SECTOR ASSESSMENT (SUMMARY): HEALTH SECTOR

Sector Road Map

1. Sector Performance, Problems, and Opportunities

1. Viet Nam has undergone rapid socioeconomic development, through the adoption of a socialist market economy, foreign investments, a relatively favorable business environment, and an energetic and low cost labor force. This business model has served well, resulting in high economic growth in the past decade despite external shocks. As Viet Nam achieves middle income status, and aspires to become a modern industrialized country by 2020, it needs to adjust its development approach requiring innovative leadership, institutional capacity, an educated workforce and services that are responsive to the needs of businesses and citizens.

2. The country's population of about 86 million in 2009 is growing at 1.2% per annum. The urban population is expected to increase from 30% to 45% in the next decade. Life expectancy has reached 73 years and the population is aging rapidly, with 9% of the population being over 60 years. Per capita income doubled in the last decade, and poverty reduced substantially. Most of the remaining poor live in rural areas, including ethnic groups in mountain districts. The government sees the health sector as a pillar of socioeconomic development. It wants to achieve the best possible health for all by ensuring access to affordable, quality health care.

3. Viet Nam is on track to reach the health millennium development goals (MDGs) by 2015.[1] Based on available data, between 1990 and 2009 the maternal mortality ratio (MMR) reduced from 233 to 69 per 100,000 live births (target 58/100,000 in 2015), and the child mortality rate reduced from 58 to 24 per 1,000 live births (target 19/1000 in 2015). The child malnutrition rate reduced from 45% to 19% between 1994 and 2009.[2] New HIV, malaria and tuberculosis cases have declined. Besides high health service coverage, better infrastructure, education, water and sanitation, and income have contributed to achieving MDGs. However, further health improvement will increasingly depend on lifestyle and specialized services.

4. The country is facing a triple burden of diseases including communicable diseases, non-communicable diseases (NCDs), and accidents and injuries. Communicable diseases have substantially reduced, but require major ongoing efforts to keep these under control. Common infections contribute to low productivity and malnutrition, while emerging diseases, endemic infections, fake drugs, and drug resistance pose serious global public health threats. NCDs including cardiovascular diseases, diabetes, cancers, and mental illness are now the major cause of morbidity and mortality in Viet Nam. NCDs increased rapidly due to population aging combined with old habits (smoking, alcohol, and salt), changing diets, and less physical work. Road accidents, injuries and poisoning are major causes of mortality in adults. The country is also prone to floods due to environmental and climate change. Addressing these challenges will require major health sector reforms and developments. The problem tree is in Appendix 1.

5. **Balance sector development**. Hospitals report rapidly increasing demand for modern health services, fuelled by population aging, NCDs and road accidents, but also people being more educated and prosperous, and health services becoming better and more affordable. In 2010, Viet Nam had about 1,110 public hospitals and about 100 private hospitals. There are about 20 public beds per 10,000 population, with average bed occupancy of 120%. In many

[1] http://www.undp.org.vn/mdgs/viet-nam-and-the-mdgs/
[2] Ministry of Health, Viet Nam. *Joint Annual Health Review, 2010*. Ha Noi

urban areas, small private hospitals are under construction. The government is exploring public-private partnerships for hospital construction. Rather than adding hospital beds which are already quite high, more effort should be made in preventing NCDs and accidents, injuries, and poisoning (AIP) by promoting a healthy lifestyle and safe environment. Demand could be further reduced by improving primary care services to reduce bypassing, reduce the hospitalization period with proper incentives, and provide specialized services at lower levels. There are about 800 polyclinics, 10,700 commune health stations (CHSs), and 35,000 private clinics.

6. **Improve access for the disadvantaged.** Within the region, Viet Nam has the largest disparities in health and other MDG indicators among social groups. Maternal mortality in rural areas is double that in urban areas and four times higher in ethnic minorities. Malnutrition remains high among the poor. Remote villages have poor access to affordable, quality health services due to staff constraints. The government prioritizes health care for the poor, in particular for women and children through upgrading of the network of village health workers in Viet Nam's 96,000 villages and commune health stations. Second, since the start of private practices and user fees in the nineties, health spending has risen sharply to about $50 per capita in 2008.[3] Rural people pay more due to transport costs, going to private services and self-medication. Insurance benefits are limited: the current insurance schemes combined cover 60% of the population, but account for only 18% of total health expenditures. About 61% of health expenditures is out-of-pocket, one of the major factors in income erosion and poverty.[4]

7. **Achieve quality care standards**. Viet Nam has a relatively large health work force of 280,000 staff in 2007, or 1.7 staff per 1,000 population. The ratio of nurses to doctors was 1.3, compared to the World Health Organization standard of 4–5. Most CHSs have a trained health worker, usually a midwife, and over 70% have a doctor. However, staff performance is not up to standards due to low salaries, poor pre-service training, and lack of supervision, equipments and supplies. Consumer dissatisfaction with services translates into a growing flow of patients seeking services in hospitals and the private sector. Teaching institutions are oversubscribed and unable to provide sound skills training. Substantial reforms are needed in staff development, support and regulation.

8. **Improve sector efficiency**. The sector is inefficient. While it has well established goals and strong stewardship, its organization is fragmented both vertically and horizontally. Since decentralization in 2006, MOH focuses on policy, programs, and projects, while provincial authorities are mostly responsible for implementation and funding. In 2009, administrative, curative and preventive services were split at provincial level and below. Provincial planning and budgeting is gradually becoming less input-driven and more comprehensive, thereby improving uses of resources. Hospitals are incentivized to raise their own revenues and manage their own staff to improve hospital performance. As sector management becomes more demanding, a wider range of management skills other than just public health skills is required.

9. **Sustaining sector achievements**. There are several risks to sustain achievements in the health sector that need to be mitigated. Improved regional connectivity has enhanced the spread of emerging diseases, HIV/AIDS and endemic diseases with major economic impact. Viet Nam is considered vulnerable to the consequences of climate change, as floods and other natural disasters are on the increase. The health sector is also at risk of escalating costs of hospital services, and a shortage of competent managers and staff.

[3] Ministry of Health, Viet Nam. *Joint Annual Health Review, 2010*. Ha Noi.
[4] Ministry of Health, Planning and Finance Department. 2011. Ha Noi.

2. Government's Sector Strategy

10. The health sector has been relatively slow to respond to socioeconomic changes. The Politburo's resolution number 46 (2005) notes that the health system has been "stagnant in reforms" and urges "renewing and improving the health system along the lines of equity, efficiency and development to facilitate the protection, care and promotion of health for all with increasingly higher quality in conformity with the socio-economic development of the country." The Socio-Economic Development Plan (2011–2015) gives high priority to improving services for the poor. The Health Sector Five Year Plan (2011–2015) specifically calls for improving primary health care (PHC) including for prevention and reproductive health; upgrading facilities for minorities and remote areas; improving health worker capacity; improving financial access; and improving governance and management capacity. The Law on Examination and Treatment, approved in 2009, was a major step towards quality assurance of health services. The 2009 Health Insurance Law aims to achieve universal health insurance and increase benefits. While the control of communicable diseases is well regulated, there is limited policy guidance to address the increasing burden of NCDs. The Strategy for the Health Sector up to 2015 with a vision up to 2020 follows the Party drivers of development, efficiency and equity, and also emphasizes quality and sustainability as sector specific issues, as described in paragraphs 5–9.

11. External aid reduced from 3.3% to 1.8% of total health spending between 1999 and 2008, now constituting 5% of public health spending.[5] With private organizations moving in and bilateral agencies moving out, there is a shift in aid from the poor to global concerns, and from services to programs. Major partners are the World Bank, the European Union, Germany, Japan, the United States of America, the United Nations group, and the Global Fund for the control of HIV/AIDS, malaria and tuberculosis. The Health Partnership Group (HPG) was established in 2004 to increase the coordination and efficiency of development assistance. The Joint Annual Health Review (JAHR) provides information on sector progress and issues. Task forces under the HPG are expanding to coordinate and guide subsectors. MOH is also participating in the International Health Partnership (IHP+) that will be piloting a health systems funding platform to help address financing gaps towards achieving MDGs.

3. ADB's Sector Experience and Assistance Program

12. Since 1995, ADB has built up a productive partnership with MOH and partners. Its financial support concentrated in three areas: (i) PHC, provincial health systems, and health equity funds for the poor; (ii) communicable diseases control including for emerging diseases, HIV/AIDS, dengue, malaria and neglected tropical diseases; and (iii) reforms in human resources development to improve regulatory frameworks, institutional capacity, and quality of health care. ADB played a critical role in terms of overall policy advice, provincial planning and budgeting, health care financing for the poor, infectious diseases control, human resources development, and regional cooperation. Between 2000 and 2009, ADB's sector assistance totalled $492 million, 4% of ADB's assistance to Viet Nam.

13. Two key lessons learned are that (i) task forces are important in subsector coordination; and (ii) capacity building of planning, budgeting and management is needed at all levels. The

[5] Ministry of Health, Planning and Finance Department. 2011. Hanoi.

Country Assistance Program Evaluation[6] concluded that ADB's health sector support to Viet Nam from 1999 to 2008 was successful. Recent completed projects were rated as satisfactory.[7]

14. ADB recognizes Viet Nam's need for technical support and targeted investments to improve sector performance to be able to respond to the transitional demands of a middle income country. No longer an ADB core sector, the forward strategy proposes to focus ADB's changing role in the health sector with more selective subsector engagement in strategic human resources, sector financing and service management areas. In line with SEDP (2011-2015), the Strategy for the Health Sector, and ADB's Operational Plan for Health, the following are five strategic support areas (SSA) in the health sector (the sector results framework is attached):

(i) **Respond to increased demand for health services**. ADB supported this area through hospital construction under various projects. ADB will consider public-private partnership in hospital development, and prevention of NCDs and accidents in other sectors.

(ii) **Improve access to PHC for the disadvantaged**. ADB has a major role in this area through various projects. It will phase out of further support for PHC for the disadvantaged unless there is a strong case in terms of achieving MDGs, funding gap, partnership, and thematic concerns, e.g., in the central highlands. Through other sectors, ADB will support village conditions, e.g. roads, education, water supply, sanitation, and food security.

(iii) **Improve human resources for health.** ADB is currently the leading partner in this subsector, and will consider further support through TA and possible program support.

(iv) **Improve sector governance.** ADB has been supporting planning and reforms in several areas, and will consider providing TA for reforms and institutional capacity building.

(v) **Mitigate risks of development.** ADB currently provides support for mitigating the spread of emerging diseases, HIV/AIDS, and other communicable diseases of regional importance through regional economic corridors. ADB will consider extending this support. ADB will also help examine the impact of environment and climate change on health.

15. **Gender**: Sector interventions will support subsidization of health care costs for poor women, gender sensitive physical design of facilities, human resource strategies with targets to increase women and especially ethnic minority women in higher level positions in the health system as well as outreach and IEC interventions to address the health seeking behavior of ethnic minority women. Efforts in HIV/AIDS prevention will ensure strengthened outreach services for vulnerable women, IEC campaigns to increase women's knowledge on HIV prevention, specifically on inter-partnership transmission and targets for women's employment and training in HIV prevention services.

16. Strong stewardship for reform will be required in each subsector and in the provinces. Risks are limited reform capacity, insufficient management capacity, weak coordination within and among levels, long administrative procedures, and limited effort to reach vulnerable groups.

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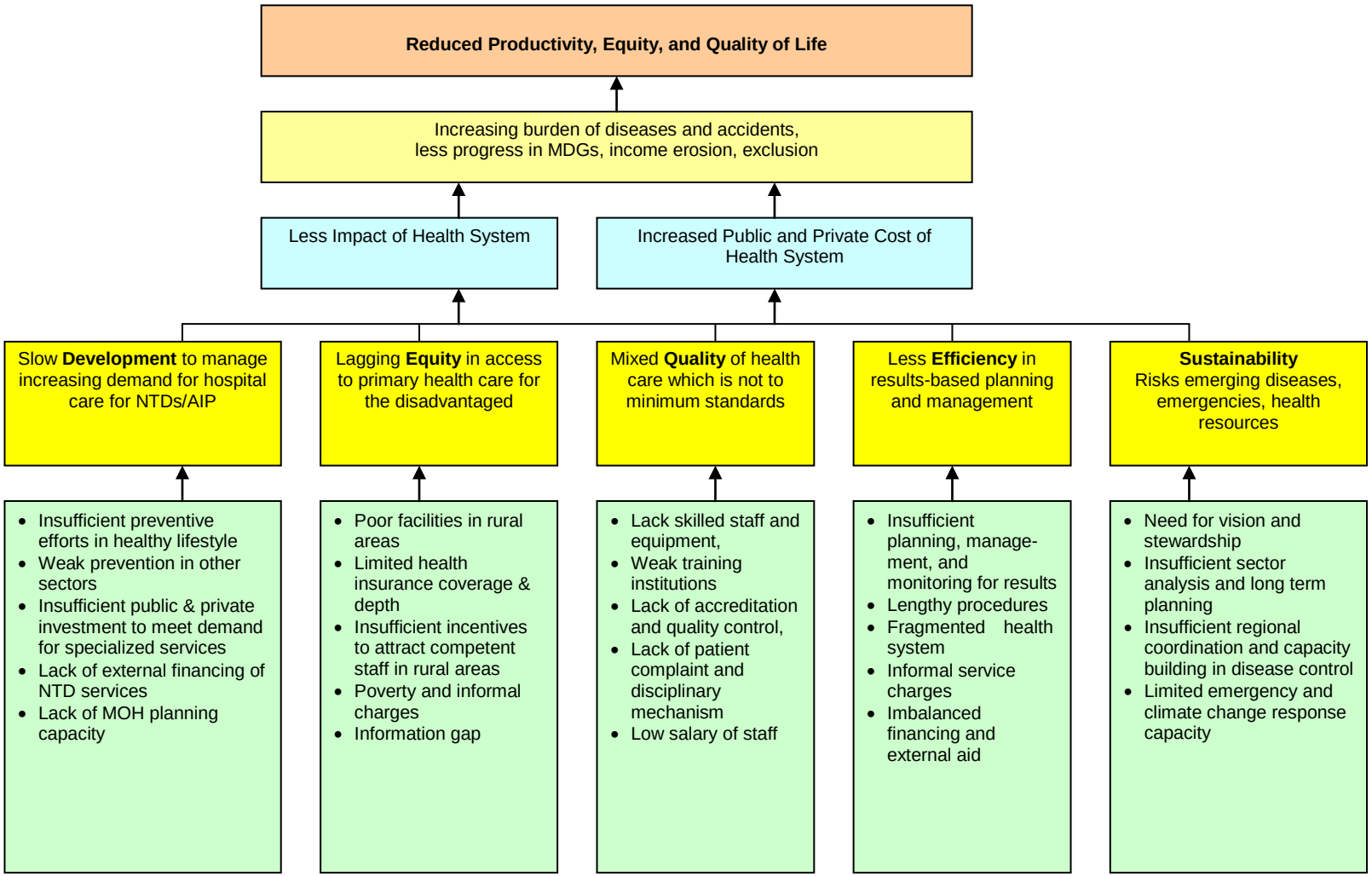
[6] ADB. Country Assistance Program Evaluation Viet Nam. 2009. Manila.

[7] ADB. *Project Completion Report for the Health Care in the Central Highlands Project*. 2011. Manila; *Project Completion Report for the Rural Health Project. 2011*. Manila.

Problem Tree for the Health Sector



Sources: Viet Nam Politburo; Ministry of Health Viet Nam; Asian Development Bank
Acc = accidents, injuries and poisoning; MOH = Ministry of Health; NTD = non-communicable diseases

Sector Results Framework (Health Sector 2012-2015)

Country Sector Outcomes		Country Sector Outputs		ADB Sector Operations	
Outcomes with ADB Contribution	**Targets with Indicators & Baselines**	**Outputs with ADB Contribution**	**Indicators with Incremental Targets**	**Planned and Ongoing ADB Interventions**	**Main Outputs Expected from ADB Interventions**
Improved health status of the poor, women and children, and ethnic minorities Achieved and sustained MDGs Universal access to health services Contained burden of NCDs Containment of epidemics of emerging diseases and HIV/AIDS	**Health Sector Plan 2011-2015** Impact indicators: • Improved life expectancy from 73 to 74 years • Maternal mortality ratio from 69 to 58/100,000 live births. • Under-5 mortality rate from 24 to 19/1,000 children • Under-5 child malnutrition from 18% to 15.0% • Percentage of HIV in adult population to be below 0.3% • Contained DALYs for NTDs, accidents and injuries, and communicable diseases Outcome indicators: • Improved lifestyle indicators (5% from baseline) • Use of public health services increased by 15%, and by the poor, women, and ethnic minorities increased by 30%. • Poor pregnant women delivering in health facilities increased from 42% to 48%. • Hospital case fatality rate for the poor reduced by 10%. • Use of health insurance fund by ethnic minorities increased by 25%. Proportion of disease outbreaks reported within 24 hrs increased from 50% to 80%	Development: Increased capacity for containing NCDs and AIP Equity: Improve access to affordable, quality care for lagging communities and disadvantaged groups, esp. women Quality: Improved health workforce and quality of care Efficiency: Improved provincial sector management Sustainability: Mitigation of health risks of infrastructure projects, connectivity, and environmental and climate change	By 2015: • # of NCD prevention programs at commune level through other sectors • Community Health Services achieving new national benchmark from 0% to 30% • Villages with active male and female VHW from 70% to 90% • Health insurance coverage from 60% to 80% • Increase of public sector health budget with 2% per annum • # of nurses per 10,000 population from 2 to 3 • All Health staff practicing in public facilities registered and participating in accredited CME programs increased from 0% to 30% • Provincial comprehensive plans that meet minimum standards increased from 5% to 20% • Proportion of border villages that conduct proper CDC increased from 40% to 60% • Increase in the share of women in higher level positions. • 70% of trainees are women.	**Planned key activity areas:** • Health sector reform (human resource development, financing and sector management); 65% of funds • Provision of health care for marginalized groups; 35% of funds **Pipelined projects with estimated amounts:** • Food Safety Project ($11 million) • Health in the Central Highlands and Coast Project ($86 million) • Second Health Human Resources Sector Development Program ($87 million) • Third GMS CDC Project ($56 million) **Ongoing projects:** • Strengthening of Preventive Health Services Project ($47.5 million) • Health Care in the South Central Coast Project ($80 million) • Health Human Resources Sector Development Program ($76.3 million) • Second GMS Regional Communicable Diseases Control Project ($30 million)	**Planned key activity areas:** • Health professional development and sector governance • Universal health care coverage, especially for poor and marginalized groups **Pipelined projects:** • Improved hygiene and food security in local markets • Health service provision marginalized groups with emphasis on mother and child health • Health training capacity improved • (regional) control of communicable diseases **Ongoing projects:** • Public health laboratory system upgraded • Health services provision improved • Health professional registration system installed • Health training capacity improved • Health care financing improved • Regional disease control system strengthened

Sources: GoI, Health Sector Development Plan 2011-2015; ADB, RRPs of currently supported projects in Viet Nam.