VIET NAM

FIND
Because diagnosis matters

HEALTHCARE PROFILE

HEALTHCARE STATUS

POPULATION (2017)	LIFE EXPECTANCY AT BIRTH (2016)	TOP 3 CAUSES OF DEATH (2012)	HEALTH INSURANCE COVERAGE***
95M	75 AVG IN EAST ASIA & PACIFIC; 76 VIET NAM	22% STROKE; 7% HEART DISEASE; 5% CHRON. PULM. DISEASE	~90% OF POP.

FINANCING AND EXPENSES

TOTAL HEALTHCARE EXPENDITURE (2014)	HEALTHCARE BUDGET PER CAPITA	DOMESTIC GOV. HEALTH EXPENDITURE AS % OF GOV. EXPENDITURE (2015)	BREAKDOWN OF HEALTHCARE EXPENDITURE (2015)
$11 BN (5.7% OF GDP)	$115-120; $332 AVG IN EAST ASIA & PACIFIC*	7.9%	13% PRIVATE INSURANCE; 2% FOREIGN DONORS; 43% HOUSEHOLDS; 42% GOVERNMENT

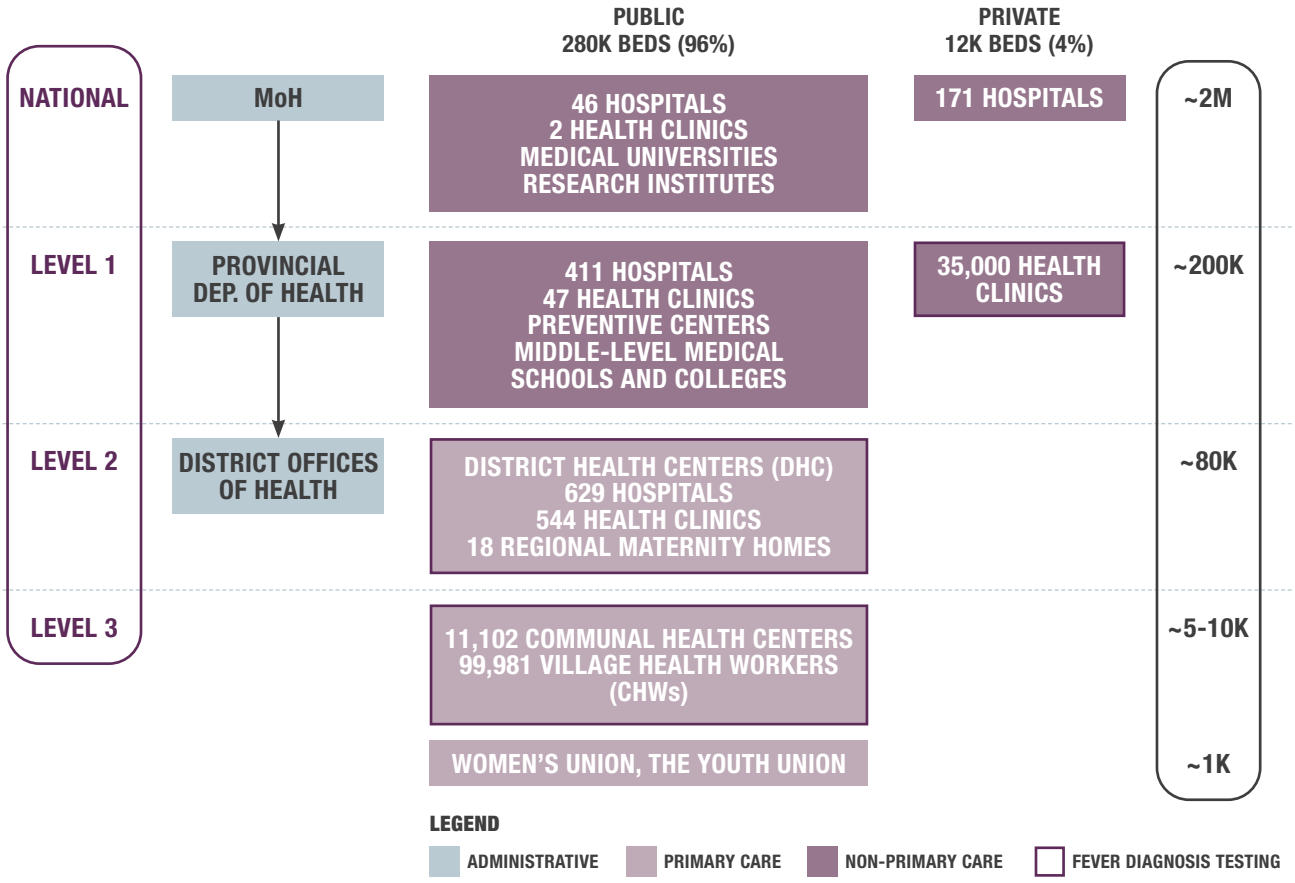
INFRASTRUCTURE

UNIVERSAL HEALTH COVERAGE (UHC): SERVICE COVERAGE INDEX (2015)	DENSITY OF PHYSICIANS (PER 1,000 POP.)	DENSITY OF NURSING & MIDWIFERY (PER 1,000 POP.)	NUMBER OF SPECIALIZED & GENERAL HOSPITALS AND CLINICS	NUMBER OF DISTRICT HOSPITALS AND CLINICS	NUMBER OF HEALTH CENTERS & HEALTH POSTS
73	~0.8 VIET NAM; 1 WHO RECOMM.	~1.4 VIET NAM; 2.5 WHO RECOMM.	~670	~1,200	~11,100

Health in Viet Nam is mainly privately funded (56%), with a lower healthcare budget per capita than the region average; UHC and life expectancy are good

Notes: (*) includes long term care, preventive care, ancillary services and other unclassified health expenditure; (**) excluding high income countries; (***) Public and private.
Sources: WHO, World Bank, BDG Viet Nam, Advention

HEALTHCARE INFRASTRUCTURE



COMMENTS

Hybrid public-private model:

- While public facilities represent the core primary care network, the Vietnamese MoH is encouraging the growth of a hybrid public-private model. Doctors in public facilities can work in private practices, and family practices are being encouraged to transition preventive and primary care to the private sector. Continuity of care is ensured across public and private facilities through private-public cooperation programmes

Social Health Insurance (SHI) reform:

- Social health insurance covers the majority (~70%) of the Vietnamese population, and includes diagnostics
- Until recently, patients were expected to visit the lowest level facility in their area, and would be referred 'up' in order to benefit from SHI. However, currently the MoH is implementing hospital autonomy where communal and district-level facilities receive funding based on the number of patients served, creating competition for services
- As the infrastructure and HCW skills at the district level are low, many patients skip district and commune facilities

Communal health centers (CHC):

- In malaria-endemic communities, CHCs have specially trained staff responsible for malaria control (among other duties)
- Village community health workers (CHWs) are the backbone of the community-level health response in Viet Nam. CHWs are engaged in outreach activities, mainly focused on health promotion and prevention, including referral of suspected malaria cases

Other malaria control stakeholders:

- The NMCP also works closely with the People's Committee, the Women's Union, the Youth Union, and village leaders

The Vietnamese primary healthcare infrastructure is transitioning towards a market-based system where patients can choose between district and communal centers

Sources: WHO, BDG Viet Nam, Advention

MALARIA DIAGNOSIS PROVIDER BUSINESS MODEL

PUBLIC HEALTHCARE FACILITIES

Primary healthcare services are of notoriously poor quality due to a lack of competence, forcing people to use services at higher levels with higher costs (accommodation costs, transportation costs and higher fees)

- While the hospital network provides the country with a high number of beds per inhabitant, Viet Nam shows a high bed occupancy rate (>100%). The outdated medical equipment, combined with limited access to the latest drugs in Vietnamese public hospitals (and specifically in the small provincial level hospitals) are commonly cited as the major challenges to improving the quality of care in Viet Nam

To address these challenges, **Viet Nam has set up a roadmap for 2020 to improve large national hospitals**

- As government funding is limited, healthcare funding in Viet Nam is partially mobilized from joint ventures with private sponsors or providers and associations to invest in upgrading healthcare equipment in public hospitals

The push for financial autonomy is driving the widespread use of a fee-for-service model that leads to potentially unnecessary hospitalization, drug use and test prescriptions:

- Over 60% of health facilities providing insured services apply additional fees-for-service beyond SHI repayments, which encourages oversupply of services to maximize revenues and profits in the context of imposed financial autonomy for public health facilities
- The law has removed copayments for the poor, ethnic minorities and those who contributed to the revolution

PRIVATE HEALTHCARE FACILITIES

The private sector is mainly focused on outpatient care, with only limited inpatient facilities which are mainly in large cities…

- Three quarters of private hospitals have less than 100 beds
- The quality of private health services is variable, considered worse than public facilities in rural areas but better in cities

…but is seen as the solution to the rapid increase in demand for healthcare services. Human resources are currently not sufficient to support growth in the public and private sectors

- Viet Nam has set up a roadmap for 2020 to notably optimize the healthcare network and unburden the large national hospitals through the support of the creation of private hospitals. Many staff have dual positions in the public and private sectors
- There are a few large and better equipped private hospitals, which are staffed with highly skilled health professionals attracted from state health sector
- The private sector is recent in Viet Nam and is characterized by growing regulation, but most services offered are covered by SHI

All care in private facilities is linked to out-of-pocket expenditure

- Both outpatient and inpatient care in private healthcare includes an out-of-pocket expenditure beyond SHI, which increases hospital revenues and creates an incentive to overtest and prescribe

The drive for financial autonomy in the public sector and additional out-of-pocket payments beyond SHI in the private sector are an incentive to overprescribe tests

Sources: interviews, Advention

HEALTHCARE STAFF AND TRAINING

	PHYSICIANS	CHWs (COMMUNE)	CHWs (VILLAGE)
GENERAL JOB DESCRIPTION	Examine in and out patients in line with standard medical procedures using various types of diagnostic mechanisms Administer and prescribe drugs based on examination, test reports and findings and counselling services	Outreach activities, mainly focused on health promotion and prevention, information regarding available facilities Monitor treatment provision and follow patients' long-term health for the TB and HIV programmes	Outreach activities, mainly focused on health promotion and prevention Triage of patients and referral to healthcare facilities
MALARIA SPECIFIC TASKS	Use IMCA and IMAI for clinical diagnosis and microscopy confirmation and treatment	Awareness of malaria and integrated vector control uptake Collection of blood smears in remote villages for microscopy testing	Awareness of malaria and integrated vector control uptake Refer febrile patients to hospitals
MEDICAL TRAINING	4-6 years (2 years for assistant physicians)	Several months, possibly including an internship (depending on region and role)	Two or three weeks initial training, as well as several days per year (depending on region)
RDT USE KNOWLEDGE	✓	✗	✗
BLOOD SAMPLING KNOWLEDGE	✓	✓	✗

	HOSPITALS	DISTRICT HEALTH CENTERS AND CLINICS	COMMUNE HEALTH STATIONS & OTHERS
TOTAL HEALTH EMPLOYEES (INCL. DOCTORS, NURSES AND ASSISTANTS) 2014	229,326	75,679	77,433

LEGEND

✓ COMPLETE KNOWLEDGE − INCOMPLETE / PARTIAL KNOWLEDGE ✗ NO / VERY LIMITED KNOWLEDGE

CHWs are involved exclusively in community engagement and supervision or referral roles, as diagnostics are restricted to physicians

Sources: GSO 2014, MoH, Advention

ACCESS TO CARE

ACCESS TO CARE, 2015

UNIVERSAL HEALTH COVERAGE INDEX (WESTERN PACIFIC, UHC)*	
NO. OF HOSPITAL BEDS FOR 10K POPULATION	2.9
NO. OF PHYSICIANS FOR 10K POPULATION	0.8

There are discrepancies in access to healthcare services among income groups and socio-economic regions in Viet Nam. The lowest rate comes from the Northern mountainous midland region, and the highest from the Mekong delta region.

Health indicators (<5 infant mortality rate, maternal mortality ratio, malnutrition rate, etc.) are poor in mountainous areas where ethnic minorities live.

There is limited access to diagnosis and treatment in most vulnerable communities. Community-based case management services delivered by village CHWs have not been widely adopted in Viet Nam, leading many febrile patients to bypass communal primary care and visit hospitals directly.

ADDITIONAL COMMENTS ON ACCESS TO CARE DYNAMICS, SPECIALLY IN RELATION TO FEBRILE ILLNESSES

Since 2017, Viet Nam has been reorganizing access rules for public healthcare, to encourage facilities to become financially autonomous

- Patients can access district hospitals directly, and no longer need a referral from community health centers
- Facilities are expected to balance their costs with Social Health Insurance payments for services provided, complemented by additional patient fees (out-of-pocket or private insurance)

The effects of this policy are not yet known, but a weakening of worst-performing community health centers is expected

- "Some patients will prefer to go to district facilities even if they are further away because they believe they will receive better treatment and care, which may reduce the budget of Communal health centers and lead to diminished capacity to provide tests and care." WHO Viet Nam Country Team, Laboratory Program Referent

Private healthcare is being encouraged by the MoH, in particular for independent GPs and family offices in rural areas

- Access to care is expected to be improved by providing additional points of care and choice for patients in rural areas
- With better knowledge of a patient's history, family offices are expected to improve quality of care provided compared to community health centers

Health coverage in Viet Nam is high, but febrile illnesses present a challenge in terms of availability of care at the most local public facilities as well as in remote areas

Note: (*) UHC is made of 16 indicators such as child treatment, malaria prevention, hospital access, health worker density. Sources: WHO, World Bank, interviews, Advention