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Health Care System in Vietnam: Current Situation and Challenges

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Abstract

Vietnam health care system comprises by four administrative levels of health establishments: central level, provincial level, district level and commune level. At the present, public health care sector widely coverage from central to grassroots levels. Vietnamese government targets to make health care system universal and affordable for all people. The Vietnamese health financing system has been remarkably improved along with multiple reforms, i.e., funding for health care for the poor and children under 6 yr; however, public expenditure is still low and total budget for health has not yet met the actual needs. In addition, user-fee for service was introduced in order to improve finance for health care system, which has caused increase in out-of-pocket payment.

Key words: health care system, health financing, Vietnam

❖Introduction

The health care system of Vietnam was established in the North after the independent declaration in 1945; subsequently the system was extended to the South when the country reunited in 1975. Before 1989, the health care system was centrally organized and fully subsidized by the government; therefore, health care services were provided free of charge from central to grassroots levels. During this period, despite of having low GNP per capita and spending relatively low resources for the health care network, health care system had made some significant achievements that were shown by some vital health indicators such as: average life-expectancy and mortality rates of infant were able to compare with wealthier countries[1]. However, because of the limitation of resources, besides those achievements some problems of the system were reported. For example, the prevalence of childhood malnutrition is high among Asian countries and micro nutrient deficiencies were problematic; the rate of low birth weight was about 12–20%; parasitic infections in children was common and vitamin A deficiency was several times higher above WHO standard; inequity in health care had been shown between remote and urban areas[2].

Along with economic reform since late 1980s, Vietnam health care system also transformed from a fully public services system to mixed public-private provider system since 1989. As the result of the health care reform, user-fee for service was introduced and private health sector as well as drug market were legalized. The participation of private health sector as well as the introduction of user-fee for services generated more alternative selections and produced more opportunities for people in getting the better health care services. The health care reforms together with economic development of about 7% each year have

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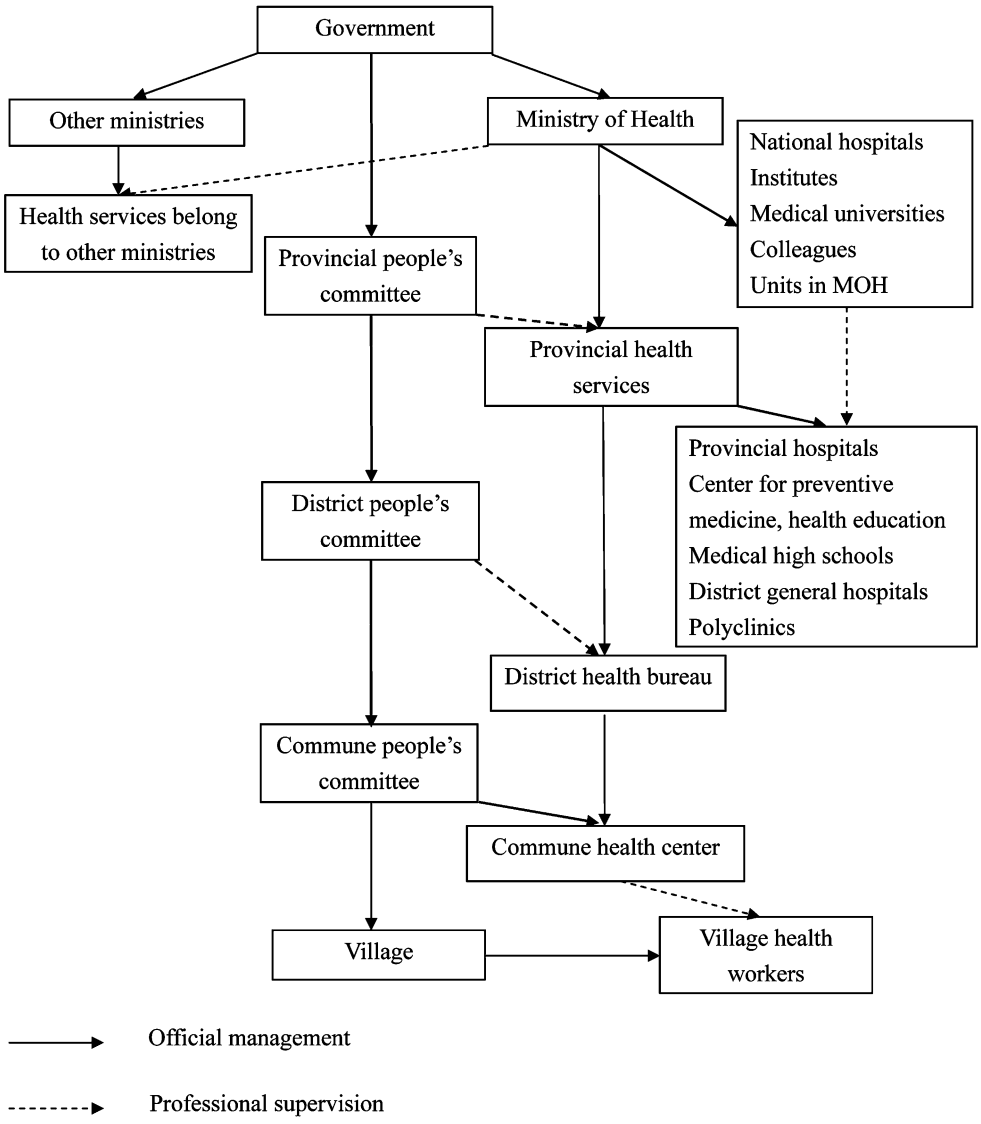

Figure 1 Outline of the Vietnamese health system

generated many positive health benefits. Additionally, introduced in 1992, health insurance has created financial protection for people when they accessed to health care facilities and provided finance for the development of health care system[3].

Although the government has put great efforts to improve the health care system, several short-comings have been occurred in health care system. Therefore, for making further progress the health care system has to overcome many challenges such as the high out-of-pocket payment and disparities in health care services[4, 5]. In addition, the deficiency in human resources and the change of disease pattern also contribute to increase the burden for the health care system.

In this paper we aimed to describe current status of health care system in Vietnam and analyze the challenges of Vietnam health care system in terms of: Health administration, health finance, health service provision, human resource and disease patterns in order to highlight the necessity to consider these issues for the policy makers in making plans and strategies for the development of the health care system.

❖Health Care Administration

Vietnam health care system comprises by four administrative levels of health establishments: central level, provincial level, district level and commune level (Figure 1). At the present, public health care sec-

tor widely coverage from central to grassroots levels. According to 2008 statistical data, there have been 21 health facilities in central level including the Ministry of Health, 64 provincial departments of health, 622 district departments and 10,917 commune health centers (CHCs)[6].

The Ministry of Health of Vietnam, the governmental agency and the leading organization in central level, is responsible for the care and protection of people's health including issuing law and other legal documents for health care and protection. This organization also has duties in making long-term plans and strategies for the further development of the health sectors[7].

Provincial, district and commune health facilities are under the competence management of the Ministry of Health and responsible for the implementation and development of health care services in corresponding level. In these levels, the people's committee is responsible for allocating finance and human resource, while provincial or district health department is responsible for professional competence under the supervising and monitoring of Ministry of Health. Provincial and district health department also have duties in supporting people's committee in corresponding level in term of health care and protection for people[7].

Commune health centers provided a range of basic services, such as: mother and child health care, family planning, treatment for acute respiratory infections, immunization and treatment of common ailments. About thirty years after the establishment of the health care system, an extensive network of commune health center has been structured throughout the country, based on population distribution and geographical condition. Although mountainous and remote areas are allowed more CHCs, some areas still lack of health care services, not only because of their difficulties in geographic issues, but also because of their lack of attractiveness for health workers.

Although public health system in communes is well established with health workers available in 100% of health facilities most of out-patients has chosen private health sectors and self-treatment rather than public health facilities[8]. Result from a previous study showed that even service quality of public health sector is better than that of private health sector; however, people more often choose private health sector because the easier accessibility derived from the higher number of private health facilities in commune level[9]. Low quality of health service in private health facilities[9] revealed that there are needs of comprehensive and consensus management system in health care quality monitoring, especially in private health sector, in order to assure the equality for people who have accessed to health care services.

Health management information system, a powerful tool for managing, organizing and planning of the health care system in multiple levels, is necessary for the development of a health care system. At the present, reports of the health care system in Vietnam are mostly paper-based and manually created. Therefore, it is difficult for managers and policy makers to analyze and receive the accurate data about the health care system. In such an inefficient system, health workers in lower levels have manually created or summarized monthly reports to higher levels; this process often takes time and sometimes become irrelevant. Thus, there is a certain need of a computerized, universal and comprehensive health management information system for all health facilities in all levels for the better administering and planning the health care system.

❖ Health Care Finance

Vietnamese government targets to make health care system universal and affordable for all people. Current health financing system, resulted from multiple policy reforms, indicates remarkable improvements in the state budget allocation for health care system by increasing total budget for health care system, funding for health care for the poor and children under 6 yr and improving the efficiency in use of the state budget for heath care; however, public expenditure is still low and total budget for health has not yet met the actual needs[2]. In addition, user-fee for service was introduced in order to improve finance for health care system, but one of the adverse effects of this policy is increase of out-of-pocket payment. Moreover, low coverage of health insurance is another issue that additionally contributes to the high out-of-pocket spending in health care service and it may lead to overspending health insurance fund.

Recent data shows that the state budget for health system increased from 6,291 billion VND in 2002 to 13,624 billion VND in 2006, but this increase mainly due to the financial support for the poor and children

under 6 yr of age[2]. Although annual budget for health care has been steadily increased in absolute value, this improvement has not yet met the actual needs. Furthermore, total health spending in Vietnam about 5–6% of GDP was similar to other countries with the same income level, but public expenditure accounting for only 30% of total health spending is considered too low in comparison with countries having the same income level and with WHO recommendation. Inflation additionally contributes to reduce the efforts of the government in financial support for health care system.

Health insurance was first introduced in 1992 in order to raise fund for the health care system and to protect people from financial risk when they have to access health care services. Starting with the first few schemes, heath insurance now consists of compulsory scheme which contains three programs: social health insurance, health care for the poor and free health care for children under 6 yr old and voluntary schemes which focus on farmers, the self-employed and students[3]. However, compulsory scheme is not included any payment for dependents member in the family.

Resulted from recent studies, outcomes of health insurance have been shown to decrease out-of-pocket spending on health care, reduce self-medication and improve access to health care for the poor and children in Vietnam[3]. However, due to the lack of funding, difficulties in implementation as well as incomplete policy, the population coverage of health insurance is only 42% indicating that the universal coverage goal targeted by government will be more challenging in the coming time[3]. In addition, increase of health insurance premium is one of the effective methods to deal with the overspending of health insurance fund in recent years[2]; however, this policy has negative effects on health insurance expansion because remainder members are not willing to pay for the higher health insurance premium.

Out-of-pocket expenditures are still dominated a high proportion in total of health care expenditures. It is reported that household expenditures for health care system were accounted for more than 60% of total health expenditure[2]. This high proportion of out-of-pocket spending prevents the poor from accessing to health facilities, therefore increases the inequity in health care[4]. According to the survey of household living standards, monthly spending for health care services was increased from 25,3 thousands VND in 2004 to 45,1 thousands VND in 2008[10]. Out-of-pocket expenditure increased while the coverage of health insurance is low making the demand of health care services of the poor or near poor more difficult. Although the government has subsidized the health insurance premium for the poor by issuing insurance card and also subsidized for 50% of premium for the near poor who used voluntary scheme.

Previous study specified that although user fees contribute to reduce the government financial burden for health care system but it also possibly caused people to become poorer and negatively affected equality in health care[4]. In addition, user-fee for services tends to focus on service quantity instead of service quality, it also reduced the performance of health care system and drained resources in higher-level of hospitals and led to overspending health insurance fund[2]. Therefore case-based package payment was introduced and some common packages have been trialed in order to transform to diagnosis-related group payment method.

❖Health Care Service Provision

Table 1 shows the number of health facilities in Vietnam. Formerly, health care services in Vietnam were freely provided by public health sector; however, after the health care reform in 1989, both public and private health sectors were participated in delivering health services; financial autonomy was implemented and user-fee for services was introduced. The provision of health care services directly impact on patients; high quality of health care services helps to improve treatment duration and diagnosis procedures; therefore, it contributes to reducing health care cost. In contrast, overuse of laboratory tests and high-technology equipments for revenue generation led to increasing health care cost and producing more burden for out-of-pocket spending.

One of the problems is over-crowding happened in central and provincial levels. Over-crowding in high levels of health facilities may be caused by many reasons such as: limitation of health service quality in lower levels, expectation and need of high quality health service of users, convenience of transportation and low differences in hospital fees between levels[2]. Furthermore, as the result of financial autonomy in health facilities, upper levels have to find more ways

Table 1 Number of health facilities in Vietnam*

	2000	2004	2005	2006	2007	2008
Hospital	835	856	878	903	956	974
Regional polyclinic	936	881	880	847	829	781
Sanatorium and rehabilitation hospital	92	53	53	51	51	40
Medical service units in communes, precincts	10,271	10,516	10,613	10,672	10,851	10,917
Medical service units in offices, enterprises	918	789	769	710	710	710
Others	65	54	50	49	41	38

*Excluding private establishments (Source: National yearly statistical book).

to attract patients including patients with mild diseases that could be treated at lower levels in order to increase their revenue. This situation contributes to drain resources for more important activities in higher levels and to waste resource in lower levels. Another problem of financial autonomy has been shown that overuse high technology and abuse expensive services in diagnose and treatment as well as the improper corporation between public and private sectors in health facilities led to the increase spending for health care services.

Commune health center provides necessary health care services for people at this root level, implements primary health care services such as: treatment for respiratory infections and provides services for mother child health cares including deliveries. These health facilities provide services and get health insurance reimbursement for their services; at the present 65% of communes or wards of health centers meet the requirement to get health insurance reimbursement[2].

It is the fact that health facilities tend to focus on modernizing equipment rather than improving quality of services has resulted in a rapid increase of health costs, while there has not been existence of a coherent national monitoring of the performance of health facilities. This will lead to generate a higher service fee.

Quality of health care services in both public and private health sectors need to be supervised and monitored. At the present, regulation on quality of health care services at public or private health sector has not been properly developed. A study on comparison between public health service and private health service reported that even though service quality in public sectors is significantly better than that in private sectors[9] but people choose private sectors more often than public sectors[8]. Moreover, private health service, common choice of people while accessing health care service also contributed to increase out-of-pocket expenditure because of their higher costs in comparison with public health sector[9] and the popularity of self-medication in out-patients[8].

❖Human Resources

Vietnam is now facing to the mal-distribution of human resources for health. This unequal distribution was due to many reasons. One of these reasons is that health staff does not want to work in remote areas because of low salaries and difficult working conditions[11]. The other reasons is the moving of medical staff from public health sector to private health sector and from lower level to upper level of health facilities because of better incentives and higher salaries.

Although the government issued policies to support training of medical staff for remote and mountainous areas and approved the decision on rotating medical health staff supporting for commune level[2], lack of medical staff in these areas is anticipated to be continued because of the difficulties in geographic situations as well as the short of incentives for medical staff to work in disadvantage areas and the trend of moving to urban areas. According statistics data, in general, the number of medical doctor/10,000 inhabitant is 6.6 (Table 2) but this number must be lower in remote areas (Tables 3, 4). Moreover, the proportion of commune health center with medical doctors in 2008 is 67.3% indicating the lack of medical doctor in rural area.

Regarding to the quality of education and training for health professionals, there are some concerns about the inadequate qualification of medical staff in comparison with the requirement of health facilities.

Table 2 Number of medical doctor and pharmacist (thousands)

	2000	2004	2005	2006	2007	2008
Medical doctor	39.2	50.1	51.5	52.8	54.8	57.3
Assistant Physician	50.8	49.2	49.7	48.8	48.8	49.8
Nurse	46.2	49.2	51.6	55.4	60.3	65.1
Midwife	14.2	17.5	18.1	19.0	20.8	23.0
Doctor per 10,000 inhabitant (person)	5.0	6.1	6.2	6.3	6.4	6.6
Pharmacists of high degree	6.0	5.6	5.6	5.5	5.7	5.8
Pharmacists of middle degree	7.8	9.1	9.5	10.8	12.4	13.9
Assistant pharmacist	9.3	7.9	8.1	7.9	8.5	8.6

Table 3 Number of medical staffs under provincial department of health in year 2008 by areas

	Doctor	Assistant Physician	Nurse	Midwife
Whole country	44,671	48,191	54,598	22,122
Red River delta	10,472	8,391	13,222	3,822
Northern midlands and mountain areas	6,781	10,386	8,184	3,374
North Central area and central coastal area	9,694	11,837	11,505	5,852
Central Highlands	2,402	2,371	3,373	1,586
South East area	7,436	4,317	10,148	3,302
Mekong River Delta	7,886	10,889	8,166	4,186

Table 4 Number of pharmaceutical staffs under provincial department of health in 2008 by areas

	Pharmacists of high degree	Pharmacists of middle degree	Assistant pharmacist
Whole country	3,804	12,704	6,735
Red River delta	1,062	2,063	2,397
Northern midlands and mountain areas	395	1,691	759
North Central area and central coastal area	557	2,236	1,364
Central Highlands	107	571	314
South East area	542	1,744	810
Mekong River Delta	745	4,399	1,091

Furthermore, investment in training human resource development for health care sector does not meet the growing demand of health care service. Some problems still remain in training system, for instance: training curricula is needed to review in order to adapt the changing health situations, practical clinical training and professional experiences for doctors after graduation and the mechanism of professional registration.

❖ Disease Pattern

The disease patterns have been changed following the trend that the prevalence of non-infectious diseases has increasing trend while the proportion of infectious diseases is still not decreased (Tables 5, 6). In addition, new epidemic diseases such as: SARS and influenza (H5N1)… make situation to be worsen. Because of high density population, lack of clean water and environmental pollution, food safety related diseases are other problems to be considered. More importantly, traffic accident accounts for one of the

Table 5 Ten leading causes of mortality in 2006

	Number of deaths	Rate per 100.000 population
Intracranial injury	2,521	3.40
Pneumonia	1,179	1.59
Transport accident	1,009	1.36
Intracerebral hemorrhage	964	1.30
Acute myocardial infarction	749	1.01
HIV/AIDS	653	0.88
Heart failure	630	0.85
Stroke not specified as hemorrhage or infarction	601	0.81
Transient cerebral ischemic attacks and related syndromes	586	0.79
Meningococcal infection	519	0.70

Source: Health Statistics Yearbook 2006.

Table 6 Ten leading causes of morbidity (inpatient care)

	Number of cases	Rate per 100.000 population
Pneumonia	309,749	417,70
Acute pharyngitis and acute tonsillitis	271,173	365,68
Acute bronchitis and acute bronchiolitis	217,751	293,64
Essential (primary) hypertension	164,863	222,32
Transport accident	124,196	167,48
Gastritis duodenitis	117,737	158,77
Influenza	99,940	134,77
Diseases of appendix	79,993	107,79
Intracranial injury	64,478	86,95
Urolithiasis	58,902	79,43

Source: Health Statistics Yearbook 2006.

highest causes of death in the ten leading causes of mortality in 2006, becoming a burden for socio-economy as well as health care system. Furthermore, the increase of HIV/AIDS and cancer proportion represent an additional burden for the health care system.

❖Conclusion

After the health care reform, health care system of Vietnam has been successfully transformed to mix public-private together with the introduction of user-fee for service payment and financial autonomy in hospitals. The system actually has attained impressive achievements in health care and protection for people; however, several problems in health care system are issues that needed to be resolved for making the further progresses. In administration, the deficiency of medical doctors in CHCs and the lack of computerized, universal and comprehensive health management information system are the issues. In finance, budget for health care system is not met the actual need. In addition, user-fee-for service is one of the possible causes of the high proportion of out-of-pocket payment and inequality in health care; therefore, one of possible resolutions is utilizing case-based package payment in order to decrease out-of-pocket expenditure. Additionally, low health insurance coverage and high health insurance premium indicated that more efforts will be needed to get universal health insurance coverage in 2014. Furthermore, quality of health care services in both public and private health sectors is unregulated and affected people. The mal-distribution of health workers influenced by low salaries and difficult working condition are crucial issues of the lack of health workers in CHCs and remote areas. All these problems demonstrated the ongoing challenges for Vietnam health care system.

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