MINISTRY OF HEALTH

PLAN

For people's health protection, care and promotion 2016-2020

Hanoi, 03/2016

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ABBREVIATIONS

<5MR	<5 Mortality Rate
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CHS	Commune Health Station
DHC	District Health Center
DoH	Department of Health
DRG	Diagnosis-Related Group
GDP	Gross Domestic Product
GMP	Good Manufacturing Practice
GSP	Good Supply Practice
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPG	Health Partnership Group
IMR	Infant Mortality Rate
IT	Information Technology
JAHR	Joint Annual Health Review
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MMT	Methadone Maintenance Therapy
MoF	Ministry of Finance
MoH	Ministry of Health
MPI	Ministry of Planning and Investment
NCD	Non-Communicable Disease
NRA	National Regulatory Authority
ODA	Official Development Assistance
PAR INDEX	Public Administration Reform Index
PHC	Primary Health Care
PPC	Provincial People's Committee
PPP	Public-Private Partnership
SRB	Sex Ratio at Birth
UHC	Universal Health Coverage
UNIDO	United Nations Industrial Development Organization
VHW	Village Health Worker
VSS	Vietnam Social Security
WHO	World Health Organization

MINISTRY OF HEALTH

SOCIALIST REPUBLIC OF VIETNAM
Independence – Freedom - Happiness

No.: 139 /KH-BYT

Hanoi, 1 March 2016

PLAN

For people's health protection, care, and promotion in the period 2016-2020

PART 1
ASSESSMENT OF THE IMPLEMENTATION OF THE 5-YEAR HEALTH PLAN IN THE PERIOD 2011-2015

I. HEALTH STATUS AND GENERAL ASSESSMENT

1. Health status

Over the past 5 years, Vietnamese people's health status has been improved remarkably, reflected in the following core health indicators: the life expectancy at birth has seen a year-on-year increase, from 72.9 years in 2010 to 73.3 years in 2015 (70.7 years for men and 76.1 years for women); the infant mortality rate decreased from 15,5‰ in 2011 to 14,7‰ in 2015; the under-five mortality rate decreased from 23,3‰ in 2011 to 22,1‰ in 2015; the under-five malnutrition rate (underweight) decreased from 16.8% in 2011 to 14.1% in 2015. However, there have been wide disparities in core health indicators between rural-urban residents, across regions, and among population groups, which have not been narrowed down in recent years.

The disease patterns in Vietnam are currently in a transitional period, with multiple burdens from infectious diseases and non-communicable diseases (NCD), accidents, trauma, and poisoning; and a number of new epidemic and rare diseases have emerged with unpredictable trends. The proportion of hospital admissions due to infectious diseases dropped from 55.5% in 1976 to 19.8% in 2010, but increased to 25.3% in 2013. The proportion of hospital admissions due to NCD increased from 42.6% in 1976 to 71.5% in 2010 and decreased to 63.5% in 2013. The rate of mortality due to NCD rose quickly from 45.5% in 2010 to 69.63% in 2013, taking up the largest proportion, followed by rates of mortality due to accidents, poisoning, trauma (18.15%) and infectious diseases (12.23%).

2. General assessment of implementation results

Thanks to attention and direction from the Party, the National Assembly, and the Government, and collaboration among ministries, agencies, and Provincial People's Committees (PPC), the

health sector has strived to basically fulfill 7 key duties of the health sector over 2011-2016[1]; achieved and exceeded most core health indicators in the 5-year plan and annual plans. Overall results obtained in operational areas of the health sector have been commended and highly appreciated by Prime Minister Nguyen Tan Dung and contributed significantly to people's health protection and care, thus generally contributing to the country's achievements over the last years[2].

Some outstanding results include: (1) Timely prevention against epidemic attacks and outbreaks;(2) Effective implementation of the Scheme on Overcrowding Reduction thanks to efforts to mobilize sources of investment capital, complete new facilities, accelerate implementation of the Scheme on satellite hospitals, transfer techniques, and sending health staff from higher levels to lower levels on a rotating basis to improve quality and qualifications of lower levels and reduce the rate of referral to higher levels; (3) 76.52% of the population has participated in health insurance (HI), which exceeds the target assigned by the Party and the National Assembly; (4) Improvement of service attitudes following a patient-centered approach towards patients' satisfaction has been agreed upon and implemented in the whole sector, and initial results have been obtained and supported by the public; (5) Recognition by the World Heath Organization (WHO) to reach standards for the national regulatory authority (NRA) of vaccines; (6) Development of a number of high technologies and new technologies, especially organ transplantation; (7) Comprehensive and consistent renovation of the health organizational system at commune level, district level, and provincial level for integration and development; (8) International recognition for implementing Millennium Development Goals in health.

However, there are still many difficulties and challenges in people's health protection, care and promotion, such as: (1) Increasing demand of the public for health protection, care and improvement despite limited funding and resources for the health sector; (2) Overlapping focal points and lack of consistency in the organizational structure of the health system; (3) A large gap in the quality of health services and people's health indicators among regions; (4) Overcrowding in a number of hospitals at Central level and in big cities not completely resolved; (5) Limited combination between prevention and treatment and rehabilitation, and between traditional medicine and modern medicine; (6) Low HI participation rates and limited budget leading to high rates of out-of-pocket expenditures and limited balancing and risk-sharing capability of the HI fund; limited mobilization of resources for health from the private sector; (7) Inappropriate allocation of human resources in health and lack of appropriate incentives for health staff; (8) Undeveloped pharmacy industry and ineffective exploitation of plentiful domestic sources of medicinal materials; (9) The health information system (HIS) unable to meet requirements for management purposes.

II. PERFORMANCE IN EACH BUILDING BLOCK OF THE HEALTH SYSTEM

1. Health service delivery

[1] (1) Reducing hospital overcrowding; (2) Renovating financial mechanisms of public non-business health units; (3) Implementing road map for universal health coverage; (4) Strengthening health care at grassroots level and primary health care; (5) Developing health workforce; (6) Piloting delivery of demand-based health services; (7) Improving effectiveness of health communication and education

[2] At the conference on 15/01/2016 on evaluation of 2015 health activities, implementation of 2016 plan, and main duties over 2016-2020

1.1. Preventive medicine

Achievements:

Capacity for forecast, supervision and prevention of epidemics has been strengthened; in the past five years, many dangerous epidemic diseases have been successfully prevented and controlled, no major epidemics occurred, and newly emerging epidemic diseases (Ebola, MERS-CoV, H7N9, etc.) blocked and prevented. Several new vaccines are included in the Extended Program on Immunization, the rates of full immunization for infants, pregnant women, and women of reproductive age have been maintained at above 90%. Polio eradication, neonatal tetanus elimination, and leprosy eradication at provincial level have been retained.

Morbidity and mortality of some prevail diseases have decreased over the years. Morbidity and mortality rates of dengue fever have reduced respectively from 147 and 0.12/100,000 people in 2010 to 84 and 0.06/100,000 people in 2015. The prevalence of dengue fever in 2015 dropped by 16.6% in the whole country, and its mortality fell by 36.8% compared to the average rate of 2006-2010. For hand-foot-mouth disease, the morbidity and mortality rates also declined from 126 and 0.19 in 2011 to 58 and 0.006 per 100,000 people in 2015; the morbidity rate fell by 31.9% in 2015, and mortality rate by 90% compared to the average rate during 2011-2013. During 2003 - 2010, the whole country recorded 119 cases of influenza A (H5N1) with 59 deaths. However, since 2011, Vietnam has only recorded 8 cases with 5 deaths

Prevention and control of NCD have, step by step, been effectively implemented. In the period from 2011 to 2014, through projects under National Targeted Programs, detection, screening and treatment services were delivered to about 600,000 people with hypertension, 236,000 people with pre-diabetes and diabetes, and 10,000 people with chronic obstructive pulmonary disease and asthma; more than 10% of the communes performed hypertension management activities. In 2012, the Ministry of Health (MoH) and the Ministry of Education and Training signed a collaborative Program and Plan on children and students' health protection, education, and care in educational institutions within the public educational system over 2012-2020.

Regarding health environment management, treatment of medical waste has seen improvements with about 54.4% of hospitals having waste water treatment systems in place, increasing by 12% in comparison with 2010. Regarding management of solid medical waste, over 95% of hospitals have daily practice of classification and collection of hazardous solid waste, 29.4% of which use double-compartment incinerators or using microwave/wet heat to disinfect medical hazardous waste while the rest still handle it with one-compartment incinerators, manual burning, land-filling or through outsourcing services. Inspection teams have been established to check and monitor quality of running water. Management of labor health environment, and evaluation of environmental impacts and management of anti-bacterial and anti-insect chemicals and products for household and medical use have been strengthened. Vietnam has reached the Millennium Development Goal in terms of access to clean water and hygienic latrines; in 2014, 92.0% of households were provided with clean water and 79.2% had hygienic latrines.

By December 2015, there were 227.154 people living with HIV, 83.538 people with AIDS, and 86.249 dying of HIV. The rate of HIV/AIDS in the community was maintained at below 0.3% of the population, which met all the three criteria: reduction in the rate of new HIV infections, the rate of infections having progressed to AIDS, and the rate of AIDS-related deaths. The number of new HIV infections reduced from 17.800 in 2010 to 10.000 in 2015, the number of

deaths from 3.300 in 2010 to 2.000 in 2015, and the number of AIDS patients from 8.900 in 2010 to 6.500 in 2015. The rate of HIV infections treated with ARV increased from 57.7% in 2011 to 67.6% in 2015. The number of drug addicts treated with Methadone increased from 12.253 in 2011 to 35.200 in 2015.

All over the country, there have been over 2.6 million inspection visits to food facilities around 20% of which have been found violating food safety regulations; the total penalty collected from the violating facilities was worth approximately 99.6 billion dong, and their names have also been publicly announced. The food safety management system has been established from the Central to the local level, and the food safety inspection system includes 01 National Food Safety and Hygiene Inspection Institute, 3 regional inspection centers, 14 State inspection authorities for imported food, and inspection offices under 63 provincial preventive medicine centers, thus basically meeting demand for food safety inspection. Communication and education on food safety on mass media have been promoted. For the first time, there was a Decree on penalties for administrative violations in food safety at considerably increasing rates.

Shortcomings and limitations:

Although the morbidity rates of some prevail infectious diseases such as dengue fever and foot and mouth disease are declining over the years, they still remain very high; some vaccine preventable diseases such as measles, diphtheria, pertussis, and hepatitis B are still at high risk of relapsing. Strengthened international exchange and integration also increase the transmission risk, especially for newly emerging epidemic diseases.

The rate of HIV infections is still high in Northern Uplands provinces and big provinces/cities; implementation of interventions in remote areas has faced a number of difficulties. TB patients' compliance with DOTS treatment, particularly in remote areas, is still limited; the parasite resistance to antimalarial drugs is at risk of spreading. Rabies is still among the top fatal infectious diseases.

The responsiveness of the epidemic surveillance and response system still remains at a low level, and announcement of cases from hospitals and private health facilities has not been performed actively enough.

The rate of NCD detected, treated, and managed in the community is still modest; the health service delivery system has not been able to meet demand; and projects are vertically implemented with overlapping focal points and a lack of integration, comprehensive approaches and long-term, continuous care services.

There remain wide disparities in coverage of latrines across regions; 18 provinces have the coverage of hygienic latrines of below 50%, and over 10% of rural households do not have latrines. Capacity for waste management, environmental monitoring, and pollution management in health facilities is still limited; and the health environment monitoring system has not been strengthened.

Food poisoning remains complicated and shows no declining trend, especially cases of fewer than 30 people which mostly occurred to family households. A number of food production and processing facilities have not complied with food safety and hygiene regulations; and the production, sale, and illegal import of dirty food are still prevalent. The stewardship and

collaboration across ministries and agencies in management and control of food safety and hygiene are still limited.

Health education and communication in some localities remain inappropriate and inflexible, and unable to spur wide-scale emulation movements for keeping hygiene and health promotion. Coordination with media agencies is still limited, inadequate and passive.

1.2. Medical examination, treatment and rehabilitation

Achievements:

Performance indicators such as patient visits, numbers of inpatients and outpatients, the length of inpatient and outpatient treatment, and numbers of surgeries and procedures are increasing on a year-on-year basis. So far, the average number of patient visits has reached 2.34 visits per person per year and the average ratio of beds reached 24 beds per 10,000 people, thus gradually narrowing down disparities among regions regarding the indicators on access to and benefit from health services. The rate of cases examined and treated with traditional medicine in the total number of cases at each level has been improved although it still takes up a small portion out of the total number of patient visits at all levels, i.e. 8.8% at province, 9.1% at district and 24.6% at commune level.

The system of traditional medicine has been formed and developed at all levels, with 61 traditional medicine hospitals; 90% of modern medicine hospitals have traditional medicine departments or sections, 74.3% of commune health stations (CHS) have traditional medicine sections. More attention has been paid to maritime medicine: A national steering committee on maritime medicine has been established, conducting research on current situations and developing a model of health service delivery for island districts[3].

All over the country, there are around 171 private hospitals, accounting for 11% of total hospitals in Vietnam, including 06 foreign invested hospitals and over 30,000 private clinics and health facilities. The rate of beds in private hospitals accounts for 4.8% of total hospital beds, making about 1.1 beds per 10,000 people.

Solutions to easing hospital overcrowding have been deployed in an active and comprehensive manner: focusing on accelerating the progress of key projects, and the ratio of hospital beds per 10,000 people increasing from 21.5 in 2011 to 24.0 in 2015 (or from 24.7 to 31.4 if actually occupied beds are counted). Most public hospitals have been renovated or upgraded out of the State Budget a majority of which comes from Government bonds; 610/766 provincial and district hospitals have been completed, and 05 Central and highest level modern hospitals under construction in order to keep up with developed countries in the region. A network of 60 satellite hospitals of 15 key hospitals in 41 provinces/ cities has been developed. Circular 40/2015/TT-BYT dated 16/11/2015 was issued on registration for insured health services and referral for insured health services. Training and technical transfer have been conducted for lower levels, and health staff sent to lower levels on a rotating basis. Overcrowding in most Central and provincial hospitals has been gradually addressed, and the bed occupancy rates have increased in district hospitals.

[3] Prime Minister approved a Scheme on Development of Maritime Medicine according to Decision 317/QD-TTg

In 2013, the hospital quality management system was established[4] and the hospital quality assessment criteria were issued. After two years, 55.4% of hospitals throughout the country have established hospital quality management sections or departments. The test quality control system has been established with 3 test centers and almost 1,400 laboratories. Medical examination procedures have been actively improved[5], and cut down from 12-14 steps to 4-7 steps (depending on each condition), and the average examination time has been reduced to 48.5 minutes per examination (about 50%) compared to the pre-intervention period. Standard competencies for medical practice have been formulated and initially applied to nurses, midwives, and general practitioners. Clinical guidelines have been developed in large quantity, i.e. nearly 4,000 technical guidelines.

The patient feedback system on service quality has been strengthened, and hotlines re-established in all health facilities. The MoH issued Circular 07/2014/TT-BYT dated 25/2/2014 on the code of conduct for doctors, and relevant training has been provided to health staff. On 4/6/2015, the MoH issued Decision 2151/QĐ-BYT on the Action Plan for "Reforming service attitude and behavior of health staff towards patient satisfaction", and after 5 months of implementation, more than 80 hospitals across the country, including 25/38 hospitals at Central level, signed the commitment. Civil servants and State officials' compliance with the code of conduct has been monitored, good examples are given compliments and violations are strictly punished; in necessary cases of serious or repeated violations, the violators may be relocated or expelled from the sector.

The health sector has succeeded in applying a number of new, advanced technologies in diagnosis and treatment, for example, organ transplantation, cardiovascular diagnosis and intervention, endoscopy and endoscopic microsurgery in cranial neurosurgery, otorhinolaryngology, ophthalmology, and digestion; reproductive support, ante-natal and post-natal screening; corneal transplantation; PET/CT-based Intensity Modulated Radiation Therapy in cancer treatment; microsurgery in treatment of deep burns, etc.

Shortcomings and limitations:

The combination between prevention, treatment and rehabilitation, and between traditional medicine and modern medicine has been limited, thus unable to promote the advantages of traditional medicine; the network of rehabilitation services remains technically limited. The health care model for the elderly has not been evenly and widely implemented.

There are still discrepancies in the health service quality and health indicators across regions; overcrowding in some Central hospitals and hospitals in big cities has been addressed to a certain extent but still needs further settlement in the coming time.

The quality management system is also limited: no independent rating agency has been established and about 44% of hospitals have not had their quality management departments/sections. The clinical audit mechanism has not been operated while refusal to accept test results across health facilities still remains common.

1.3. Population – Family Planning and Mother-and-Child Health Care

[4]According to Circular 19/2013/TT-BYT of the Minister of Health dated 12/7/2013
[5]According to Decision 1313/QD-BYT of the Minister of Health dated 22/4/2013

Achievements:

Quality of population – family planning services has been gradually improved, and communication on population – family planning has been promoted in various forms to access different target groups. Population and family planning services have been delivered to people in 5,700 communes with high birth rates in disadvantaged areas. Provision of free-of-charge contraceptive devices is guaranteed at the same time with acceleration of social marketing activities. The population growth rate has been maintained at approximately 1.05%/year, the population in 2015 was 91.7 million people, achieving the set target (<93 million people), and the model of families with fewer children is becoming more widely accepted. Vietnam reached the replacement fertility rate in 2006, and this has been maintained since then. The population quality has been improved, and the average life expectancy is also increasing.

The scheme on ante-natal and post-natal screening has been expanded from 11 to 63/63 provinces/cities; the rate of ante-natal and post-natal screening has increased over the years: that of ante-natal screening increased from 1.5% in 2011 to 15% in 2015, and that of post-natal screening from 6% in 2011 to 30% in 2015. By 2015, the model of pre-marriage health counseling and check-up had been extensively and intensively implemented in 63 provinces/cities. Communication activities for behavioral change have been actively conducted in order to control the sex imbalance at birth, and the sex ratio at birth (SRB) only increased 0.18%/year over 2011-2015 (from 111,9 to 112,8 boys to 100 girls), in comparison with the increase of 0.7%/year over 2009-2011. Since 2011 when Vietnam officially entered the stage of "population ageing", the health sector has been preparing for developing relevant policies and action programs, and implementing the Scheme on community-based health care for the elderly in 29 provinces/cities having high rates of elderly people.

Many documents on management and technical guidelines on reproductive health have been updated, supplemented, revised, and developed. The Government issued Decree 10/2015/ND-CP dated 28/01/2015 on In Vitro Fertilization and conditions for surrogacy for humane purposes. Systematic measures have been taken, and inspection, supervision (even in private clinics), and specialized support for lower levels have been strengthened to minimize obstetric complications. Communication for policy advocacy and behavioral change in mother and child health care have also been paid attention to.

The coverage of most essential reproductive health services has been expanded at both district and commune levels. The MoH issued Circular 07/2013/TT-BYT dated 08/03/2013 on standards, functions, and tasks of village health workers (VHW) among whom village birth attendants are also considered a type of VHW; 1,737 village birth attendants throughout the country have been trained, thus significantly contributing to the improvement of health status for mothers and children in ethnic minorities and disadvantaged areas. The child malnutrition rate (underweight) dropped from 17.5% in 2010 to 14.5% in 2015; the stunting rate also sharply fell from 29.3% in 2010 to 24.9% in 2015. Vietnam has reached the MDGs in reduction of the maternal mortality ratio to 58.3% per 100.000 live births, and reduction of the infant mortality rate to 14.7%. The rate of pregnant women receiving ante-natal care at least 3 times is over 90%, the rate of deliveries assisted by trained birth attendants is 98%, and the rate of mothers and newborns receiving postnatal care in the first week after delivery is 81%.

Shortcomings and limitations:

Unmet needs for reproductive care services, birth control methods, and family planning services still remain high in some vulnerable groups, including adolescents, unmarried juveniles, migrants, people living with HIV, disabled people, people who are affected by natural disasters, sex workers, and gays and lesbians.

Sex imbalance at birth remains high and the fertility rate is at risk of increasing in some regions. Vietnam still maintains the replacement fertility rate, however, the fertility rate shows some signs of increase, from 1.99 children per woman in 2011 to 2.09 in 2014.

There are still wide and increasing disparities in reproductive health indicators among population groups and across regions. The maternal mortality ratio and infant mortality rate in some mountainous areas are even 3-4 times as much as those in lowland and urban areas, and almost twice as much as the national average rate. The child malnutrition rates are still high in the Northwest and Central Highlands regions.

Access to and use of quality ante-natal and intranatal care services in ethnic minorities and disadvantaged areas remain limited[6]. The need for prevention and early detection of preventable congenital defects is still prevalent due to unavailability of highly cost-effective screening services and interventions before and during pregnancy, and during the neonatal period.

2. Health workforce, science and technology

Achievements:

The number of types of health staff has been increasing over the years, reflected in the number of doctors per 10,000 people which increased from 7.2 in 2010 to approximately 8.0 doctors in 2015, and the number of graduate pharmacists per 10,000 people which increased from 1.76 in 2010 to approximately 2.2 pharmacists in 2015. In order to deal with the lack of health staff in some fields and in remote and disadvantaged areas, a number of policies and projects have been implemented, for example, a project on encouraging training and development of health human resources in the specialties of tuberculosis, leprosy, mental health, forensic medicine, and pathological anatomy during 2013–2020; a pilot project on voluntary young doctors; and a circular on standards, functions and tasks of VHW.

The Law on Medical Examination and Treatment effective from 2011 required the medical practitioners to have a license for medical practice and continuously update their medical knowledge. By 2015, 95% of the health facilities and 92% of the health staff in MoH hospitals; 25% of the health facilities and 67% of the health staff in hospitals under other ministries and agencies; 65% of the health facilities and 89% of health staff in hospitals under provincial Departments of Health (DoH) had been licensed. Competency standards for certain types of health staff, including nurses (2012), midwives (2014), general practitioners (2015) have been issued. Educational accreditation for different types of health staff training and training institutions have been developed and implemented.

The system of medical and pharmaceutical training institutions has been strengthened, re-

[6] Among 225 geographically disadvantaged districts 33 districts were unable to conduct Cesarean sections, 48 districts did not performed blood transfusion, 73 districts did not have neonatal units, 81 district were unable to provide newborn jaundice treatment with light therapy, 137 districts were unable to treat neonatal respiratory failure with CPAP machines; among the 62 poorest districts, 23 districts remained unable to conduct Cesarean sections and blood transfusion.

arranged, and gradually upgraded in terms of infrastructure and equipment. Need-based and address-based health staff training for disadvantaged provinces has been provided. In leading hospitals, training - vertical direction centers have been established to provide intensive and advanced training to lower levels. Schools and training centers for hospital management have been established with thousands of hospital managers trained.

Having mastered the technology of vaccine production, Vietnam has produced 10/11 types of vaccines for the Expanded Program on Immunization and been among 39 countries that possess advantages in vaccine production in the world. The NRA of vaccines has been recognized by WHO to meet standards. Many hospitals have mastered technologies of multi-organ transplantation, vascular diagnosis and intervention, endoscopy, and reproductive support. Research has been conducted for preservation and sustainable exploitation of genetic resources for precious and rare medicinal materials with nearly 4,000 kinds, advantages in terms of medicinal materials have been utilized, drugs have been produced out of medicinal materials with high treatment effectiveness for replacement of imported drugs, and over 300 types of medicinal materials have been exported for a high value.

Shortcomings and limitations:

The health workforce is unevenly distributed across regions and levels of care while quality of workforce remains an issue of concern to be given priority, especially at the grassroots level and in remote areas. The current health workforce is insufficient in quantity and poor in quality, and the number of provincial health staff in preventive medicine only meets about 60% of needs.[7]

Quality control for types of health staff training and training institutions has not been effectively performed.

Management capacity of health staff at all levels remains limited; only 30% of health managers in health facilities are trained in management, and over 95% of them suppose that they lack management skills.[8]

As a consequence of hospital overcrowding, irrelevant remuneration policies and negative impacts of the market economy on a number of health staff, there have been cases where health staff show improper behavior or attitudes to patients upon service provision, thus affecting the image of the health sector.

3. Health information system

Achievements:

The system of legal foundation on health information and statistical indicators have been systematically promulgated, including the HIS Development Strategic Plan for the period 2014-2020 with a vision to 2030; the set of health core indicators consisting 88 indicators of various sub-sectors; the list of core indicators for provincial, district, and commune levels; the catalogue of health statistical indicators; the system of health statistical forms applicable to public health facilities; reporting forms, reporting obligations and responsibilities of private health facilities;

[7] Nguyen Thanh Long, Vu Sinh Nam. Health workforce for preventive medicine: Current situation, challenges and solutions. Preventive medicine journal Vol.12 2013

[8] World Bank. International Development Association Project Appraisal Document: Health Professionals Education and Training for Health System Reforms Project. Report No: 82318-VN. April 2014.

and regulations on issuance and utilization of birth reports to improve the quality of birth information.

Many annual publications as important outputs of the health statistics system have continually been issued, for example, the Annual Health Statistical Yearbook, Joint Annual Health Review (JAHR), Statistical Yearbook of infectious diseases, etc. The quality of statistics has been improved as a result of training of statistical staff, strengthened monitoring and evaluation, and strengthened use of information at all levels. In 2013, the MoH conducted a national survey on human resources and training needs for health statistics, compiled materials, and organized training-of-trainers courses for 63 provinces/cities and Central units.

Application of information technology (IT) in management and administration, and use of document management software and web-based administration have been deployed in all MoH units and DoH of all 63 provinces/cities. In terms of specialized applications, database and population changes of the population of over 90 million people have been developed and updated routinely; other applications include software programs for hospital statistical reporting and management of medical practice in private sector; software programs for HIV/AIDS patient management and management of immunization; and hospital information software. A project on electronic HIV/AIDS database; software for surveillance of infectious diseases and medical records and management of the medical examination and treatment system and a pilot project on application of electronic HI cards in management of insured patients have also been implemented; IT application in training, technical transfer, and telemedicine under a scheme on satellite hospitals have been deployed.

Shortcomings and limitations:

There are many data sources but the data dissemination mechanism is unclear; there are no focal points for disseminating data of the health sector as well as related data of other sectors. The system of information on death and causes of death is not yet compatible with WHO's recommendations. Information in medical records is not relevant to ensure the continuity in health monitoring, appropriate treatment, prevention of complications, adverse reactions and to ensure the effectiveness of health care.

The quality of information has not been improved markedly. Information provided by health facilities and localities is neither timely nor complete; there lacks information from private health facilities and health units of other ministries. IT application in data processing, analysis and reporting is limited.

Most statistical indicators are collected through routine reports with inaccurate and unavailable data; statistical survey and mining of civil registration information have been implemented but remains at a limited level.

4. Pharmaceuticals, medical equipment and infrastructure

4.1. Pharmaceuticals, vaccines and biologicals

Achievements:

The MoH has advised competent agencies to issue, or directly issued 37 documents, including two important documents orienting the development of the pharmaceutical industry, which are:

(i) Medicinal Material Development Master Plan until 2020 with vision to 2030[9]; (ii) Vietnam National Strategy for Pharmaceutical Development until 2020 with vision to 2030[10]. The MoH has promulgated the 6th list of essential drugs of Vietnam, the list of modern medicines, herbal medicines or drugs made of medicinal herbs and traditional medicines paid by HI scheme. The (revised) Pharmaceutical Law has also been drafted and submitted to the National Assembly for consideration and promulgation.

Drugs are supplied timely and adequately for medical examination, treatment and prevention of epidemics and natural disasters. The drug supply system covers the whole country, with a ratio of 1 retail pharmacy to 2,123 people. Average expenditure on drugs increased from USD 22.25 per head in 2010 to USD 34.48 per head in 2014. Domestically produced drugs account for nearly 50%, meeting two-thirds of the active ingredients included in the 5th list of essential drugs of Vietnam. In response to the project "Vietnamese people prioritize domestically produced drugs", many hospitals use up to 80% of domestically produced drugs, which helps reducing costs for patients.

The drug market is in a stable status with no sudden and irrational increase of prices, which may affect the prevention, examination and treatment of diseases of people. The implementation of legal documents on management of drug prices and drug procurement has started to take effect, reduced expenditures on medicines in hospitals. Vietnam Social Security (VSS) is increasingly enhancing its role in controlling drug prices and costs paid by social HI.

Quality of drugs has been managed strictly and comprehensively in all stages from production, storage, circulation, distribution to whole sale, retail. All factories producing chemical pharmaceuticals have achieved Good Manufacturing Practice (GMP) compliance, 100% of big-size enterprises importing and trading drugs achieve Good Supply Practice (GSP) compliance. Inspection and monitoring the quality of drugs sold in the market are conducted regularly and systematically from central to local levels; the proportion of sub-standard drugs has been decreased from 3.12% in 2010 to 2.38% in 2014.

Shortcomings and limitations:

The development of the pharmaceutical industry into a key economic-technical industry in accordance with the Pharmaceutical Law 2005 is difficult. According to the United Nations Industrial Development Organization (UNIDO), the pharmaceutical industry in Vietnam is somewhere between levels 3 and 4 among the 5 levels. Value of locally-produced of drugs accounts for 0.72% of total GDP of Vietnam in 2014 and only 2.18% of the total national industrial production revenue in 2014, with small and medium-sized enterprises in terms of both human resources and financing.

Domestically produced drugs in Vietnam are not competitive in the world market because most of them are used to treat common diseases, generic drugs have been produced but their bioequivalence has not been well proved so it is difficult to export them. Generally, most people and even health workers like to prescribe and use imported drugs in health care and treatment. Control of drug prices is still challenging since there are no specific mandated authorities and

[9] Decision no.1976/QD-TTg dated 30/10/2013 of the Prime Minister
[10] Decision no. 68/QD-TTg dated 10/01/2014 of the Prime Minister

responsibilities between related ministries and sectors. Irrational use of drugs remains popular and over-the-counter sale of drug is prevalent while safe use of drug remains a concern of health facilities. Proportion of antibiotics use is high with rising risk of antimicrobial resistance.

Inspection, check and control of origin and quality of pharmaceutical materials used for production of eastern medicines, drugs made of herbal materials and the use of these drugs in traditional medicine facilities are not done properly. Quality of blood tests is limited whereas the network of facilities providing blood transfusion is scattered and fragmented.

4.2. Medical equipment and infrastructure

Achievements:

Investment in infrastructure to reduce hospital overcrowding and to improve health service quality is continued, with 610 out of 766 provincial and district hospitals constructed with the government's bonds. Five modern and tertiary referral hospitals are under construction to be on a par with other advanced regional countries[11], the system of satellite hospitals has been established in almost all provinces[12]. In the 2012-2015 period, 119 new hospital have been constructed and put into operation (at central level: 03 hospitals; at local levels: 116 hospitals); 1,839 departments/wards have been constructed, expanded, renovated (at central level: 172, at local level: 1,667). The MoH is collaborating with the Ministry of Construction, People's Committees of Hanoi and Ho Chi Minh City to plan and decide the location and size of land to accommodate some hospitals after they are relocated from inner cities.

Inspection of investment activities and use of equipment in health facilities is strengthened. The MoH continues to collaborate with the Ministry of Science and Technology, Medical Equipment Association of Vietnam and experts to promote research, to propose research priority topics and manufacturing/production of medical equipment. The system of production, business and importation of medical equipment has been expanded. Currently the country has 48 research and manufacturing facilities of medical equipment with 621 products domestically produced and licensed to be sold in the market. The MoH is working with Ministry of Finance (MoF) to review and propose supportive tax policies for domestic manufacturers of medical equipment. IT is gradually applied in licensing importation of medical equipment in order to reform administrative procedures.

The health sector is trying to strengthen storage and maintenance of medical equipment in which more attention has been paid to training of medical technologists. The MoH has collaborated with Hanoi Polytechnic University to train a contingent of bio-medical electronic engineers; made investment in and upgrade of the Medical Equipment and Technique College with a new branch in Hanoi and Hai Duong Medical Technique College. So far, 62% of provincial general hospitals, 26.1% of provincial specialized hospitals and 31.9% of district general hospitals have a medical equipment maintenance team. The MoH has worked with related sectors to develop and issue a total 135 sectoral standards and 35 national standards for medical equipment. Capacity of the network of medical equipment calibration and quality control has been strengthened.

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[11] Decision no.125/QD-TTg dated 16/01/2014 by the Prime Minister

[12] Decision no.774/QD-BYT dated 11/3/2013 of Minister of Health approving the project on satellite hospitals for 2013-2020

Shortcomings and limitations:

Enforcement of policies on investment in and development of medical infrastructure and equipment at grass-roots level remains limited; Decision No. 1402/QD-TTg in 2007 on investment in district preventive health centers and Decision No. 950/2007/QD-TTg on investment in CHS in disadvantaged areas have not been implemented due to lack of funding.

Several lists of essential equipment and technical construction standards for different types of health facilities issued prior to 2010 have not been updated yet. Health technology assessment, calculation of cost-effectiveness of the investment in and use of high-tech, expensive medical equipment remain very limited.

Mechanism for quality control (calibration, external control) has not been implemented in all health facilities. Accreditation and calibration centers have not been established in 3 regions. Although the proportion of locally-produced medical equipment is increasing but it is still below the set targets. In addition, the production of medical equipment uses only simple technologies.

The master plan for investment in medical infrastructure and equipment is not updated based on the people's health care needs and usability, and excludes investment from the private sector.

5. Health financing

Achievements:

Total health spending from the state budget and government bonds in the period 2011-2015 was approximately 357,971 billion dongs, equivalent to 7.52% of the total state budget expenditure. If health spending is excluded from government bonds it is around 6.8% of total state budget expenditure. The growth rate of health spending was higher than the average growth rate of the state budget expenditures. In the context where aid to Vietnam tends to be reduced, the health sector has constantly mobilized grants, thus the proportion of aid has been maintained at 2% of the total health expenditure.

According to Decree No. 85/2012/ND-CP, by 2018 the price of health care services will include fully 7 components of cost[13]. In 2012, the MoH in collaboration with the MoF has adjusted the price bracket of some health services to include 3/7 direct components of cost.[14] In 2016, the MoH will continue to add wages and allowances of health workers to the costs of insured health services. The implementation of the roadmap for calculating service costs correctly and fully will help health facilities have additional revenues to cover the costs spent on patients, contributing to gradually improving the quality of service, at the same time the interests of patients with HI cards are increased.

In recent years, the health sector has mobilized many resources outside the state budget by enhancing socialization through the form of loans for investment in infrastructure, delivery of health services upon request; joint-venture in medical equipment installation; public - private partnership (PPP). In implementation of Resolution 93/NQ-CP dated 15/12/2014 of the Government on a number of mechanisms and policies for health development for the purpose of

[13](1) Drugs, consumables, medical supplies; (2) electricity, water, waste management, cleaning; (3) wages and allowances of health workers; (4) maintenance and repair costs; (5) depreciation of properties; (6) costs for running supporting units in health facilities; (7) costs for training and application of new techniques.

[14] (1) Drugs, consumables, medical supplies; (2) electricity, water, waste management, cleaning; (3) maintenance and repair costs

mobilizing resources of the society for development of the health sector, some banks have preferential credit packages for hospitals and investors who want to borrow loans to invest in construction and procurement of equipment in order to increase capacity and quality of healthcare.

Health facilities continue to be sorted and changed from partially autonomous facilities to fully autonomous ones in terms of revenues and expenditures so that the state budget can save costs to help people buy HI cards, striving for universal HI coverage. The sector continues to pilot capitation as a HI provider payment method at district level and diagnosis-related group (DRG); as well as develops a basic health benefit package.

The Fund for Tobacco Control was established in 2013 as a new source of financial contributions to the state budget for health care, with approximately 400-500 billion dongs per year. The Health Care Fund for the Poor continues to be maintained in provinces and cities, with funding from local budget and other legal sources.[15]

The MoH has worked closely with VSS and related ministries/sectors to develop and finalize HI policies and legislations, especially the Revised Health Insurance Law 2014 which has been passed by the National Assembly and effective since 1/1/2015. HI coverage has been increased from 60.9% in 2010 to 76.52% in 2015. Apart from the increased HI coverage, benefits and entitlements of HI card holders are also expanded. Co-payment rate is adjusted down to some groups. On average, a card holder had 2.1 visits per year in 2014 - an increase by 8.5% compared to that in 2010. Some PPC have spent local budget to pay parts of HI premium for people from near-poor households, contributing to increasing the HI coverage. This practice has been done by 39 out of 63 provinces nationwide, in which 27 provinces pay the remaining 30% of HI premiums and 12 provinces pay 5-20% of the premium.

Shortcomings and limitations:

Investment of the State in health has not met the needs for people's health protection, care and promotion; the out-of-pocket expenditures on heath of households remain high (about 45%); the expansion of HI coverage to the remaining 24% uncovered population is difficult, the possibility to balance the HI fund and risk sharing is low.

There lack a relevant investment budget allocation mechanism and an incentive financial mechanism to promote the quality and effectiveness of preventive medicine and public health.

The accessibility of private health facilities to preferential policies is quite difficult; joint-venture in installation of medical equipment in public health facilities brings positive results, however there is abuse of technical services, tests, imaging services which leads to increased health care costs.

Service price has not been calculated correctly and fully; the operation and management of health facilities, especially public hospitals, are not renovated. There are no models or methods for administrating public hospitals in line with the socialist-oriented market economy.

6. Health governance

[15]Decision No. 14/2012/QD-TTg of the Prime Minister dated 01/3/2012 amending and supplementing a number of Decision No. 139/2002/QD-TTg dated 15/10/2002 on medical examination and treatment for the poor.

Achievements:

Health policy-making has shown progress: many laws and health policies have been developed and issued, e.g. the Law on Tobacco Control (2012), the Law amending and supplementing a number of article of the Health Insurance Law (2014); Resolution No. 68/2013/QH13; legal documents guiding the implementation of laws; Health Sector Strategy for 2011-2020 with a vision to 2030,… At the moment, a number of other laws are drafted or revised, e.g. the Pharmaceutical Law, the Law on Alcohol Control, the Law on Blood and Stem Cell, the Population Law, Decree on Management of Medical Equipment, Decree on Vaccination, Government's Resolution on a number of mechanisms and policies for health development; the scheme on building and developing heath care at grassroots level in the new context, etc., creating a legal frame work for the health sector to operate and develop.

The organizational structure of the health sector has been adjusted to meet its management needs. At central level, the Information Technology Administration and the Department of Communications and Emulation were established; the organizational model of a number of departments (e.g. Traditional Medicine Department, Administration and Science, Technology and Training,...) was revised; a list of 71 MoH's non-business units was submitted to and issued by the Prime Minister in Decision No. 246/QD-TTg dated 12 February 2014; the Vietnam National Coordinating Center for Human Organ Transplantation, 2 training institutions for health managers located in Hanoi School of Public Health and Ho Chi Minh City Public Health Institute and 5 regional centers for forensic psychiatry have been established, bringing the total number of non-business units under the MoH to 81 units.

At local level, Decree No. 117/2014/ND-CP on health care at commune/ward/town level has formally affirmed that CHS is a health facility under the management of district health centers (DHC) and CHS staff are public servant. The MoH has collaborated with the Ministry of Home Affairs to issue a circular guiding the functions, tasks, powers and organizational structure of DoH which are managed by the People's Committees of provinces and centrally-run cities and Health Offices which are managed by District People's Committees; to issue a circular guiding the functions and tasks of CHS as the basis for unified vertical management and direction. Currently, 100% of provinces and cities have a food safety agency and a population and family planning agency under the DoH; 100% of districts have a Health Office; 60/63 provinces consider DHC as units under DoH[16]; ; 60/63 provinces consider CHS as technical units under DHC[17]; 62/63 provinces (except for Ho Chi Minh city) have established Population and Family Planning Centers at district level, in which 46 provinces consider them as units under the provincial population and family planning agency and 16 provinces consider them as units under District People's Committees; 03/63 provinces have established Food Safety Centers at district level.

The network of public health facilities has been widely developed, 100% of communes/wards/towns have active health staff, only 1% of communes do not have their own CHS and have to borrow facilities to operate their health care activities . The model of family

[16] Ho Chi Minh city, Thai Binh province and Binh Phuoc province consider DHC as units under District People's Committees
[17] Lao Cai, Hoa Binh and Quang Binh provinces consider CHS as units under Health Offices

doctor clinic was launched in 2013[18] and has obtained initial achievements after two years with 240 clinics being established.

Health inspection has undergone changes regarding legal regulations and network organization in line with the Decree no.122/2014/ND-CP and Decision No 2176/QD-TTg. The MoH and localities have conducted series of thematic inspection to find out shortcomings as a foundation for consolidation of the management and execution of health activities. The MoH has promulgated criteria and tools to improve quality of inspection and supervision of health facilities[19], promoted the operation of hotlines to receive comments and feedback of the people.

Shortcomings and limitations:

Health policies are not issued timely, are overlapped and inconsistent. Collaboration between stakeholders are limited, there lack information and reliable evidence for health policy development.

The effects and effectiveness of health policies fall below expectations, especially master plans and work plans with unidentified resources for implementation; there lack detailed plans and information to translate policies into practice. There lacks the link between planning and budgeting by priority area ; budget planning is mainly based on input indicators (e.g. human resources, population).

The health system is unstable with many focal points and inconsistency, especially at grassroots level, causing insufficient human resources, increased administrative expenditures and low effectiveness. Health facilities are managed by administrative boundary, which discourages the development and upgrade of hospitals. There is no incentive mechanism to encourage and strengthen the linkage and collaboration between health facilities at the same level and across levels to assure the continuity of service provision.

The health inspection network is weak in quality and quantity. The supervisory roles and capacity of political, social and professional organizations are limited.

Administrative reform in the health sector is imlemented but not very effective due to failing to meet requirements of Public Administration Reform Index (PAR INDEX).

[18] The project "Building and development of the model of family doctor clinics in Vietnam for 2013-2020" was launched in accordance with Decision No. 935/QD-BYT dated 11/3/2013 of the Health Minister

[19] E.g. the set of criteria for hospital quality assessment, national criteria for commune health in the period 2011-2020

PART 2 PLAN FOR PEOPLE'S HEALTH PROTECTION, CARE AND IMPROVEMENT IN THE PERIOD 2016-2020

1. Opportunities and challenges

The 5-year Health Plan 2016-2020 will be implemented in the context when our country continues to promote the comprehensive and systematic reform process as well as develop a firm foundation for quickly turning the country into a modern industrialized nation, with many interwoven opportunities and challenges.

1.1. Opportunities

- Policies of the Party, the National Assembly and the Government keep affirming the important role of people's health care in the process of achieving social advancement and equity, improving people's life and meeting requirements of industrialization and modernization of the country; and consider that investment in health is a direct investment for sustainable development.

- The legislation system relating to health care is gradually elaborated; many Laws, Decrees of the Government, Decisions of the Prime Minister, guiding Circulars of ministries were issued, creating a clear and transparent legal framework for the building and development of the health system.

- The national economy continues to develop in stable political-economic conditions; there have been positive changes in rural areas in Vietnam creating favorable conditions for guaranteeing social security and investment in health.

- Globalization and international integration create opportunities for Vietnamese goods and workers in general and in the health sector in particular to penetrate the world market, people have more options for quality health services in the country.

Traffic infrastructure is upgraded, modern means of communication are developed, facilitating people to get access to health facilities and to health knowledge.

- Awareness and participation of the people, the party committees and authorities at all levels in health care are improved widely and deeply; inter-sectoral collaboration in health care is increasingly widespread and effective.

1.2. Challenges

- Regarding socio-economic factors, the difference in per capita income between regions and population groups is big; the poverty rate remains high, especially in ethnic minority areas, along with many backward practices leading to unequal health, the burden of disease and limited access to health care services.

The costs of health care are growing while our country is still a poor one, investment in health care is low and foreign aid to Vietnam has been decreasing.

Beside opportunities, globalization and international integration also create challenges for the social economy in general and the health sector in particular, e.g. management of the practice of foreign-invested health facilities and foreign health workers in Vietnam; competition between domestic and foreign production of goods and delivery of health services; the risk of brain drain

from the health sector of Vietnam to other countries in the region; increased risk of epidemics, especially the emerging ones.

Remuneration for health workers is unreasonable, wages and allowances for them are low and not commensurate with their study and performance whereas their working conditions are hard, especially in mountainous and rural areas.

- Regarding demographics, our population is big and continues to grow. Vietnam is one of the ten countries with the most rapid aging rate in the world; SRB imbalance remains high; migration has not been well controlled, creating big pressure for the health system.

- As for natural environmental factors, Vietnam is one of the six countries bearing the greatest impact of climate change and is one of the five countries with the highest disaster risks in the world. Environmental pollution becomes increasingly serious, especially due to the fast urbanization. Food contamination due to the use of banned chemicals in aquaculture and food processing remains a persistent problem that has not been effectively controlled.

- In terms of behavioral factors and lifestyle, the impact of negative factors such as smoking, abuse of alcohol, drug use, prostitution, improper diet, lack of physical activities, etc. on health is increasing.

2. Objectives

2.1. Overall objective

To reduce morbidity and mortality rates caused by diseases and epidemics, contribute to improving people's life expectancy and core health indicators; to enhance capacity and performance of the health system, to create a solid foundation for the development of an equitable, effective, quality and sustainable health system, meeting people's health care needs in the course of industrialization and modernization.

2.2. Specific objectives

- To implement universal health coverage (UHC), ensuring that all people have access to basic and quality health care services; to prevent occurrence of major epidemics; to gradually control health hazards related to the environment, food safety, lifestyle and behaviors of people;

- To improve the quality and effectiveness of the service delivery network; to ensure collaboration, linkage and integration among levels of care, among curative services, rehabilitation, preventive services and primary health care (PHC); to reduce overcrowding in hospitals at higher levels; to promote the leading roles of intensive and hi-tech health facilities in the transfer of techniques and support to the entire service delivery network; to modernize and develop traditional medicine, and to combine traditional medicine with modern medicine;

- To maintain a reasonably low fertility rate; to contain the increasing speed of SRB; to reduce congenital defects and diseases for improving well-being of the population; to meet the needs for family planning services of the people; to increase accessibility to quality reproductive health care services;

- To ensure balance in the allocation and use of health human resources between regions and levels, between training and utilization of health workers.

- To rapidly increase proportion of public expenditures on health and on achievement of universal HI coverage, to improve the efficiency of budget allocation and utilization; to develop health infrastructure; to develop health care in poor, mountainous, remote areas and to have preferential treatment in health care for poor people and beneficiaries of social policies.

- To ensure sufficient supply of quality medicines, vaccines, bio-medical products, blood, blood products and medical equipment at reasonable prices, meeting people's needs for disease prevention and treatment; to manage and use drugs and equipment in an appropriate, safe and effective manner.

- To improve the capacity of managing and implementing health policies, to promote administrative reform to meet the needs for innovating and developing the health sector in the new period; to consolidate and perfect the organizational structure of the health sector at all levels, to re-structure health facilities towards narrowing the focal points for more effective performance and investment.

3. Health core indicators

The list of health core indicators proposed to be included the national 5-year and annual socio-economic development plans consists of 16 indicators (see details in Annex 2), of which the following two indicators are assigned by the National Assembly and the Prime Minister: (1) The number of hospital beds per 10,000 population; (2) HI coverage. The remaining indicators are assigned by the Ministry of Planning and Investment (MPI) as authorized by the Prime Minister.

Besides, this plan for people's health protection, care and promotion in 2016-2020 also introduces indicators and targets to assess the overall performance of the health sector, the implementation of health-related MDGs and targeted programs (see details in Annex 3).

4. Major tasks and solutions

4.1. To reduce hospital overcrowding and to improve the quality of medical examination, treatment and rehabilitation

a) To concentrate on speeding up the implementation of key projects in order to increase the number of health facilities and beds with focus placed on overcrowded specialties such as cardiology, oncology, traumatology, obstetrics, pediatrics, respiration, neurology....
b) To expand and develop the network of satellite hospitals: to establish more tertiary referral hospitals capable of being nuclear hospitals; to expand satellite hospitals to all provinces and cities.

c) To strengthen technology transfer to lower levels through various forms; to continue rotating health human resources between health facilities and across levels; to enhance vertical mentoring, training and coaching; to provide mobile health counselling.

d) To complete the service quality management system at all levels and the patient feedback system; to promulgate care pathways.

e) To reform administrative procedures in health care regularly and constantly in accordance with Decision No. 1313/QD-BYT dated 04/22/2013 of the Ministry of Health.

f) To combine PHC and specialized health services/high-tech services; to combine traditional medicine and modern medicine.

g) To adjust levels of technical service delivery towards expanding health services and technology, especially at lower levels, facilitating patient to access quality services in the nearest location; to develop management models for chronic diseases such as hypertension, diabetes, asthma...in the community; to implement the model of family doctors and health care for the elderly in the community.

h) To diversify forms of health care; to develop a number of quality and key medical areas in line with the conditions and capabilities of Vietnam; to develop quality health facilities to meet people's increasing needs for health care.

k) To establish an optimal referral network, to simplify referral procedures and strengthen linkages between levels for ensuring the continuity of care.

4.2. To develop the health care network at grassroots level, to focus on preventive medicine and health promotion

a) To increase investment in medical infrastructure, equipment and essential drugs for district and commune health facilities with priorities given to communes in mountainous, remote, disadvantaged and extremely difficult areas so that they can meet the national criteria for commune health in accordance with Decision 4667/QD-BYT dated 07 November 2014 of the Health Minister.

b) To restructure the organization and operation of the grassroots health care network given the changes in epidemiology and disease patterns, and to link it to specialized health facilities at upper levels; to integrate the model and principles of family medicine in the operation of the grassroots health care network; to replicate the model of civil-military CHS/clinics in border areas, islands and remote areas; to develop health care activities in schools and offices/organizations towards strengthening of PHC.

c) To reform financing mechanisms in the grassroots health care network towards making public budget the key financial resource, motivating health staff to perform PHC, at the same time securing financial protection for service users; to calculate full price of services including direct costs and salaries/allowances at the level of district hospitals; to develop cost norms for preventive services at district and commune levels which are suitable to each region and geographical conditions, HI payment mechanism for family doctor clinics, payment mechanism for home-based and community-based health services.

d) To improve service delivery of the grassroots health care network, to strengthen health management, palliative care, home-based and community-based rehabilitation, particularly for NCD (NCD); to promote health education and communication activities, to apply household-based health management; to guarantee regular, continuous and comprehensive health care delivery; to provide integrated services for infectious diseases, NCD and injuries; to improve the capacity of examining, detecting, screening and referring patients to higher levels in a flexible and effective way, and receiving, monitoring and treating patients referred back from higher levels.

To actively prevent epidemics; to forecast, detect early and prevent the occurrence of epidemics especially major ones; to monitor and control infectious diseases and epidemics in international border gates in order to prevent them from penetrating into Vietnam or causing outbreaks in the community; to develop emergency plans to respond to epidemics.

f) To concentrate on directing expanded vaccination activities to maintain the expanded immunization rates at >90%, to manage well (paid) immunization services; to gradually strengthen the biosafety system in laboratories; to promote NCD prevention, school health and gradually control health hazards.

g) To increase the quality of HIV-related care, antiretroviral therapy (ART) and prophylaxis to prevent mother-to-child transmission; to improve the quality and effectiveness of drug detoxification, to scale up methadone maintenance therapy (MMT) and other effective modalities for drug detoxification; to reduce HIV/AIDS incidence and control HIV/AIDS prevalence in the community to <0.3%, striving to achieve the 90-90-90 targets by 2020[20]; to control drug-resistant tuberculosis and malaria; to adopt specific interventions to prevent tuberculosis and malaria for the mountainous and ethnic minority areas.

h) To continue guiding the implementation of the project on developing waste management systems for health facilities, which has been approved by the Prime Minister [21]; to implement effectively the sanitation component of the national targeted program on water and rural sanitation; to promote the prevention of occupational diseases, health care for workers, prevention of injuries; to strengthen inspection and supervision of the management of medical waste, chemicals, insecticides, disinfectants used by households and health facilities.

k) To enhance the implementation of policies and legislation on quality management, food safety in line with Resolution No. 34/2009/NQ-QH12 of the National Assembly and the Law on Food Safety 2010; to strengthen inter-sectoral collaboration; to be able to control food safety effectively throughout the food supply chain by 2020.

4.3. To promote mother and child health care, population and family planning services

a) To promote interventions which help reduce maternal and newborn mortality rate; to continue completing policies and incentives to attract more obstetricians and pediatricians to disadvantaged areas as well as policies for village birth attendants; to encourage the delivery of outreach and home-based services; to organize the service delivery network in accordance with local culture and practices, especially in ethnic minority areas.

To enhance maternal and newborn mortality audit, to implement interventions proven to be effective; to enhance the monitoring of technical procedures: prevention, detection, management and referral of obstetric and newborn emergency cases; to strengthen collaboration between obstetricians, pediatricians and other specialists, intensive care units.

b) To strengthen inter-sectoral collaboration during the implementation of hygiene and nutrition interventions to reduce the stunting rate in children; to promote community involvement in improving nutritional status for mothers before and during pregnancy and providing nutritional supplements for children of all ages.

c) To focus on reducing unmet needs for reproductive health care services, contraceptives, family planning services, especially in adolescents, unmarried youth, migrants, people living

[20] 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive ART; 90% of all people receiving ART will have viral suppression to enjoy a healthy life and reduce HIV transmission risks.

[21] Decision No. 2038/QD-TTg dated 05/11/2011, Decision No. 170/QD-TTg dated 08/02/2012

with HIV, people with disabilities, people affected by natural disasters, sex workers, homosexual people.

To reduce fertility rate in regions with high fertility rate, in mountainous, remote, disadvantaged areas, and maintaining a reasonably low fertility rate in areas with low fertility rate; to contain the increasing speed of SRB; to expand prophylaxis for congenital defects, antenatal screening, newborn screening, premarital counseling and health check-up; to guarantee logistics and delivery of reproductive health care and family planning services.

4.4. Development of health workforce, science and technologies

a) To formulate and promulgate legal documents on training of health workers; to focus on building and perfecting a comprehensive model of medical training for physicians and nurses towards regional and global integration; to develop a collaboration mechanism between hospitals and medical schools to link theoretical training and medical practice.

b) To build a contingent of health workers with rational structure, sufficient quantity and quality in order to be able to perform jobs assigned to them or required by the job description of each health facility; to continue developing competency requirements for each type of health worker; to standardize outputs of training of health personnel.

c) To balance the allocation of health human resources between regions, levels, between training and use of health workers; to implement measures which are effective and in line with local socio-economic conditions to attract health workers to work permanently in mountainous, remote and disadvantaged areas; to implement regulations on obligations and social responsibilities of newly-graduated health workers.

d) To focus on training of general doctors, to apply family medicine and health management approach; to continue providing demand-based training, contracted training and training of village birth attendants with a reasonable scale to meet the needs of remote and disadvantaged areas, to gradually decrease contracted training when these areas have enough staff.

e) To strengthen the management of training quality through regular monitoring, accreditation, development of evaluation standards for training quality; to develop health human resource database; to enhance close cooperation with Ministry of Education and Training in the direction and management of training quality.

f) To develop practice guidelines for people applying for medical practicing certificates.

To promote scientific/technology research and application of advance medical technologies, especially in essential medicine, hi-tech medicine, clinical medicine, public health and health management.

4.5. To implement well code of conduct and improve professional ethics

a) To continue implementing regulations on democracy and code of conduct of health staff; to encourage health workers and cadres to learn from and follow the moral example of Ho Chi Minh.

b) To promote the implementation of Decision No 2151/QD-BYT dated 04 June 2015 of the Health Minister approving the plan on "Innovation of attitude ad behaviors of health workers towards patients' satisfaction ".

4.6. Reform of health financing and implementation of the universal health coverage roadmap

a) In 2016, to issue the Health Financing Strategy of Vietnam for 2016-2025, which clearly defines objectives and targets to be achieved by the health financing system as well as comprehensive and effective solutions.

b) To strive for making the proportion of public expenditures on health (including state budget, social HI and grants) reach at least 60% of the total social spending on health by 2020; to mobilize resources in the society for investment in health, to create new revenue sources for health budget such as sin taxes on tobacco, alcoholic drinks, etc.; to develop and scale up models of investment loans, cooperative investment and public-private partnership (PPP) in health care.

c) To enhance communication on the obligations and benefits of participation in HI; to promote the use of state budget and local budget to pay full/partial HI premium for vulnerable groups; to expand HI participants towards household-based HI, particularly among households working in agriculture, forestry, fishery and salt production so that by 2020 the HI coverage is >80%.

d) To implement focused investment, prioritizing the allocation of investment budget to hospitals in disadvantaged areas, preventive medicine centers, regional testing centers, medical research institutes as well as prioritizing the allocation of recurrent budget to preventive medicine, targeted programs, leprosy hospitals, psychiatric hospitals and hospitals in disadvantaged areas; to continue implementing HI policies and other policies on health care for the poor, the near-poor, children under 6 years old, the elderly, ethnic minorities in areas with socio-economic difficulties and vulnerable groups.

e) Gradually allocate state budget to health facilities based on performance and outputs; to shift parts of recurrent budget allocated to hospitals to support people's participation in HI along with the process of calculting service prices correctly and fully; to expand the scope of HI payment for outpatient services at commune level, community-based and home-based PHC, preventive services for individuals.

f) To use efficiently public financial resources, especially HI payment:

To strengthen the autonomy of public non-business units; to improve the mechanism for managing public hospitals towards explicitness, transparency and efficiency; to pilot a model of public hospital administration which is similar to the business administration model.

To review and apply evidence-based evaluation methods to choose drugs, medical supplies and technical services covered by HI, to conduct health technology assessment and health care need assessment; by 2018 to develop and promulgate the basic health benefit package to be paid by HI, PHC package based on evidence on cost-effectiveness and people's health care needs.

To develop and issue a circular guiding the application of capitation payment method for insured health services to replace provisions of Article 10 of the Joint Circular No. 41/2014/TTLT BYT-BTC dated 24 November 2014 of MoH and MoF guiding HI implementation; to extend the pilot of capitation model and DRG; to familiarize with the change of Official Development Assistance (ODA) modality from projects to budget support programs.

To generate resources for increasing wages of health workers; to allocate properties to facilities

for efficient, safe and practical management, utilization and development.

4.7. To renew the organizational structure of the management apparatus to guarantee the safety of foods, drugs, vaccines, biologicals and medical equipment

a) To renew management methods, to consolidate and perfect the management system and network of agencies responsible for controlling food safety, quality of drugs, cosmetics, vaccines, biologicals and medical equipment.

b) To ensure sufficient supply of quality medicines, vaccines and biologicals, blood, blood-derived products and medical equipment with reasonable prices to meet people's preventive and curative health care needs.

c) To enhance domestic production of medical equipment so that it can meet at least 60% of the needs for common medical equipment of health facilities; to develop domestic pharmaceutical industry, striving to make domestically produced drugs meet 80% of total drugs to be used in 2020; to improve the capacity for domestic production of vaccines, biologicals with priority given to hi-tech dosage forms.

d) To manage and utilize drugs and medical equipment rationally, safely and efficiently; to enhance the utilization, preservation, maintenance and repair of medical equipment and infrastructure; to improve capacity of the network of medical equipment calibration and testing.

e) To review and promulgate regulations on centralized procurement of drugs; to establish a central drug procurement unit for national procurement and price negotiation; to promote centralized procurement of drugs at local level as prescribed in Decree No. 63/2014/ND-CP of the Government.

4.8. To reform, consolidate and complete the health system from central to local levels; to improve the effectiveness of state management for health and strengthen international cooperation

a) To reform and perfect the organizational structure of the health system from central to local levels in accordance with the Master Plan for Vietnam's Health System Development to 2025, which has been approved by the Prime Minister, towards reducing the number of focal points and in line with international trend in order to utilize resources efficiently at all levels:

- To merge district hospitals and DHC into dual-function DHC responsible for preventive and curative services as well as management of CHS.

- To gradually merge provincial centers/units in charge of preventive medicine into provincial centers for disease control and shift their curative function to hospitals.

- To merge separate testing units for drugs, cosmetics, vaccines, biologicals, medical products, food safety, medical equipment into food and drug testing and quality control units; to establish a number of regional testing centers.

b) To complete the system of legal normative documents on health; to increase the capacity for policy making and advocacy, to strengthen evidence-based policy development with the involvement of social-political organizations, social-professional organizations and the people.

c) To speed up the reform of administrative procedures, to enhance IT application in health system management, health service delivery, HI payment and in provision of online public

services; to strengthen supervision, inspection and strictly handle violations of laws and regulations on people's health protection, care and promotion.

To strengthen international cooperation and integration in the health sector; to continue mobilizing financial resources, technical support and experience from foreign countries and organizations; to collaborate with neighboring countries in the prevention and control of epidemics such as HIV/AIDS, malaria, dangerous and emerging epidemics; to employ appropriate solutions to actively respond to negative impact of globalization and international integration.

4.9. To develop the HIS, to enhance and improve the effectiveness of health communication and education

a) To consolidate and strengthen the HIS through promoting the implementation of the HIS Development Strategic Plan during 2016 - 2020 with a vision to 2030, to establish an information management system which is strong and effective enough to provide managers and policymakers with sufficient quality information in a systematic, regular and timely manner.

b) To develop a collaboration mechanism and to identify specific responsibilities for health communication among the health sector and ministries, sectors, local governments at all levels, press agencies.

c) To increase the effectiveness and activeness of health communication and education in order to achieve consensus, support and involvement of party committees, local governments, media, the public; to improve people's knowledge on health care so that they can proactively protect, care and improve the health of themselves as well as of the community.

5. Budget estimation for the period 2016-2020

Estimated budget for the entire health sector is 742,320 billion dongs; equivalent to 8.4% of the total state budget expenditures if expenditures from Government bonds are included.

5.1. Spending on investment and development

Capital from state budget and Government bonds is directed to prioritize:

- Completion of ongoing projects to put into operation;

- Investment in preventive medicine as planned in the Master Plan for Vietnam's Health System Development to 2025 vision to 2025 with the establishment of provincial and regional centers for disease control, regional testing centers;

- Investment in grassroots health care network (CHS, polyclinics, district hospitals that have not been invested in the period 2008-2016)

- Investment in hospitals that have no revenues such as leprosy hospitals, psychiatric hospitals, forensic institutes, regional institutes/centers of forensic psychiatry.

- Government bonds are expected to be used to invest in central and provincial hospitals that have not been invested in previous stages.

- Investment in some new facilities such as: Southern Orthopedics Hospital, Southern Endocrinology Hospital, Biomedical Research Institute, etc.

- Prioritizing the use of counterpart funding for ODA and PPP projects

The MoH needs 176,148 billion dongs to complete the health system as planned by 2025 and vision to 2, and 035has reported this need in writing to the Prime Minister.

a) Commune level: investment in CHS in accordance with Resolution No 68/2013/NQ-QH13 dated 29 November 2013 and Resolution No 76/2014/QH13 of the National Assembly dated 24 June 2014. By 2020, there is a need to construct 1,192 CHS and renovate of 1,239 dilapidated, downgraded or severely deteriorated CHS; renovate and provide additional equipment for the remaining CHS; and build several testing centers for CHS clusters. The total need is approximately 17,688 billion dongs.

b) District level: In the next period, there is a need to invest in districts without a district hospital/health center (i.e. 25 newly divided districts and those in disadvantaged areas), invest in district preventive medicine after merging hospitals and single-function DHC into dual-function DHC which will perform both curative and preventive care. The minimum investment need is approximately 9,130 billion dongs.

c) Provincial level: Investment in the completion of the preventive medicine system as planned. Continue to renovate, upgrade and expand a number of general hospitals in mountainous and difficult provinces. Invest in some provincial hospitals that have not been invested in the period 2009-2016 from Government's bonds and state budget. Invest in some traditional medicine hospitals in accordance with Decision No 362 of the Prime Minister. Invest in the development of under Decision No. 317 of the Prime Minister. Renovate operating theatres, equipment rooms, patient rooms. Procure equipment for satellite hospitals to perform the techniques transferred by nuclear hospitals. The total need is 66,000 billion dongs.

d) Central level: The total need is 60,374 billion dongs.

* For hospitals: upgrade, renovate and construct outpatient department in hospitals; upgrade, renovate and expand hospitals; construct additional campuses of hospitals; procure equipment for hospitals which have got their infrastructure upgraded,...

* For testing units: institutes of forensic medicine, institutes of forensic psychiatry and regional centers for forensic psychiatry, etc.

* For preventive medicine: intitutes of hygiene and epidemiology, Pasteur institutes, malaria institutes, testing institutions, construction of the Bio-medical Research Institute...

e) Central institues/tertiary referral hospitals (Project No. 125): 22,956 billion dongs.

5.2. Non-business health expenditures

- By 2020, to complete the shift of recurrent budget allocated to health facilities to support people's participation in HI along with the process of calculting service prices correctly and fully.

- Implement the roadmap of universal HI coverage (i.e. increase the percentage of people covered by HI).

- Implement the roadmap of adjustment of health service prices:

+ By 2016: to include wages and direct costs in the service prices.

+ By 2018: to include wages, direct costs and management costs in the service prices.

+ By 2020: to include wages, direct costs, management costs and depreciation of fixed assets in the service prices.

- Adjustment of HI premium from 2018: annual increase of 0.3% of the minimum wage.

Following the above plan, the **estimated recurrent budget for the period 2016 – 2020 is 550,314 billion dongs** (530,922 billion dongs as recurrent expenditure and 19.392 billion dongs for national targeted programs on health and population), including:

(i) The central budget is 119,187 billion dongs, of which:

a) Recurrent expenditure: **98,687** billion dongs, of which MoH: 21,689 billion dongs, foreign capital: 6,676 billion dongs, other ministries: 4,461 billion dongs, central budget as contingency and support for provinces: 5,000 billion dongs;

b) Expenditures of national targeted programs on health and population: **19,392 billion dongs**, of which 3.500 billion dongs are from foreign capital and 15,892 billion dongs are from domestic funding;

c) Additional allocation for localities to buy and support the purchase of HI cards for the poor, people in ethnic minorities, island communes, island districts, children under 6 years old, the near-poor, pupils, students; incentive allowances for health workers in accordance with Decision No. 73 of the Prime Minister; spending for disease prevention and other unexpected tasks: **60,860 billion dongs** (in which 45,110 billion dongs are for supporting the purchase of HI cards. It is planned that from 2017 onwards, the State will support 50% of the HI premium for pupils, students and people with average living standards).

(ii) Local budget balance: 432,234 billion dongs according to per capita norms for recurrent expenditures of health facilities which are managed by local authorities and for buying HI cards for children under 6 years old, the poor, ethnic minorities and for supporting the near-poor, pupils, students to buy HI cards from local budget.

5.3. Health expenditures in national security, defense and reform of salaries: 19,750 billion dongs

5.4. Expenditures from the retained revenue: 625,641 billion dongs (central budget: 144,397 billion dongs, local budget: 481,243 billion dongs), of which direct service fee is 164,402 billion dongs, HI reimbursement is 455,462 billion dongs and other non-business revenue is 5,776.5 billion dongs.

6. Monitoring, supervision and evaluation

On the basis of the assigned targets, the MoH is responsible for evaluating the implementation of the plan and the annual assigned targets, which will serve as a foundation for making health plans in the following years.

The National Assembly conducts annual supervision of the implementation of targets assigned by the National Assembly to the health sector.

Data collection and publication of achievement of targets are conducted in compliance with regulations of the Prime Minister on national statistical indicators. Indicators under responsibility of the MoH need to be collected and aggregated from the routine HIS of the health sector, combined with other reliable data sources.

Annually, the Ministry of Health in collaboration with the Health Partnership Group (HPG) produces JAHR, serving as a basis for policy making, health planning and mobilization of international aid for the health sector. JAHR is used to evaluate performance of the health sector annually.

DoH are responsible for monitoring and supervising the implementation of the plan and health indicators at provincial level.

7. Organization of implementation

The MoH takes overall responsibility to the Government for implementing the plan and assigned targets

Pursuant to the 5-year health sector plan 2011-2015, MoH's subordinates,

DoH of provinces and centrally-run cities, health agencies of other ministries/sectors organize and implement the annual plan for people's health care, protection and promotion, and periodically report their performance to competent authorities.

Line ministries/sectors, Vietnam Fatherland and Front and relevant social organizations work closely with the MoH – within their functions and tasks – to implement, monitor and supervise the implementation of this plan.

The MPI, MoF mobilize resources, submit the Government proposed annual budget allocation for the health sector in the spirit of Resolution No. 18 of the National Assembly.

PPC direct respective DoH to develop local plans in line with the orientation, directions and policies of the Government for health – based on local conditions: submit local plans for appraisal and approval as regulated by current procedures; direct DoH and relevant provincial departments to implement the assigned plans and targets.

MoH's departments, general departments, administrations, Cabinet, Inspectorate and subordinates are responsible for developing annual work plans in line with specific priorities, objectives and tasks set out in the 5-year plan for people's health protection, care and promotion in the period 2016-2020.

The Department of Planning and Finance (MoH) is the focal point to assist the Minister of Health to monitor, supervise and update the implementation of this plan./.

Recipients:

- Government's Office;
- MPI, MoF;
- Provincial/city DoH;
- MoH's subordinates (Departments, Administrations);
- Health agencies of other sectors;
- Filing: Administration, KHTCC2

MINISTER

(signed)

Nguyen Thi Kim Tien

Annex 1: IMPLEMENTATION RESULTS OF KEY HEALTH INDICATORS SET FOR THE PERIOD 2011-2015

No	Indicator	Target for 2011-2015	Implemented in 2011	Implemented in 2012	Implemented in 2013	Implemented in 2014 (Preliminary)	Forecast implementation in 2015	Achievement vs. target for 2011-15
	Input indicators							
1.	Number of medical doctors per 10,000 population	8	7.33	7.34	7.61	7.8	8	Target achieved
2.	Number of graduate pharmacists per 10,000 population	1.8	1.92	1.96	2.12	2.15	2.2	Target exceeded
3.	% of villages with active VHW	90	96.9	96.6	96	96	96	Target exceeded
4.	% of CHS with at least a medical doctor	80	71.9	73.5	75	78	80	Target achieved
5.	% of CHS with at least a midwife or assistant doctor in pediatrics and obstetrics	> 95	95.3	96.4	96.0	98.0	> 95	Target achieved
6.	Number of beds per 10,000 population (excluding CHS beds)	23.0	21.5	22.0	22.5	23.5	24.0	Target exceeded
	Performance indicators							
7.	% of infants fully vaccinated	>90	96.0	95.9	91.4	>90	>90	Target achieved
8.	% of communes meeting the national criteria for commune health (in 2011, reported data did not separate communes that met old benchmarks and those meeting new criteria)	60	76.8	45	50	55	60	Target achieved
9.	% of health insurance coverage	75	65.0	66.4	70.0	71.6	76.5	Target exceeded
	Output indicators							
10.	Life expectancy at birth (years)	74.0	73.0	73.0	73.1	73.2	73.3	Target not achieved
11.	MMR (per 100,000 live births)	58.3	69	69	61.9	60	58.3	Target achieved
12.	IMR (per 1,000 live births)	14.8	15.5	15.4	15.3	14.9	14.7	Target

No	Indicator	Target for 2011-2015	Implemented in 2011	Implemented in 2012	Implemented in 2013	Implemented in 2014 (Preliminary)	Forecast implementation in 2015	Achievement vs. target for 2011-15
								achieved
13.	<5MR (per 1,000 live births)	19.3	23.3	23.2	23.1	22.4	22.1	Target not achieved
14.	Population (million people)	<92	87.84	88.77	89.7	90.7	<92	Target achieved
15.	Reduction of birth rate (‰)	Reduced by 0.1	Reduced by 0.5	Increased by 0.3	Increased by 0.1	Reduced by 0.1	Reduced by 0.1	Target achieved
16.	Population growth rate (%)	0.93	1.04	1.06	1.06	1.08	1.03	Target not achieved
17.	SRB (boys/100 girls)	113	111.9	112.3	113.8	112.2	113	Target achieved
18.	<5 malnutrition rate (weight/age) (%)	15.0	16.8	16.2	15.3	14.5	14.1	Target exceeded
19.	HIV/AIDS prevalence rate in community (%)	<0.3	0.225	0.237	0.24	0.24	<0.3	Target achieved

Annex 2: INDICATORS IN THE NATIONAL SOCIO-ECONOMIC DEVELOPMENT PLAN

No	Indicator	Unit	Target for 2016	Target for 2017	Target for 2018	Target for 2019	Target for 2020	Target for 2016-2020
1	Average population (last year of the 5-year period)	Million	92.4	93.3	94.2	95.2	96.1	<97
2	Population growth rate (last year of the 5-year period)	%	1.02	1.01	1.0	1.0		1.0
3	Life expectancy at birth	Year	73.4	73.5	73.6	73.7	73.8	73.8
4	SRB	# of boys /100 girls	113	113.5	114	<115	<115	<115
5	Number of hospital beds/10,000 population (excluding CHS beds)	Bed	24.5	25.0	25.5	26.0	26.5	26.5
	- Number of public hospital beds/10,000 population	Bed	22.9	23.3	23.7	24.1	24.5	24.5
	- Number of private hospital beds/10,000 population	Bed	1.6	1.7	1.8	1.9	2.0	2.0
6	Number of medical doctors/10,000 population	Doctor	8.2	8.4	8.6	8.8	9.0	9.0
7	MMR (per 100,000 live births)	Person					52.0	52.0
8	IMR (per 1,000 live births)	‰	14.6	14.5	14.3	14.2	14.0	14.0
9	<5MR (per 1,000 live births)	‰	21.6	21.4	21.0	20.7	20.4	20.4
10	<5 malnutrition rate							
	- Weight for age	%	13.6	13.1	12.7	12.3	12.0	12.0
	- Height for age	%	23.9	23.3	22.8	22.3	21.8	21.8
11	% of communes meeting the national criteria for health	%	64	68	72	76	80	80
12	% of infants fully vaccinated	%	>90	>90	>90	>90	>90	>90
13	% of CHS with at least a medical doctor	%	82	84	86	88	90	90
14	Health insurance coverage	%	78.0	79.8	81.4	82.5	84.3	84.3
15	HIV/AIDS prevalence rate	%	<0.3	<0.3	<0.3	<0.3	<0.3	<0.3

No	Indicator	Unit	Target for 2016	Target for 2017	Target for 2018	Target for 2019	Target for 2020	Target for 2016-2020
	in community							
16	% of households with sanitary latrines	%	76.6	78.3	80.0	81.6	83.3	83.3
	- Urban	%	96	97	98	99	100	100
	- Rural	%	67	69	71	73	75	75

Annex 3: OTHER INDICATORS OF THE PLAN FOR PEOPLE'S HEALTH PROTECTION, CARE AND PROMOTION

No.	Indicator	Target for 2020
	Input and process indicators	
1	Out-of-pocket share of households as percentage of total health expenditure (%)	40
2	Number of graduate pharmacists per 10,000 population	2,5
3	% of (rural) villages with active VHW	90
4	% of CHS with at least a midwife or assistant doctor in pediatrics and obstetrics	95
	Output and outcome indicators	
5	% of deliveries attended by health staff	98
6	% of delivering women receiving ≥4 antenatal care visits during 3 trimesters	85
7	% of mothers and newborn receiving post-natal care	95
8	% of specific population groups getting access to reproductive health care services	50
9	% of patients treated by traditional medicine, or by a combination of traditional medicine and western medicine	25
10	Contraceptive prevalence rates by women aged 15-49 (%)	71,9
11	% of pregnant women receiving antenatal screening	50
12	% of newborn receiving screening	80
13	% of health facilities having medical waste treated correctly	100
14	% of people with diabetes detected	50
15	% of detected diabetes patients receiving treatment in accordance with clinical guidelines	50
16	% of people with COPD detected in early stage	50
17	% of detected COPD patients receiving treatment in accordance with clinical guidelines	50
18	% of people with asthma detected and treated in early stage	50
19	% of treated asthma patients achieving asthma control	50
20	% of people with cancers detected in early stage	40
21	% of women aged 30-54 screened for cervical cancer	50
22	% of women aged over 40 screened for breast cancer	50
23	% of people with hypertension detected	50
24	% of detected hypertension patients being managed and treated in accordance with clinical guidelines	30
25	% of the elderly receiving preventive care, regular health check-up and treatment in health facilities	70

No.	Indicator	Target for 2020
26	% of disabled people with rehabilitation needs getting access to appropriate rehabilitation services in district health centers, CHS or receiving home-based care (%)	90
27	% of hemophilia patients being diagnosed and managed (%)	60
	Impact indicators	
28	Population growth rate (%)	1
29	% of people aged 15-49 with full knowledge on HIV/AIDS	80
30	ART coverage among HIV+ people eligible for ART (%)	80
31	Mother-to-child transmission rate (%)	2
32	Diabetes prevalence rate among people aged 30-69 (%)	<8,0
33	Number of people with acute food poisoning per 100,000 population	7
34	Malaria prevalence rate per 1,000 population	0,15
35	Malaria mortality rate per 100,000 population	0,02
36	TB prevalence rate per 100,000 population	131
37	TB mortality rate per 100,000 population	10
38	Annual dengue fever morbidity/mortality rate (%)	0,09
39	Hypertension prevalence rate among adults (%)	30
40	Smoking rate (%)	
	- Among youth aged 15-24	18
	- Among men	39
	- Among women	1,4
41	Obesity rate (%)	
	- Among adults	15
	- Among children	10
42	Abortion rate (%)	25
43	Adolescent fertility rate (%)	4,0