

Acknowledgements

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This document was produced under the overall direction of Vivian Lin, Peter Cowley, Khin Pa Pa Naing and Anjana Bhushan (WHO, Regional Office for the Western Pacific, WPRO).

The principal writing team consisted of Laura Subramanian, Jocelyn Fifield, and Asaf Bitton at Ariadne Labs, United States of America.

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Background

In recent decades, the Communist Party of Viet Nam (CPV) and the Government of the Socialist Republic of Viet Nam (GOVN) have embraced primary health care (PHC) as a strategy to achieve universal access to health care, aligning with the call for increased attention to PHC from the 1978 Alma-Ata Conference (1,2). Before the 1980s, the CPV promoted a state-financed health system with free health care for all (3,4). In the 1980s, the financing model shifted as the CPV and GOVN launched the *Doi Moi* policy (1986) which established a socialist-oriented market economy including a private health-care system, and then issued Decision No. 45 (1989) which made it possible to charge user fees in state health facilities. This transition affected quality and access to the public sector community-level PHC infrastructure, known as Commune Health Centers (CHCs) (3,5–7). Subsequently, in the late 1980s and 1990s, several factors (reduced local financing for CHCs, staff migration to the private sector and perceived low quality of care at CHCs) drove patients to provincial and national hospitals, which became overcrowded (3,6). By the mid-1990s, out-of-pocket expenses soared to 80% of total health expenditure, leaving the poor less able to access care (4). Despite national gains in health indicators since the 1960s, regional gaps remained, indicating the need for revitalization of the PHC system to improve health care access and outcomes (7).

In the spirit of the 1978 Declaration of Alma-Ata, and in response to the challenges facing the PHC system, the GOVN Ministry of Health (MoH) and the CPV introduced a number of broad national health system reforms beginning in the 1990s. These reforms address numerous parts of the health system, including service coverage, access, use, leadership and health financing (3,6,8). The overarching goal of many of these reforms has been to improve community-level health outcomes and public satisfaction with CHC services, as well as reduce hospital overcrowding and costs.



Interventions

Expanding CHC infrastructure and service access

Viet Nam launched the first of its CHC-focused reforms in 1994, with Prime Minister Decision No. 58 on CHC network organization and manpower. This landmark decision facilitated improvements in CHC infrastructure and staff training (6,9); it also allowed CHC staff salaries to be paid from the central budget, to improve CHC staff remuneration and morale (4). The GOVN worked to expand CHC coverage and infrastructure with international donor support; as of 2004, 98% of communes have a CHC and at least one health worker, and this progress has been sustained (4). Decrees and circulars in the 2000s further supported these changes through clear delineation of CHC functions and tasks (10), guidance on the responsibility of higher level hospitals to support community-level facilities (11), establishment of steering committees to oversee CHC activities (3), and compulsory CHC funding norms and budgets (4).

Improving CHC service capacity and quality

In addition to these improvements in CHC infrastructure and support, CHC service capacity was strengthened by a subsequent series of reforms. The 2011 MoH Benchmark Standards for CHC Readiness specified 90 indicators relating to equipment availability, facility standards, staffing and other criteria. In 2014, the MoH issued a list of essential medications and supplies required for CHCs to meet national standards (3), and specified national benchmarks for commune health. In 2017, MoH Circular 39 qualified the basic package of PHC health services that CHCs must offer, including the eight basic services from the Declaration of Alma-Ata (13). CHCs are now responsible for a range of PHC services, including preventive care for maternal and child health, curative care, and hygiene and health promotion (3,6). The MoH is currently conducting a pilot project in 26 communes across eight provinces to assess CHC human resources, equipment, infrastructure and services, with the results informing both an updated CHC readiness framework and capacity-building efforts (14).





Increasing availability of qualified CHC providers

Availability of qualified CHC providers has been influenced by several national reforms. The Law of Examination and Treatment (2009) provided a legal framework for quality assurance by mandating educational institution accreditation, and health worker licensing and continuing education (3). The MoH has issued competency standards for nurses (2012), midwives (2014) and general practitioners (2015), as well as accreditations for health worker training institutions and programmes (10), and has specified professional standards and functions for each health facility level (2013). In 2017, the Health Professionals Education and Training for Health System Reforms Project launched, with an objective of strengthening PHC through training community-level teams (15). Project No. 1816 (2010) instituted capacity-building for health providers at lower level hospitals, which was intended to trickle down to CHCs (3).





Transforming health financing for PHC

Concomitant health insurance reforms in Viet Nam have improved the financial accessibility of CHC services, particularly for the poor. PHC fee exemptions for the extreme poor were introduced in 1994 (6); Program 135 (1998) offered a service package including free health care to nearly 1800 poor communes (16); and the "Strategy for the Protection and Care of People's Health, 2001–2010" promoted equity in access to and use of basic health care services (17). An MoH decision in 2002 mandated a provincial "Health Care Fund for the Poor" (4), and subsequent decrees (2005) mandated free health services for children aged under 6 years, and enrolment of the poor in free health insurance. The 2009 Social Health Insurance Law resulted in nearly complete enrolment of the poor in health insurance by 2011 (8), although gaps remain in translating enrolment to effective service coverage (most notably for preventive and promotive services, which are not covered by the health insurance fund) (8). In 2014, a law mandated health insurance for all. Together, these reforms have improved financial access to community-based care for a significant part of the Vietnamese population. Currently, the GOVN is targeting 85–90% participation in health insurance by 2025. with 100% coverage of the poor, elderly and other vulnerable groups, alongside financing reforms for PHC services (18).

Private sector

Aside from the privatization that occurred in the public sector (i.e. user fees) since *Doi Moi*, a parallel private health sector has played an increasingly important role in PHC, accounting for 40% of total outpatient visits in 2010 (19). The private sector consists mainly of outpatient clinics and pharmacies at community level (many of which are staffed by public employees after official working hours), and a growing number of hospitals in urban areas. Since the late 1980s, patients from a variety of socioeconomic backgrounds have sought outpatient care at private clinics because of convenience, better staff attitudes and shorter waiting times (3,19). Opportunities remain to strengthen integration of the public and private sectors for PHC, and to regulate private sector health services.

Impact

Viet Nam's initiatives to strengthen CHCs have greatly improved coverage, access, use and quality of PHC services (3). There is now a vast network of about 11 000 CHCs, each serving about 5000 people (3, 19). The country has made great strides in equitable access to PHC; for example, services for and experiences of patients at CHCs do not vary greatly by socioeconomic background (7,20), there is a pro-poor distribution of benefits at the PHC level (21), and CHCs and district hospitals provide a substantial share of care for all but the wealthiest citizens (20). CHCs generally have the basic infrastructure, staffing and equipment to provide quality preventive and curative services, although some gaps remain in provider competence and availability of essential medications (3,5,10,20,22,23). Patients are generally satisfied with CHC care (20,24), and out-of-pocket expenditures have decreased for insured outpatients seeking covered services at the commune level (on average VN\$ 3600, equivalent to US\$ 0.15), although expenditures are considerably higher for non-insured outpatients (on average VN\$ 48 400, equivalent to US\$ 2.08) (20). CHCs are also increasingly integrated in the health insurance system, with 80% of communes participating in 2014 (20).

The revitalization of the CHC network has substantially improved service coverage, including the percentage of pregnant women who attend four or more antenatal care visits (from 29% to 74%, 2002–2014), rates of children receiving appropriate treatment for diarrhoea (from 24% to 58%, 2000–2014), and facility-based delivery rates (from 59% to 94%, 2000–2014). This has spurred remarkable gains in health outcomes, including Viet Nam's achievement of the United Nations Millennium Development Goals (MDGs) (3). Mortality in children aged under 5 years (MDG 4) dropped from 51 to 22/1000 live births (1990–2016), maternal mortality (MDG 5) decreased from 81 to 54/100 000 live births (2000–2015), and life expectancy increased from 71 to 76 years (1990–2016) (25).



Way forward

PHC remains a priority in Viet Nam as a key strategy to ensure health care for all. Urbanization and an ageing population has brought a rapid epidemiological transition and shifting disease patterns (26), highlighting the need to strengthen PHC capacity for noncommunicable disease (NCD) prevention and management through evolving the functions and structure of CHCs (12,20,23,27). As Viet Nam transitions to a middle-income country, increased national investments are needed in CHC infrastructure and coverage of preventive and promotive health services under the health insurance fund. There is also an ongoing need for quality improvement of PHC services, particularly in the rapidly expanding and loosely regulated private sector, where further development is being encouraged by the government to reduce pressures on the public system.

The MoH Health Sector Development Plan for 2016–2020 proposes restructuring community services to reflect the rise in NCDs, increasing investment in CHC infrastructure, reforming financing mechanisms to incentivize the provision of PHC, and reforming health worker training and allocation to improve CHC staffing (10). In addition, Prime Minister Decision No. 2348 set forth a national plan to strengthen the PHC network at district and commune levels in 2016–2025 by reforming PHC structure, working mechanisms, financing mechanisms and health worker development (28). The Viet Nam Health Financing Strategy for 2016–2025 proposes financing reforms to institute payment mechanisms for PHC services, allocate funds for community health care, include PHC services in health insurance fund coverage, and prioritize PHC services and NCD care in a cost-effective health service package (18). In 2017, the GOVN issued Resolution 20-NO/TW on strengthening health protection, health care and health promotion; this resolution emphasizes that health prevention and PHC will be covered from the government budget (29). Together, these reforms will indirectly improve the quality of PHC services through improving CHC infrastructure and staff training and availability.

The case of Viet Nam shows that strong political will to improve access to care, combined with a supportive policy environment, can successfully increase the availability and quality of PHC services, and contribute to improved service coverage and health outcomes.



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