Health Service Delivery Profile

Viet Nam

2012

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Viet Nam health service delivery profile

Demographics and health situation

In 2011, Viet Nam had a population of 87 836 million[1]; 8% under 5 years, 24% under 15 years, and 7% over 65 years. There are 54 ethnic groups in Viet Nam and the majority is the Kinh, accounting for 85.7% of the total population.[2] Most of the population (69.5%) lives in rural areas.[3]

Since the reunification of North and South Viet Nam (1976), the country has experienced a number of changes in the way health services are structured and delivered. From the 1990s there has consistently been a focus on poverty reduction. Since the 2001 National Strategy on Protection and Care of the People's Health, the State has reasserted its role in the health sector by seeking to ensure a basic level of health services for all Vietnamese and calling for an increase in the share of the state budget to cover recurrent spending on healthcare. Effects of the global economic crisis and climate change have slowed socioeconomic development and affected achievement of health goals. Nevertheless, in the past few years, there have been clear improvements in the health status of Vietnamese people, apparent in basic health and human development indicators outlined in Table 1.

Table 1. Key development indicators in Viet Nam

Key development indicators	Measure	Year
Human development index[a]	0.593	2011
Gini coefficient[a]	37.6	2000-2011
Total health expenditure[b]	6.9% GDP	2010
Multidimensional poverty index[c]	0.094	2008
Popolation living below the poverty line	14.5%	2010
Life expectancy at birth[d]	73.0 years (70.4 males,75.8 females)	2011
Literacy rate (15 years and over)	94% (96.1% males,92% females)	2002
Infant mortality rate[d]	15.5 per 1000 live births	2011
Under 5 mortality rate[d]	23.3 per 1000 live births	2011
Maternal mortality ratio[a]	69 per 100 000	2009

In 2008 the top five causes of burden of disease measured in DALYs for males were stroke, road traffic accidents, alcohol use disorders, liver cancer and HIV/AIDS, while for females the top causes were depression, stroke, vision loss, diabetes and road traffic accidents.[4] For children under age 15, the top 5 causes of burden of disease are pneumonia, drowning, falls, road traffic accidents and epilepsy. The main causes of death are increasingly related to non-communicable disease and injuries.

Health system strategies, objectives and legislation

The *Constitution of the Socialist Republic of Viet Nam (1992)* states: "Every citizen is entitled to benefit from health protection" and includes reference to combining traditional and modern medicine. The *Law on People's Health Protection and Care (1989)* states: "Health is the most precious asset… Every citizen is entitled to health protection, rest, recreation and physical exercise; assurance of hygiene in work, food and living environment and provision of professional health care services". Together these provide the basis for entitlement to health protection, including health promotion and preventive and curative care. The *National Policy on Traditional Medicine (2003)* addressed the decline in traditional medicine practice during the 1980s by expanding the network of traditional medicine hospitals and training establishments, and promoting use of traditional medicine at the commune level. The *Law on Pharmacy (2005)* also covers western and traditional medicine products. The *Law on Health Insurance (2008)* and related documents set the goal and measures to achieve universal health insurance coverage. Other important legislation includes the *Law on HIV/AIDS Prevention and Control (2005),* the *Pharmaceutical Law (2005), the Law on Organ Donation and Transplants (2006),* the *Law on Infectious Diseases Prevention*

and Control (2007), the *Law on Examination and Treatment (2009)*, the *Food Safety Law (2010),* and the recent *Tobacco Control Law (2012).*

The *Socio-economic Development Strategy (2011–2020)* influences the design, implementation, and resources of health care programs for the poor and other disadvantaged groups, and is the key national development plan. Other plans include the *Master Plan on Viet Nam Health System Development to 2010, vision 2020,* and the *Comprehensive plan on Examination and Treatment System Development to 2010, vision 2020.*

The Ministry of Health (MOH) is responsible for developing national strategies and programmes, planning and budgeting, manpower allocation, technical direction and supervision of national institutions and facilities. The Ministry of Health's *Five-year health sector plan (2011–2015)* emphasizes investing in preventive medicine (especially at the district level), communicable diseases prevention, environmental, occupational and emergency health, health education and school health, maternal and child health, health care for the elderly, rehabilitative activities, food safety and hygiene, and HIV/AIDS control. A traditional medicine department was established within the MOH in 1957 and the National Institute of Medicinal Materials in 1961. A national programme on traditional medicine was established in 2010, and goals to the year 2020 include: 100% of provinces/cities will establish or renovate traditional medicine hospitals by 2015; 100% of hospitals will have traditional medicine patient beds and all general hospitals will have traditional medicine departments by 2020; and that 100% of clinics and commune health stations will have a traditional medicine team headed by a traditional medicine practitioner by 2020 (currently 79.3%).

Service delivery model

Universal access to quality health services is a primary goal of the Vietnamese Government. Social health insurance is considered the main measure to achieve this goal by ensuring that all of society takes responsibility for health.

Currently, Viet Nam's health system consists of a highly unregulated public-private mix. In the public system there are four levels: national, provincial/municipal, district, and commune. At each of these levels, the system delivers three types of services: 1. Medical examination & treatment, , 2. Primary health care, preventive medicine & National Health target Programs, and 3. population and family planning. The development of the private health sector is strongly encouraged by the government to reduce pressures on the public system but at present consists mainly of a large number of outpatient clinics and pharmacies with a few hospitals. (Table 2).

Traditional medicine has been integrated into the national health system since the 1950s. It involves two components: a plant remedy-based form of medicine (southern medicine) based on indigenous medicine from 54 ethnic groups, and a Chinese-Vietnamese system of healing (northern medicine), which includes herbal medicine, acupuncture, massage and exercise techniques.

There are provincial, district and commune levels of responsibility for health, mirroring levels of Peoples' Committees. The Provincial Health Bureau, under the Provincial People's Committee, is responsible for overall administration of the provincial health system, including provincial services and the district, commune, and private services within the province. The District Health Bureau, under the District People's Committee, is responsible for administering district and communal service delivery funded by the District People's Committee. The Commune People's Committee coordinates with the commune health station for service delivery and implementation of health programs in the commune.

Private medical and pharmaceutical practice has been permitted since the early 1990s and plays an increasingly important role in providing medical services. The various ordinances on private practice have been replaced by the *Law on Examination and Treatment (2009)*, providing an improved unified legal framework for both public and private sectors. However linkages with public institutions are weak, regulation remains inadequate, and the profit motive often puts private facilities at odds with public health goals. Private health facilities mostly operate as for-profit enterprises, but public facilities also face incentives to increase revenues to pay higher incomes to their staff. Private investment to build private hospitals and to equip public hospitals is strongly encouraged and has risen rapidly in recent years.

Communities and citizens have opportunities to participate in the policy-making process and to provide feedback through hotlines, letter boxes and patient committees set up at all hospitals, though so far participation is weak. The *Law on Examination and Treatment (2009)* includes specific articles on patient rights, but there is currently no organization responsible for advocating for the rights of patients.

The provider network

The health-care system includes 13 500 public curative care facilities and a large and growing private facilities is mainly in the form of clinics and pharmacies.[5] The public sector plays a leading role in providing inpatient health services in 1087 hospitals with 188 613 patient beds, compared to only 102 private hospitals, 7124 private beds. In 2010, number hospital beds per 10 000 inhabitants is 21.9,

Most inpatient care is provided by public hospitals, but there is a growing number of private hospitals in municipalities and provincial capitals providing an important source of competition. Tertiary care is still largely provided by national hospitals, although some provincial hospitals and even private hospitals have capacity to provide highly specialized care. For outpatient care, private clinics account for a large share of patient visits although many patients still prefer to use public hospitals. Despite efforts to provide care for common conditions at lower levels of the health system, provincial and national hospitals continue to account for a very large share of all inpatient services.

Table 2. Level and type of services provided in Viet Nam, 2010

Level of service	Type of service and Number	Characteristics
Curative care services		
Commune	Commune health stations: 10 926	Deliver most primary care services and national targeted health programs to the population, especially in rural and mountainous areas. Hygiene, vaccinations, antenatal care, safe delivery and health education. Also provide screening examination, treatment and referrals for outpatients. Collaborate in out-reach activities with village health workers (VHW). Extensive coverage of commune health network: 99% of communes have a health station, 70% have a doctor, and 79% of villages have active VHWs; 79.3% provide traditional medicine services and 79.9% had a garden of traditional herbs.
District	Regional polyclinics: 686	Deliver some primary care services and act as satellite facilities for some district hospitals.
	Hospitals: 615	Basic inpatient treatment, emergency care, and treatment of common diseases. Commonly have regional polyclinics to increase coverage and prevent patient overloads at higher levels. These also act as a referral transition point between service levels.
	Maternity homes: 18	Deliver basic prenatal and delivery services.
Provincial	Hospitals: 376 Traditional medicine hospitals: 53	General and specialized hospitals including traditional medicine, leprosaria and sanatoria. Each province has at least one hospital at this level.
	Specialty clinics: 47	Provide specialized outpatient services.
National	Hospitals: 44	Provide curative care, sanatoria and traditional medicine services with intensive specialization and modern technologies. National hospitals exist for many specialties such as oncology, endocrinology, etc. Provide technical support to services at lower levels and implement research.
Sectoral	Hospitals: 52	Deliver basic and specialized curative care, includes sanatoria.
	Clinics: 759	Sanatorium, polyclinics and health stations of other sectors like military, police, transportation, etc.
Private sector	Hospitals: 102	Provide general and specialized curative care, primarily located in urban areas. Mainly fully privately owned, but some are formed as joint ventures between public facilities and private investors.
	Clinics:	Most private services are provided in private clinics. Doctors working in the public sector are permitted to have private practice after working hours.

Level of service	Type of service and Number	Characteristics
	Registered private traditional medicine facilities (approx. 10 000)	Provide diagnosis and treatment using herbal medicines, acupuncture or other traditional medicine techniques learned in traditional medicine professional schools or family tradition.
Preventive medicine and other services		
District	Preventive medicine centres	Stand alone or integrated with district hospitals, these centres implement disease control and other preventive medicine services at the district level and below.
	Population / family planning centres	Stand-alone units implement communication activities on population issues and provide reproductive and family planning services in almost all districts.
Provincial	AIDS Centres: 63	Stand-alone centres deliver HIV/AIDS prevention, mitigation, care and treatment services.
	Reproductive health centres: 64	Stand-alone centres deliver reproductive health and family planning services, some also provide healthcare for children and the elderly.
	Preventive medicine centres: 63	Stand-alone centres implement disease control activities including occupational and environmental health, but also provide outpatient examination and treatment.
	IEC Centres: 63	Stand-alone centres run health information and communication services.
	Food Safety Centres: 63	Stand-alone centres implement food safety communication, testing and inspections.
	Drug and cosmetics testing centres	Test drugs and cosmetics for safety (stand-alone unit in most provinces).
	Forensic and health assessment centres	Implement assessments of ability to work and forensic investigations. In most provinces it is a stand-alone unit.
	Other preventive medicine facilities	Some provinces have additional stand-alone preventive medicine facilities such as malaria control centres, leprosy control centres, eye disease control centres, social disease control centres, labour and environmental health centres, border quarantine stations.
National	Public Health Institutes: 10	Implement research, guide and monitor programs in area of expertise such as malaria, hygiene and epidemiology, nutrition, etc. at regional and national levels

Primary care is provided mainly by regional polyclinics, commune health stations, village health workers and private clinics. However, a variety of public health facilities have been set up to provide services for specific diseases or population groups including provincial AIDS centres, population and family planning centres, reproductive health or maternal and child health centres, social disease control centres, IEC centres, and various others at the provincial level. Public health functions are provided by several other centres including preventive medicine centres, food safety centres, drug and cosmetics testing centres, forensics and lost ability to work assessment centres, and some border quarantine services. Preventive, promotive and public health services are primarily provided by the public sector, although some non-governmental organizations are also involved. Fragmentation of various public health and preventive medicine functions is detrimental to efficiency and coordination. Many of the public health functions require coordination not only between health sector facilities, but with other sectors as well. This has improved somewhat over recent years especially in the areas of food safety, animal-borne diseases, and increasingly in relation to risk factors for non-communicable diseases such as tobacco control.

Traditional medicine is widely used, but of special importance to people who face difficulty in accessing primary health care services, either due to cost or distance, as they can rely on locally available herbs and other remedies. The most commonly used forms are herbal medicine, acupuncture, traditional Chinese medicine, and Tam quat. Efforts have been made to increase knowledge of traditional treatments through mass media and increasing availability at public health facilities. In 2010, the Ministry of Health reported the proportion of consultations relying on traditional medicine to be 25% at the commune level, and 9% at the provincial and district level. Most commune health stations (79.3%) offer traditional medicine services.[6] In addition to affordability and accessibility, traditional medicine is considered effective, especially for treatment of chronic disease.

Health financing

In 1992, the government introduced a national social health insurance scheme with three key aims: to contribute to poverty alleviation; to raise additional resources for the public sector; and to protect against catastrophic household spending on health care as a result of user fees. The *Law on Health Insurance* (2008) consolidates and strengthens the scheme. In 2010, it was estimated that 60.3% of the population was covered by the scheme.[7] Compulsory participation in this social health insurance is being rolled out gradually to cover the entire population. In 2010, 50% of those in the scheme were making compulsory contributions (includes employees and school children), 42% were fully or partially subsidized by the state budget (mainly the poor, ethnic minorities, children under age 6), and 8% contributed voluntarily.

Of the estimated total health expenditure in 2010, government expenditure accounted for 44.6% and non-government expenditure 55.4%. Government expenditure came from central and local government revenue (26%), health insurance (17%), and foreign aid (1.6%). Most non-government expenditure came from out-of-pocket payments, a large and increasing share of which is payments of service fees at public health facilities (43.5% in 2009), while the self-medication share of spending has declined to 34.5% in 2009.[8] Even though state budget and health insurance are considered to be the two most important sources of health financing in Viet Nam, out-of-pocket payments remain high and the health insurance share has not risen as rapidly as expected.

The MOH and Ministry of Finance jointly set the medical service fee schedule, with maximum fees that are applied to services in the public sector. The fee schedule covers services such as hospital examination and inpatient stays, laboratory and diagnostic imaging services, and surgeries or procedures. In addition patients pay for all drugs and material costs. Fees are paid either by patients as out-of-pocket payments, or by the insurance scheme through provider reimbursement. Traditional medicine services are also covered in the comprehensive government fee schedule. Social health insurance covers acupuncture, herbal medicines, and Chinese traditional medicine treatment. Fees do not yet cover all cost components and public facilities continue to receive state budget subsidies. The private sector is permitted to charge what it wants to cover its costs.

There are a number of official development assistance health-related organizations and projects related to health service delivery ranging from health systems development, to provider payment reforms, to small-scale projects in single facilities or localities. Examples of projects include facility renovation, medical equipment procurement, subsidies to the poor, and near-poor, HIV/AIDS care and treatment and reproductive health services. Some short-term projects funded by international NGOs support research, training, and small-scale health interventions. Aid coordination has improved in recent years with strong commitments from the Ministry of Health and Development Partners to work towards aid effectiveness[9] and since 2007 collaboration on the Joint Annual Health Review.[10]

Human Resources

The number of state health workers per 10 000 people has increased over the past few years, meeting national health sector goals (Table 3). However, there is an uneven distribution of human resources with shortages in some regions, facilities and specializations. The most qualified health workers are concentrated in urban areas including 82% of total university pharmacists, 59% of doctors and 55% of nurses[11], even though only about 30% of the population live in urban areas.

The health human resources training network includes 32 universities/university departments, 42 junior colleges, 66 secondary schools, 8 research institutes, 11 university hospitals, 3 national hospitals and 2 traditional medicine hospitals that participate in training new medical personnel from secondary to post graduate levels.[12,13,14] Medical schools are required to provide training in modern medicine in addition to compulsory courses in traditional medicine. Despite increased training intake quotas of medical and pharmaceutical schools, the number of health workers in state health facilities has not increased proportionally and the distribution of health human resources between socioeconomic regions and fields of practice remains imbalanced. Problems with deployment and remuneration of health workers contribute to this imbalance.[15]

In 2010 there were about 14 300 traditional medicine practitioners working in provincial medical facilities[16], of which 194 had classical training.[17] Among 11 859 traditional medicine practitioners in the private sector, 33.2% had professional training as a medical doctor or assistant doctor of traditional

medicine, 54.2% had classic training in theory and philosophy of traditional medicine or pharmacy, 12% had no professional training but learned the profession through traditional apprenticeship and a small percentage were foreign practitioners.

Table 3. Numbers of state sector health workers in Viet Nam (2010)

Profession	Number per 10 000 population	Characteristics
Doctors	7.20	
Nurses and midwives	9.35	Nurses: Doctors ratio 1.3 (2010)
University pharmacists	1.76	University- and higher-level trained
Assistant doctors	6.22	Mainly working at the commune level
Total health workers	39.7	Increased from 29.2 in 2001

Regulations regarding the licensing of western and traditional medicine practitioners are included in the *Law on Examination and Treatment (2009)*. The practice of traditional and herbal medicine is regulated through mandatory medical education standards and apprenticeships.

Medicines and therapeutic goods

A large range of pharmaceuticals is available in Viet Nam with systems in place to promote good practice in manufacturing, storage, testing and distribution. There were 171 pharmaceutical factories in 2009, of which 78 were producing traditional medicine products.[18] Good Manufacturing Practice requirements have been extended to the manufacture of herbal medicine products since 2011. A post-market surveillance system for safety of all medicines, including herbal medicines, was initiated in 2002 but not actively implemented till 2009 when an adverse drug reactions monitoring centre was also set up at the Hanoi Pharmaceutical University.[19]

Medicines listed in the health insurance benefit package are reimbursed by the social insurance fund and dispensed by hospitals. Other medicines can be purchased by the patient from hospital or private pharmacies. The list of drugs eligible for insurance reimbursement at national facilities, updated in 2010, covers 900 active ingredients, including 300 traditional (herbal) medicines, and 57 radioactive and radiocontrast agents. However the lower the level of the facility, the more limited is the list, with 297 active ingredients covered by insurance at the commune level.[20] While the officially allowed benefit package is quite generous, actual availability of pharmaceuticals to patients depends on the drug list used for procurement by individual hospitals based on their case mix and practitioner preferences. For patients without health insurance or who self-medicate, out-of-pocket payments for medicines is very high, strongly influencing access, financial protection and equity.

Western and herbal medicines can be sold in pharmacies, by licensed practitioners, or in other outlets as prescription or non-prescription medicines. In addition, households can grow or purchase their own herbs to use medicinally. The regulatory status of herbal medicines ranges from tight control over addictive substances to good practice standards for herbal medicines. The 4th edition of the *Vietnamese Pharmacopoeia* (2009) includes 314 monographs for herbal medicines and is legally binding. An unknown number of practitioners also produce traditional medicines. In 2009, there were 2058 registered traditional medicine products. Of these, 1965 were produced in Viet Nam and 92 were imported from China, Korea, Germany and France.

Over the past decade the health sector has seen a rapid increase in medical equipment available in public and private facilities due to a policy to mobilize funds for the health sector from both government and private sources. In consequence, the number of services provided per population has increased rapidly. In 2010 for every 1000 people in the population, 16 CT scans, 209 X-rays, 146 ultrasounds and 3030 lab tests were performed in public facilities, and an additional unknown number in private facilities.[21]

Movement and linkages through the provider network

Patient entry into health services is determined by insurance, cost, quality of care, and convenience. Insured patients register for care at a primary facility where health insurance funds are then allocated to pay for their care. The referral process is outlined in documents relating to health facility registration and the health insurance scheme. If patients bypass their primary facility without a referral letter they will pay higher co-payments. Health seeking behaviour of uninsured patients, while not subject to gate-keeping for rational use of health services, is influenced by higher fees at higher level and private facilities. At any facility, regardless of insurance status, every patient could be referred to higher level care. The public sector does not generally refer patients to the private sector, but private providers often refer to the public sector. Providers operate independently and medical records do not follow the patient, resulting in poor continuity of care and weak linkages between facilities. Coordination between treatment and prevention is also weak except for a few vertical target programs focused on specific diseases.

For inpatient care, public hospitals, especially at provincial and national levels, are still the primary choice of patients because of the widespread network throughout the country and increased investments in technologies over the past decade. The public sector accounted for 93.9% of total inpatient admissions in 2010.[22] Highly specialized care is still mainly at the national level for most diseases. However private hospitals are increasing competitive pressures on public hospitals in cities and provincial capitals both in terms of medical technologies and better service orientation. For less serious illness, patients often choose private clinics because of convenience, better attitude of health staff, and shorter waiting times. In 2010 the private sector accounted for 40% of total outpatient visits.[23] Nevertheless, the public medical care network is often the only choice for patients in rural and especially remote, disadvantaged areas.

Quality

Improving quality of care across localities and facilities is an important priority of the health sector. The government has so far focused on strengthening capacity through training and mentoring and upgrading hospitals, but is increasingly turning to health systems measures to improve quality. The L*aw on Medical Examination and Treatment (2009)* provides a legal framework for quality assurance (e.g. via accreditation, licensing and continuous medical education). The MOH has made other efforts at developing a quality management system for hospitals, including development of technical standards, gathering information in an annual hospital survey to rank hospitals and initial development of electronic information systems. However so far the results are limited and compliance remains weak. Little is known about quality differences between private and public providers, however, rapidly increasing levels of health service provision and over-provision of antibiotics and other drugs have resulted in calls for stronger regulation and monitoring of both public and private facilities.

Professional organizations in many countries have important roles in administration and quality assurance in the health sector. While there are a total of 134 medical/health professional associations throughout Vietnam[24] their role in ensuring quality of care has been limited both by lack of legislation and resources.

Efforts have been made to improve quality of the health workforce through increased postgraduate training, an expanded training system and efforts to increase practical training. Continuous medical education programs are nascent but their importance has been recognized and measures are being developed to set up systems. Measures to improve skills at lower level facilities include seconding professional staff from higher-level facilities to work temporarily in lower-level facilities to mentor their colleagues.

Equity

There is a vision for greater uniformity in service quality and availability throughout the country. However, there is disparity in progress towards this goal mainly due to differences in availability of resources between wealthy and poor provinces. Geographic disparities in resources, rapid medical cost escalation and inadequate financial protection are associated with continuing inequalities in access to care in recent years. Health financing reform has been introduced with the objectives of achieving health care for all. The social health insurance system is considered by the government as the way to ensure the right to

health care for all people, and a tool to achieve equity in health care. Despite these efforts, inequities in health status and health care continue to challenge policymakers. In 2010, while 37.5% of people in the poorest income quintile received any medical care in the past 12 months, for the richest income quintile the figure was 45.5%. While state funded health insurance provides some financial protection to the poorest, a large proportion of the population, the urban poor and the rural near poor and middle-income people in rural areas, are still without financial protection. Some 26.5% of all households reporting a decline or no improvement in living standards between 2006 and 2010 attribute it to illness or death to family members.[25] In recent years, the policy orientation for equitable health care has focused on: a) continuing to expand compulsory insurance coverage towards the near poor and self-employed, b) strengthening capacity for commune health stations by direct recruitment of students from mountainous and disadvantaged areas to medical schools with commitments to return to their origin areas and c) ensuring everybody has easy access to basic primary and preventive health care services, especially the elderly, children and ethnic minorities.

Demands and constraints on the service delivery model

Health service delivery in Viet Nam is the responsibility of a large number of different institutions. The government-run sector shows evidence of: innovative strategies to improve, manage, integrate and scale up health services. However, there remain a number of demands and constraints:

- Financing is a major challenge. Universal access to quality health services is a primary goal of the government, but achieving this is hindered not only by a large uninsured population, but also by the high and rising costs of medical care and inadequate policies to ensure cost effectiveness in treatments. The MOH is currently struggling to ensure health insurance coverage for informal sector workers and their families and to improve the quality of district and commune services. The intention is to progressively mandate contributory participation in the social health insurance scheme, improve the benefit package and to apply new provider financing and payment methods.
- Financial and managerial autonomy in public hospitals has been granted over the last decade, but results are mixed. Some facilities have adopted efficiency and quality improvements, and also increased revenues to improve staff incomes. However, facilities in remote areas have difficulty in covering their costs and some others have focused largely on revenue maximization to the detriment of the insurance fund and patient financial protection. Provider payment reform to move away from fee-for-service payments towards capitation and case mix payments is occurring slowly because of a lack of research and technical capacity.
- Overcrowding in central and specialized hospitals is a major problem. The MOH is preparing a comprehensive program to deal with the issue of overloading, and to improve quality of care in the public sector. This long-term comprehensive program contains solutions to increase investment for provincial and central hospitals, to strengthen the referral system, and to improve financing and payment systems.
- The organization and administration of preventive medicine and primary care units from central to local levels remains fragmented, leading to inefficiency and ineffectiveness. There is a lack of unified solutions, comprehensive, intersectoral approaches in some service areas, monitoring, sharing of information with other service levels, and awareness of the 'socioeconomic determinants of health' approach. The system is responding too slowly to changing patterns of disease and the demands for services this creates.
- While Viet Nam trains an adequate number of health workers, the incentives, working conditions and career development opportunities are inadequate to attract and retain them in public sector facilities in rural and disadvantaged areas, and in specific fields such as preventive medicine.
- The private sector, including private investments in medical equipment in public hospitals, is uncoordinated and inadequately regulated. There are strong incentives to over provide services, which may impede achievement of public health and equity goals.
- Health management information systems are inadequate to monitor clinical effectiveness, to monitor quality and safety of care and to set up and maintain provider payment systems in public sector facilities, but even more so in private facilities with few obligations to report to the authorities.

Indicators of progress

2010 was the final year for implementing the '*National strategy for the protection and care of people's health during 2001–2010'.* The government and international development partners jointly monitor the MDGs and Vietnam's own health goals. All basic health targets were achieved (Table 4).

Table 4. Achievement of national health targets, 2010

Indicator	2010 goal	Estimated level in 2010
Reduction in fertility (‰)	0.2	0.3
Crude birth rate (‰)	17.6	17.1
Population growth rate (%)	1.14	1.05
Average life expectancy (years)	72.0	73
Maternal mortality ratio (per 100 000 live births)	70	68
Infant mortality rate (‰)	<25.0	<16.0
Under 5 mortality rate (‰)	<32.0	25.0
Under 5 malnutrition rate (%)	<20	18.0

Source: Plan for the protection, care and promotion of the people's health, 2011–2015, Government of Viet Nam.

2010 goals for health sector resource inputs were also largely met. By 2010, for every 10 000 people there were 7.2 doctors (2010 goal was 7) and 1.76 university pharmacists (goal was 1.2). The proportion of communes with a doctor reached the goal of 70%, but the proportion of villages with village health workers only reached 78.8% compared to the goal of 84%. With 21.7 hospital beds per 10 000 people the 2010 goal of 20.5 was exceeded. Some 80.1% of all communes met national benchmark standards.[26]

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