Moving toward UHC

Viet Nam

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

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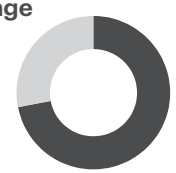
Viet Nam's snapshot

UHC Service Coverage Index *(SDG 3.8.1, 2015)*

72%



Catastrophic OOP health expenditure incidence at the 10% threshold *(SDG 3.8.2, 2011)*

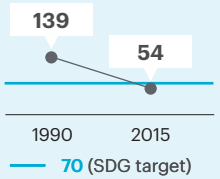
9.8% of households

Results of Joint External Evaluation of core capacities for pandemic preparedness *(JEE, 2016)*

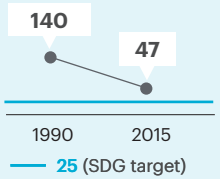
Score (for capacity)		# of indicators (out of 48)
5	Sustainable	0
4	Demonstrated	8
3	Developed	25
2	Limited	15
1	No capacity	0

Health results

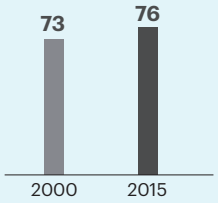
Maternal Mortality Ratio *(WHO)*
Per 100,000 Live Births



Under-Five Mortality Rate *(WHO)*
Per 1,000 Live Births



Life Expectancy at Birth *(WHO)*



Wealth Differential in Under-Five Mortality *(PHCPI)*

37.7

More deaths in lowest than highest wealth quintile per 1,000 live births

Performance of service delivery – selected indicators

(PHCPI, 2014-2015)

	Viet Nam	LMIC average
Care-seeking for symptoms of pneumonia	**81%**	61.5%
Dropout rate between 1st and 3rd DTP vaccination	**1%**	7.5%
Access barriers due to treatment costs	**NO DATA**	47.4%
Access barriers due to distance	**NO DATA**	35.8%
Treatment success rate for new TB cases	**91%**	80.1%
Provider absence rate	**NO DATA**	28.9%
Caseload per provider	**NO DATA**	9 per day
Diagnostic accuracy	**NO DATA**	47.9%
Adherence to clinical guidelines	**NO DATA**	33.6%

See page 12 for References and Definitions.

Existing national plans and policies to achieve universal health coverage (UHC)

SERVICE DELIVERY REFORMS

Strengthening the grassroots health care system. The newly issued 2017 Communist Party Resolution on People's Health Protection, Care, and Improvement reorients the health system toward prevention and a foundation of grassroots care (district level and below). The National Health Strategy 2011–2020 also gives prominence to renovating primary care to achieve national health goals, and in 2016 the Prime Minister issued a master plan for developing the grassroots health system. Family medicine principles are being introduced to strengthen primary care, particularly at commune health stations (CHSs), to respond to rapid population aging and noncommunicable diseases (NCDs).

Investing in skilled health workers. The Ministry of Health (MOH) has a comprehensive human resource development plan for 2012–2020. Recent efforts have focused on strengthening preservice training and developing competency-based curricula for doctors and nurses, as well as upgrading general doctors to family doctors and expanding the scope of their primary care responsibilities. The number of establishments accredited to provide continuing medical education (CME) is increasing, and professional mentoring is used to strengthen competencies in lower-level facilities. New regulations under consideration include the creation of a Medical Council and requirements for licensing exams alongside periodic renewal of professional licenses.

Pandemic preparedness. In 2016, the Viet Nam One Health Strategic Plan for Zoonotic Diseases (OHSP) 2016–2020 was approved; this is aligned with international and regional initiatives such as the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010). There are also National Action Plans for antimicrobial resistance, reduction of antibiotic use in livestock and aquaculture production, and rabies control and elimination. The Viet Nam One Health Partnership for Zoonoses (OHP) was launched in 2016 with 27 national and international partners.

HEALTH FINANCING REFORMS

Health insurance coverage. Viet Nam enshrined universal social health insurance (SHI) coverage in its 2013 Constitution. The Prime Minister and Communist Party have set national SHI targets of over 90% coverage by 2020 and 95% coverage by 2025. Coverage roadmaps and provincial-level targets to be incorporated into annual plans will help local authorities achieve these targets.

Shifting from supply-side to demand-side subsidies. Supply-side subsidies to health facilities are being phased out by setting health service charges at full cost-recovery rates, while demand-side subsidies have been introduced in the form of state budget payments of SHI premiums for disadvantaged or "meritorious" individuals. A transition from state budget toward health insurance financing of disease-specific programs, like HIV and TB, is also underway. State budget spending on health continues to increase, including as a share of the overall budget, and is increasingly directed toward public health, preventive measures, and equity, while health insurance covers curative care.

GOVERNANCE REFORMS

Reorganization of the health system. Preventive medicine activities are being consolidated under a national and provincial Centers for Disease Control model to ensure greater coordination and enhance allocative efficiency across various functions. At the grassroots level, the fragmentation of curative and preventive care is being tackled by reintegrating district health centers and district hospitals, which together will be responsible for managing CHSs.

Health information systems. The MOH has approved a Health Information System Development Strategic Plan for 2014–2020 and issued a set of 88 core health indicators disaggregated by gender, region, and ethnic group—there are plans to update this to reflect the health-related sustainable development goals (SDGs). In 2016, an MOH plan for application of information technology in the health sector was issued. Web-based administration and specific databases are also being developed to support this system.

Strengthening stakeholder involvement. For a full decade, the MOH and the Health Partnership Group (HPG) have collaborated to produce the Joint Annual Health Reviews which provide up-to-date information on the health system, serve as an accountability mechanism for the 5-year and annual plans, and contribute to priority-setting processes. HPG meetings are held to strengthen health and intersectoral coordination with other ministries, provinces, international organizations, and local and international NGOs. The HPG also provides advice to the Ministry on major health policy issues.

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Key challenges on the way to UHC

WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

Coverage of essential health services. Viet Nam is considered one of 10 "fast-track countries" for national performance on the health-related MDGs, but it faces regional and ethnic disparities. The full immunization and skilled birth attendance rates are well over 90%; government investments have extended and upgraded the network of district and provincial hospitals; and existing CHSs cover 99% of administrative jurisdictions in the country. However, there are substantial and persistent geographic, ethnic, and living standards disparities in health outcomes including malnutrition, maternal and under-5 mortality, and access to essential services, such as antenatal care. There are also substantial deficits in health facility capacity in rural (mountainous and coastal) areas, particularly shortages of well-qualified and experienced staff.

Quality of care. Quality assurance systems have been set up in all hospitals; national protocols and guidelines have been developed for many medical conditions and are being applied in hospitals; and health professional education reform is shifting toward competency-based training, from undergraduate through to postgraduate levels. Nevertheless, in this hospital-centric system, the CHS does not yet satisfy the primary care needs of the population: staff often have inadequate competencies, lack expertise in areas such as basic first aid and screening and management of NCDs, and have few opportunities for continuing education; the list of pharmaceuticals that they can dispense is limited; and few basic medical tests or imaging services are available. Consequently, patients lack confidence in the quality of primary care facilities, often choosing to seek care at higher-level hospitals despite substantially higher co-payments and inconvenience.

Viet Nam is considered one of 10 "fast-track countries" for its strong national performance on the health-related MDGs, but it faces regional and ethnic disparities.

Moving toward UHC: **Viet Nam**

Pandemic preparedness. A 2016 Joint External Evaluation (JEE) of the International Health Regulations (IHR) core capacities revealed that Viet Nam has many of the necessary systems and processes established, but also identified key areas for improvement and a general need to enhance the sustainability of established capacities. Areas where current capacities are most limited are: measures to combat antimicrobial resistance; development and implementation of a preparedness and response plan, with priority risks and resources mapped; linking public health and security authorities; medical countermeasures and personnel deployment; and mechanisms to detect and manage chemical events.

THE STATE OF HEALTH FINANCING

Overall funding for health. Viet Nam's health spending continues to grow, but allocative and technical efficiency could be substantially improved to attain greater health improvements with existing funds. Between 1995 and 2014, total health expenditure increased steadily, from 5.2% to 7.1% of GDP (WDI, 2017). State budget spending on health rose from 7.9% to 14.2% of government spending over the same period (WDI, 2017). Out-of-pocket spending has continued to increase in absolute terms, but has fallen in relative terms, from 63% to 37% of total health expenditure (WDI, 2017). Continued growth in health spending will be difficult to maintain due to government budget and borrowing constraints making efficiency imperative, particularly in the face of rapid population aging and the availability of new, more costly technologies. Provider payment arrangements do not incentivize providers to focus on cost-effectiveness, resulting in overuse of high-tech services. Increases in prices, coupled with the expanded scope of the SHI package, translate into greater costs to be reimbursed by the SHI fund without a commensurate increase in resources. At the system level, the large share of public subsidies allocated to secondary and tertiary hospitals diverts funds from strengthening primary and preventive care.

Financial protection and targeted assistance to disadvantaged groups. Viet Nam ensures that a large share of the population is covered by a fairly generous package of services. The Health Insurance Law (2014) entitles many groups to fully subsidized SHI, including the poor, near-poor who have recently escaped poverty, children under six, ethnic minorities in disadvantaged regions, and social assistance beneficiaries. In addition, school children, the near-poor, and average and lower income farmers are entitled to partial subsidies.

The SHI benefits package of essential health services covers a broad range of services, including ambulatory care, rehabilitation, advanced diagnostics, and curative services. However, about one-fifth of the population still lacks SHI coverage, mainly the self-employed or employees of small enterprises. Insured individuals, even those who are not required to pay co-payments, still face burdensome and unpredictable out-of-pocket (OOP) payments, including fees for equipment provided by private investors, drugs outside of the insurance formulary, and costs of transportation, food, and accommodations for family members accompanying patients. There are also large inequalities in access to quality services in the benefit package between the poor and nonpoor. Some important health interventions, such as disease screening among asymptomatic individuals, smoking cessation, or substance abuse treatments, are neglected because they are covered by neither state budget nor SHI. There is also a risk that groups targeted in the national health programs for HIV and TB may fall between the cracks during the transition from government subsidy to SHI coverage for these conditions.

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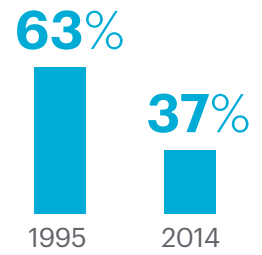

Despite the rapid adoption of information technology, almost no data are available about the private health sector, which makes a substantial contribution to outpatient care.

GOVERNANCE CHALLENGES

Reorienting the health system away from the current hospital-centric model toward PHC. Despite major efforts to refocus the health system on primary care, prevention, and health promotion, resource flows and policies still favor secondary and tertiary care. Policies calling for capital investments in district hospitals and CHSs, mentoring arrangements to strengthen competencies of district hospital staff, and the expansion of services covered by health insurance at lower-level facilities have begun to strengthen primary care. However, the health system remains strongly hospital-centric. In the absence of a strong regulatory framework for supervision and control of hospitals, the "socialization" policy and public-private partnership (PPP) arrangements (in place to recover capital investments from private investors, including hospital staff) are further aggravating the overuse of high-tech health services. At the same time, the CHS level is under resourced: staff tend to have poorer qualifications, the facility is authorized to provide only a limited scope of services, and CHS budgets are highly dependent on local budget allocations (with health insurance reimbursements accruing to the district even if services are delivered at the CHS). Patients are often referred upward, but then are retained at the hospital rather than being sent back to the CHS for follow-up. Preventive and promotive health measures have been inadequately integrated into curative care services because of policies that assign these roles to different agencies and financial incentives that favor curative interventions at the expense of prevention.

Role of the MOH and Provincial Health Departments. Current organizational reforms in the health sector focus on consolidating the units working on preventive medicine (e.g., HIV/AIDS control centers, reproductive health centers, etc.) and reintegrating district-level preventive and curative care units. The regulatory function in health insurance has been separated from the operational and payment functions, with health insurance policy making residing with the MOH while payment is the responsibility of Viet Nam Social Security (VSS). Despite these reforms, as both a regulator/steward of the system and a provider of services through direct management of government health facilities, MOH policies and resource allocations conflict with the need for income generation for its health facilities. Also, private health facilities face regulations and enforcement that can be more (or less) stringent than the public sector (depending on the area). The MOH has also faced substantial difficulties in advocating for measures outside of the health sector to enhance population health; more attention needs to be paid to promoting health in all sectors.

Health information systems. Major efforts are under way to increase the application of information technology in the health sector and clinical management. Websites for the Ministry, local health authorities, and facilities are increasingly used to disseminate information. Various agencies and units of the health sector collect vast amounts of administrative data, including on health professional registration, infectious disease surveillance, and pharmaceutical prices. VSS now has a consolidated database to facilitate electronic claims processing, from the lowest level of care. Discussions to create unique electronic patient records are under way. Despite the rapid adoption of information technology, rules on how health information can be used, by whom, and for what purposes have not yet been developed. Sharing of information across departments remains weak. The MOH's dissemination of health statistics is typically delayed, with inconsistencies in estimates over time. Consequently, the use of data for policy making, regulation, and planning remains weak. Almost no data are available about the private health sector, despite its substantial contribution to outpatient care.

Collaborative efforts to accelerate progress toward UHC

EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

External partners are engaged in Viet Nam to build national capacity and strengthen the health system. The Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), as well as the UHC Partnership led by the WHO, and supported by the European Commission and Luxembourg, are supporting the Viet Nam government and strive to accelerate progress toward UHC. Cooperation between these partners is close, facilitated by formal and informal coordination mechanisms. Formal mechanisms include the Health Partnership Group (convened by the MOH) and the technical working groups of the MOH (e.g., on nutrition, reproductive health, human resources, information systems, health financing). Currently, the areas in which these partners are collaborating most closely are health financing reform (especially provider payments), equity, grassroots service delivery reform, human resource development, and pandemic preparedness. Other important partners include the European Union (EU), the Asian Development Bank (ADB), the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the United Nations Population Fund (UNFPA), the Food and Agriculture Organization (FAO), and the government of Korea.

The PHRD program, financed by the government of Japan and carried out by the World Bank, consists of two main activities: analytical and advisory work intended to enhance the efficiency with which health sector financing is used in Viet Nam, and a set of activities intended to strengthen Viet Nam's preparedness for pandemic emergencies.

PLANS FOR FUTURE COLLABORATIVE WORK

Policy and Human Resources Development (PHRD)-funded advisory support

The PHRD program, financed by the government of Japan and carried out by the World Bank, consists of two main activities. First is analytical and advisory work intended to enhance the efficiency with which health sector financing is used in Viet Nam. The objective is to help the Ministry of Finance, the Ministry of Planning and Investment, the Ministry of Health, Viet Nam Social Security and the provinces to (i) identify areas of the health system where money is being spent without yielding substantial improvements in health with a view to getting more value for money out of existing spending, and (ii) identify how, in a select subset of these areas, spending on activities with low returns to health can be reduced, thus freeing up funds for activities with better returns.

Second are a set of activities intended to strengthen Viet Nam's preparedness for pandemic emergencies. The objective is to provide analytical and advisory services to the government of Viet Nam to implement key recommendations of the Joint External Evaluation) and, in so doing, strengthen pandemic preparedness. The specific objectives are to: (i) improve overall preparedness and coordination of capacity for pandemic risk reduction, and (ii) strengthen management of specific priority sources of zoonotic and pandemic risk.

In carrying out these activities, the World Bank and the government of Japan collaborate with other agencies, including JICA, WHO, UNICEF, CDC, EU, and ADB, who also have current and future engagements with the government of Viet Nam in these areas.

Activities to improve efficiency in health spending will also inform the design and implementation of an IDA-financed project (which also benefits from a buy-down from the Global Financing Facility) that seeks to improve the overall efficiency of the health system through strengthening the capacity of primary care facilities.

References & Definitions (page 1 indicators)

UHC Service Coverage Index (2015) – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country) – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country) – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015) – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

Wealth Differential in Under-five Mortality (Single data point, year varies by country) – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

Performance of service delivery – selected indicators (Single data points, years vary by country) – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/

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