Viet Nam: a primary health care case study in the context of the COVID-19 pandemic

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Acknowledgements

The primary health care (PHC) case studies in the Western Pacific Region were commissioned and overseen by the Alliance for Health Policy and Systems Research, a hosted partnership based at the World Health Organization (WHO) headquarters, in collaboration with the WHO Regional Office for the Western Pacific (WPRO). This study was authored by Oanh Tran Mai, Thang Nguyen Thi, Cuc Nguyen Thi Thu and Tuan Khuong Anh. WHO WPRO, the WHO Country Office for Viet Nam and a team of independent experts provided critical review and input. Special thanks go to Stephanie Topp and Alexandra Edelman for their helpful reviews, and Lluis Vinals Torres, Ogochukwu Chukwujekwu, Anis Kazi, Robert Marten, Jeffrey Knezovich, Sonam Yangchen, Yasmine Yahoum, Joanna Fottrell and David Lloyd for their support in the development of this publication.
Executive summary

Viet Nam is a lower-middle income country located in the South-East Asia Region with a population of more than 97 million people (1). The aim of this case study is to examine key aspects of primary health care (PHC) in Viet Nam to inform future policy and practice, incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022.

Viet Nam successfully achieved the targets of the Millennium Development Goals (MDGs). However, Viet Nam’s health system has been severely affected by the double burden of infectious diseases and noncommunicable diseases (NCDs), with the latter on the rise and accounting for two-thirds of all Vietnamese deaths each year (2).

The current health system operates under a mixed model of public and private providers. There are three main levels of service: the central level with central hospitals; provincial levels with provincial hospitals; and the grassroots level with district health centres (DHCs) and commune health stations (CHSs). CHSs are considered the basic unit of primary care delivery and serve as a foundation for the national health care system. Viet Nam has a wide primary care network. Across the country, 98.7% of communes have health stations, 72.7% of villages have village health workers (3) and 80% of CHSs provide health services under the health insurance scheme (4).

Grassroots health facilities (CHSs and DHCs) play an important role in providing curative and preventive services. They account for 48.4% of total outpatient visits and 49.4% of total inpatient admissions (5). About 70% of insured patients use health care services at CHSs and DHCs (4), and CHSs also deliver essential health prevention functions. However, DHCs and CHSs in disadvantaged areas face challenges such as a shortage of doctors, limited capacity, insufficient budgets, lack of medicines and poor medical equipment. As an open referral policy allows insured people to seek health care from district or upper-level service providers, CHCs do not play a gatekeeper role in the health service delivery system.

The government provides policy direction on health care and emphasizes that protecting, taking care of and improving people’s health is the responsibility of each citizen, the whole political system and the whole of society, thus requiring the active participation of all relevant stakeholders. Multi-sectoral engagement assists the achievement of health outcomes. Strengthening grassroots health facilities is a high government priority as evidenced in policies that facilitate investment in DHCs and CHSs to expand services, staff rotations and the capacity of commune health workers.
Factors that facilitate Viet Nam’s PHC success include: i) high political commitment and strong leadership; ii) good governance structures and regulations, involving partnerships within and across sectors; iii) availability and accessibility of primary care infrastructure; iv) sufficient budget for grassroots health facilities; and (v) engagement of communities and other stakeholders to address social factors that influence health and health care.
Introduction and national context

Viet Nam is a lower-middle-income country in South-East Asia with a population of more than 97 million people. Gross domestic product (GDP) per capita was US$ 2385 in 2017 and estimated to be US$ 2587 in 2018 (1). National poverty lines reduced from 20.7% in 2010 to 6.7% in 2018. Viet Nam has observed significant improvement in life expectancy from 44.4 years in 1960 to 76 years in 2017 (1).

Viet Nam successfully implemented the MDGs and made outstanding achievements against the MDG targets. It has made significant progress in reducing the infant mortality rate (IMR), the under-5 mortality rate (U5MR) and the maternal mortality ratio (MMR). IMR declined from 36.9 deaths per 1000 live births in 1990 to 16.9 deaths per 1000 live births in 2017 (6); and U5MR from 58 deaths per 1000 live births in 1990 to 21.1 deaths per 1000 live births in 2017 (7). MMR declined from 233 deaths per 100 000 live births in 1990 (8) to 43 deaths per 100 000 live births in 2017 (2). On the Sustainable Development Goals (SDGs), Viet Nam needs to accelerate progress by 2030 to achieve SDG3.1 to reduce the MMR to below 45 deaths per 100 000 live births, the IMR to below 10 deaths per 1000 live births and the U5MR to below 15 deaths per 1000 live births (9).

Since 2012, Viet Nam has had an ageing population. The number of people aged 60 and over constituted 12% of the total population in 2022, and it is predicted that the proportion of people aged 60 or over will exceed 20% by 2038 and 28% by 2050 (10). Similar to other countries, Viet Nam is experiencing an epidemiological transition with a double burden of disease. Estimates from WHO of the burden of disease (2) show that the percentage of deaths due to NCDs was 77.2% of the total number of deaths in 2018. Results from a study on the burden of disease and healthy life expectancy in 2017 also showed that NCDs caused the highest burden of diseases and deaths, accounting for 74.3% total disability-adjusted life years (11). To respond to these changing disease patterns, health service delivery models need to include health promotion and prevention to address key risk factors, including screening for early disease detection and management.

The current health system operates under a mixed model of public and private providers, with the public sector playing a substantial role. It is structured across four layers that reflect the state administration system, including central, provincial, district and commune levels – with the latter two constituting the grassroots health care network. Central health facilities are managed directly by the Ministry of Health (MoH); provincial and district health facilities and CHSS are managed by the Provincial Health Department (12). The private sector is growing, driven by the increasing number of people residing in urban areas. The government has also been encouraging public–private hospital partnerships to ensure adequate service provision to meet growing health care needs.

Viet Nam’s total health expenditure as a share of GDP is comparable to countries of similar income levels and was measured at 5.25% in 2019 (13). Furthermore, there has been a substantial increase in the country’s total health spending.
Of total health expenditure, the share of public financing increased from 35% in 1998 to 47% in 2017 (14). In the same period, the share of government health spending out of total government spending increased from 7.6% to 9.3% (14). The state budget for health is channelled either through direct subsidies to public health care providers or through subsidies for social health insurance (SHI) premiums for vulnerable population groups (such as low-income groups, ethnic minorities, people over 80 years, returned services personnel and pupils/students). Although public financing increased in 2019, private health expenditure still constituted roughly 50% of total health expenditure that year, of which (13).

Health system governance is decentralized. While the MoH is responsible for developing health policies and technical guidelines and for monitoring policy implementation, local authorities are responsible for the management of health-related activities in their provinces. Under decentralization, the health care sector at local levels controls budget allocations and personnel, facilitating responsiveness to local needs.

This case study examines key aspects of PHC to inform future policy and practice, incorporating lessons learned during the COVID-19 pandemic between January 2020 and July 2022.

Methodology

A desk-based literature review and analysis was conducted to synthesize evidence. This included an analysis of existing policies related to health care and PHC, as well as a document analysis of MoH reports, international organizations and published research studies to understand the policy implementation process and identify challenges. Data from Viet Nam Social Security, the Health Statistics Yearbook and a health workforce database were also accessed and analysed.

Field surveys were carried out in two provinces (Binh Phuoc and Ha Tinh) to enable a rapid assessment of the performance of selected DHCs and CHSs. Stakeholder consultations with MoH policy-makers and health managers, health care providers, related social associations and service users were also conducted. The aim of the consultations was to understand policy gaps, difficulties in implementing related health care policies, factors influencing the performance of CHSs, and system-related challenges and supply-side bottlenecks.

Data were synthesized narratively against the five strategic actions from the WHO Regional Framework on the Future of Primary Health Care in the Western Pacific Region (15), namely: service delivery models, empowered individuals and communities, fit-for-purpose PHC workforce, PHC financing, and a supportive and enabling environment.
Service delivery models

The health service delivery network includes both the public and private sectors. The public sector provides services to 83.4% of all inpatients and 72.1% of all outpatients (16).

At the primary care level, DHCs and CHSs are responsible for providing primary care services. Each district has one DHC or a district hospital. In total, there are 629 DHCs – about 70% of districts have a DHC that provides both curative and preventive functions, while 30% of districts have a district hospital and separate DHC. There are 11,101 CHSs and about 544 regional polyclinics (inter-commune polyclinics). Across the country, 98.7% of communes have CHSs, 72.7% of villages have village health workers and 80% of CHSs provide health services under the health insurance scheme (3,4). CHSs function under the umbrella of DHCs. Together with the facilities in the public sector, more than 35,000 private clinics across the country also participate in providing PHC services in the community (17).

CHSs are considered the first level of care, each serving a population of roughly 5000-10,000 people, located in both rural and urban areas. The DHC is the next level up and serves as the first level with inpatient hospital services. Provincial hospitals and specialist hospitals serve as referral centres at the district level. From the provincial level, national-level hospitals serve as the final referral centres. Bed occupancy rates are high, often close to 100% – especially at the central and provincial hospitals. This leads to severe overcrowding and reflects the highly hospital-centred nature of the system when health prevention and health promotion have not been well implemented at the primary care level. The average length of hospital stay per inpatient decreased from 7.3 days in 2010 to 6.1 days in 2018 (16). Data on readmission rates are not available.

Grassroots health facilities (CHSs and DHCs) play an important role in providing curative services. In the COVID-19 pandemic, CHSs were responsible for the treatment and management of about 80% of confirmed cases with mild or no symptoms isolating at home. In 2019, 48.4% of total outpatient visits and 49.4% of total inpatient admissions were at DHCs and CHSs (18). However, even though 80% of insured people registered at grassroots facilities as their first point of contact (18), DHCs and CHSs are not necessarily able to play a gatekeeper role because the government allows inpatients to freely self-refer to any other health facility. Many patients opt for hospital care over CHSs due to staff shortages, limited capacity and lack of medicines in CHSs. Viet Nam Social Security reported in 2019 (18) that 69.7% of insured patients used curative health services at district hospitals and CHSs; and that 72% of the poor and 50% of the near poor received curative services at CHSs and district hospitals. Potentially due to the open referral policy, the proportion of people using outpatient services at CHSs shows a downward trend, from 17.7% of the population in 2016 to 15.9% in 2018.
Village health workers are the extended arm of the grassroots health care network. Over 72.7% of villages have village health workers (3) and about 2700 village midwives work in 8000 hard-to-reach villages in 10 mountainous provinces (12). Village health workers are responsible for delivering health prevention activities and public health programmes. The government has prioritized the development and implementation of different policies to maintain and improve the performance of these community health workers. They are trained and receive a monthly income as well as free health insurance cards. It was reported in the focus group discussions with local health managers that these community health workers have made significant contributions to the achievement of health outcome indicators, such as reducing the MMR and U5MR.

Shortcomings and limitations of grassroots health facilities include their focus on treating sick people at medical facilities and limited attention to disease prevention, health promotion, early disease detection and disease management. Human resources capacity is limited, which likely diminishes service quality. A key barrier to improving grassroots health care is inadequate financial resources to support preventive and public health functions, reflecting inequitable allocation of health insurance funds for CHSs (funding for CHSs only accounts for 2% of total health insurance fund utilization) (19).

Recognizing these challenges, the government has implemented reforms to shift health care from hospital-based provision to primary care, disease prevention and health promotion (20). The grassroots health care network plays a vital role, as more than 65% of the population live in sub-urban and rural areas. Since 2016, these facilities have been upgraded to share the responsibility of managing and treating NCDs locally (21). Changes include increased investment in DHCs and CHSs, staff rotation to strengthen capacity for district health workers, and adding preventive care to the scope of services covered by the government budget and screening by health insurance scheme. The family medicine model is being introduced at CHSs to ensure comprehensive care for the population in which the CHSs are responsible for receiving patients, management, primary care, counselling, disease prevention, health promotion, emergency care, medical examination and treatment according to family medicine principles for individuals and households (22).

Nonetheless, grassroots health facilities still face challenges. Changing disease patterns (e.g., growing rates of NCDs, injuries and the emergence and re-emergence of infectious diseases) and an ageing population are changing population health care needs. In addition, growing demand for health services is occurring against a backdrop of limited public understanding of the health system. This is reflected in low levels of trust in health care services in grassroots health facilities and the use of more costly health services in hospitals. A further challenge is the imperative to reduce disease risk factors, which is likely to require a robust risk communication strategy. Finally, there is a need to re-establish referral systems in health service delivery to strengthen the gatekeeper role of CHSs. Leadership commitment with better regulatory capacity and enforcement are likely to be key enablers for health system reform.
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to strengthen PHC. Overall, more investment is needed to enable grassroots facilities to gain people’s trust and become their first point of contact for health care services.

Empowered individuals and communities

Community participation and empowerment are seen as fundamental to achieving equitable, people-centred PHC. Policy directives (23) have clearly identified the responsibilities of individuals, communities and the whole of society in health care. The objectives and tasks of protecting, caring for and improving people’s health must be incorporated into both national and local socioeconomic development strategies and policies.

Steering Committees for the Care and Protection of People’s Health have been established in every commune, district and province with participation from all relevant stakeholders. Commune Steering Committees include the vice chair of the Commune People’s Committee (the head of the Committee), the head of the CHS (the vice head of the Committee), the chair of the Fatherland Front Committee, the chair of the Women’s Association, the chair of the Farmer Association, the chair of the Veteran Association, the head of the Youth Union and representatives of schools located in the commune. The Commune Steering Committee fulfils the following functions, to: (i) develop an action plan, directing and guiding the implementation of activities related to the protection and care of people’s health in the commune as well as implementing the National Criteria for Communal Health; (ii) monitor, supervise and evaluate the results of health care of the commune; and (iii) issue operating regulations and assign specific tasks to members of the Steering Committee. The engagement of stakeholders in this Steering Committee is a mechanism to ensure intersectoral collaboration in health care at the community level.

Civil social organizations (CSOs), including the Fatherland Front, the Women’s Association and the Youth Union, have directly implemented interventions to improve the health, economic and social well-being of their members. They also provide services such as nutritional awareness classes for parents, microcredit for the poor, adolescent and youth health promotion, and mediation in cases of domestic violence. The four-layered organizational structure of these mass organizations (central, provincial, district and commune levels) enables effective transmission of directives and decisions and the identification of needy households based on locally contextualized knowledge. In addition, under the 2015 Law on the Fatherland Front, the affiliates of these organizations are allowed to participate in formulating policy, and implementing and monitoring social debate, including presenting citizens’ concerns to political leadership (24).

Efforts to prevent and control COVID-19 transmission underscore the importance of intersectoral collaboration and community engagement in health care. The whole of society engaged in preventing and controlling COVID-19 and the government enacted high-level response measures. The National Steering Committee on COVID-19 Prevention and Control was established in January
Empowered individuals and communities

2020, within a week of the first few confirmed cases being reported. This Committee was first led by the Prime Minister and involved a multi-ministerial and multisectoral composition. The presence of key ministers and parties in the Committee enabled it to make decisions and systemically coordinate the implementation of response measures. At local levels, COVID-19 Steering Committees were also established in all 63 provinces and 707 districts in 2020.

Recognizing the vital role of the community in responding to COVID-19, the government mobilized communities and empowered them to prevent virus spread. To promote the active engagement of the community, the government implemented different communication activities to improve public awareness and understanding of individual responsibilities. This improved community trust in the capacity of the government to lead the response. Community networks and primary care facilities played an important role in providing communication and in detecting suspected COVID-19 cases or communities at risk. This experience highlighted that active engagement of individuals and communities is critical to ensure the success of PHC.

Key challenges in empowering people and communities in health care, include: (i) that people lack information and knowledge on health as well as disease management, especially among those living in disadvantaged areas; and (ii) that cultural barriers exist in some areas so people may lack the confidence and skills to participate in health care activities. Strong local leadership is a key enabler of public trust and community participation in health care.
PHC workforce

According to MoH statistics published in 2021, 49.8% of health workers work at provincial health facilities, 34.6% at DHCs and only 15.8% work at the commune level (25). On average, each CHS has 4.85 staff. In addition, each village also has a village health worker who is attached to a CHS and who is responsible for information, education and communication activities and people’s health management in the village.

In 2020, the density of doctors per 10,000 inhabitants was 9.4. In some localities, this figure is much lower than the target set by the government for 2025 of 10 doctors per 10,000 inhabitants (26). The nursing index per 10,000 inhabitants is also low, with only 14.3 nurses per 10,000 inhabitants against a target of 25 (13). According to WHO data, Viet Nam has a low density of doctors and nurses, and an average density of pharmacists compared to other countries in the region (27).

Imbalanced geographic distribution of the health workforce remains a challenge. Many health care providers have moved from rural to urban areas for better working conditions and opportunities for professional development. The government has issued policies to support training, attract quality human resources for grassroots health care with higher remuneration. However, there are still challenges in attracting and retaining health workforce at the grassroots level (28).

The capacity of health care providers in CHSs is still limited due to: (i) fewer opportunities to participate in training programmes to update knowledge continuously (in a 2020 study, 38% of interviewed doctors working at CHSs reported there was no opportunity for short-/long-term training); and (ii) poor working conditions (26.0% reported that infrastructure and equipment did not meet requirements, and that there were budget shortages and lack of medicines) (29). Even though the government develops policies to strengthen the capacity of grassroots health facilities, policy implementation is often weak due to low commitment among local leaders.

In this context, several policies have been implemented to enhance the quantity and quality of the health workforce at the grassroots level, including policies to recruit students in rural areas, enable additional allowances for health staff working in rural/remote areas, and support rotation of health staff at district and commune levels. As a result, in 2020, 90% of CHSs had a doctor, 95% had an obstetrician or midwife, and 99.7% had active health workers (30). Medical education reforms were introduced in 2013 that shifted training curricula for doctors, nurses and midwives to a competency-based model (31). These reforms aim to improve training quality for the health workforce.
PHC financing

Viet Nam's health care system is financed through a mixture of sources, including government budget allocations, social insurance contributions and direct out-of-pocket payments. According to the MoH, 90.85% of the population were covered by national social health insurance (SHI) in 2020. The government’s goal is 95% SHI coverage by 2025 (20). The SHI benefits package focuses on curative services, while preventive and promotive care for the whole population (for both SHI and non-SHI members) are subsidized by the government through the state budget. However, health insurance currently only pays for medical examination and treatment services. Preventive services such as counselling, health management and disease screening remain unfunded.

Financial sources for DHCs and CHSs are insufficient. Findings from one assessment show that the recurrent budget allocated for CHSs is very low and only covers about 30–50% of actual needs (29). The allocation of health insurance funds to district and commune health facilities is also low. While as many as 70% of insured patients use services at district and commune health facilities, these facilities receive only 32% of health insurance funds, and only 2% of health insurance funds are allocated to CHSs in 2021 (18). As a consequence, CHSs often lack key resources, including medicines (32). Nor do many CHSs have enough required medicines as per the MoH’s list, especially antihypertensive medicines to provide patients with drugs for 30 days. Insured patients must pay out-of-pocket to buy additional medicines due to the medicine shortage in CHSs.

The revised Health Insurance Law (33) introduced in 2014 allows for three provider payment methods: capitation, fee-for-service and diagnosis-related group (DRG) payment. Currently, providers receive a combination of budget funding and other payments from Viet Nam Social Security and directly from patients, of which fee-for-service has been the dominant mechanism since 1995, with the associated risks of cost escalation and fragmentation of service delivery. The MoH has been implementing reforms to the provider payment mechanism consisting of capitation payment for outpatient care and DRG for inpatient care to increase its effectiveness; however, this was still in the pilot phase at the time of writing in 2022.

Health financing policies have also been issued and implemented to expand coverage in terms of the population, services and financial protection. However, as there is no gatekeeping function (giving patients a choice of health facilities for their examination and treatment), there are challenges in applying capitation payment methods for outpatient care at grassroots health facilities.
Enabling environment for PHC

Political commitment and leadership

Key service delivery challenges include severe overcrowding at central and provincial hospitals and the inability of primary care facilities at the grassroots level to play a gatekeeper role. Strengthening the capacity of the grassroots health network, especially around the role and capacity of CHSs, is likely to be key in ensuring the provision of comprehensive, continuous and effective PHC services.

Against this backdrop, political commitment and leadership are needed to address the challenges and shift from hospital-based care to PHC. Evidence indicates better health system performance in the localities where local government leaders are committed to supporting the health sector and to integrating health indicators into socioeconomic development indicators of communes, districts and provinces (32). Viet Nam has achieved target health outcome indicators even when compared to other countries with similar GDP per capita. This likely reflects political commitment and strong leadership in implementing pro-poor policies to reduce financial barriers and increase people’s access to health care services.

At the early stage of the COVID-19 pandemic, the government implemented different strategies to prevent the spread of the virus. It increased the budget for the health sector as well as other sectors to prevent transmission and limit the impact in the country. Expenditure related to COVID-19 – including testing for case detection, treatment, contact tracing and institutional quarantine – was subsidized by public financing. Government budgets covered the treatment of confirmed COVID-19 cases, contact tracing and quarantine of suspected cases, while the health insurance fund covered the testing and treatment of other diseases. The government budget also covered the supply of drugs, materials, consumables and biologicals for testing and an extra allowance for health sector staff involved in COVID-19 prevention and control.

Governance and policy frameworks

The decentralization of the health system has given more power and responsibilities for the health care sector to local levels of government and has allowed them to be more responsive to local health care needs. The roles and responsibilities of the national and local government, as well as related stakeholders, are clearly defined in specific policies which also facilitate cooperation between the health sector and other related sectors. This governance structure gives the provincial governor more freedom in setting health and multisectoral priorities and in supporting provinces to allocate resources across districts and communes to promote PHC. Evidence from stakeholder consultations indicate that governance structures and regulations support partnerships within and across sectors and promote community leadership and mutual accountability.
Enabling environment for PHC

PHC infrastructure

Viet Nam’s success in achieving MDG targets also reflects the country’s wide grassroots health service delivery network that facilitates the provision of accessible primary care. Most CHSs have physicians, nurses and midwives. The provision of health care services at the grassroots level is based on a family medicine approach that includes health promotion, disease prevention and treatment, with a focus on hypertension and diabetes. In addition, Viet Nam has a large number of village health workers – 72.7% of villages had a village health worker in 2020 (3) – who are responsible for delivering health prevention activities and public health programmes. These community health workers contribute significantly to the achievement of health outcome indicators, such as reducing the MMR and the U5MR.

Resourcing for grassroots health facilities

Ensuring sufficient financial resources for PHC is critical. Financing for health prevention and grassroots health facilities comes from the government budget. The government has issued a policy that stipulates that the state budget needs to prioritize preventive medicine and grassroots health care and allocate at least 30% of the total government health budget for these aspects (34). There is anecdotal evidence that the health system achieves good results in the localities where the local government ensures sufficient budget for DHCs and CHSs.

Multisectoral collaboration

Several initiatives support multisectoral engagement. For example, Steering Committees for the Care and Protection of People’s Health have been established in every commune, district and province involving participation from health sector actors and CSOs.

Addressing the social determinants of health needs to occur concomitantly with addressing clinical care services. Viet Nam has mapped the 17 global SDGs to 115 country-specific social development targets and has identified clear responsibilities for the MoH. Ten health targets are led by the MoH and other ministries under the National Action Plan for the Implementation of the 2030 Agenda for Sustainable Development (issued in conjunction with Decision No. 622/QD-TTg of 10 May 2017 by the Prime Minister) (9). Successful achievement of the SDGs will require the cooperation of ministries, agencies and all other stakeholders in designing and implementing multidimensional and multisectoral solutions (9).
Conclusions and lessons learned

The grassroots health service delivery network plays an important role within the Viet Nam health system. CHSs improve health service accessibility and contributed to the country’s achievement of the MDGs. About half of all outpatient visits and inpatient admissions are at DHCs and CHSs and about 70% of insured patients use health care services at these grassroots facilities (18). The government has devoted significant effort towards strengthening the capacity of grassroots health facilities. However, challenges include that DHCs and CHSs still face health workforce shortages, limited capacity, insufficient budgets, lack of medicines and poor medical equipment, particularly in disadvantaged areas.

Grassroots health facilities are also facing challenges due to changing disease patterns and an ageing population, alongside growing demand for services and higher expectations from the population. Efforts to change behaviours to reduce disease risk factors are challenged by low health literacy levels. Empowering individuals, families and communities to optimize their health requires investment in improving knowledge in the community on how to protect their health. Political commitment with strong leadership and engagement of the whole of society including individuals, communities and civil society can help to strengthen PHC.

Evidence from the COVID-19 pandemic shows that the primary care system played a critical role. CHSs were responsible for the treatment and management of about 80% of COVID-19 patients with mild or no symptoms who were isolating at home. In parallel, the government issued fiscal and monetary policies to support the socioeconomic recovery and development of the country after the acute phase of the pandemic. A key imperative has been to continue to develop policies to attract medical staff to work at public health facilities, especially health workers in the field of preventive medicine.

Strengthening PHC is likely to require continuous political commitment and leadership to shift health service delivery models, to implement UHC and to achieve the SDGs. Strengthened multisectoral action is also needed to address the social determinants of health. At the grassroots level, more resources could strengthen the health workforce, including support for adequate training. There is also an opportunity to invest in enhancing health literacy of the population to help communities to be proactive in self-care for better management of NCDs.
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This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Western Pacific (WPRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.