated and used by consumers.

coding for inpatients. Electronic medical records and computerized drug prescription has also been implemented in some hospitals.

The annual assessment of hospitals using the *inventory checklist* has shown some positive effects but it is not an evidence-based specialized method for quality assessment. Basic properties of service quality such as efficiency, effectiveness, safety, equity, access, patient-centeredness, continuity of care … have not been taken into account when designing these checklist tools for health facility quality assessment. The international classification of disease codes have only been used at a small-scale and received inadequate attention for proper use, lack internal inspection and oversight as well as external oversight from administrative agencies.

Arrangement of health service provision network

Legal and sub-legal documents do not stipulate the design of the health service provision network. The Law on Examination and Treatment lists organizational forms of health care facilities, but does not regulate relations between these organizations in the network of health service provision while sub-legal documents do not clarify these linkages. At present, there is an absence of regulation to ensure continuity of care including management and information sharing on care and treatment for patients across levels. Regulations on organizational structure at the grassroots level have split the district health care system into a general hospital and a district health center, where the commune health station is under the administration of the health center, resulting in a breakdown in integration of curative and preventive care within a single district health center as in the previous organizational structure.

Systems characteristics of the health service provision network have badly deteriorated: patients bypass health facilities at the lower level to seek care at higher level facilities. Some health facilities at the lower levels have invested in providing medical services that are intended only for provision at higher level facilities with proper conditions. Conversely, many hospitals at higher level facilities use their specialized workforce and high tech equipment to examine and treat common diseases. Both trends result in resource waste, reduced quality of care and contribute to overcrowding at higher levels.

Priority issues in macro management and regulation for health service providers/organizations include:

- Licensing of health facility operations has no time limit for when conditions of licensing need to be rechecked such as a license expiration date.
- Lack of specific tools/indicators to measure quality of the health facility.
- Lack of incentives to encourage health facilities to voluntarily undertake an accreditation process.
- Quality of care is negatively affected due to overcrowding at higher levels and lack of continuity of care.

- Limited capacity in monitoring, supervision to ensure service quality.

4.2. Macro level management for health care practitioners

Issues of macro level management and regulation to assure that health professionals have adequate technical competence, professional ethics and social norms to assure service quality are summarized below.

Issuance of technical competence regulations and standards for health workers

Professional standards for state health officials, including doctors, assistant doctors, nurses, midwives, medical technicians, pharmacists, pharmaceutical technicians, pharmacist assistants, health workers, orderlies and traditional medicine practitioners have been issued. In recent years, professional standards for some specialties have been revised, or new ones developed (nursing, midwifery, medical technology and public health). The hospital regulations do not cover professional standards but refers to tasks of the staff of each department of the hospital.

The professional standards for some human resource categories working in state service provision facilities such as medical doctor, pharmacist, and assistant doctor were formulated in 1993 and are no longer appropriate. Health facilities have not yet developed specific job descriptions for each working position. Recruitment and promotions to higher grades and steps in the pay scale are notional, but lack a grounding in practice. There is no routine assessment of technical and professional skills of health workers in hospitals. In the hospital inspections regulated by the Ministry of Health, there are no items for assessment of professional skills of health workers.

Continuous medical education and evaluation of competencies: Ministry of Health Circular No. 07/2008/TT-BYT stipulates regulations on continuous medical education for health workers. The Law on Examination and Treatment includes some articles regulating continuous medical education, retraining and updating medical knowledge.

However, regulations for post-graduate training and continuous medical education for health workers remain inadequate. Many provincial and district health facilities are under-equipped to become an enabling environment for learning, and career development for health workers.

Management of health human resources development: The Minister of Health has approved the master plan for human resource development, including measures for state management, improvement of remuneration for attraction and retention of staff, improving capacity of training institutions; regulations for recruitment, deployment of health workforce, professional salary supplements, and hardship pay for disadvantaged regions and difficult specialties.

Although regulations on medical ethics have been issued, the gap between principles and practice remains wide. There is no active support mechanism for health workers to learn and draw lessons from medical errors.

Regulations for accreditation are common to all universities, colleges and secondary schools in the education system. However, specific accreditation of the quality of health workforce training programs has not been undertaken. Training quality is unlikely to be maintained with the rising number of students while the number of teaching hospitals and teachers remains unchanged, and the training program has not been reformed.

Priority issues in macro level management and regulation for health practitioners include:

- Lack of professional competency standards for almost all types of health workers.
- Lack of quality accreditation system for health sciences training programs.
- Continuous medical education remains limited.
- Health workforce quality (especially doctors) at lower levels is very poor.

- Low participation of professional associations in health workforce quality assurance in both professional and ethical aspects.

4.3. Macro level management of pharmaceuticals, medical equipment and infrastructure

Pharmaceuticals and biologicals

The health sector has a system of legal documents covering almost all areas of pharmaceuticals, and medical biologicals management. The Law on Pharmacy was issued in 2005, and the National Assembly is currently considering revisions. Regulations on good practice of drug distribution, storage, guidance for pharmaceutical processing, import-export of drugs and packaging have been enacted. There are many regulations on management of drug prices, drug quality and use.

Difficulties, limitations: Implementation and oversight of legal documents, enforcement of drug quality management, pharmaceuticals production and business management… remain limited.

Inspection and oversight agencies for drug quality are understaffed. Counterfeit and sub-standard drugs can still be found in circulation and use by consumers. There is no inter-ministerial agency responsible for controlling counterfeit and sub-standard drugs. Inspection of traditional and herbal medicine quality has not been adequately strict. Performance of the drug and therapy committee in drug use oversight in hospital remains limited. Antibiotic use and antibiotic resistance surveillance program is unfunded and on standby mode. The pharmaceutical workforce is inadequate to