JOINT ANNUAL HEALTH REVIEW 2013

Towards Universal Health Care

Summary Report

The Joint Annual Health Review 2013 (JAHR 2013) is the seventh annual review developed by the Ministry of Health (MOH) in collaboration with the Health Partnership Group with a view to supporting annual planning of the MOH, and laying a foundation to select key issues for cooperation and dialogue between the Vietnamese health sector and international partners. The main contents of JAHR 2013 include: (i) update the current situation of the health system, including information about new health policies, implementation of tasks and goals set out in the Five-year health sector plan 2011-2015, and progress towards achieving the UN MDGs and Vietnam's health goals; (ii) provide in-depth analysis on *universal health coverage (UHC).* Major contents of the JAHR 2013 are summarized below.

PART ONE: UPDATE ON THE SITUATION OF THE HEALTH SYSTEM

Chapter I. Health system situation

1. Major tasks of the health sector in 2013

Major tasks of the health sector in 2013, presented by the Health Minister in the conference on health sector performance in 2012 and initiation of tasks for 2013, include: Strengthen health sector governance capacity; Focus on measures to reduce hospital overcrowding. Continue to implement Project 1816, and projects on satellite hospitals and family doctors; Improve the quality of medical services and increase patient satisfaction; Urgently implement the roadmap towards universal insurance coverage; Implement remuneration policies for state health workers; Actively implement surveillance for early detection and prevention of disease outbreaks, particularly of emerging diseases; Effectively implement the NTPs on health, population-family planning, HIV/AIDS and food safety; Promote health environmental management; Coordinate with other agencies to strictly implement policies on food safety; Reduce fertility in areas with high fertility and maintain reasonably low birth rates; Reduce the rate of increase in the sex ratio at birth; Expand antenatal and neonatal screening, premarital counseling and health care; Reform operational and financial mechanisms in state hospitals linked with service quality improvements; Ensure adequate essential drugs for medical care; Regulate and monitor drug procurement, prescription, prices and quality; Strengthen effectiveness of health information, education and communication for health-related behavior changes; Reform administrative procedures in licensing medical and pharmaceutical practice and drugs for domestic distribution; Promote the application of information technology in health sector management.

2. Implementation of the Five-year plan for the period 2011–2015

2.1. Health sector governance

Achievements and progress: The MOH has developed and submitted new legal documents to the relevant authorities for issuance, particularly the Strategy for protection, care and promotion of the people's health to 2020, and is currently revising the Laws on Health Insurance and on Pharmaceuticals and is also developing 24 projects to submit to the Government. The MOH has been restructured according to Decree No. 63/2012/ND-CP. Some departments and administrations have been set up, split or reorganized and 2 new deputy ministers have been appointed. The MOH is developing a new Decree on the organization of the grassroots healthcare network in order to replace Decision No. 58/1994/TTg and a circular on the functions and obligations of district health centers. It has developed a master plan for a comprehensive reform of health planning, including assessing health plans and reforming health statistics with financial and technical assistance from the EC and WHO, developing the annual provincial health planning framework and assessment instruments for health plans according to JANS evaluation criteria (funded by the EC and Rockefeller Foundation). The MOH has issued guidelines on sanctions for administrative violations, trained health inspectors, published draft health regulations on the website and organized conferences and workshops to collect comments and feedback from stakeholders. The MOH has also developed guidelines on social mobilization for health, encouraging private health care activities and promoting the roles of professional associations in health management.

Difficulties and shortcomings: There is not yet a consistent set of legal documents on health; *capacity to develop health policies* is inadequate. The *organizational structure* and functions and obligations of the grassroots health network have limitations. *Effectiveness of evidence-based planning* remains limited due to the lack of reliable information. Localities are not yet proactive in developing health plans and budgets. The health inspectorate is understaffed. There is not yet an effective *operational mechanism and inspection* remains largely an ex-post activity once errors have already been made. Inspection and supervision lack a supporting character. Involvement of the community in policy formulation and health management is limited and ineffective. There are *many barriers to encouraging investment* in the private health sector and public and private partnership. Implementation of *policies on financial autonomy* and social mobilization for health under conditions of inadequate regulation have led to some undesirable effects.

2.2. Human resources for health

Achievements and progress: *Training curricula have been developed* on the basis of a framework of the Ministry of Education and Training and are annually updated and revised, a 4-year university program on midwifery is being developed. *The health workforce continues to increase* in terms of the number, quality and organizational structure. *The number of doctors reached 7.46 per 10 000 population in 2012*, while the number of university-trained pharmacists reached 1.92 per 10 000 population in 2011. Over 96% of rural villages are served by VHWs; 76% of CHSs have doctors; 93.4% of CHSs have obstetrics/pediatrics assistant doctors. *Training projects are being implemented* to provide in service training to upgrade skills and qualifications and to train local people committed to return to serve their communities. *A policy has been issued* to develop health human resources for TB, leprosy, mental illness, forensics and pathology specialties. *Various projects are being implemented* including projects on: support for the development of health manpower for the grassroots level in disadvantaged areas, temporary secondment of practitioners to serve lower level medical

care facilities, sending young volunteer doctors to the 62 poorest districts, development of family doctor clinics and Health development for islands and coastal areas.

Difficulties and shortcomings: *Improvement in training quality is incommensurate* with people's demand for health care. *Updating of training curricula is slow*, and inadequate time is allocated for practical skill training. Systems for accreditation of training quality and quality control of medical school graduates are lacking. *Physical facilities of training establishments* remain inadequate. *Shortage of health workers and qualified doctors at the grassroots level* is still prevalent. It is *difficult to recruit doctors for the grassroots level* due to low income, inadequate salary supplements, and unfavorable living and working conditions. *Health workforce quality at the grassroots level remains low*. The *proportion of health workers with adequate knowledge and skills* in first aid, diagnosis, treatment, and response to outbreaks is low. *Practical skills of new doctors remain weak* while continuing medical education receives inadequate attention. Planning for HRH management remains limited. Training is not yet linked to health worker deployment.

2.3. Health financing

Achievements and progress: *State budget spending on health has increased* by 34.2% per year on average in the period 2008–2013, higher than the pace of increase in overall state budget recurrent spending. In 2012, health spending accounted for 8.28% of total state budget recurrent expenditures. Some 1.7 billion VND from the state budget was allocated to the national health target programs in 2012. Government bond revenues amounting to 21 454 billion VND were disbursed for medical facility upgrade projects. The MOH managed 52 ODA projects, with a total value of approximately 1.5 billion USD. *Conditions to expand health insurance have improved* since Politburo Resolution No. 21 and the project on the implementation of the roadmap towards universal health insurance were issued and implemented. The Law on Health Insurance is being revised. In 2012, 66.8% of the population was covered by health insurance; 60% of the insured were totally or partially funded by the state budget. *Preventive medicine accounted for 31.3% of state budget spending on health* in 2009. *State budget allocation coefficients for remote and mountainous areas* were from 1.7 to 2.4 times higher than for urban areas. Per capita state budget expenditures on health were highest in the regions of the Northern midlands and mountain and Central Highlands. *Decree No. 85/2012 on reforming the operational and financial mechanisms* of state health facilities is being implemented. Adjusted medical service prices according to Circular No. 04/2012 are being applied in 62 out of 63 provinces and all central hospitals. Some 42% of medical facilities in 58 out of 63 provinces are applying the capitation payment mechanism. *Case mix payments are being piloted* for 26 common diseases at the provincial and district level. Result-based funding is being piloted in 24 communes in 2 districts of Nghe An province.

Difficulties and shortcomings: The *growth in state budget spending on health has slowed down* remarkably over the last 3 years due to macroeconomic difficulties and tight fiscal policies following Government Resolution No. 11/2011. *Legislation to ensure compliance* with regulations on compulsory health insurance remains inadequate. *Health insurance coverage for some groups*, including the near poor, the voluntarily insured and workers in enterprises, is relatively low. *VSS management capacity* does not meet requirements. *Sustainability and efficiency* in management and use of health insurance funds are limited. Provider payment methods are still ineffective. There are not yet *specific and consistent strategies and roadmaps to reform providers payment methods* in the context of health system reform. *Efficiency in using available resources* remains limited. *Efficiency of*

investment projects funded by the state budget have not yet been assessed. *Technical capacity and responsiveness* of the health information and data system remain limited.

2.4. Pharmaceuticals and medical equipment

Achievements and progress: The healthcare system *ensures adequate essential drugs* to serve people's demand for medical care. In 2012, domestically produced drugs were available for 234 out of 314 active ingredients in the Essential medicines list, with 29 pharmacological effects as recommended by WHO; all types of vaccines for EPI are produced domestically, satisfying 80% of demand. New regulations on competitive tendering for procurement of drugs, especially generic drugs are being applied. New drug price controls involving a ceiling on the margin allowed between import and wholesale prices, have been piloted in 9 health facilities for drug procurement of 12 active ingredients using state budget or health insurance funds since 1 April 2013. The increase in the drug price index in 2012 was 5.72%, much lower than the increase in the overall consumer price index of 6.8%. Prices of 10 types of winning bid drugs in 2013 have decreased from 56% to 34.6% compared to 2012. Good practice standards are being implemented widely. All modern pharmaceutical manufacturers achieve GMP, 100% of drug quality testing laboratories achieve GLP, and 39% of pharmacies achieve GPP standards. A national action plan for combatting drug resistance for the period 2012–2020 has been issued. Production and management of phytopharmaceuticals and herbal medicine preparations is being strengthened. Some 872 wholesalers and retailers have been certified to meet conditions for traditional medicine business. The MOH has collaborated with the Ministry of Finance to *propose measures to implement tax incentive policies* for domestic medical equipment manufacturers. The Circular on issuing licenses for sale and certificates of free sale for domestically manufactured medical equipment has been refined. Health facilities at all levels are receiving investments for construction, renovation and upgrading. Hazardous medical waste treatment has improved.

Difficulties and shortcomings: The *share of domestically produced drugs* (47%) remains low compared to the target (60%). There is still a heavy dependence on imports for ARV. *Access to drugs* in remote, mountainous, island and coastal areas remains limited. *Drug price levels* have not yet been controlled. Competitive tendering regulations for drug procurement have some limitations due to discrepancy between drug prices and drug quality. There is a wide difference between generic drug prices and international reference prices. The winning bid prices for the same drugs vary substantially across hospitals. A national competitive tendering model for drug procurement has not yet been developed. The drug quality monitoring system remains weak. Compliance with regulations on drug prescription among doctors is weak. *Measures for strengthening rational use of drugs* have not been uniformly implemented nor regularly assessed, indicating slow progress. Sales of drugs without a doctor's prescription and overprescription of antibiotics are still common. *Management of the origin and quality of traditional and herbal medicines* faces some difficulties. Assessment of the current situation and requirements for *medical equipment* and recommended lists of equipment for different types of facilities have been delayed. Measures to prioritize and encourage *domestic manufacturing of medical equipment* remain ineffective. HTA activities are not yet being implemented.

2.5. Health management information system

Achievements and shortcomings: The Health Information Administration, Health Statistics Division under the Department of Planning and Finance, the Data Integration Center, and the Center for Medical Information Technology Application has been set up. Directive

07/CT-BYT on strengthening health statistics information has been issued. The Department of Planning and Finance is assigned to be the only focal point responsible for issuing official statistical data collection forms for each level. The MOH is also developing a *master plan for the health management information system* and is reviewing, updating and completing basic health indicators for each level with the objective of reducing overload of official forms at the grassroots level. The health sector has compiled some important statistical products such as the Health Statistics Yearbook, JAHRs, MDG implementation report, and the NHA. Dissemination of health information through diverse forms continued to be strengthened. Vietnamese health information is published on websites of WHO and some other international organizations. The MOH is developing and standardizing training materials for statistical staff. The websites of the MOH and of other health sector governance agencies are being refined. The MOH is developing and piloting an online system for registering practice certificates.

Difficulties and shortcomings: There are still *no regulations on data dissemination*. The source of health information remains limited and suffers from long delays in dissemination. Insufficient health information is available about private health facilities and health facilities in other sectors. Different sources of data indicate inconsistencies in figures. Limited funds hinders implementation of surveys and in-depth analysis. Most statistical indicators are collected through periodic administrative reporting, leading to inaccuracies and unavailability of data. Human resources in health statistics are insufficient, have weak professional capacities and frequent job turnover at all levels. Health databases remain poor and do not include relevant statistics from different sources. There are still no lists of general health indicators. Interoperability of medical care management software with that of VSS has not been achieved.

2.6. PHC, preventive medicine, national health target programs, reproductive health and population-family planning services

Achievements and progress: *The organizational structure of preventive medicine has been stabilized in most localities*. At the provincial level, there are 63 provincial preventive medicine centers, 63 departments of population and family planning, 62 centers for HIV/AIDS prevention, 20 food safety agencies, and a number of centers for endocrinology, TB and social disease prevention. In district health centers, 15% of health workers have university education or higher and over 80% of health workers are trained on preventive medicine and are assigned to manage CHS activities in 55 out of 63 provinces. 74.1% of communes meet former or new commune health benchmarks. The health network in coastal and island areas is being strengthened. *Epidemic diseases and major epidemic outbreaks are basically kept under control.* The immunization rate remains high and achievements in eradication of polio, neonatal tetanus, and measles have been maintained. TB indicators and almost all HIV/AIDS indicators have been achieved. The program for TB prevention and control covered 100% of the population and reduced the TB prevalence to 225 cases per 100 000 population in 2011. 92% of 100 000 newly detected TB cases have been cured. The number of incidents and deaths from HIV/AIDS has gradually fallen since 2008. *The programs for prevention and control of NCDs are expanding* in terms of coverage, screened subjects and treatment management. Hypertension prevention programs achieved and exceeded the planned targets for hypertension communication and managed 58.3% of hypertension patients (the target set in the plan was 50%). The network of diabetes prevention programs has been set up and implemented screening of 1 443 438 people (accounting for 1.6% of population in 18.5% of communes nationwide). Activities to control preventable blindness in the national plan on blindness control for the period 2009-2013 have been effectively implemented. The project

management units for chronic obstructive pulmonary diseases and asthmas were set up in 10 Northern provinces, screening 48 395 people and detecting 3575 cases. Some *50 national technical standards for food safety*, 35 Vietnamese standards for testing and an official accreditation system for 2 food safety testing agencies have been developed and issued. The number of *food poisoning cases* has fallen compared with previous years. 2012 targets for maternal health and antenatal care indicate that they have been achieved or exceeded including antenatal and neonatal screening, antenatal care and management. The *malnutrition rate of children* under age 5 in 2012 was estimated at 16.2%, down 0.6 percentage points compared to 2011, exceeding the target set by the National Assembly. The MOH is completing and submitting 5 basic intervention packages for maternal and child health for approval.

Difficulties and shortcomings: Investment in facilities and allocation of funds for preventive medicine are limited and do not keep up with demand. The health management information system remains weak and lacks uniformity and effectiveness. Administration of the NTPs is still vertical, with little intersectoral collaboration in the management, mentoring and implementation of the programs. The organizational structure of preventive medicine lacks a linkage and integration between prevention and treatment activities and does not ensure continuity and comprehensiveness of care. Disease prevention only achieved 88% of the set target. Some diseases such as TB, dengue fever, and hand-foot-mouth disease have not been effectively controlled. Most NCD prevention and control programs have not achieved the targets set in the plan, including targets for developing the organization and training network for health human resources, screening, detection, and management of patients at PHC facilities. Achievements in food safety programs lack sustainability, especially in food safety indicators and food poisoning control. The contraceptive prevalence rate fell from 78.2% in 2011 to 76.2% in 2012. The crude birth rate increased from 16.6‰ in 2011 to 16.9‰ in 2012, thus not achieving the target of reducing fertility rate by 0.1‰. Neither the population growth rate nor population size met the targets. The sex ratio at birth continues to increase. Some indicators for population and family planning and reproductive health care have not been effectively monitored in some areas, including fertility rate control and supply of contraceptive methods in mountainous, border, coastal and island areas.

2.7. Medical service delivery

Achievements and progress: The master plan for the hospital network according to Decision 30/2008/ QĐ-TTg continues to be implemented. The master plan for health sector development is being revised. Projects for upgrading medical equipment and facilities at the grassroots level are being implemented. CHS upgrades to meet commune health benchmarks have been integrated and linked with the NTP on Building a New Countryside. Measures to strengthen capacity of health workers and regulations on the functions and obligations of VHWs have also been implemented. In 2012, 5 new private hospitals were licensed, 45 415 practice certificates and nearly 3000 operating licenses (16% of the planned target for 2015) were issued. The MOH has implemented Directive No. 05/CT-BYT on improving quality of medical services, issued Circulars guiding quality control of medical services and laboratory testing, and implemented training of trainers on laboratory testing quality control. The MOH has issued professional standards for medical services and is developing medical procedures and regulations on referral. More than 1000 technical procedures guidelines have been updated and supplemented and another 2000 technical procedures is reviewing. Hundreds of procedures for medical processes and guidelines at the commune level have been developed and piloted in 2013.

Difficulties and shortcomings: The *increase in the number of hospital beds* has not kept up with growth in outpatient visits and inpatient admissions, thus hospital overcrowding has not been improved to any clear extent. Bed occupancy rates in central hospitals remain high, particularly in specialties such as oncology, pediatrics, cardiology, gynecology, and endocrinology. *Legal documents regulating referrals* and assignment of interventions to different level facilities have not been issued. Clear policy documents are not yet available to guide state facilities providing higher quality medical services for higher fees. *Regulations on the functions and obligations of medical facilities* at the district levels have limitations. Conditions to ensure operation of lower levels (e.g., human resources, medical equipment, and infrastructure) face difficulty, *Health service quality* does not meet demand. Legal documents and policies on health service quality have not yet been refined. *Hospital regulations* issued in 1997 have not been revised. Medical service quality accreditation has not yet been implemented. *Technical services and professional guidelines* remain inadequate and are not regularly updated; no mechanism is in place to involve professional medical associations to participate in their development. *Criteria for assessing quality and efficiency* have not yet been developed. *Monitoring and supervision* remain ineffective, particularly preventative monitoring, while monitoring and evaluation data remain inadequate. The *system of managing and issuing of practice certificates and licenses* remain inadequate: legal documents on partial or overall suspension and revocation of practice certificates and licenses are lacking. Progress in issuing licenses and certificates has been slow.

3. Implementation of goals set forth in the Five-year plan 2011-2015

The Five-year plan of the health sector set out 19 health targets that are disaggregated into 3 main groups. The planned target for 2012 was achieved or exceeded for 4 of 6 targets in the input group. Specifically, the number of doctors per 10 000 population reached 7.46 while the 2012 target was 7.4. The number of pharmacists with university education was 1.92 per 10 000 people in 2011 while the 2012 target was 1.4. Medical doctors were available in 76% of communes while the 2012 target was 74%. The number of hospital beds per 10 000 people (excluding CHSs) was 24.3 while the 2012 target was 21.5. Two targets in this group were not achieved, namely the proportion of communes with obstetrics-pediatrics assistant doctors or midwives (93.4% compared to the target of more than 95%) and the proportion of villages with VHWs (81.2% compared to the target of 90%).

Two of 3 targets represented by process indicators were exceeded including the proportion of infants fully immunized (with 7 types of vaccine in 2010 and 8 types since 2011) and the proportion of the insured population (achieving 66.8 while the target was 66.0%). The proportion of communes meeting commune health benchmarks could not be determined because of insufficient information since the new national benchmarks for a higher standard of commune health services only began to be applied in 2011.

Two out of 10 targets measured by output indicators have been achieved in 2012, including HIV/AIDS prevalence, at 0.24%, (the target was to stay below 0.3%), and under-five malnutrition rate (underweight), at 16.2% (the target was 16.6%). Seven targets were not achieved including: IMR (15.4 per 1000 live births compared to target of 15.3), U5MR (23.2% compared to target of 23.0%), life expectancy (73 years compared to target of 73.4 years), sex ratio at birth (112.3 compared to target of below 112), rate of fertility increase (increased by 0.3‰ compared to target of decline by 0.1‰), population growth rate (1.06% compared to the target of 0.99%), population size (88.77 million compared to target of 88.67 million). There is not yet adequate data to assess progress in reducing the maternal mortality ratio (MMR).

MMR was estimated at 69 deaths per 100 000 live births in 2009 while the planned target for 2012 was 66. (Appendix 1)

4. Implementation of the MDGs in Vietnam

Vietnam has made significant progress in implementing health-related MDGs.

MDG 1: By 2012, the under-5 malnutrition rate (underweight) had fallen from 41% in 1990 to 16.2%, a decrease of more than 60%, thus exceeding the goal of halving the rate by 2015. However, in some regions, such as the Central Highlands, the rates remained high, at 25% in 2012, while the target for this region by 2015 is 23.5%.

MDG 4: The IMR dropped from 44.45 per 1000 live births in 1990 to 15.4 in 2012 and is likely to fall the necessary 0.6‰ to achieve the 2015 goal. The U5MR decreased from 58 per 1000 live births in 1990 to 23.2 in 2012. Reducing this rate by the necessary 3.9‰ to reach the planned goal for 2015 will be difficult if the pace of reduction remains unchanged at 0.4‰ per year. Greater efforts are required, concentrating on regions with high U5MR and specific causes of child deaths, including accidents, and antenatal and neonatal mortality. The proportion of infants vaccinated against measles increased from 55% in 1990 to 95.6% in 2008 and remained at over 95% till 2012, thus achieving the goal. However, according to data in MICS 2011, this proportion was only 84%. This implies that Vietnam did not achieve the planned goal, and further efforts are needed towards better vaccination records and raising maternal awareness of vaccination.

MDG 5: The MMR has decreased markedly, from 233 deaths per 100 000 live births in 1990 to 80 in 2005 and to 69 in 2009. With the pace of decline of recent years, this goal will be hard to achieve without much greater effort. The proportion of women receiving 3 or more antenatal care visits increased to 87.7% in 2009. Starting 2010 the indicator was changed to specify more precisely 3 antenatal care visits, one per trimester of pregnancy, and by 2012 the proportion had reached 89.4%. The proportion of deliveries assisted by trained medical personnel has been maintained at an average of 97% since 2010. However, according to the MICS survey, this proportion reached only 92.9%. The contraceptive prevalence rate among married reproductive aged women reached 76.2% in 2012; thus greater effort is required to achieve the target of 82% planned for 2015. In 2011, 4.3% of women had unmet need for family planning.

MDG 6A: The HIV prevalence rate remained unchanged at less than 0.3% in 2012. HIV prevalence among injecting drug users fell to 13.4% in 2011. The goal of 80% of people using a condom in the last high-risk sexual relation is achievable if the current achievements are maintained.

MDG 6B: The ARV program has been implemented since 2000 and currently meets the needs of 68.3% of adult patients and 81.3% of child patients. Maintaining this achievement is a challenge as external assistance funds decline.

MDG 6C: In 2012, malaria morbidity fell to 49 cases per 100 000 people and deaths from malaria fell to 0.01 per 100 000 people, a decrease of 49% and 68% respectively compared to 2000.

MDG 6D: The MOH reported a reduction of 62% in TB prevalence and mortality compared to 1990 and a reduction of 40% in prevalence and mortality compared to 2000. However, United Nations estimates indicate that from 1990 to 2011 Vietnam has only seen a reduction of 20% in TB prevalence and 28% in mortality, thus there is need for continued strong efforts to achieve 50% reductions in prevalence and mortality by 2015.

MDG 7: According to the Joint Monitoring Program (JMP) report, Vietnam achieved MDG 7 in 2011. However, 19.5 million people still do not use sanitary toilets and 7.1 million do not use a safe drinking water source.

Assessing the implementation of MDGs faces difficulty due to a lack of consistent statistics and data and reliable evidence. In general, alongside the achievements, there are still challenges to ensuring equity in health care. There are 5 objectives that need to be prioritized at the national level including: (i) access to HIV treatment services, (ii) maternal mortality and under-5 mortality, especially in mountainous and ethnic minority areas, (iii) demand for contraception of migrant women, single women, adolescents in mountainous and disadvantaged areas, (iv) TB detection and treatment, and (v) access to better sanitation conditions in mountainous and rural areas.

PART TWO: UNIVERSAL HEALTH COVERAGE

Chapter II. Theoretical framework and concepts related to UHC

1. Concepts of UHC

The review analyzes recent conceptualizations of UHC, paying special attention to those of the United Nations, WHO and World Bank: "UHC implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population". UHC is a process that requires progress in multiple dimensions including: availability of health care services, conditions for providing quality and effective services, the proportion of the population covered, and the level of financial protection when using health services. The objective of UHC is not just to achieve a fixed minimum package. UHC is a continuous process without a 'completion' point.

2. Key requirements for UHC

In order to implement UHC, there should be a "resilient and responsive health system that provides comprehensive PHC services, with extensive geographical coverage, including in remote and rural areas, and with a special emphasis on access to populations most in need, and has an adequate skilled, well-trained and motivated workforce, as well as capacities for broad public health measures, health protection and addressing determinants of health through policies across sectors, including promoting the health literacy of the population".

There is a need to improve the quality of PHC services and achieve extensive geographic coverage, with a special emphasis on vulnerable groups. Investing in the PHC to facilitate access to inexpensive medical services for the people is the key to UHC.

Drugs, medical services and supplies need to be selected in order to meet demand for treatment and to ensure cost-effectiveness and affordability to the state budget, health insurance fund and users. The health sector needs to *control medical cost increases* through effective preventive programs, early detection and management of conditions in the community or in homes to implement UHC. There should be policies on to fix prices and fees, adjust provider incentives, promote use of generic drugs, rationalize use of expensive medical technologies, and reduce overprovision of medical services.

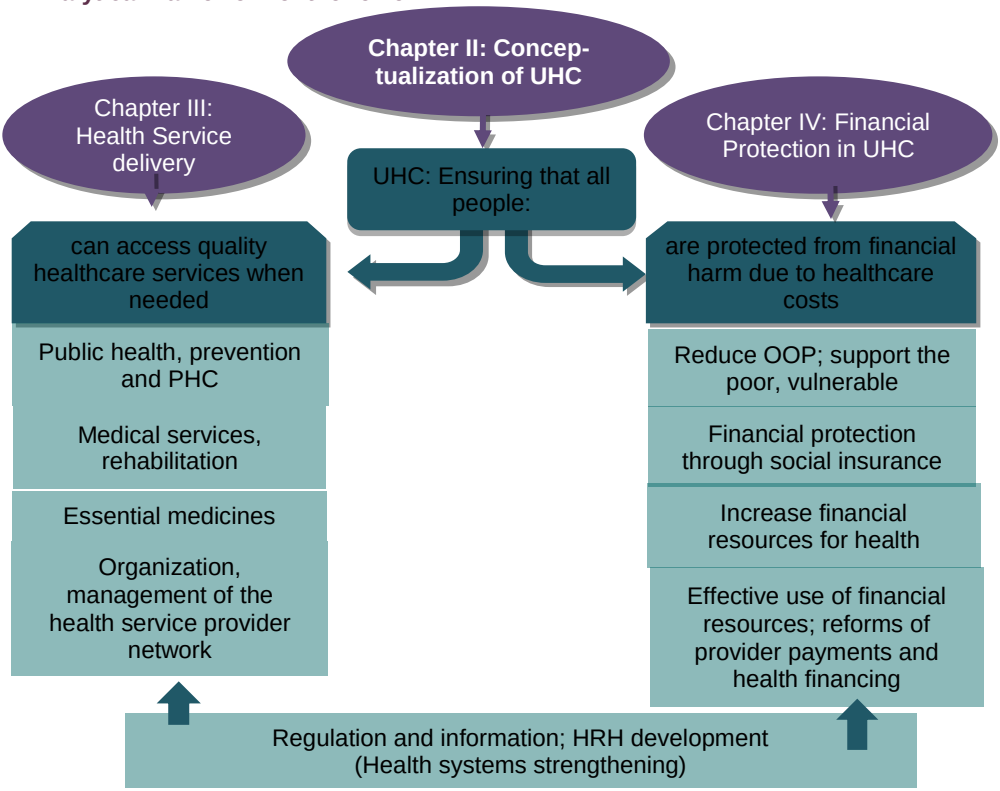
UHC cannot be achieved if effort is only made by the health sector. It requires determination and political commitment of the Government and the participation of the whole society.

3. Selection of health financing mechanism for UHC

The financing mechanism for UHC needs to achieve the four following objectives: (i) equity; ii) financial protection; iii) cost-effectiveness; iv) coverage of the informal employment sector. There are 2 financial mechanisms suitable for implementing UHC, namely tax-based financing and social insurance-based health financing. Developed countries use the state budget to cover health costs for those who cannot afford medical services. Developing countries that have successfully implemented UHC use the state budget instead of contributory health insurance to cover the informal sector.

In order to use financial sources effectively, it is necessary to implement strategic procurement and to improve efficiency of the health sector through: (i) selecting services that meet people's demand on the basis of safety, cost-effectiveness and appropriateness with priorities of the health sector; (ii) selecting provider payment methods that encourage the most effective use of financial sources; (iii) selecting service providers on the basis of quality and efficiency.

4. Analytical framework of the review



The analytical framework of this review is designed on the basis of the 3 dimensions of the objective of UHC including: ensuring that all people (the whole population, rather part of population) (i) can access quality health services when needed and (ii) are protected against financial harm due to healthcare costs.

When analyzing the situation and making recommendations, the review will focus on the perspective that there should be a good and accessible health system in which the state plays a dominant role to achieve the objectives of UHC.

Chapter III. Health service coverage

1. Concepts and policy orientation on provision of basic health services

1.1. Concepts

Basic health services (or *essential* health services, *minimum* services, *benefit* packages) are essential services that are determined on the basis of a nation's priorities for the health care system and availability of resources. Essential health services need to include public health services and clinical health services. Public health services need to put an emphasis on services that promote changes in people's behavior, environmental management services and preventive services. Basic clinical services are typically PHC services or services that are determined separately for each level on the basis of diagnosis and treatment capacity of health facilities at each level.

Delivery of basic health services is closely linked with concepts of preventive medicine, public health and PHC that are aimed at improving people's health and quality of life and reducing disease transmission in the community. Investment in preventive medicine, public health and PHC is a strategy for improving community health effectively at a low cost and is the most effective measure to implement UHC.

1.2. Policy orientation on provision of basic health services

The UN General Assembly acknowledges that the effective and financially sustainable implementation of UHC is based on a health care system that is "*resilient, highly responsive, and provides comprehensive PHCs*". According to WHO, in order to achieve the goal of UHC, it is necessary to define a set of basic health services to fit a nation's health care priorities in the current context of limited resources. Basic health services need to be uniform, delivered in a comprehensive and integrated manner and based on a PHC approach.

Resolution No. 15-NQ/TW of the 11th Central Committee on social policies for the period 2012–2020 specifies the objective of "*Ensuring minimum health care*", laid out some objectives related to basic health services namely: improve health care for people at the grassroots level, with priority on poor districts and communes, isolated and remote regions, and areas inhabited by ethnic minorities; improve quality of mother and child health care; fully immunize 90% of children under age 1 year by 2020; reduce the malnutrition rate of children under age 5 to below 10%; and strengthen implementation of the national TB prevention programs.

The National Strategy for the protection, care and improvement of the people's health in the period 2011–2020 specifies the standpoints of *"Reform and refine the Vietnamese health system towards equity, efficiency and development; ensure all citizens, especially the poor, ethnic minorities, children under age 6, beneficiaries of social policies, residents in disadvantaged, isolated and remote areas, border, island and coastal areas, and other vulnerable groups have access to quality basic health services."*

2. Coverage of preventive medicine, PHC, reproductive health and population – family planning services

2.1. Situation assessment

Achievements and progress:

The provincial preventive medicine network in most localities has been stabilized in terms of organization. All provinces have provincial preventive medicine centers and district health centers set up to perform the function of preventive medicine and management of CHSs. In 2013, the project on health development for islands and coastal areas was approved by the Government. This project aims to strengthen the capacity of the healthcare network, develop human resources both in quantity and quality for implementing activities such as protection and care of people's health, emergency medical care and transport in coastal and island areas. NTPs continue to receive financial support from the state budget.

Prevention and control of communicable diseases: The health sector has kept dangerous communicable diseases and major epidemic outbreaks under control. The immunization rate remains above 90% and achievements of the extended immunization program have been maintained. The TB prevention program is implemented nationwide, application of the DOTS approach has achieved cure rates of over 90% of TB patients and 80% among recurrent cases of TB and treatment failure cases. Communication, counseling, screening, prevention and intervention activities have been expanded.

Prevention and control of NCDs: The programs for prevention of hypertension and diabetes have been developed and expanded. Nearly 72 000 hypertensive cases were screened and 42 000 are being managed. Diabetes screening was implemented for 1.6% of population. The program for chronic obstructive pulmonary disease prevention has begun to be implemented in selected provinces and cities.

The NTP for food safety has reduced incidents of food poisoning and reduced incidence over time. An intersectoral Steering Committee on food hygiene and safety has been set up in each province. There are 25 food safety testing laboratories achieving ISO/IEC 17025:2005 standard; 50 national technical standards for food safety have been developed. A system of quality accreditation has been set up in 2 agencies responsible for testing food safety.

Management of health environment and occupational health: The master project for medical waste treatment for the period 2011–2015 with an orientation to 2020 is being implemented. Some 58.3% of health facilities causing serious pollution have been strictly dealt with. Promotion of the campaign for ameliorating hygiene to improve people's health, the NTP for safe water and sanitation in rural areas, programs for labor safety and hygiene, and programs for prevention and control of occupational diseases have been implemented. Guidelines have been issued for licensing the transport of dangerous goods, such as insecticides used for household and medical purposes.

Population-family planning, reproductive health care and child nutrition: Population-family planning and reproductive health care services are delivered in most localities and 2012 targets have been met for antenatal and neonatal screening, new users of contraception and abortion ratio. Approximately 90% of pregnant women received antenatal care consisting of at least 3 visits in each of the trimesters of pregnancy, more than 90% were assisted at delivery by skilled attendants and received postnatal care at home. The malnutrition rate (underweight) for children under age 5 decreased to 16.2%.

Other interventions for health promotion: The Tobacco Control Law has been approved by the National Assembly and has come into effect. The MOH is compiling sublegal documents and is completing the draft Law on alcohol control to include in the National Assembly legislation agenda.

Difficulties and shortcomings:

Linkages and integration between health programs, between preventive medicine centers, between preventive and curative facilities, and between health care levels remain weak. The organizational structure of preventive medicine centers, the grassroots health network and PHC is fragmented, causing difficulty in managing, mentoring and implementing delivery of preventive and PHC services. *Capacity of the preventive medicine system and grassroots level* remains limited, while investment policies, financial mechanism, overheads, medical facilities and equipment, medical training, and motivation subsidies face many difficulties. Policies to encourage the private health sector to invest in preventive medicine are not yet in place. *Investment in NCD prevention* is not commensurate with disease burden. Management of risk factors remains inconsistent. *Preventive activities* are not based on cost-effectiveness. Hand-food-mouth disease and malaria are not yet controlled effectively. TB is still a burden. There are *disparities in maternal and child health* and population-family planning indicators among regions including the MMR, birth rate among adolescents, CPR, proportion of deliveries attended by skilled attendant and proportion of women receiving antenatal care. The *information system for monitoring* and surveillance of communicable diseases remains inconsistent and is not yet computerized. There is not yet an epidemiological database or an information processing and management system for monitoring and surveillance of diseases and risk factors.

2.2. Priority issues

- *Activities in disease control and risk factor control are not yet managed* in a unified way, and have received investments that are not in line with the disease burden or assessment of cost-effectiveness of interventions.
- The *management and delivery of preventive medicine services* exhibit many limitations and lack integration.
- *Capacity to deliver preventive medicine and PHC services* remains limited due to lack of appropriate investment and incentive mechanisms; Interventions to improve the environment, limit risk factors and promote health receive inadequate attention.
- *Unmet need for reproductive health* and family planning services is substantial among certain population groups, yet support for outreach activities is insufficient.

3. Coverage of medical services, rehabilitation and traditional medicine

3.1. Situation assessment

Achievements and progress

The *health care network* is expanding. Through the end of 2012, there were 1180 public and private hospitals with 25.04 beds per 10 000 population. There were 35 general and specialized hospitals at the central level and 382 general and specialized hospitals at the provincial level, largely concentrated in provincial capitals. Most districts (561 districts) have general hospitals providing first level medical care services. Some 150 private hospitals with 9611 patient beds have been licensed. In addition, medical services at 78.8% of CHSs are reimbursed by health insurance. *Medical services* have increased significantly. In 2012 there

were nearly 132 million hospital visits, an increase of 6.8% compared to 2011. The highest growth was in the private hospital sector, with an increase of 19.1%. Hospital overcrowding at the central and provincial level has been reduced to a certain extent; bed occupancy rates decreased slightly. Service *delivery of the grassroots level* is improving. Renovations and upgrading of 145 district hospitals and 46 regional polyclinics has been completed and put into use since Projects 225 and 47 were implemented. At the district level, the number of district general hospitals has increased by 17%; the number of patient beds has increased by 64% after 10 years. In 2010, 80.1% of communes achieved the former commune health benchmarks; assessment of achievement of new benchmarks is not yet possible.

Use of health services at the grassroots levels, especially in district general hospitals has increased markedly. The proportion of the population receiving outpatient medical services increased from 11.9% in 2004 to 17.6% in 2010 and the share of population receiving inpatient medical services increased from 35.4% to 38.2%. Inpatient visits increased by 1.5 times while outpatient visits increased by 3 times over the decade. In 2012, district hospital beds accounted for 30.5% while medical examination visits at these facilities represented 45% of the total in all facilities. *The Family medicine model receives increasing attention* with over 500 First-level specialists being trained. The project on developing the Family medicine model has been approved with the objective of strengthening capacity of management and provision of comprehensive and continuous care for individuals and households. Some 80 family medicine clinics will be piloted in Hanoi, Ho Chi Minh City and other selected provinces from 2013 to 2015. *Continuity of care* has shown encouraging results, especially in some national target health programs such as TB and HIV prevention and control programs.

A *network of nursing-rehabilitation hospitals* has been set up in most provinces. The community-based rehabilitation program has been widely scaled up in 337 districts and 4604 communes in 51 provinces. Through the end of 2010, this program screened, detected and managed more than 170 000 people with disabilities, and implemented rehabilitation therapy for 23.2% of the needy and 44.7% of people with disabilities.

Delivery of medical services in traditional medicine facilities has expanded according to the Government action plan for developing traditional medicine by 2020. Currently, there are 58 traditional medicine hospitals nationwide. All provincial general hospitals and 90% of district hospitals have a traditional medicine department or division. Some 85% of CHSs provide traditional medicine services. In addition, there are 3 private traditional medicine hospitals and more than 10 000 private traditional medicine clinics. The share of outpatient treatment using traditional medicine is 8.8% at provincial, 9.1% at district and 24.6% at commune healthcare facilities.

Difficulties and shortcoming

The *capacity to deliver health services* has not caught up with changes in morbidity patterns, including a rapid increase in NCDs, especially at district and commune level health facilities. Overcrowding in tertiary hospitals has shown no significant reduction; bed occupancy rates in central hospitals remain high. The capacity of lower level health facilities remains limited. Many district hospitals do not have the capacity to apply medical techniques for which they are assigned responsibility in the technical referral system largely due to a shortage of health workers with relevant professional competencies. *The organizational structure and management mechanisms* of the district and commune level healthcare network underwent several changes in the period 1999-2008, creating instability in the organizational structure and a disturbance in both health human resources and capacity to provide services. Regulations on the functions of health facilities at the district level are still insufficient,

hindering the implementation of professional tasks. *Management of private health care facilities* faces difficulty. Unlicensed foreign medical practitioners have been found working in some clinics. Lack of regulations have led to negative effects of granting financial and operational autonomy mechanisms and promoting joint ventures and business partnership between state and private hospitals. Capacity to provide rehabilitation and traditional medicine services remains limited. *Quality of service* does not meet demand for health care. Most hospitals do not have a service quality control system. Only 9% of hospitals have hospital quality plans and 5% of hospitals have hospital quality improvement plans. Policies and guidelines on professional medical interventions are inadequate and are not regularly updated. The policy of issuing licenses and certificates once for a lifetime and on the basis of the application dossier rather than on the basis of qualifications and practical skill examinations, without a linkage with continuing medical education affects the quality of health professionals. *Continuity of care* is affected due to the lack of linkages between prevention and cure and due to the hospital autonomy mechanism. Hospitals tend to keep patients longer than necessary for medical treatment. Patient referrals are hindered by lack of specific regulations. Referrals back to lower levels remains limited due to lack of linkage and information feedback.

3.2. Priority issues

- Delivery of medical services, rehabilitation and traditional medicine does not meet demand: overcrowding in tertiary hospitals has not been reduced; capacity of the grassroots health remains limited.
- Quality of medical services remains limited: There is not yet a system of hospital quality instruments, policies and professional standards. Compliance with regulations and monitoring of compliance remain weak.
- Continuity of care has received inadequate attention due to limited collaboration in the referral system between different facility levels and due to impact of the autonomy mechanism.
- Regulation of private sector medical facilities is still lax. The role of the private health sector in reducing overcrowding and expanding health service coverage remain weak. Joint ventures and business partnerships between the private health sector and state-run hospitals have not been effectively managed, leading to overprovision of technical services and laboratory tests.

4. Access to essential medicines for UHC

4.1. Situation assessment

Achievements and progress

The List of essential medicines was first issued by the MOH in 1985 and was then updated in 1989, 1995, 1999 and 2005. In 2008 the MOH issued the major drug list for use in medical facilities, serving as a basis for reimbursements for insured patients.

The pharmaceutical supply network, especially for essential medicines has broad coverage and is easily accessible with relatively high availability of essential drugs in medical facilities and in the community. On average, there is 1 retail pharmacy per 2000 population. Some 39% of pharmacies achieve GPP. In 2010, the proportion of essential drugs available in private pharmacies was 55.3%, hospital pharmacies (56.4%), public facilities (55.9%) and in homes (70%). Drugs for national health programs are funded by the state budget (e.g., drugs for TB and mental illness prevention programs) or international organizations (e.g. ARV,

methadone). The State has issued policies and measures to support access to pharmaceuticals for disadvantaged groups and to ensure adequate pharmaceutical supply for health programs.

The State has implemented many policies to strengthen drug price control, with an orientation towards integrated solutions and strengthening transparency in licensing, pharmaceutical supply, sales, and competitive tendering for procurement, including open tendering for drug procurement at hospitals, announcement of drug prices, drug price declaration, and drug price control involving a ceiling on the profit margin allowed between import and wholesale prices for drugs procured using state budget or health insurance funds. These policies aim at increasing access to drugs and reducing financial burden. In 2012, the drug consumer price index increased by 5.27% while the overall consumer price index rose 6.81%. Generic drug prices in Vietnam are not much higher than the average price in the world.

Difficulties and shortcomings

The current list of essential medicines is outdated, but has not yet been adjusted or updated. Policies on generic drugs do not receive adequate attention. Access to essential drugs in disadvantaged and remote areas and among the vulnerable group (e.g. pediatric medicine, ARV, methadone) remains limited. Drug price control is ineffective. Competitive tendering for procurement of drugs is fragmented, resulting in variation in winning bid prices for the same drug across health facilities. Prices of drugs, especially branded innovator drugs are high (12.1 times higher than international reference prices). High drug prices and high share of drugs in total health spending are important factors leading to increases in household OOP spending on health. Irrational and unsafe use of drugs, high rates of antibiotic use, low share of essential, generic and domestically produced drugs in prescriptions leads to high drug costs and indirectly impedes people's access to drugs. Domestically-produced drugs currently meet less than 50% of national demand for drugs. Some 90% of drug ingredients are imported, making it difficult to be proactive in drug supply and drug price management.

4.2. Priority issues

- *Assess to* essential *drugs in disadvantaged areas and among vulnerable groups remains limited* due to an inappropriate drug distribution network and inaccessibility of drugs for patients with HIV, cancer, hepatitis A and B.
- *Irrational and unsafe use of drugs* due to ineffective management of drug prescription and drug use, and sales of drugs without prescription.
- *Drug prices are not effectively controlled and high drug costs create a financial burden for users* due to ineffective drug management mechanisms, limitations in selection of drugs and competitive tendering for drug procurement and inadequate attention to generic and essential drug prescription.

Chapter IV. Financial protection in the implementation of UHC

1. Reducing household OOP health payments

Situation analysis

The household OOP payment share of total health spending in Vietnam is much higher than the WHO recommendation (30-40%). Household OOP spending on health accounts for from 8.3 to 11.0% of household capacity to pay and approximately 4.6 to 6.0% of total household expenditure. Although a downward trend has been seen in recent years, household

OOP spending on health remains high. The proportion of households suffering from catastrophic spending and impoverishment due to health spending in Vietnam is relatively high compared to other countries in the region. There were 3.9 to 5.7% of households, or approximately 1 million households facing catastrophic spending and 2.5 to 4.1% of households, or approximately 600 000 households facing impoverishment due to health spending between 2002 and 2010. Households without health insurance cards, households in rural areas and poor households have lower OOP spending on health, but higher catastrophic spending and impoverishment due to health spending. In 2010, the OOP payment share of total health expenditure and the proportion of population facing catastrophic spending and impoverishment due to health spending in Vietnam decreased compared to previous years. The health insurance share of total health spending and insurance reimbursed medical service volume have increased over time. This result can be attributed to some recent social and health policies, especially policies on healthcare for the poor and children under age 6, healthcare subsidies for beneficiaries of social welfare policies, and most recently, the Law on Health Insurance.

Difficulties and shortcomings

More than 30% of the population, mainly the near poor and residents of rural areas do not yet have health insurance coverage. The proportion health spending for self-medication and private sector services (not covered by health insurance) and use of costlier secondary and tertiary medical services remain high. The poor with health insurance cards tend to use fewer medical services than others. Co-payments are still a financial burden for low-income households. Informal payments and payments for non-treatment costs related to healthcare seeking remain high.

2. Financial protection for disadvantaged and vulnerable groups

2.1. Situation assessment

Achievements and progress

Many legal documents aimed at adjusting and expanding rights and coverage of medical services for disadvantaged and vulnerable groups including the poor, near poor, ethnic minorities living in disadvantaged areas, children under age 6, the elderly, people with disabilities and rural-urban migrants have been issued, including Decision No. 139/2002/QD-TTg, Decree No. 63/2005/ND-CP, the Law on Health Insurance (2008), the Law on the Elderly (2009), Decision No. 797/QD-TTg (2012), Decision No. 14/2012/QD-TTg , etc. *Supply-side subsidies for recurrent costs of medical facilities* are gradually being replaced by demand-side subsidies for users of health services through state budget funding of social health insurance premiums. State budget funds allocated for health care for the poor and children under age 6 have been increasing over time in terms of allocation norms, total recurrent spending and spending on medical care. *Health insurance coverage for the poor is nearly universal*. This has significantly reduced OOP health spending among the poor. The age for the elderly to receive allowances has been reduced from 90 to 80 years, thus expanding the entitlement population. Approximately 50.4% of households that have members with disabilities have benefited from health support policies; nearly 40% have received free medical check-ups and 45.4% have received a health insurance card.

Difficulties and shortcomings

Only approximately 25% of the near poor have been enrolled in health insurance. Individual rather than family enrollment of near poor households means coverage is often only

for a few household members. Although there is a 70% subsidy, the 30% of the premium that the near poor have to pay is less than they are willing to pay. High premiums, combined with 20% co-payments without a stop-loss provision to limit total co-payment risk of patients reduces the ability of health insurance to protect the insured from financial hardship due health spending. Health care use among the poor remains lower than for other income groups, so only 75% of the funds contributed to the health insurance fund for the poor are used to reimburse facilities, and in some localities, this rate is only 40–60%. Progress in issuing health insurance cards for children under age 6 and elderly over 80 is still slow. In 2011, about 19.7% of children under age 6 were not issued with health insurance cards, especially children from ethnic minority groups or those living in locations other than where they have permanent household registration. Implementation of health care for the elderly policies still faces difficulty, especially in rural areas. Approximately 50% of people with disabilities face difficulties in accessing health services. High medical treatment costs, lack of appropriate forms of transportation, geographical distance, bureaucracy, lack of appropriate services and discrimination are the main causes of limited access. Migrants often have to pay more for health services because many of them are not enrolled in health insurance.

2.2. Priority issues

- Coverage of health insurance for the near poor, the elderly, people with disabilities and migrants is low. Health insurance card issuance for the elderly age 80 or older and children under age 6 have been subject to delays. Frequency of medical service use reimbursed by health insurance is low among disadvantaged groups, especially those living in mountainous and remote areas.
- Collaboration between sectors and departments and levels in the implementation of policies on financial protection for the poor and the disadvantaged is weak. Subsidies for direct payments for non-treatment costs (e.g., transportation, food and accommodation) have not yet been implemented.
- Monitoring and assessment of results and impacts of policies supporting the disadvantaged are not yet systematically performed. There is inadequate information on the implementation of financial protection policies for these groups.

3. Expanding universal health insurance

3.1. Situation assessment

Achievements and progress

Many *policies on health insurance have been promulgated and effectively implemented*, especially the Law on Health Insurance (2008). The Government has approved the project for implementation of the roadmap towards universal health insurance, striving to achieve at least 70% of the population enrolled in health insurance by 2015. The State has continuously increased insurance premium subsidies for the poor, the near poor and other beneficiaries of social assistance policies. Health insurance covers a large number of medical services, from examination and treatment to rehabilitation services at all levels. The State has fully subsidized health insurance premiums for over 27 million beneficiaries of social assistance policies including the poor and children under age 6 and has continuously expanded entitlements and increased health insurance premium subsidies for the near poor, pupils and students. Health insurance has also expanded medical care and rehabilitation service coverage at each level. In 2012, about *59.31 million people were insured*, accounting for 66.8% of the population. In some mountainous provinces with a large number of poor and ethnic minorities population

coverage was over 75%. Frequency of use of medical services reimbursed by insurance reached 2.02 visits per person. There were 15.6 inpatient visits for every 100 people in the population. The *health insurance fund has become an important funding source* for health care. In 2012, the health insurance fund reimbursed facilities approximately 33 419 billion VND (1.7 billion USD) for medical services. The health insurance fund has contributed to strengthening and upgrading the health service delivery network, expansion of medicines lists and technical services available at medical facilities to better meet people's demand for health care.

Difficulties and shortcomings

Health insurance coverage in the formal labor sector remains low due to a lack of measures to ensure compliance with regulations on health insurance. Support from the state budget for insurance premiums for the informal sector is incommensurate with people's ability to pay. Health insurance coverage continues to be implemented on an individual rather than household basis. There are still *nearly 30 million people without health insurance*, and only 25% of the near poor are enrolled in health insurance. The *health insurance fund is not used effectively* due to the inadequacy of existing regulations and basic measures to ensure safety, effectiveness and quality in selection of drugs, medical services and medical supplies. *HTA is not yet being implemented*, thus selection of drugs, technical services and medical supplies is largely based on proposals of hospitals rather than on evidence of cost effectiveness, while provider payments continue to be made on a fee for service (FFS) basis. *Some of the insured* still have to pay for *services that* exceed their ability to pay due to the lack of a stop-loss provision, OOP payments for many services and drugs excluded fr.om the major drug list, and high non-treatment costs. Meanwhile, price management for drugs and medical consumables is not effective. Irrational choice of drugs and medical services by practitioners and FFS payments lead to increased treatment costs. Thus, the health insurance fund faces the risk of going bankrupt and the risk-sharing ability of the health insurance fund is declining.

3.2. Priority issues

- There are difficulties and challenges in expanding population coverage due to low compliance by enterprises, low willingness and ability to pay among the near poor and the informal sector.
- Sustainability and cost-effectiveness in use of the health insurance fund are not yet ensured due to difficulties in selection of drugs and medical services to be covered. HTA and analysis of cost-effectiveness are not yet being implemented. Drug prices are not effectively controlled.
- Financial protection through health insurance remains limited due to inappropriate use of medical services, inappropriate provider payment methods, high rate of co-payment and direct payments for non-treatment costs, lack of sustainability, and low risk pooling of the health insurance fund.

4. Mobilization of financial resources for the implementation of UHC

4.1. Situation assessment

Achievements and progress

Total health care expenditure per capita in Vietnam has nearly reached the minimum level needed to ensure basic health care as estimated by WHO. The health spending share of state recurrent expenditure budget increased continuously from 2008–2012, reaching 8.3%.

State budget health spending as a share of GDP reached 1.97% in 2011 and is projected to increase by an additional 0.4% by 2015. With the universal health insurance orientation, *the goal of UHC in Vietnam is being implemented with a financial mechanism through health insurance with state budget subsidies*. Currently the state budget is subsidizing fully or partially the premiums for 60% of all insured people, or approximately 45% of total health insurance revenues. *The foreign aid* share of total health spending is not high, at approximately 2.3% of total health expenditure in 2009, but still plays an important role in supporting indirect costs of healthcare seeking among the insured poor, support for the near poor to enroll in health insurance and technical support for provider payment reforms. Regarding *initiatives to increase mobilization of financial resources*, so far only revenues from lottery have been mobilized for health nationwide. In 2011, this mobilized financial source reached 2154 billion VND, accounting for 7.1% of total state budget recurrent spending on health. The tobacco control fund to be raised according to the Tobacco Control Law will be an important additional source for health financing.

Difficulties and shortcomings

The *household OOP share* of health spending is still above 50%. State budget spending on health accounted for 26% of overall spending on health in 2010. The *ability to increase state budget health spending* in the current context is affected by macroeconomic difficulties and fiscal policy tightening as required in Government Resolution No. 11/NQ-CP (2011). Projected increases in state budget spending on health by 2015 are insufficient to ensure the target of health insurance coverage of 70% of the population. *Medical facility revenues from health insurance* are much lower than the share of insured population. Meanwhile, *premium collection suffers from non-compliance*. Premium arrears have not been resolved. *Expanding insurance coverage* to uninsured groups faces great difficulties. Measures to increase the insurance premium are not feasible. *Foreign aid funds* are gradually decreasing while use of foreign aid funds remains ineffective with low disbursement rates (51% in 2012). *Initiatives for mobilizing* additional financial sources for health are still limited and generally ineffective.

4.2. Priority issues

- *State budget spending* on health has been negatively affected by macroeconomic difficulties. The pace of increase in state budget health spending has declined. The share of state budget spent on health is below 10% and has begun to see a downward trend.
- *Funds mobilized through health insurance* for medical care remains low compared to population coverage by health insurance. *Premium collection* has been low for some groups. Expanding health insurance coverage to remaining uninsured groups faces difficulties.
- *Foreign aid* accounts for only a small share of total health spending and has begun to fall. Disbursement rate and effectiveness in use of foreign aid funds are still low.
- *Implementation of initiatives* for mobilizing financial resources are still limited.

5. Increasing efficiency in using available resources

5.1. Situation assessment

Achievements and progress

If we compare health spending per capita (about 95 USD per person in 2011) with health indicators, it can be said that the *efficiency* in using available resources of Vietnam's health system is relatively good. The Government prioritizes fund allocation for areas that yield high

efficiency, including preventive medicine, grassroots health facilities, PHC, MCH care and support for the poor. The share of state budget spending on preventive medicine accounted for 31.32% of total budget spending on health in 2009. State budget allocation is prioritized for remote and mountainous areas, with allocation norm from 1.7 to 2.4 times higher than for urban areas and highest in Northern Uplands and Central Highlands.

Difficulties and shortcomings

The share of spending on pharmaceuticals remains high, accounting for 42% of total health expenditure and 70% of total payments from the insurance fund. Rational and safe use of pharmaceuticals is not yet ensured and use of drugs, especially antibiotics, has many shortcomings. The proportion of prescriptions involving antibiotics reached 49.2% in general and 60% in district and commune level facilities. Prescription and use of unnecessary medical services by both medical doctors and patients led to a continuous increase in medical care costs (19.4% in outpatient services and 13.3% in inpatient services over the period 2006–2011). The fee-for service payment mechanism is still the most common payment method and is applied in 64.5% of medical facilities that deliver services to the insured, hindering medical cost control. Irrationality in health service delivery within the health system is also a factor affecting resource use efficiency. Selection of drugs and services for both insured and uninsured patients is not based on evidence of cost-effectiveness.

5.2. Priority issues

- *Health sector resource waste* has not been comprehensively studied and evaluated.
- *Cost-effectiveness evidence* is not yet used for financial allocations or selection of services/drugs to be reimbursed.
- *Efficiency in using health financing resources* is low due to *ineffective provider payment methods*, *lack of transparency and control* over drug prices and medical services reimbursed by insurance and a high proportion of unnecessary hospital admissions (accounting for 20%).

6. Reforming providers payment methods

6.1. Situation assessment

Achievements and progress

Input-based financing has been applied for a long time and is currently being applied in national health target programs and for payment of salaries, part of operating overheads, depreciation and maintenance of medical equipment in state health facilities. This payment mechanism enables health facilities that are not capable of full financial autonomy to receive relatively stable resources to provide health services. *FFA payments* combined with administratively set user fees has been applied parallel with budget allocation according to expenditures since the policy on partial user fees was piloted in 1994, and has gradually become the main providers payment mechanism in the health system. *Capitation* has been piloted since 2005 and was regulated in 2010 as one of the three providers payment methods between health insurance and medical facilities by the Law on Health Insurance. In 2012, 58 out of 63 provinces applied capitation in 786 out of 1952 first level medical facilities slated to use this method (achieving 40.2%), among which 175 health facilities applied capitation for outpatient services and 611 health facilities applied capitation for both outpatient and inpatient services. Application of *case mix payments* is stipulated in the Law on Health Insurance and Decree 85. District hospitals that are applying capitation payments will gradually shift to case

mix payments for inpatient services. Case mix payments have been piloted since 2010 for selected disease groups in 2 hospitals (Thanh Nhan general and Ba Vi district hospitals) and there are plans to apply this method to over 26 groups of diseases in 30 hospital in 9 provinces by 2015. *Results-based financing* is a prospective payment method that promotes concentration on service quality and cost reduction. This method of payment is at the pilot stage in 24 communes in 2 districts of Nghe An province. *Policies on salary supplements and motivation subsidies* for health workers in disadvantaged areas have contributed to some extent to increasing performance. VSS is gradually becoming the main health service purchaser and is playing a more prominent role in controlling costs and ensuring quality of medical services.

Difficulties and shortcomings

There is not yet a consensus about the role and responsibility of stakeholders, nor about resources and a roadmap needed for systematic provider payment reforms. FFS is still the main provider payment method, creating financial barriers to health care seeking that impeding access and use of basic medical services and increasing risks of catastrophic spending and impoverishment when using medical services. This method of payment also lacks incentives to encourage continuity of care. Other provider payment methods including capitation, case mix payments and results-based financing are gradually being implemented, yet conditions and mechanisms to support these payment methods are lacking. Co-payments and informal payments still create a financial burden for low income groups. Limitations of the implementation of hospital autonomy and policies on joint ventures and business partnerships between private sector and state health facilities are resulting in overuse of high tech services, medical cost escalation and impediments for low income people to access medical services.

6.2. Priority issues

- *Providers payment methods applied are not actively used* as a health system control knob due to lack of necessary preconditions and resistance to change.
- *Research and application of new provider payment methods* are facing difficulties.
- *Application of capitation payments* currently lacks a comprehensive design and appropriate mechanism for managing quality improvement.

PART THREE: RECOMMENDATIONS

1. Strengthen health sector governance

- Recommend the MOH implement a review of 30 years of reforming the health system and propose an orientation and major solutions for continued health sector reforms and development in Vietnam.
- On the basis of identifying UHC as a priority in the orientation of health policy development in Vietnam, the MOH should submit a draft Resolution/project on strengthening grassroots healthcare to leadership organizations for promulgation.
- Provide training and strengthen capacity for health policy formulation
- Review and evaluate the organization of health facilities in the provinces in order to make appropriate adjustments to their structure and functions; strengthen grassroots health facilities to ensure delivery of quality basic health care services.
- Develop mechanisms for integration between curative and preventive care, referrals between facilities and public-private partnerships; ensure uniform management and integration in PHC.

- Encourage reform in provincial planning and budget estimation; strengthen monitoring and supervision of the implementation of health policies at all levels.
- Promote policy dialogue between various stakeholders, including the general population.
- Rapidly complete and issue a circular guiding social mobilization specific to health care.

2. Human resources for health

- Develop a long-term master plan for reform of the medical manpower training system. Review, standardize and upgrade the training curriculum and improve training quality. Promote continuing medical education.
- Assess effectiveness and amend policies on attraction and deployment of the health workforce and on salary supplements in order to strengthen and improve the quality of health manpower in disadvantaged areas, paying attention particularly to preventive medicine and PHC.
- Promote activities for health manpower management; strengthen information systems relating to training and use of health manpower in both the state and private health sectors.

3. Health management information systems

- Complete the architecture and master plan for developing the health management information system.
- Issue a list of basic health indicators and statistical reporting software for each level.
- Develop a surveillance system for monitoring priority health issues, collect information on mortality and causes of death, assess disease burden.
- Develop a circular on health information dissemination and widely disseminate information products through diverse forms.
- Apply information technology in the health sector. Deploy ICD-10 disease coding and ICD-9 procedure coding in all medical facilities.
- Develop a circular regulating official forms for private sector statistical reporting.

4. Pharmaceuticals and medical equipment

- *Increase people's access to essential drugs*: revise the Law on Pharmaceuticals and the National Drug Policy to the year 2020; develop the Master plan for drug production development and distribution and the Strategy for the development of the pharmaceutical sector to the year 2020. Expand drug supply; increase the proportion of drugs on the essential medicines list that should be available in CHSs; develop mechanisms for ensuring supplies of essential drugs for disadvantaged areas; strengthen capacity of domestic pharmaceutical and medical equipment companies and seek sources of funding for specific treatment drugs from international organizations.
- *Promote rational and safe use of drugs*: strengthen the role of the drug and therapy committee in hospitals; strictly implement regulations on drug prescriptions and sales of prescription drugs; impose sanctions on those offering commission to doctors for

prescribing specific drugs; monitor drug advertising; develop standardized care pathways; and develop a system of monitoring antibiotic use.

- *Control drug prices and gradually reduce the drug share of overall health spending*: propose regulations on functions and obligations of ministries and sectors in drug price control, amend limitations in regulation of competitive tendering for procurement of drugs, increase funds for essential drugs in CHSs, promote domestically manufactured generic drugs.
- *For medical equipment and facilities:* Assess demand for and update the list of essential medical equipment for health facilities. Develop a database of medical equipment; set up a unit for HTA. Prioritize procurement and use of medical equipment manufactured by domestic companies. Promote disbursement of funds for projects aimed at developing infrastructure of provincial and district hospitals.

5. Coverage of preventive medicine, PHC, reproductive health and population-family planning services

- *Increase investment to improve and strengthen capacity for preventive medicine units and the grassroots health network*: assess management capacity and effectiveness of preventive and PHC service delivery, reform preventive medicine towards reducing the number of contact points. Evaluate effectiveness of policies aimed at investing in preventive medicine and health facilities at the district and commune level, reform methods for state budget estimates and allocations for CHSs. Prioritize and accelerate investments in physical infrastructure at the grassroots level; strengthen service provision at CHSs.
- *Effectively implement disease and outbreak management activities, gradually achieve consistent management of risk factors for disease*: strengthen the role and responsibilities of all level of authorities and agencies; promote collaboration and linkage between medical facilities; identify basic health services to ensure cost effectiveness at each level; prioritize investment in NCDs; develop policies to effectively deploy and retain trained health workers for remote and mountainous regions; refine the information system for disease control.
- Strengthen population-family planning and PHC activities: expand to ensure universal access to sexual and reproductive health services to reduce unmet need for these services; assess the organization structure for service delivery, assign functions and obligations, and strengthen involvement of other sectors.

6. Coverage of medical services

- *Strengthen grassroots level capacity for medical service delivery*: pilot and evaluate the model for linking CHSs with district health centers; improve capacity for CHSs, especially the capacity to manage NCDs and implement some national health target programs; develop appropriate incentive mechanisms for commune health workers and mechanisms for attracting private doctors and herbal practitioners to participate in medical service delivery at the grassroots level.
- *Promote activities to reduce hospital overcrowding*: issue guidelines on the system that determines which types of services should be available at which levels of facilities, referrals, and information feedback; implement projects on reducing hospital

overcrowding; promote outpatient care rather than inpatient admissions; and monitor inpatient admissions.

- *Improve quality of medical services at each level*: develop criteria, standards, tools and mechanisms to assess service quality; supplement regulations and guidelines on improving quality of services; strengthen inspection and supervision of compliance with laws on medical care at medical facilities; develop guidelines for providing medical care with high-end hotel services for those who desire higher quality services and can afford to pay.
- *Continuity of care and referrals*: expand the scope of management of chronic NCDs to the commune level; refine and issue a circular guiding referrals; complete and issue guidelines stipulating which types of facilities should provide which types of technical medical services.
- *Refine legal documents guiding implementation of the Law on Examination and Treatment*: propose licensing practitioners on the basis of practical skill examinations, granting licenses that are renewable after a set period of time, and linking renewals with requirements for continuing medical education; develop and compile professional medical guidelines; and apply information technology in management of medical services.

7. Health financing

Reducing household OOP spending on health

- Implement more uniform measures to reduce the household OOP spending share of total health expenditure to 30–40% as recommended by WHO.
- Continue to implement policies on expanding health insurance coverage to approximately 90% of households; reform and apply more effective provider payment method; and improve quality of medical services.
- Conduct in-depth research on household OOP spending on health to identify trends and underlying causes of problems.

Financial protection for disadvantaged and vulnerable groups

- Revise some articles in the Law on Health Insurance towards gradually increasing subsidies from the state budget to health insurance premiums for residents of disadvantaged areas; continue to expand coverage of financial protection for the elderly under age 80; eliminate co-payments for some groups
- Recommend that Provincial People's Committees strengthen monitoring for expanding health insurance and link insurance coverage with the implementation of the provincial socio-economic development plans.
- Strengthen intersectoral collaboration and monitor and supervise the implementation of policies supporting disadvantaged groups.
- In the long term, issue policies for full state budget subsidies to purchase health insurance with payment conditions appropriate for the poor and other disadvantaged groups.

Expand universal health insurance

- Expand health insurance coverage: focus on the informal employment sector in private enterprises, informal employment groups with middle-income or higher, and the near

poor. Increase state subsidy for the insurance premium, empower VSS with authority for specialized inspection of compliance with payment of insurance premiums, include targets for health insurance coverage rates in the Resolution on annual socio-economic development of the National Assembly.

- Ensure sustainable and effective use of health insurance funds: apply HTA approaches and cost-effectiveness criteria in selection, procurement and use of drugs and medical services. Apply principles for developing a list of drugs and medical services based on evidence of cost effectiveness and affordability to the people. Increase efficiency of drug procurement.
- Improve financial protection capacity of health insurance: revise regulations on co-payments; ensure a balance between the average health insurance premium and the average medical care cost per capita, reduce ineffective costs; reform provider payment methods; revise policies on financial autonomy and social mobilization.

Mobilize financial resources to implement UHC

- Maintain the rate of increase in state health spending at a higher rate than the increase in overall state budget spending and ensure that the health share of total state budget spending reaches 10%. Study to identify requirements for state budget mobilization for health care.
- Promote financial mobilization through the health insurance fund: refine legislation and strengthen inspection and supervision to ensure implementation of regulations on contribution to the health insurance fund; expand health insurance coverage; gradually shift from allocating state budget supply side subsidies to hospitals towards demand-side subsidies through subsidizing enrollment in health insurance with the roadmap for appropriate and full cost recovery pricing of state health services to improve the effectiveness of health insurance.
- Implement innovations to mobilize financial resources for health: study application of tax policies on unhealthy products such as tobacco and alcohol to increase financial resources for health care.

Increase efficiency in use of available resources

- Study to clarify causes of waste of available resources in the health sector in order to propose proper solutions.
- Apply cost-effectiveness criteria in selection of medical services, assess and adopt results of HTA.
- Increase effectiveness of measures for drug and health services price control; openly post prices of drugs and health services for effective use of drugs and health services.

Reform provider payment methods

- Develop a comprehensive program for reforming providers payment methods for health care services. Ensure that provider payment methods serve as a control knob of the health system. Promote the process of applying a system of payment methods with harmonious integration of new and more effective payment methods. Promote capacity for HTA.
- Adjust the capitation rates taking into account population age-sex structure, disease burden and basic PHC services; adjust payment norms.

- Implement reforms of provider payment methods consistent with reforms in organization of health care service delivery and other related financial mechanisms, ensure prerequisite conditions are met for application of more effective payment methods. Implement linkages in management and provision of preventive and curative care services. Increase financial resources and strengthen the role of the health insurance fund. Minimize negative impacts of existing financial autonomy policies.

Appendix 1: Implementation status of Five-year plan targets, 2011–2015

	Indicators	2010	2011	2012	2015 target
	Input indicators				
1.	Number of doctors per 10 000 population	7.20	7.33	7.46 (7.4)	8
2.	Number of university-trained pharmacists per 10 000 population	1.8	1.9	.. (1.4)	1.8
3.	Proportion of villages served by VHWs (%)	78.8	82.9	81.2 (87)	90
4.	Proportion of communes with a doctor (%)	70.0	71.9	76.0 (74)	80
5.	Proportion of communes with an obstetrics/ pediatrics assistant doctor or midwife (%)	95.6	95.3	93.4 (>95)	>95
6.	Number of hospital beds per 10 000 population	21.7	22.5	24.3 (21.5)	23.0
	Process indicators				
7.	Proportion of children under 1 year of age fully immunized *(with 7 types of vaccines in 2010 and 8 types of vaccines 2011-2015)*	94.6	96.0	95.9 (>90)	>90
8.	Proportion of communes meeting national commune health benchmarks (Data for 2011–2012 include a mix of those meeting old and new standards)	80.1 (old bench mark)	76.8	74.1 (45)	60
9.	Proportion of the population covered by health insurance (%)	60.3	65.0	66.8 (66)	70
	Outcome indicators				
10.	Average life expectancy (years)	72.9	73.0	73.0 (73.4)	74.0
11.	Maternal mortality ratio per 100 000 live births	69 (2009)	..	.. (66)	58.3
12.	Infant mortality rate (‰)	15.8	15.5	15.4 (15.3)	14.8
13.	Under-5 child mortality rate (‰)	23.8	23.3	23.2 (23.0)	19.3
14.	Population size (million people)	86.9	87.8	88.77 (88.67)	<92
15.	Annual reduction in fertility (‰)	0.5	0.5	-0.30 (0.10)	0.10
16.	Population growth rate (%)	1.05	1.04	1.06 (0.99)	0.93
17.	Sex ratio at birth (boys per 100 girls)	111.2	111.9	112.3 (112)	<113
18.	Malnutrition rate of children under age 5 (weight for age) (%)	17.5	16.8	16.2 (16.6)	15.0
19.	HIV/AIDS prevalence rate (%)	0.21	0.22	0.24 (<0.3)	<0.3

Appendix 2: Implementation of Millennium Development Goals

Goal	Indicators	Data and year	2012	2015 goal
MDG1: Eradicate extreme poverty and hunger				
Indicator 1C: Halve the proportion of people suffering from hunger between 1990 and 2015	1.1 Malnutrition rate for children under age 5 (weight for age)	41% (1990)	16.2%	20.5% Achieved
MDG 4: Reduce child mortality rate				
Indicator 4A: Reduce under-five mortality by two-thirds between 1990 and 2015	4.1 Under-5 child mortality rate	58 (1990)	23.2	19.3 Hard to achieve
	4.2 Infant mortality rate	44.4 (1990)	15.4	14.8 Achievable
	4.4 & 4.5 Measles immunization rate	55%	96.4% (2011)	>90% Achieved
MDG 5: Improve maternal health and universal access to reproductive health				
Indicator 5A: Reduce maternal mortality ratio by three quarters, between 1990 and 2015	5.1 Maternal mortality ratio	233/100 000 (1990)	69/100 000 (2009)	58.3/100 000 Hard to achieve
	5.2 Proportion of deliveries assisted by a trained health worker	86% (2001)	97.9%	96-98% Achievable
Indicator 5B: Universal access to reproductive health by 2015	5.3 Contraceptive prevalence rate	73.9% (2001)	76.2%	82% Hard to achieve
	5.5 Proportion of women giving birth who had 3 or more antenatal visits over 3 trimesters	87.9% (2004)	89.4%	
MDG 6: Combat HIV/AIDS, malaria and other diseases				
Indicator 6A: Halt and begin to reverse the spread of HIV/AIDS by 2015	6.1 HIV prevalence rate among people aged 15–49	N/A	Age 15-49: <0.45%	N/A
	6.2 Condom use rate at last high-risk sex	51.9% (PWID) 77.7% (FSWs 66.5% (MSM)	80.2% (PWID) 89.7% (FSWs) 71.5% (MSM)	≥ 80% Achievable
Indicator 6B: Universal access to HIV/AIDS treatment for all those who need it by 2010	6.4 Proportion of population with advanced HIV infection with access to antiretroviral drugs	5% (2005)	53% 68.3% for adults and 81.3% for children	70% Hard to achieve
Indicator 6C: Halt by 2015 and begin to reverse the incidence of malaria	6.6 Malaria incidence and death rates	Incidence rate: 96/100 000 Mortality rate: 0.031/100 000 (2000)	Incidence rate: 49/100 000 Mortality rate: 0.01/100 000	Achieved
Indicator 6D: Control tuberculosis	6.10 Tuberculosis prevalence rate (TB)	375/100 000 (2000)	225/100 000 (2011)	187/100 000 [MOH] Achievable
		403/100 000 (1990)	323/100 000 (2011)	201/100 000 [UN] Hard to achieve
MDG 7: Ensure environmental sustainability (focusing on safe water and sanitation)				
Indicator 7C: Halve the population without access to basic sanitation and safe drinking water	7.1 Proportion of population using sanitary toilet	37% (1990)	78% (2011)	68.5% Achieved
	7.2 Proportion of population using safe drinking water source	57% (1990)	92% (2011)	78.5% Achieved