C. Public hospital governance in Viet Nam

A case study in two provinces

Tran Thi Mai Oanh, Khuong Anh Tuan, Hoang Phuong, Nguyen Khanh Phuong, Ong The Due, Krishna Hort
Abstract

The purpose of this study was to identify health policy reforms affecting public hospital governance introduced over the last ten years in Viet Nam, and how interactions between these reforms and governance have impacted performance in public hospitals.

The case study provides an overview of the Vietnamese health system, highlights relevant policy developments and identifies performance issues in relation to the function of hospitals within the system, using information from the Joint Annual Health Reviews (JAHR) of 2010, 2012 and 2013. This is supplemented with an in-depth study of six public hospitals in two of Viet Nam’s provinces: Quang Ninh (north) and Ho Chi Minh City (south). The study sample of six hospitals, included two hospitals from central, provincial, and district levels, respectively. Researchers conducted a document review and qualitative data collection to address the study questions. Documents reviewed included local policy and regulation documents as well as third-party country reports. Interviews with patients and providers, and focus groups, were the main data collection tools.

Viet Nam has predominantly public provision of hospital services, with only 7% of hospital beds contributed by the private sector. The government has been active in reforming the system, with a series of reforms since 1995 providing increasing autonomy to public hospitals, while introducing social health insurance and strengthening regulation in other areas of licensing and quality of care. Significant problems in the current system identified by JAHRs include: bypassing of lower-level hospitals and overloading of central and provincial hospitals, increasing total health expenditure, and persistently high levels of out-of-pocket expenditure for patients.

Study data reveals that health insurance payments and user fees are the dominant source of finance for public hospitals, and that central and provincial hospitals have more ability to increase their revenues. As a result, district hospitals face lower levels of funding and have difficulty attracting staff, contributing to poor quality services and bypassing. Despite nominally significant autonomy, hospitals need approval from local or central government bureaucracy for most human resource and investment decisions.
On the whole, changes in autonomy, finance and accountability pursuant to reforms have provided more autonomy for public hospitals in management of finance and investments in clinical services, but accountability, particularly for clinical quality and patient safety, is weak. Hospitals in urban environments have been able to take advantage of the reforms, while those at lower levels have been relatively disadvantaged. Further reforms in areas of payment mechanism and regulation of user fees are currently being developed to address these issues.
### Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>JAHR</td>
<td>Joint Annual Health Review</td>
</tr>
<tr>
<td>JPG</td>
<td>Joint Partnership Group</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imager</td>
</tr>
<tr>
<td>PCP</td>
<td>Provincial Centre for Preventive Medicine</td>
</tr>
<tr>
<td>PHB</td>
<td>Provincial health bureau</td>
</tr>
<tr>
<td>PHD</td>
<td>Provincial health department</td>
</tr>
<tr>
<td>VND</td>
<td>Vietnamese dong (currency)</td>
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<tr>
<td>VSS</td>
<td>Vietname Social Security</td>
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</table>
1. **Introduction**

The study is one product of the multi-country study project of the Asia Pacific Observatory on Health Systems and Policies on hospital governance and performance to increase the understanding of how policy reforms are affecting the governance of public hospitals. This case study was conducted in six public hospitals spanning central, provincial and district levels. The objectives of this study are:

- to describe the policy context, policy developments and reforms concerning public hospital governance and performance in Viet Nam during the past 10 years;
- to assess public hospital governance and performance of selected public hospitals in Viet Nam; and
- to identify internal and external factors affecting hospital governance and performance and to understand their interactions.

2. **Methodology**

The study uses two main sources of information:

- review of findings and recommendations from Joint Annual Health Reviews (JAHR), reported each year by the Ministry of Health and the Joint Partnership Group of development partners. Reports from 2010 to 2013 are the principal sources of information. The reports provide an annual update of key performance indicators, policy development, and an assessment of system performance.
- in-depth study of six hospitals, one each from the central, provincial and district levels, respectively in two provinces. This study reviewed financial and performance information from the annual hospital reports, and conducted interviews with hospital managers, providers and patients at each hospital site.
3. General background and description of health system

Viet Nam’s land boundaries measure 4639 km, its coastline is 3444 km in length, and its land mass is 330 951 km$^2$. The country has 63 provinces/cities that are categorized in six main subregions according to geographical and socioeconomic characteristics. The population reached 90 million in 2013, consisting of 53 ethnic groups. Viet Nam is one of the most densely populated countries, at 268 persons/km$^2$ (Index Mundi 2013).

Viet Nam is a middle-income country, with annual economic growth at over 6%. In 2012, Viet Nam’s nominal GDP reached $156 billion, with a nominal GDP per capita of $1755, according to the World Bank (World Bank 2013).

Basic health indicators: The health status of Vietnamese people has improved markedly, as reflected in basic health indicators such as life expectancy, infant mortality rate, maternal mortality rate, and malnutrition rates of children under 5 years of age (Table 1).

### Table 1: Basic health indicators in Viet Nam

<table>
<thead>
<tr>
<th>No</th>
<th>Indicators</th>
<th>2010</th>
<th>2011</th>
<th>Target for 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Average life expectancy (years)</td>
<td>72.9</td>
<td>73.0</td>
<td>74.0</td>
</tr>
<tr>
<td>2</td>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>68</td>
<td>67</td>
<td>58.3</td>
</tr>
<tr>
<td>3</td>
<td>Infant mortality rate (per 1000 live births)</td>
<td>15.8</td>
<td>15.5</td>
<td>14.8</td>
</tr>
<tr>
<td>4</td>
<td>Under-five mortality rate (per 1000 live births)</td>
<td>23.8</td>
<td>23.3</td>
<td>19.3</td>
</tr>
<tr>
<td>6</td>
<td>Decrease of crude birth rate (‰)</td>
<td>0.50</td>
<td>0.50</td>
<td>0.1</td>
</tr>
<tr>
<td>7</td>
<td>Population growth (%)</td>
<td>1.05</td>
<td>1.04</td>
<td>0.93</td>
</tr>
<tr>
<td>9</td>
<td>Under-five child malnutrition rate (underweight) (%)</td>
<td>18.0</td>
<td>16.8</td>
<td>15.0</td>
</tr>
<tr>
<td>10</td>
<td>HIV/AIDS prevalence rate (%)</td>
<td>&lt;0.3</td>
<td>&lt;0.3</td>
<td>&lt;0.3</td>
</tr>
</tbody>
</table>

Source: Indicators 1, 3, 4, 5, 6, 7, 8 – General Statistics Office. Survey of population change and family planning, 01/04/2011. Indicators 2, 9 and 10 – Ministry of Health Report on Health Sector Work 2011 (MOH and JPG, 2013)
4. Viet Nam’s health system

Primary care is delivered by a network of commune health stations. In 2010 there were 10,866 commune health stations covering 98.6% of all communes/wards in the country (MOH and JPG, 2010).

By end of 2012, Viet Nam had 1,180 public and private hospitals, with a total of over 200,000 beds, or a ratio of 25.04 beds per 10,000 people, one of the highest levels in South-East Asia (MOH and JPG 2013).

Management of hospitals is decentralized, with the Ministry of Health managing 35 central hospitals, provinces managing 382 hospitals (about 50% of hospital beds), and there are 561 district hospitals (about 30% of beds). Provincial hospitals are mainly in provincial capitals. Almost all districts have general hospitals or district health centres to provide first level referral services (MOH and JPG, 2013).

The private sector is relatively small, comprising 150 hospitals with approximately 9,600 beds. Private hospitals are mainly concentrated in large provinces and cities and focus on services with high returns on investment, small hospitals and specialities in high demand such as obstetrics, oncology, dentistry and family practice (MOH and JPG, 2013).

Curative services are complemented by a public health and preventive network, which consists of 679 district health centres and provincial preventive medicine departments in 63 provinces. Programmes focus on the national target health programmes, including control of infectious diseases, hygiene and food safety, prevention of injuries and noncommunicable diseases, and HIV/AIDS. The population and family planning network has integrated into the Ministry of Health and fully covers all 63 provinces/cities (MOH and JPG, 2010).

5. Utilization

Rates of outpatient utilization are around 2.2 visits per person per year, while hospital admissions reached 12.6 admissions per 100 people in 2008 (MOH and JPG, 2010) and rose to 13.7 in 2011 (MOH and JPG, 2013). However, utilization of both outpatient services at public hospitals and admissions to public hospitals was much lower among the poorest quintile than the richest quintile, despite the overall increase in utilization (Table 2).
Table 2: Utilization of hospital services by income quintile

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Outpatient visits to public hospitals per 100 people in last 4 weeks</th>
<th>Public hospital admission per 100 people in last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>10.6</td>
<td>16.4</td>
</tr>
<tr>
<td>Richest</td>
<td>53.9</td>
<td>63.3</td>
</tr>
<tr>
<td>Overall</td>
<td>26.0</td>
<td>35.7</td>
</tr>
</tbody>
</table>

Source: MOH and JPG, 2010

6. Health workforce

Viet Nam has a relatively high ratio of health workforce to population, with 7.5 doctors per 10,000 population in 2012, and 1.9 university-trained pharmacists per 10,000 in 2011. Increases have also occurred in the availability at commune level with 76% of commune health stations having doctors in 2012 (MOH and JPG, 2013).

However, the health workforce is not equally distributed, with a concentration of highly-qualified health workers at central level (14.5% of the workforce and 54% of the postgraduate-trained workforce), while 28% of the workforce work at district level, but only 5% of those with postgraduate qualifications. There continues to be a shift of health workers from public to private facilities, and from lower to higher level facilities (MOH and JPG, 2010).

7. Health finance

Total health expenditure as a proportion of GDP rose to 6.9% in 2010, up from 4.9% in 1998, with about 45% from public (government) expenditure, and the remaining 55% private. The majority of private expenditure is out of pocket, which made up 48% of total expenditure in 2010. The allocation of state budget for recurrent health expenditure was 8.3% in 2012, similar to the 8.1% in 2011 but much higher than 4.9% in 2008 (MOH and JPG, 2013).

While the share of out-of-pocket expenditure on private health services has fallen from 30% in 2001 to 22% in 2009, the proportion of payment for public sector services rose from 12% in 1998 to 44% in 2009, while the proportion spent on self-medication has fallen from 68% to 35% (MOH and JPG, 2013).
Viet Nam introduced a social health insurance programme to reimburse facilities for the cost of health care for the poor, commencing in 2004. The programme has progressively expanded and now covers the poor and children under six years of age, consuming 18% of the budget allocation for health. Health insurance covered 67% of the population in 2012, with high coverage among the poor and ethnic minorities, but less among children (81%), and the near poor (25%) despite a 50% government subsidy for premium payments by the near poor (MOH and JPG, 2013).

8. Hospital system

The reforms of 1989, when Viet Nam switched from a central subsidy system to a market economic system, also led to significant reforms of the health system, which have continued since then.

The first change was the Law on Health Care for People (1989), which allowed Vietnamese people to seek health care services at any public health care facility without a referral document. Prior to this law, patients were entitled to all health care services free of charge, but they were not allowed to bypass to upper-level hospitals without referral documents.

In 1995, the government launched Resolution 90-CP about social mobilization for the health and education sectors, which allowed public institutions to obtain funding from other sectors and non-state sectors to contribute to investments for the health sector and health service provision. This policy was strengthened and specified by Decree 69/2008/ND-CP.

Decree 10/2002/ND-CP provided limited financial autonomy, allowing recovery of operating costs, reducing staff and increasing income (through payment of “additional salary” from surplus revenues) for workers. The extent of autonomy was subsequently extended through Decree 43/2006/ND-CP, which provided for autonomy and accountability in operations, organization, human resources and financing in all public services. According to this regulation, all public hospitals could be fully autonomous both in financial and human resources as well as other management/operational matters. In particular, hospitals were allowed to mobilize financial resources from different sources (private sector and public sector) and to make allocative decisions on which health services would be funded.
through different sources of revenues. Revenues could be allocated to
supplement staff salaries, with limits on the amount of addition to basic
salaries that could be provided.

The new policies and social mobilization within the health sector enabled
public hospitals to achieve three levels of autonomy, namely: 1) self-
financing institutions (those able to finance their entire operating costs); 2)
partially self-financing institutions; and 3) institutions fully subsidized by
the state budget (revenue covering less than 10% of total expenditure).

Currently, all public hospitals utilize three main types of payment methods:
(i) fee-for-services; (ii) capitation (applied only in district hospitals for both
in-patient and outpatient); and (iii) health insurance payment based on
actual expenditure. Public hospitals may also raise investment capital from
the private sector, and medical workers and other staff in the hospital are
allowed to contribute to investments to procure medical equipment for the

The government has also introduced financial protection for the poor
through social health insurance, commencing with Decree 139 in 2002, and
expanded with Decree 63 on Health Insurance Regulations in 2006, and
the Law on Health Insurance in 2008 (MOH and JPG, 2010). Government
subsidies cover the cost of premiums for the poor, ethnic minorities, and
children under six years, as well as certain other groups (disabled, widows,
veterans); while other members make a full or partial contribution (MOH
and JPG, 2013).

Reforms to payment mechanisms under the insurance scheme are
progressively being introduced, with a shift to capitation-based payments
for first point of contact services (Circular 09/2009/TTLT-BYTG-BTC).
By 2011, 52% of district facilities were using capitation, as were 14% of
provincial facilities. Case-mix payments for hospitals are being piloted
(MOH and JPG, 2012).

To assign clear functions to each level of the system, the Ministry of Health
has issued a referral guide (the list of services and the level of medical
facility that should be capable of performing those services) since 2005
(Ministry of Health Decision 23/2005/QD-BYT), and is drafting a revised
The referral guide that is being updated in line with developments in the sector (MOH and JPG, 2010).

The Law on Examination and Treatment (40/2009) introduced requirements for practice licenses for practitioners and operating licences for facilities, and proposed quality management standards and procedures (MOH and JPG, 2012).

The Government has also introduced various measures to strengthen district health services, including the use of government bonds to upgrade district-level facilities, reaching 91% of district hospitals by 2011 (MOH and JPG, 2012), and Ministry of Health Decision 1816/QĐ-BYT on rotating health workers from higher-level facilities to lower-level facilities to improve the quality of medical examination and treatment services. Additional salary supplements for health workers in remote locations have been provided under Decree 56/2011/ND-CP (MOH and JPG, 2012).

9. Hospital system performance: key issues

In some regards, the hospital system is performing well, with increases in consultations and admissions each year (up 6.8% and 6.0% respectively between 2011 and 2012), and a reduction in average length of stay to 7.0 days overall, and 8.3 days at central level (MOH and JPG, 2013).

9.1 Bypass of lower-level facilities and overcrowding at central level

According to the Law on Health Insurance, patients are entitled to receive medical services at any health care facility without restrictions related to administratively-set geographic boundaries or the technical level of the facility. This allows bypass of lower-level facilities and direct self-referral to higher-level facilities and especially central facilities, resulting in under-utilization of district hospitals and overcrowding at central hospitals (MOH and JPG, 2013).

Overall, public hospital bed occupancy decreased slightly from 100.5% to 99.4% in 2012, but the rate at central level was still 112.5%. Overcrowding in tertiary hospitals remains a key issue. Major referral hospitals such as the
National Hospital of Pediatrics, Ho Chi Minh City Oncology Hospital, Cho Ray Hospital, Pediatrics Hospitals 1 and 2 in Ho Chi Minh City and Central Obstetrics Hospital have occupancy rates over 120%. At district level, occupancy rates average 60%.

A study in 2008 (HSPI 2008) found bed occupancy rates of between 132% and 200% among central hospitals in 2007. The study noted that 48% of patients attending central hospitals were from other provinces, but only 18% were at the correct level of care. Over 50% could be treated at lower levels.

The main causes identified were:

- the weak capacity of lower-level hospitals (particularly district hospitals) to provide services and the inability of these hospitals to attract patients (district hospitals are able to provide about 70% of the total services that they are supposed to);
- the financial mechanisms and payment methods do not support and encourage lower-level hospitals to provide better quality services, as their cheaper prices negatively affect the quality of services, lower-level hospitals have cheaper prices to draw patients away from more expensive upper-level hospitals offering the same services). Moreover, the benefit packages do not incentivize patients to seek treatment at lower-level hospitals;
- public hospitals are autonomous. Thus, they try to attract and retain patients. Upper-level hospitals have a better capacity to attract patients; and
- the referral system is weak and the health service provision network lacks a “gatekeeper”.

### 9.2 Licensing/service provision/quality

Currently, public hospitals are categorized by level of care, with a list of technical services that the hospitals in a particular grouping have to provide. In addition, public hospitals are also categorized by hospital grade
I, grade II or grade III, according to the list and the kind of services that they can provide based on their professional capacity. The technical lists for hospitals at different levels and grades are regulated by Circular 43/2013/TT-BYT, Ministry of Health.

Few hospitals have established quality systems. Only 9% of hospitals currently have quality plans: 29% of grade 1 hospitals, 12% of grade 2 hospitals and 2% of grade 3 hospitals. Only 5% of hospitals have projects or programmes for quality improvement [121] (MOH and JPG, 2013).

The Law on Medical Services (2009) mentions the licensing and accreditation of all public and private health facilities, but there is no official system or organization for accreditation of public hospitals as yet. On the other hand, there was no official or national set of indicators for quality assurance at the time of the study and no official model of quality management was found among the six hospitals studied.

9.3 Health workforce

The major problem identified in relation to workforce is the continuing inequitable distribution of health workers, and the difficulty that mountainous, isolated and remote areas have in attracting staff (MOH and JPG, 2010).

There are two laws that relate to human resource management in hospitals, and specifically the recruitment and use of health staff and health managers in public hospitals: the Labor Law and the Law on Public Officers and Employees.

The Labor Law governs the rights of hospital managers in using and contracting health staff, while the Law on Public Officers and Employees regulates the recruitment and promotion of health staff and health managers in state organizations. The other regulations that also affect the management of the health workforce and relate to the competency of health professionals are Circular 41/2011/TT-BYT of the Ministry of Health, regarding the conditions for professional practice licensing, and Circular 22/2013/TT-BYT, Ministry of Health, which specifies the continuous/in-service training required for health professionals in health facilities.
The other policy being implemented creates the mechanism for health professional rotation in order to support and strengthen capacity for health care facilities at lower levels (Decision 1816/2008/QĐ-BYT of the Ministry of Health). According to this policy document, doctors at upper-level hospitals have to complete rotations in lower-level hospitals for a minimum of 3–6 months to give technical transfer, training, or to help lower-level hospitals provide assigned services that they had not been able to provide.

9.4 Increasing total expenditure on health and persistently high out-of-pocket expenditure

Total health spending increased at an average rate of 9.8% over the period 1998–2008, higher than the average GDP growth of 7.2%. Viet Nam’s GDP share of 6.9% is higher than many neighbouring countries (MOH and JPG, 2010). The share of government budget allocated to health has also increased from 4.8% in 2002 to 10.2% in 2008 (MOH and JPG, 2010). However, the proportion of out-of-pocket expenditure remains high, at around 55%, despite increased expenditure on social health insurance. It was estimated that 30% of people with health insurance for the poor still faced catastrophic health expenditure (exceeding 10% of non-food expenditure) (MOH and JPG, 2010). A major driver of this increasing expenditure is increasing medical costs. Costs of an outpatient visit increased 2.3 to 3 times between 2005 and 2008, and the average inpatient admission cost doubled (MOH and JPG, 2010). Factors identified include increased use of laboratory tests and diagnostic imaging, and more use of medication.

10. Impacts of reforms

The Joint Annual Health Review of 2010 reports that, in general, the revenues of hospitals have increased considerably in the past few years, especially hospitals that have a high degree of autonomy. The increase is primarily from user fee revenues and health insurance reimbursements. Of total revenues, service revenues account for the biggest share in almost all hospitals (96.8% in completely autonomous hospitals; 72% in central hospitals; 81.7% in provincial hospitals; and 59.4% in district hospitals). The share of total hospital expenditures spent on medical inputs (including drugs, chemicals, blood, medical consummables, and spending on other
professional activities, administrative costs and maintenance) varied between 46% and 66% (2008). The share spent on human resources varied between 22% and 45%. The share spent on drugs was very high, while controls on supply and use of drugs faced many difficulties (MOH and JPG, 2010).

A study of the impacts of autonomy (MOH 2011) noted the following.

- Significant growth in total hospital revenues, including Government budget, health insurance payments, and user charges. Between 2005 and 2008, hospital revenues multiplied by 1.8 in fully autonomous hospitals, by 3 in centrally managed hospitals, by 2.9 in provincial level hospitals, and by 2.5 in district-level hospitals. Most growth came from increased social health insurance payments, as the share of Government budget for recurrent expenditures decreased 2.5 to 2.7-fold.

- Increased capital investment in hospitals, particularly in medical equipment. Between 2005 and 2008, the range of health care services expanded 25% in fully autonomous hospitals, 17% in centrally-managed hospitals, 14% in provincial hospitals, and 16% in district hospitals. During the same time period the number of hospital consultations and admissions increased 1.3–1.5 fold, and 1.2–1.4 fold, respectively.

- Substantial growth in incomes of public hospital medical staff. The average additional income per hospital staff member was higher than the monthly salary in most hospitals, but varied from 2.3 times monthly salary in fully autonomous hospitals, to 1.3 times in centrally-managed hospitals, 1.4 times in provincial hospitals, and half the monthly salary in district hospitals.

The JAHR of 2013 provided the following assessment of the results of strengthening financial autonomy in health facilities according to Decree No. 43/2006/ND-CP:

Assessment has identified some fundamental weaknesses and unexpected results related to irrational delivery and use of health care services. The current mechanism of linking revenues of health facilities and
supplementary income of health workers to facility performance provides insufficient motivation for health facilities and health workers at the grassroots level to increase provision of basic health services, especially in the preventive care sector or to improve Quality of Care. Health facilities have to generate revenues in order to pay their workers supplementary income. These arrangements are only really effective in socioeconomically affluent areas, in the curative care sector and specialties that are more marketable. The financial autonomy and social mobilization mechanisms lead to increased inequality because they have little effect on the incomes and remuneration package for health workers in socioeconomically disadvantaged areas or those providing services with little revenue generation potential (MOH and JPG 2013).

The same report also noted that:

“…there is widespread acknowledgement of the existence of inappropriate use of medicines, lab tests and medical services resulting in unnecessary health spending such as using innovator brands instead of generic medicines, overuse of drugs, overprovision of antibiotics, lab tests and diagnostic imaging, and rejection of the validity of lab test results and diagnoses across medical facilities. Fee-for-service payments are still widely used while there is not yet an efficient mechanism for management of quantity and prices of medical services and medicines, which leads to an unavoidable increase in health care costs (MOH and JPG, 2013, page 27).”

The in-depth case studies explore the current situation and responses to these reforms in the six selected hospitals.
11. Findings: case study hospital experiences

Selection of hospitals and site of study: Due to time constraints and limited financial resources, only two provinces were selected – one province in the north and one province in the central or in the southern region. Additional selection criteria included that each province must have central hospitals (of which at least one fully autonomous hospital)\(^ {24} \), and that the tentatively selected hospitals in each province (of which one central, one provincial, and one district hospital) should be performing well.

Therefore, according to the selection criteria, in each province, three hospitals were selected for the investigation. In total, six hospitals were selected, including two central hospitals, two provincial hospitals, and two district hospitals. Among the six selected hospitals, only Cho Ray Hospital is fully financially autonomous; the other hospitals are partially autonomous (Box 1). Some general information about the hospitals studied is included in Table 3.

<table>
<thead>
<tr>
<th>Box 1: Selected hospitals in the case study</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of care</strong></td>
</tr>
<tr>
<td>Central hospital</td>
</tr>
<tr>
<td>Provincial hospital</td>
</tr>
<tr>
<td>District hospital</td>
</tr>
</tbody>
</table>

\(^ {24} \) According to the current regulations, “Fully autonomous” means that the hospital is “fully autonomous in hospital financing”, not fully autonomous for human resources.
Table 3: Descriptive and performance information on selected hospitals

<table>
<thead>
<tr>
<th></th>
<th>Central Hospital</th>
<th>Provincial Hospital</th>
<th>District Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cho Ray</td>
<td>Uong Bi</td>
<td>Nguyen Tri Phuong</td>
</tr>
<tr>
<td>Level of autonomy</td>
<td>Full</td>
<td>Partial</td>
<td>Partial</td>
</tr>
<tr>
<td>Number of beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of planned beds</td>
<td>1800</td>
<td>750</td>
<td>700</td>
</tr>
<tr>
<td>Number of actual beds</td>
<td>2445</td>
<td>793</td>
<td>894</td>
</tr>
<tr>
<td>Volume of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patient visits</td>
<td>1 197 134</td>
<td>199 935</td>
<td>401 392</td>
</tr>
<tr>
<td>Number of inpatients</td>
<td>123 015</td>
<td>40 463</td>
<td>44 716</td>
</tr>
<tr>
<td>Occupancy rate of planned beds</td>
<td>139%</td>
<td>91%</td>
<td>117%</td>
</tr>
<tr>
<td>Occupancy rate of actual beds</td>
<td>102%</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>Human resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of doctors</td>
<td>698</td>
<td>162</td>
<td>245</td>
</tr>
<tr>
<td>Number of nurses</td>
<td>1483</td>
<td>294</td>
<td>498</td>
</tr>
<tr>
<td>Hospital finance (VND 1 000 000 000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total hospital revenues</td>
<td>2299.11</td>
<td>235.04</td>
<td>306.56</td>
</tr>
<tr>
<td>In which:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent state budget</td>
<td>0%</td>
<td>21.9%</td>
<td>16.7%</td>
</tr>
<tr>
<td></td>
<td>1124.01</td>
<td>94.9</td>
<td>108.0</td>
</tr>
<tr>
<td>Health insurance</td>
<td>51.8%</td>
<td>40.4%</td>
<td>35.2%</td>
</tr>
<tr>
<td></td>
<td>1044.46</td>
<td>83.69</td>
<td>97.26</td>
</tr>
<tr>
<td>Hospital user fee</td>
<td>48.2%</td>
<td>35.6%</td>
<td>31.7%</td>
</tr>
</tbody>
</table>

Source: Annual hospital reports, administrative data
11.1 Finance

According to Decree 43/2006/QD-CP, all public hospitals have autonomy in hospital financing, including budget motivation, reallocation within the hospital, and proactive hospital expenditure. However, in terms of budget reallocation within the hospital, all six hospitals reported that they still encounter common challenges, including:

- the difficulty in balancing hospital revenues and expenditure due to gradual reductions in state budget and limited revenue from service provision; and
- the Ministries of Health and Finance require state budget expenditure on several specific activities and items, thus limiting hospital autonomy with regard to budget allocation, and in particular expenditure on infrastructure, medical equipment maintenance, salaries, and incentives.

Hospitals’ capacities to reallocate their budgets vary. Central hospitals reported that having greater capacity to expand service provision (like Cho Ray Hospital) can gain greater revenues from fees for services and health insurance; thus, these hospitals only face difficulties in budget allocation for infrastructure, medical equipment maintenance, and reallocating revenues (25% from interest) in order to increase salary for health staff. However, in poorer rural areas, district hospitals with partial autonomy (such as Uong Bi District Hospital and Dong Trieu District Hospital in Quang Ninh Province) reported that they were limited in the extent to which they can proactively use their budgets for hospital development.

11.2 Health insurance income

Payments from health insurance are provided as fee-for-service (with service caps) or capitation (mainly for district hospitals). Four of the six hospitals studied (Cho Ray Hospital, Nguyen Tri Phuong Hospital, Uong Bi Hospital and Quang Ninh General Hospital in Quang Ninh, and Thu Duc District Hospital in Ho Chi Minh City) use the fee-for-service payment method for insured patients with level 2 payment cap. Only one district hospital (Dong Trieu) uses the capitation payment method for
insured patients (including inpatients, outpatients, and referral patients). In addition to fee-for-service, Uong Bi Hospital and Quang Ninh General Hospital also apply the capitation payment mechanism for those who register for primary care at these hospitals.

The case studies show that most hospitals exceed the cap on insurance payments, and are owed money by the social insurance agency (Viet Nam Social Security – VSS). For example, in 2012, Uong Bi Hospital’s payment cap and fund exceeded VND 18 billion and VND 4 billion, respectively. Quang Ninh General Hospital’s fund exceeded VND 13 billion. Dong Trieu District Hospital’s fund exceeded VND 7.8 billion, while Nguyen Tri Phuong Hospital’s payment cap exceeded VND 4 billion. Cho Ray Hospital’s fund exceeded VND 5 billion for three quarters in 2013, and is predicted to exceed VND 25 billion; and Thu Duc Hospital’s payment cap exceeded VND 27.7 billion.

A major factor causing hospitals to exceed the cap is the bypass of patients directly attending central hospitals. Whenever insured patients bypass or are referred to upper-level hospitals, the costs of treatment for that patient in the upper-level hospital will be charged to the health insurance budget of the lower hospital, according to the health insurance regulation.

VSS has not reimbursed most hospitals exceeding the level 2 payment cap because VSS need approvals from the National Assembly prior to making any excess payments. Uong Bi Hospital, Quang Ninh General Hospital and Dong Trieu District Hospital were partially reimbursed; however, VSS still owes large sums of funds to the studied hospitals (i.e. VND 5 billion to Cho Ray Hospital, VND 4 billion to Uong Bi hospital, and VND 8 billion to Quang Ninh General Hospital).

The incomplete reimbursement by VSS since 2012 has caused many difficulties for hospitals’ spending. Hospitals have debts to pharmaceutical companies or must reduce the salary bonuses paid to staff. To resolve the funding deficits, hospitals reduce referrals and self-referrals, and attract patients by improving clinical quality and expanding the types of services. As a result, some hospitals have an increasing number of patients; the rate of referrals to higher levels has been reduced significantly.
11.3 User fees

According to current regulations (Circular 04/2012/TTLT-BYT-BTC regarding the ceiling price for health services applied in public hospital), public hospitals are not allowed to set their own clinical service prices because the Ministries of Health and Finance have devised a list with price ranges for each health care service. Based on this national list, each province must develop its own health service price list with relevance to the local socioeconomic situation. In practice, all four hospitals at the provincial and district levels review the list approved in the previous year by the Provincial People’s Committee annually, then propose the same or a revised price list (some new services or procedures can be added). They must then submit the new list to the Provincial Health Bureau (PHB). This list is used as a reference together with those of other hospitals in the province to rebuild the common price list for that province.

This common list must then be submitted to the Provincial People’s Committee for approval.

The two central hospitals also build their own price lists based on the national price list before submitting them to the Ministry of Health for approval. However, hospitals are able to set their own prices for such non-clinical services as sanitation, food, and provision of special foods according to current local market prices.

All hospitals included in this study complained about the inappropriately low prices on the current service price list. Because the set prices may not cover the true costs of services, hospitals may face deficits if they do not provide a certain number of supplementary services. The lower-level hospitals also voiced similar complaints that the prices set for provincial and district hospitals are significantly lower than those set for upper-level hospitals for the same clinical services. These low prices provide no incentive for lower-level hospitals to provide the given services or provide support for hospitals to develop further services.

11.4 Services for the poor

All of the investigated public hospitals must serve all patients, including poor or very poor patients, even if they are unable to pay for health services. Normally, all the poor are provided with health insurance from
the government; however, a number of people either do not possess a health insurance card or have a card with incorrect information, posing many difficulties for hospitals attempting to serve poor patients. The main reason for this implementation gap is that the current regulations do not specify the mechanism for budget allocation to provide free services to poor patients who are not covered by health insurance. To solve this problem, hospitals must set up their own procedures to identify poor patients unable to pay for services. Hospitals must also make their own decisions to use a portion of their own budget savings to support such patients. According to the hospitals included in this study, every year, hospitals must support the poor through the hospital’s savings that should actually be allocated for salaries or reinvestment, while the state budget does not provide any support for this expense.

11.5 Workforce

This study found that most hospitals, including fully autonomous or partly autonomous hospitals, have independence in the recruitment and contracting of health staff for hospitals.

However, this independence is limited to contract staff. According to the Labor Law and Law on Public Officers and Employees, public hospitals do not have full autonomy to recruit health professionals as permanent staff, including government staff.

Permanent staff are recruited by the Provincial Health Department (PHD) and the hospital itself recruits contracted staff paid from the hospital revenue (Dong Trieu District Hospital). For permanent staff, public hospitals have to set up human resource plans according to the local government’s quota on human resources, and gain approval from the relevant Provincial Health Bureau. Within the hospitals, the director or the management board can make decisions on reallocating health staff or recruiting contracted health staff according to requirements, while the heads of departments may only propose the need for staff.

The Provincial Health Department proposes its staff plan, while the Directorate conducts the recruitment. The hospital has an annual staff recruitment plan but we don’t know the actual recruitment process. Staff in their probationary period are assigned to each department. Departments
propose only the number of staff they need but are not involved in the recruitment process (Focus group discussion among leaders of district hospital departments).

However, to terminate the employment of permanent and long-term health staff, all hospitals must also comply with the Labor Law and Law on Public Officers and Employees, and must gain the approval of the authority with direct responsibility for the administration of the hospital. Similarly, for promotions of hospital managers (director, vice director), the hospital follows a long procedure to acquire approval from local authorities (provincial dept. of human resources, Provincial People’s Committee, and Provincial Health Bureau) or the Ministry of Health.

Due to their limited autonomy with regard to human resources, all public hospitals have faced many difficulties and complications in proactively recruiting health professionals, particularly highly skilled health professionals and some specialists for the provision of services expected and needed.

11.6 Appointment of hospital directors or vice directors

According to current regulations, in the public sector, the director/vice director or manager of a hospital belongs to a government office, so hospital themselves cannot hire or remove such staff. However, the director can promote or remove lower-level managers within the hospital. In practice, the local authority that directly manages the hospital (Provincial People’s Committee or Provincial Health Bureau) decides and approves hospital director appointees. The approved hospital director can be from either the hospital or another health facility.

11.7 Rewards and sanctions

Because all public hospitals are autonomous, especially in terms of financing, each has a document called “Internal regulation for expenses” that contains very strict mechanisms regarding the reward and sanction conditions for hospital staff. The reward and sanction of health staff is mainly based on their performance. In general, none of the six hospitals have much difficulty in rewarding and sanctioning staff.
As stipulated in the regulations, salary bonuses can be provided up to a maximum of three times the basic salary for fully autonomous hospitals and twice the salary for partially autonomous hospitals. However, most hospitals have not reached these target levels; the bonuses given by the studied hospitals only range from 0.6 to 1.5 times the basic salary. Although hospitals aim to increase bonuses every year, some hospitals have cut bonuses for half of the hospital staff in recent years (i.e. Cho Ray Hospital, a fully autonomous hospital since 2012). Setting coefficients for bonuses is based on criteria from the internal expenditure regulations, which mainly consider the performance efficiency of teams and individuals, attitudes towards colleagues, and the working hours of each individual.

In addition to income from salary and allowances from the hospital’s operating surplus, the hospital may arrange extra income for staff from other non-clinical services, such as restaurant services (food shop), motorcar parking, etc. However, despite these efforts, many staff complain about the low level of income. Most participants said that although hospitals contribute to improving the spiritual and material well-being of staff, the current incomes do not. The income gap within hospitals (e.g. among positions and among departments, such as internal medicine and surgery departments) and among different levels and regions to which hospitals belong also leads to “brain drain” problems inside the country, whereby health staff move from public hospitals to private hospitals or from rural areas to urban areas.

Participants in the process of discussion, priority-setting, and decision-making around salary and incentives include the hospital directorate, leaders of different departments, the chief accountant, and the trade union. The review of salary and incentives of each staff member is done by a council with the involvement of representatives of the hospital’s directorate, representatives of accountants, and the hospital trade union. The additional salaries and incentives/bonuses derived from the hospital’s savings is public to all hospital staff through the Hospital’s Internal Expenditure Regulation. All staff have their own job descriptions. This is one of bases on which the Council can decide salaries, incentives, and bonuses for staff.
11.8 Infrastructure and capital investment

All six hospitals face difficulties in maintaining or improving hospital infrastructure and equipment. The main issues mentioned were:

- infrastructure not aligned to the requirements for health service provision;
- lack of budget and mechanism for reallocating budget to the maintenance and repair of infrastructure and medical equipment; and
- lack of medical equipment, or equipment not aligned with requirements for services.

Regarding other non-medical infrastructure and equipment, not all hospitals are fully equipped with waste management, water, heating, AC, power supply, and oxygen centres.

11.9 Capital investment

According to Decree 69/2008/NDD-CP regarding social mobilization policy and the Circular 15/2007/TT-BYT, which guides implementation of joint venture non-state sector investments in public hospitals, public hospitals can formulate plans for expanding services, investment in infrastructure, or new equipment procurement based on their own situations. However, in practice, all public hospitals, including fully autonomous hospitals such as Cho Ray Hospital, must still seek approval of their investment plans from the Ministry of Health or the Provincial Health Bureau, and the local People’s Committee. For example, in order to purchase an MRI machine through funds from the local government or social-mobilization joint ventures, provincial hospitals must develop a proposal for investment and then submit their plans to the Provincial Health Bureau. If the Provincial Health Bureau agrees with the proposal, the hospital should submit the proposal to the Provincial People’s Committee for final review. For simpler kinds of service or services that require less sophisticated medical equipment, hospitals can make their own decisions.

However, the volume of capital investment from non-state partners varies among the six hospitals and depends on the hospitals’ capacity to provide services and the outsider partners’ forecast of the benefits they will gain.
from their investments. The capacity of lower-level hospitals, such as the two district hospitals included in this study, to attract capital investment is very limited. For these hospitals, capital investment is used only for pre-clinical service tests such as blood test equipment and ultrasound machines. In contrast, in central or provincial hospitals, capital investments are used for broader services and constitute a bigger slice of the budget. In addition, central hospitals such as Cho Ray Hospital are able to draw their budget from several sources, including not only non-state sector actors and partners, but also low-interest bank loans facilitated by the local government’s support of the hospital.

11.10 Assets leasing/sales
All hospitals included in this case study also have limited authority over asset lease. The extent of such autonomy depends on the kind of asset. The most common assets leased are infrastructure or free land that hospitals are not using for providing services. Hospitals can lease these assets for private or public use through canteens or restaurants for patients and health staff, or mini shops, in order to get more revenue for the hospital.

11.11 Priority-setting and decision-making in hospital equipment procurement and expansion of technical activities
For the hospital itself, a decision on equipment investment or professional expansion always requires establishment of a committee. Membership of such a committee consists of the directorate, leaders of administrative and technical departments and representatives of the hospital’s different organizations (party, trade union, youth union, etc.). In addition, before buying new equipment or expanding professional activities, all hospitals consult with national or even international experts on the equipment’s characteristics, its investment efficiency; the same applies for professional activities (Cho Ray Hospital is a case in point). All equipment procurement processes and professional expansion activities are conducted according to the direction and regulations issued by the Government and the Ministry of Health in response to the health care needs of the people.

11.12 Procurement
Autonomy with regard to drugs and supplies varies among hospitals according to their level of care and province. All the hospitals included in
the study are required to follow the national regulations, including the list of essential drugs and regulations for drug bidding.

Both of the central hospitals (Cho Ray and Uong Bi), are under direct administration of the Ministry of Health, so they can make their own decisions regarding drug procurement and supplies. In contrast, the provincial and district hospitals in both Ho Chi Minh City and Quang Ninh Province do not have the right to make these decisions themselves. Depending on the regulations issued by the local government, the organization responsible for making decisions regarding drug bidding can be either the Provincial Health Bureau or the Provincial General Hospital. However, all drug bidding processes have to comply with the Bidding Law and Circular 10/2007/TTLT-BYT-BTC (being replaced by Circular 01/2013/TTLT-BYT-BTC).

The challenges faced by the six hospitals included in this study are mainly related to the implementation of current regulations for drug procurement, including:

- Lack of clarity and consistency between regulatory documents in terms of guidelines and list of drugs. According to the regulations, all drugs included in the bidding should be listed by their generic names, but in practice, the same drugs are listed by different brand name and trade names, each with different prices, qualities, and suppliers. These branded drugs are thus included in the drug lists for hospital use. This complicates hospital processes, particularly health professionals’ decision-making regarding drug prescriptions.

- The specific drug bidding lists set for distinct types of hospitals (levels of care, as well as specialties covered, etc.) are often inappropriate. The drug list does not coincide with the list of services provided at lower-level hospitals. This discrepancy limits hospitals’ capacity to both provide services that they are capable of delivering and attract patients to use their services. For instance, the district hospital may have health professionals and medical equipment available to treat different stages of hypertension, but the drug required to treat the third stage of
hypertension is excluded from the drug list assigned for hospitals at this level. As a result, district hospitals must refer such patients to upper-level hospitals.

- All six public hospitals often encounter drug shortages at certain times due to supplier delays.

11.13 Service mix and quality

Currently, public hospitals are required to provide the services according to their level and category within the health system. According to the functions assigned for each hospital, hospitals in higher levels or in higher grades must provide a higher number of services with more specialized techniques. However, not all hospitals can provide all of the services in the list as assigned by regulation (Ministry of Health Decision 23/2005/QD-BYT).

Of the hospitals in our study, Cho Ray and Uong Bi are central hospitals that provide the most advanced services, but the hospitals at the provincial and district level are able to provide about 80% of the services in the list assigned to their hospital level or grade.

For example, Quang Ninh General Hospital is able to conduct 85% of the total of medical services that it should. District hospitals only have the ability to provide about 75–85% of their assigned service list. This is mainly due to: (i) lack of medical equipment (Quang Ninh still lacks 30% of the medical equipment listed for grade II hospitals); (ii) lack of health professionals, particularly specialists and (iii) the provider payment mechanism and service price list, which do not support or encourage district hospitals to provide services.

On the other hand, lower-level hospitals can provide all of the services assigned, but they can also provide a number of high-tech services that are assigned to upper-level hospitals or higher-grade hospitals, as there is no policy or mechanism to ensure compliance with the functions that are assigned to each level of hospital.

Upper-level hospitals are also responsible for providing technical support and assistance for lower-level hospitals in case of emergency and medical consultation. Decision 1816 by the Ministry of Health requires rotation of health staff from upper-level hospitals to lower-level hospitals for technical
support and transfer from the upper to lower hospitals in order to help increase their capacity to increase quantity and quality of services. However, the six hospitals studied currently all face difficulties in this activity due to the limited budget for implementation of technical support activities.

11.14 Enforcement of safety and quality standards

None of the six public hospitals included in the study were required to be licensed or accredited, as the procedures have yet to be stipulated. To supervise the quality of professional practice, all six hospitals also established professional councils, which are medical councils that have responsibility for auditing and supervision of professional practice via review of medical records and prescriptions. They include a technical council, a drug council, a science council and a patient council. These councils’ regular activities assist other departments in technical aspects when they have problems and develop new techniques. The technical councils of hospitals are also involved in treatment at different levels. Most respondents agree that these councils work effectively and enable hospitals to ensure their technical quality. However, in practice, the effectiveness of their activities is very limited and not clearly reflective of the quality and safety of treatments due to potentially irrelevant quality measurement tools.

The main constraint to safety assurance faced by all hospitals included in this study is the absence of treatment guidelines for the application of quality management for medical procedures. The lack of relevant tools to supervise and manage the quality of services in the hospital, both in terms of hospital management and local health administration, is another constraint.

11.15 Clinical management systems

Among the six hospitals, only Uong Bi applied a model clinical management system. This hospital inherited the system from the Viet Nam–Sweden cooperation project many years ago and this system has been retained. Recently, this hospital developed and applied 150 intensive care procedures. The other hospitals in the study provide very few intensive care procedures in intensive care units, operation rooms, and procedure rooms.

In terms of protection against clinical accidents and security for health staff, all six hospitals have applied some measures including organizing safeguards.
11.16 Continuous quality improvement

Uong Bi Hospital has also applied the process of continuous quality management since the Viet Nam–Sweden cooperation project. However, the hospital faces difficulties in maintaining this process. Among the other five hospitals, there is no official model or process of continuous quality improvement.

11.17 Clinical knowledge and skills of medical, nursing, and support staff

The extent of the clinical knowledge and skills of medical, nursing, and support staff among the six hospitals decreases down the hierarchy from central to district hospitals. The two central hospitals (Cho Ray and Uong Bi) have many advantages in the development of capacity for both clinical and technical staff, as both hospitals are teaching hospitals. In addition, they also have more capacity for professional peer reviews, and more opportunity for medical practice and new knowledge absorption. Thus, the professional staff in these two hospitals have greater professional knowledge and skills.

The four lower-level hospitals (provincial and district) face many difficulties in assuring the professional competence of their health staff, particularly for specialist doctors and district hospitals. The following factors often cause inefficiency in health service provision:

- ineffective service training and continuous education even though the ministry has issued regulations for obligatory continuous training of health staff (Circular 07/2008/TT-BYT, replaced by Circular 22/2013/TT-BYT); and
- reluctance of lower-level hospitals to send doctors and skilled health staff for additional training due to health workforce shortages.

11.18 Citizen/patient involvement

Findings from the study of six hospitals are that most hospitals do not include organizations and individuals outside the hospital or patients’ representatives in decision-making on hospital direction or policies. The hospital’s leaders manage all of the hospital’s work and activities. Since the enforcement of the social mobilization and hospital autonomy policy, private partners (individuals or organizations) can be involved in some of
the hospital’s social mobilization activities approved by the Ministry of Health or the Provincial Health Bureau as joint venture activities. However, private partners only participate in the initial stage of negotiation on profit-sharing in the contracting process; the entire equipment operation as well as tracking of financial revenues and expenditures is undertaken by the hospital. The partners also undertake the training of staff in operating equipment and the regular or irregular servicing of equipment at the hospital’s request.

11.19 Consumer satisfaction/voice and complaints mechanisms

All hospitals included in this study have established a mechanism for collecting complaints and feedback from patients and their relatives, consistent with national regulations. The model includes:

• a patient council, which is a temporary unit that consists of representatives for patients during hospitalization. The council has one meeting per week to relay their complaints and comments to the hospital (often to the chief nurse and planning department of the hospital); and

• a 24/7 hotline and comment box, which, according to current regulations, must be publicly announced and described so that every patient and consumer understands that he or she can receive and make phone calls if he or she has any comments or complaints. However, the mechanisms to receive and synthesize feedback, and the use of this information to improve the performance of hospitals, are still very limited and differ among hospitals. Outside of hospitals, there is no organization that routinely conducts surveys for patient satisfaction.

11.20 Management decision-making

Leadership skills and behaviour

In the six public hospitals, the director, vice director, and other administrative departments all have backgrounds as medical doctors or pharmacists. They have not undertaken formal courses in hospital management, but have participated in short courses organized by the Ministry of Health or other institution. In the interviews, they complained
about their limited abilities in hospital management and their need for more training. The hospital leaders also undertake clinical work, and often have to perform operations on patients.

**Professionalized management**

All six hospitals currently apply some form of professional management guidelines according to the Ministry’s “Hospital regulation,” which specifies the process and steps that every hospital must follow to control and ensure the quality of many hospital activities and services, including medical record management, professional practice, and patient feedback. However, according to the information from the focus group of hospital managers and health staff from six hospitals, adherence to this regulation document is not easy to measure, monitor or evaluate. Thus, each hospital has designed its own model of professional management based on the common regulations; however, the models are not consistent across hospitals. In addition, this document has not been updated since 1997 and needs to be revised.

**Strategic direction/vision and quality and use of information**

All six hospitals have developed five-year strategic plans and annual action plans with clear objectives and target indicators. The activity of developing strategic and action plans is a routine mission that all public hospitals have to follow. Most of the typical hospital issues and activities are mentioned in the action plan, including clinical and non-clinical activities, human resources, hospital financing, issues of salaries and benefits, and incentives for health staff. The strategic and action plan is developed based on information synthesized from the plan proposed by each department within the hospital and other data and information related to the hospital’s situation. However, interviews show that the methods used to identify problems and set priorities and objectives still lack rational use of data analysis both for data from hospitals as well as data for the local action plan for socioeconomic development.

In the action plan, the issues of monitoring and evaluation are not highlighted, and the persons or organizations responsible are unclear. In addition, the indicators and tools for monitoring and evaluation are also not listed or mentioned in the plan.
All hospitals have applied information technology fully in hospital management with a local area network (LAN) and management software, although they have not yet implemented electronic medical records. However, the management software used differs among hospitals and comes from different software companies, not from the Ministry of Health. These differences may complicate the adoption of a routine reporting system as well as a consistent health insurance management system.

Most respondents said that in the process of developing their hospital’s investment plan, relevant information is regularly and publicly shared with all hospital staff through the annual or biannual staff meeting. The hospital’s financial statement or report, in which all concerns are clearly explained, is also transparently publicized.

All hospital staff can join or participate in giving comments on hospital development investment through monthly meetings. At the same time, hospitals have a LAN where information is regularly updated. Through these channels, hospital staff also have opportunities to learn and share information with each other.

11.21 Accountability

Supervisory structure (capacity, role, function, independence)

Central hospitals (Uong Bi and Cho Ray) are under the direct management of the Ministry of Health in terms of professional and financial issues. These hospitals are also under the management of the Provincial Health Department in terms of epidemic prevention and staff assignment for prevention initiatives. Furthermore, these hospitals simultaneously send reports to the Ministry and PHD.

Provincial hospitals are under the direct management of the Provincial Health Bureau for professional and financial issues. These hospitals are also under the management and supervision of the Provincial People’s Committee.

District hospitals (Thu Duc and Dong Trieu) are under the direct management of the Provincial Health Bureau for professional issues. Regarding financial management, including investments in infrastructure, both district hospitals are managed by the District People’s Committee’s
Finance Department. These two hospitals have to submit regular reports, including quarterly and annual reports as well as irregular reports, to PHD and related agencies.

Not all studied hospitals have a Stewardship Council, but all do have steering committees in some specific activities such as social mobilization and joint ventures. These committees includes representatives of hospital leaders, hospital parties, trade unions, and leaders of functional and professional departments.

### 11.22 Reporting on performance domains

In terms of professional issues (clinical activities), hospitals at the central level have to report their activities directly to the Ministry of Health. Provincial hospitals have to report direct to Provincial Health Departments as well as the Provincial Center for Preventive Medicine (PCPs) for epidemic cases or for cases that have any signs of abnormality; district hospitals have to report to Provincial Health Departments and the District Health Unit (belonging to the District People’s Committee) when required.

In terms of finance, central hospitals have to report directly to the Ministry about health insurance, by directly sharing their reports for Viet Nam Social Security; provincial hospitals have to report to PHD, Provincial Social Security and the Provincial Department of Planning on Basic Construction. District hospitals have to report to PHDs or District Financial Departments, Provincial Social Security or District Social Security.

Hospitals have to submit reports monthly, quarterly, and annually. Hospitals also have to submit reports on request to the Ministry of Health, PHDs, Provincial People’s Committee, and District People’s Committees (e.g. when auditors visit the committees). Inside the hospitals, there are semi-annual review meetings and final meetings for reviewing hospital performance and planning for following years. Therefore, hospitals’ activities as well as financial performance are transparent to all staff and financial reports are publicly shared at congresses of officials and workers.

### Output/volume targets and information/reporting

As mentioned above, a clear list of indicators and data are collected, reported, and synthesized to monitor the output volume and targets of
hospitals quarterly, semi-annually and yearly according to Ministry of Health regulations. The reporting is not only for the health sector but also for the local government, which receives a more brief and focused summary. All hospitals must report the outputs of clinical activities, finances and human resources by separate reports linked with overall information related to hospital performance. However, the absence of a mechanism for checking the accuracy of data and information, as well as feedback from upper-level organizations is a primary weakness. Another constraint is that the reporting form and method to categorize the reported data/information sometimes differs among departments and divisions. These discrepancies make it difficult for hospitals to collect and synthesize the data and information, leading to inaccuracy of information. In addition, the utilization of data and information related to outputs and targets is very limited in terms of making local health sector plans.

12. Conclusions

12.1 Managers’ authority

In general, with the policy of hospital autonomy and social mobilization, public hospitals have more independence in decision-making, but mainly in governing their finances and expanding their clinical services and expertise. Public hospitals can be proactive in reallocating their budgets to invest in their priority activities. They also have the right to raise funds from outside sources or coordinate joint ventures with the private sector to invest in both clinical services and non-clinical services in the hospital. Public hospitals are still limited in their autonomy over human resource management focusing on long-term and short-term health staffing, particularly in the recruitment and firing of permanent staff.

12.2 Accountability

Regarding accountability mechanisms, financing and human resources for reporting information regarding output and volume targets are reasonable. All hospitals lack mechanisms to ensure the participation of health staff/labour in setting priorities, strategies and annual plans, as well as investments for hospital development.
The accountability related to the participation of other outside stakeholders in hospital performance is very weak, with no strong mechanism that allows other stakeholders to contribute to the hospital’s process of decision-making.

With regard to performance accountability, hospital accountability for the clinical quality and patient safety is weak.

### 12.3 Incentives in operation

The current provider payment mechanisms of health insurance do not strongly help and encourage public hospitals to provide services, particularly for district hospitals. Provincial and district hospitals have difficulty in balancing their budgets. The lower-level hospitals have less capacity to maintain surpluses; therefore, hospitals at the district level have many difficulties in hospital reinvestment as well as in rewarding health staff and improving their salaries. Thus, the provider payment mechanism should be changed and revised to encourage hospitals to produce better services.

### 12.4 Management capacity

Hospital management capabilities have improved in recent years, both in upper-level and lower-level hospitals. Public hospitals have better capacity to make strategic and action plans for hospital development, are more proactive in decision-making for investment in expanded services and are optimizing their resources and budgets. However, the major constraints are: leadership skills, and management capacity for quality management and patient safety in hospitals.

Hospital management training programmes should be introduced in training institutions and mechanisms for management training should also be created. Quality management, quality improvement programmes and patient safety measures should be developed and implemented in hospitals.

### 12.5 Technical capacity

Provincial and district hospitals are not able to provide the full list of services expected, due to a lack of medical equipment; limitations of
health professionals both in the number of doctors and the capacity of
doctors, which are exacerbated by the ineffectiveness of in-service training
and continuous education. In addition, inappropriate provider payment
mechanisms do not encourage hospitals to produce services.

12.6 Current policy responses

Further reforms recently introduced by the Government of Viet Nam
include Decree 85/2012/ND-CP on the operating and financial mechanism
in state health service facilities and medical service prices in state medical
facilities; and the Prime Minister’s project to reduce hospital overcrowding.

Decree 85, issued on 15 October 2012, replaces Decree 95/CP/1994 on
partial user fees and stipulates in great detail the operational and financial
mechanism and medical service prices in state medical facilities, which are
classified into four groups based on the degree of financial autonomy of
the facility. With regard to the operating mechanism, besides regulations
on development of service provision plans and organization of health
personnel, Decree 85 has an article regulating joint ventures and business
partnerships, specifically stating, “capital contributions and mobilization,
and joint ventures must be accounted for independently or an independent
accounting unit must be set up”. In terms of the financial mechanism, the
Decree separates the financial mechanism for development investment
spending from that for recurrent spending. With regard to prices of medical
services, Decree 85 stipulates implementation of the roadmap towards
appropriate and adequate calculation of user fee by 2018 and stipulates
gradual inclusion of salary and wages in medical service prices (MOH and
JPG, 2013).

The JAHR 2013 comments that “Obviously, Decree 85 has created a
fundamental change in the operating and financial mechanisms of state
health facilities. Implementation of Decree 85 will certainly promote further
implementation of hospital autonomy and strengthen social mobilization
for health care services” (MOH and JPG, 2013).

The project to reduce hospital overcrowding for the period 2013–
2020 approved by the Prime Minister in Decision 92/QD-TTg dated
9 January 2013 has the immediate goal of reducing overcrowding in
oncology, surgery/trauma, cardiology, obstetrics and pediatric specialties in a number of tertiary hospitals in Hanoi and Ho Chi Minh City. It has the complementary objective of improving the quality of medical services in district and provincial hospitals where bed occupancy rates are low, raising the rates to 60% by 2015 and 80% by 2020. Following approval of that policy, the Ministry of Health has approved the Project on Satellite Hospitals in Decision 774/QD-BYT dated 11 March 2013 and has set up a network of 50 satellite hospitals linked to 14 hub hospitals and added 7150 beds for the five overcrowded specialties above (MOH and JPG, 2013).

While there are clearly problems with the current health policy settings in Viet Nam, this study demonstrates the wide-ranging nature of policy reform in Viet Nam and the continuous development and adjustment in response to changing circumstances that have characterized the last two decades of the country’s health sector.
References


