Achieving Health for All

Schleiff, Meike, Bishai, David

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Vietnam has made great strides in socioeconomic development in the transition from a central planning economy to a market-oriented one. *Doi Moi* (literally “renovation”) is the term used for a large set of 1986 reforms to create a socialist-oriented market economy. Economic and political reforms begun under *Doi Moi* in 1986 have spurred rapid economic growth and development and have transformed Vietnam from one of the world’s poorest nations to a lower-middle-income country (World Bank 2017). There has been dramatic progress in health, economics, and demography. The integration of health policies into many other aspects of development was critical to this progress and owes inspiration to the vision of comprehensive, multi-sectoral, community engagement enshrined in the 1978 Alma-Ata Declaration. This chapter briefly reviews Vietnam’s achievements in health and then supplies the historical context for how these gains were achieved through a primary health care (PHC) approach.

Vietnam’s Recent Progress in Health, Economic Growth, and Demography

Vietnam’s life expectancy at birth reached 75.6 in 2016, which is the second highest in Southeast Asia according to the Human Development Report 2016 (UNDP Vietnam 2016) (figure 12.1). Since 1990, Vietnam’s gross domestic product (GDP) per capita growth has been among the fastest in the world, averaging 6.4% a year in the 2000s. Stable economic growth has resulted in steadily increasing GDP per capita, to its current level of $6,290.50 (in pur-
chasing power parity–adjusted dollars). According to the World Bank, the proportion of the population living below the line reached 13.5% in 2014, down from close to 60% in 1993. More than forty million people escaped poverty over the course of these two decades (World Bank and Ministry of Planning and Investment of Vietnam 2016). Fertility decline has allowed Vietnam to start reaping a demographic dividend. Vietnam had a population of more than ninety-three million in 2017 (GSO of Vietnam 2017). Young people aged 10 to 24 constitute the largest age group, accounting for approximately 30% of the total population. These youth are the most highly educated generation ever, with a 99% primary school completion rate as of 2014 (GSO of Vietnam and United Nations Children’s Fund 2015). However, Vietnamese demography includes a growth in aging—the population over 65 has risen to 11.1% (General Statistics Office of Vietnam 2016). Development policy in Vietnam has needed a life course perspective to simultaneously address the health and welfare needs of both young and old. The PHC approach has been an ideal way to embrace a complex variety of concerns.

**Historical Context**

*Colonial Legacy and Health System in 1950s and 1960s*

After it declared independence in 1945, the government of the Democratic Republic of Vietnam inherited a health system from the previous colonial government, who was incapable of meeting the needs of its population, with a physician-to-population ratio of 1 to 180,000 (Nguyen 1972; Cima
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1987; Lahmeyer 2003). In the years following independence in 1954 and the development of its health policy, the Vietnamese health system remained underdeveloped. In noncombat zones, the health system was based on the Soviet model, in which all health care facilities were owned by the state and made services available to the public. All citizens were entitled to free access to the health care system (Democratic Republic of Vietnam 1959; Socialist Republic of Vietnam 1980). Built on a four-layer system of care, from central to commune levels, the system operated on centrally top-down planning and management processes with no competition in providing health care services. It focused on achieving specific quantitative health systems outputs (e.g., number of medical doctors and hospital beds) rather than on outcome measures indicating changes in health status (Le 2013).

**Effect of War on the Health System**

During the Vietnam War (1945–1975), a state-socialist health system was implemented based on collectivist and centrally planned economic management. Health care facilities received an operating budget and resources from both central and local governments. Agricultural collectives provided a community contribution (agricultural benefits) as payment for commune health workers, while medicine, equipment, and labor were allocated by the central government as planned (Nguyen 1972). Although health care services were provided free of charge, the Vietnamese health system experienced uneven spatial development due to the wartime economy. Commune health centers in rural areas and district health centers in urban areas were designed to oversee basic preventive and curative services (Nguyen 1972). Numbers grew from only 500 commune health centers and 800 private maternity homes in 1959 (Ministry of Health 1959) to 5,764 commune health centers associated with agricultural collectives in the early of 1970s (Nguyen 1972). The sick were served by a group of trained individuals: family health workers and barefoot doctors (Nguyen 1972; Bryant 1998). Although family health workers no longer exist, barefoot doctors are still prevalent and are now known as village health workers (VHWs). Due to wartime scarcity, commune health centers were bare bones with obsolete equipment and no way to perform medical tests, hence diagnoses were based on clinical symptoms only. Relatives of the sick pitched in to offer patient care due to labor shortages (Nguyen 1972; Ladinsky and Levine 1985).
Postwar Influence from Communist Bloc Countries

During postwar recovery, public expenditure for health was severely reduced. Health expenditure was low compared with other sectors, because the government considered health an unproductive sector (Hanoi Medical University 2002). Around 30% to 40% of the national health budget was committed to financing drugs, health equipment, training, and buildings, but this was insufficient to meet estimated medical needs. The remaining 60% to 70% of the health expenditure was for salaries (Hanoi Medical University 2002). Vietnam’s pharmaceutical industry had produced only about 30% of its domestic needs for medicines (Council of Ministers 1982). Health care facilities, especially health care centers at commune and district levels, were paralyzed because of limited public funds and the lack of local health personnel (Gellert 1995; Witter 1996).

The 1980 Constitution of Vietnam was committed to free health care for all citizens; however, the constitutional promise was not adequately financed. Only 2% of the total government budget was spent on health during the 1980s (Valdelin et al. 1992). The political report at the Seventh Communist Congress noted that the health system faced many challenges in the period from 1986 to 1991 based on insufficient state funding for health care needs (Communist Party of Vietnam 1991). Despite limited resources, state-funded health services and the PHC network at the grassroots level still played a vital role in the bright picture of health systems in Vietnam. Remarkably, the health outcomes achieved have been higher than those of other countries with similar incomes (Ensor 1995; Bloom 1998; Ladinsky et al. 2000; Ministry of Health 2001; World Bank 2001; Carrin 2002).

One-Party Communist Rule

Established in 1930, the Communist Party of Vietnam (CPV) plays a unique role in the country’s political scene (National Assembly of Vietnam 2013). The 2013 Constitution of Vietnam affirms the CPV as the only ruling political party (National Assembly of Vietnam 2013). The Doi Moi progress with economic reform is a dynamic illustration of the CPV’s leadership in every sector, including the health sector (Communist Party of Vietnam 1986). The CPV’s views on health as a priority and its commitment to applying strong PHC delivery systems by developing a health care network at the grassroots level and combining preventive and curative health care have been reflected
Doi Moi Effect on Health System

The guidance of the CPV at the Doi Moi Congress (1986) regarding the health system required that health facilities at the grassroots level (figure 12.2) be enhanced and developed. The key issue was amending essential policies to ensure the rights and benefits for health workers at all levels, especially at the commune level, which aimed at improving the attitudes and behaviors of health workers. The policies also ensured increasing the stock of inpatient beds at the PHC level and gradually renovating and changing health equipment at national hospitals (Communist Party of Vietnam 1986).

Private health care services began booming after the Doi Moi introduction. In the early 1990s, there were no private health facilities, but in the 2010s, the private sector had grown to 212 hospitals (Hanoi Department of Health 2017) and about 35,000 private clinics and 40,000 drug stores (Ministry of Health 2019). The private sector now plays a significant role in health systems in Vietnam (Ministry of Health 2017a). Importantly, the private sector in Vietnam has been used to mobilize private finances for PHC services that people value, helping the public sector conserve resources for VHWs and more essential public health operations.

At the grassroots level, VHWs continue to be focal points of PHC programs. From 1999 to 2009, they were paid only a small amount of money for their health-related work at the community level, offering PHC services such as health education, some epidemiology activities, health care for

Figure 12.2. Grassroots health network in Vietnam.
mothers and children, and family planning, first aid, and general health care (Ministry of Health 1999, 2010, 2013). In 2009, the monthly allowance for VHWs was increased from about VND40,000 a month (equivalent to US$1.72) to VND402,500 a month (equivalent to US$17.30) for delta/mountainous areas and VND632,500 a month (equivalent to US$27.20) for especially difficult areas (Prime Minister 2009). This more generous financial support policy helped to reform the PHC system, with a focus on the first point of contact. In 2017, approximately 97.5% of villages had VHWs (Ministry of Health 2017a). VHWs play a crucial role in improving population health by supporting the implementation of national targeted programs in their local areas, such as malaria prevention, vaccination, malnutrition prevention for children, safe motherhood, and among others, as well as other disease prevention programs in the mountainous, remote, and island areas (Ministry of Health 2017b).

PHC has been a key strategy for health system development in Vietnam as part of Doi Moi (National Assembly of Vietnam 1989; Vietnam Government 1996; Prime Minister 2001, 2013). PHC policies aim at ensuring that all people receive quality primary care. Comprehensive strategies focus on human resource development for health, universal health insurance coverage, and upgrading regional polyclinics and hospitals (Ministry of Health and Health Partnership Group 2015). By the end of 2015, 86.9% of commune health centers had at least one physician, 96.4% of commune health centers had a midwife, 97.2% of children under 1 year had been fully vaccinated, and only 14.1% of children under 5 years had had stunting (Ministry of Health 2017a).

Health as Part of the Social Economic Development Strategy

Integration of Health with Development

Policies of the CPV, the National Assembly, and the government continue to stress the important role of people’s health in achieving social advancement and equity, improving people’s lives and meeting requirements of industrialization and modernization in the country. Leaders see investment in health as a direct investment in sustainable development. Vietnam’s top leaders see health objectives as development policy objectives (Ministry of Health 2016b).

The success of Doi Moi shifted the state’s focus from a narrow focus on GDP growth to sustainable socioeconomic development of Vietnam’s capability to improve all aspects of human thriving. The Social Economic
Development Strategy (SEDS) plans for 2001 to 2010 focused on efficiency and equity. There was special attention to improving access for the poor, ethnic minorities, people in remote areas, and war-affected people. Maternal and child health were made high priorities (Vietnam Government 2000a). The government’s Socio-Economic Development Plan (2006–2010) increased investment in PHC, with an explicit focus on education in reproductive health, nutrition, traffic safety, and tobacco control (National Assembly of Vietnam 2006).

In Vietnam’s SEDS plans for the period of 2011–2020, health was identified as one of twelve pillars for growth and restructuring of the economy. The plan stated, “Strongly develop health . . . and improve the quality of healthcare work for the people.” The government is concentrating on strengthening the capability of commune health centers, completing the construction of hospitals at the district level, and guaranteeing quality health service accessibility, especially for the poor, children, and the elderly (Vietnam Government 2010).

How Vietnamese Traditional Culture Accords with Primary Health Care

According to traditional Vietnamese health beliefs, the notion of prevention is very important (Jansson, 2012). Traditional medicine informs the health beliefs of many (Schirmer et al. 2004). The relationship between culture and health care therefore helps to explain why health was given priority in Vietnam’s development plans. Traditional cultural respect for women has ensured that women are engaged and reached by community health programs. A flexible combination of traditional and modern medicine is one of the mainstays of the health strategies. The term integration/hybrid medicine has come to be widely used to express the official incorporation of traditional medicine

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**Vietnamese Proverbs**

Suc khoe la vang
Health is gold.

Co suc khoe la co tat ca
Good health is everything.

—Vietnamese proverbs
into national health systems and services (Raffin 2008). The government has strengthened audits of quality of care of traditional medicine and integrated traditional medicine from the central level to local levels. Integration of traditional medicine offers greater equity and cultural sensitivity, and makes health services more acceptable to all people (Ministry of Health and Health Partnership Group 2017).

Community Participation

Community participation along with equity, intersectoral coordination, and appropriate technology are pillars of PHC. In Vietnam, community participation was traditionally seen by the medical establishment as mobilizing people to adopt an intervention such as mass immunization or nutrition campaigns. Above and beyond this, community participation in Vietnam has attempted to address the wider social and structural determinants of health, such as access to clean water and safe sanitation conditions (Vietnam Government 2000), as well as housing and infrastructure upgrading (Ngo 2016). For example, Vietnam’s Participatory Hygiene and Sanitation Transformation is a method to encourage community management of water and sanitation facilities, improve hygiene behaviors, and prevent diarrheal diseases. It consists of preparing trainers to assist villagers in identifying and analyzing of problems, selecting among different types of water supply and sanitation facilities as well as different hygiene practices, planning, and monitoring and evaluation through a standard set of participatory activities (Mai et al. 2004).

Community participation has embraced many forms of citizen action for community problem-solving, including self-help, and social support groups such as those for tuberculosis and HIV/AIDS prevention and treatment. Formal and informal activities are voluntarily undertaken by organized individuals who share interests and goals in programs that aim to bring about a planned change or improvement in community life and services. Community participation has always been supported by national policies that promote bottom-up planning and decision-making. For example, the 2007 Grassroots Democracy Ordinance (National Assembly of Vietnam 2007) called for extensive public involvement at the commune level in decisions related to the use of public resources. According to the ordinance, people have the right to be informed, to participate in discussions, and to make decisions on local socioeconomic development activities, especially when these activities require community resources. Ultimately, most community-based projects have not been initiated and conducted by the communities themselves; thus, community
participation requires support from the local government for its activities (Ngo 2016).

**High-Placed Support for Population-Level Prevention**

Vietnam has focused on disease prevention and health promotion. Resolution number 4 of the Central Communist Party Session VII (1993) clearly states: “Health care and dealing with health problems should be done from the perspective of positive and active disease prevention, promotion of hygienic movement, physical practices and effective treatment” (Communist Party of Vietnam, 1993a, n.p.). Resolution 46 (2005) of the Standing Committee of the Politburo reaffirmed this by stating: “Practice overall health care: integration of prevention and treatment, rehabilitation and physical training so as to promote health” (Politbureau of the Communist Party, 2005, n.p.). More recently, Resolution 46 also specified some major tasks: (1) develop and effectively operate national target programs on health and health promotion; (2) develop hygienic, preventive, and physical practice activities; (3) apply preventive measures and limit negative impacts to people’s health caused by changes in lifestyle, environment, and working conditions; (4) speed up preventive activities on occupational diseases; (5) strengthen and develop school health; (6) emphasize health for mothers, children, and older persons, and rehabilitation; and (7) effectively strengthen intersectoral cooperation in health protection, caring, and promotion for the people. This direction has continued to be emphasized in the recent Resolution number 20 of the Central Communist Party Session XII (2017) as it relates to strengthening health protection, care, and promotion in new context (Politbureau of the Communist Party 2017). Health promotion and strengthening capacity on epidemic prevention and control together with reforming grassroots engagement in health are some essential strategies mentioned in this resolution.

A system of national health target programs (NHTPs) must be credited with helping Vietnam realize the goals of government leadership. Priority setting and concentration of available resources to address key problems of population health through NHTPs has been an effective approach, positively contributing to equity and efficiency in people’s health care and protection. The NHTPs started in 1991, with an initial five-year program from 1991 to 1995, and have been conducted up to now under a new name: “Health and Population Target Program in the 2016–2020 Period” (Vietnam Government 2017).
Multisectoral Collaboration for Health

At the central level, the Ministry of Health has carried out a series of programs that involved a joint effort between and among different ministries and other stakeholders. All other line ministries, such as the Ministry of Planning and Investment, the Ministry of Finance, the Ministry of Labor, Invalids and Social Affairs, the Ministry of Education and Training, the Ministry of Home Affairs, the Ministry of Public Security, the Ministry of Transport, and the Ministry of Defense, have important roles in collaborating and supporting the Ministry of Health in providing health care and protection as well as promotion for the population as indicated in various national strategies over time, such as the National Strategy for People’s Health Care, Protection and Promotion in the Period 2011–2020 and Vision to 2030 (Vietnam Government 2011). At the provincial and district levels, and especially at the commune level, the coordination among education, health, and social welfare sectors is also emphasized.

The Ministry of Health has also taken the lead in mobilizing and broadening participation of a variety of other stakeholders, such as international agencies, states, and nongovernmental organizations and communities (Health Partnership Group 2013). The government has a high degree of coordination with civil society organizations (CSOs) (Ministry of Health 2015) who act as a bridge toward improved implementation of health and development plans (Association Batick International and Centre for Development and Integration 2013). CSOs have been generating evidence on best practices in dialogues and contributing to support policy advocacy and program intervention, especially in remote areas (Ministry of Health et al. 2015).

The Vietnamese media have played an active role in disseminating information about health issues and have received considerable support from various national bodies in this process. Mass organizations including the Vietnam Fatherland Front, the Women’s Union, and the Youth Union usually have a four-layered organizational structure—central, provincial, district, and commune levels—and have implemented many development-oriented activities. Mass organizations have provided supplemental public services that the government does not provide (e.g., childcare, HIV/AIDS clubs, nutritional awareness classes for parents, microcredit for the poor, intervencience in the case of domestic violence disputes). This four-level structure has distinct advantages, including helping the health sector identify households in need of PHC based on locally contextualized knowledge (Jones et al. 2014). Vietnam’s experience has shown the value of developing task force units for

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coordination and investing in capacity-building in planning, budgeting, and management (ADB 2016). Engagement with the business sector has helped the government start sustainable public-private partnerships (UNFPA 2011).

Priority Given to Those in Need

The social protection system in Vietnam currently comprises four basic policy groups: (1) minimum income and poverty reduction, (2) social insurance, (3) social assistance, and (4) basic social service. Social services include education, health care, accommodation, clean water, and information (National Bureau of Asian Research and Institute of Social and Medical Studies 2009; Dao 2017). Targeted groups span the life course, from infants (the law on child protection and care, adjusted in 2016) to seniors (the law on the elderly, 2009) as well as disabled people (the law on people with disabilities, 2010).

Resources for social assistance come from diversified sources, combining the central budget with local budgets and other social resources. Assistance forms, including health care, education, accommodation, and clean water, continue to be diversified.

In Vietnam, a government-led health insurance system was introduced in the early 1990s, and by the end of 2018 about 89% of the population (Financial News 2019) covered by health insurance in which all children under 6, the poor, the near-poor, ethnic minorities, and other people living in border or difficult areas received full or partial premium subsidization (National Assembly of Vietnam 2014) (figure 12.3).

Recent Challenges and Solutions to Overcome Health System Bottlenecks

Challenges for the Health System

The organizational structure and management mechanism of the grassroots health network have changed three times within ten years, creating instability in the system nationwide. This has affected the efficiency of the health workforce and decreased the ability to deliver integrated, comprehensive, and continuous health services (Ministry of Health and Health Partnership Group 2015).

An aging population and increasing burden of noncommunicable diseases (NCDs) requires more comprehensive and continuous integration of care. At the same time, the appearance and unpredictable evolution of some emerging diseases have resulted in the increase in health care needs and costs. The
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The epidemiologic transition is continuing, and the magnitude of NCDs is sure to increase further. The epidemiological disease structure is changing, with NCDs accounting for an increasing share of death and morbidity (Ministry of Health and Health Partnership Group 2015). Recently, Vietnam was ranked twelfth in terms of tuberculosis burden and fourteenth in terms of multi-drug-resistant tuberculosis burden worldwide, and the country continues to be a hot spot for emerging diseases such as influenza A (H7N9 and H5N6) and reemerging diseases like dengue hemorrhagic fever and influenza A (H5N1 and H1N1). The country faces an increasing number of risk factors due to industrialization, urbanization, unhealthy lifestyles, and environmental pollution. Within the region, Vietnam is among the nations with a comparatively high smoking prevalence and high consumption of alcohol. It is also dealing with health issues related to climate change and is considered to be one of the ten countries most heavily affected by the rise in sea levels (Ministry of Health and Health Partnership Group 2014, 2015).

Rapid increases in health care costs are confronting limited health resources. The foremost challenge is to ensure universal access to quality health care at an affordable cost for the country and with manageable out-of-pocket expenses for families. Regarding total social expenditure on health, although Vietnam spends up to 6% of its GDP on health care, health spending per capita in Vietnam is only ranked 127 out of 191 countries (World Health Organization 2015).
Nevertheless, health insurance coverage reached 87.62% by the end of 2018 (Social Insurance Magazine 2018). By law, insured patients are entitled to 80% to 100% coverage (National Assembly of Vietnam 2014). However, in practice the reimbursement from the pool is less than 50% of patients’ actual expenditures (figure in 2017; see Pekerti et al. 2017). The share of out-of-pocket payments has not decreased much over the years; this figure was 48.8% in 2012 (Ministry of Health 2016a).

The organization of health service delivery is fragmented, leading to inability to provide integrated, comprehensive, and continuous care. Linkages are limited between preventive and curative care, between levels of care, and between public and private health facilities, leading to low levels of cooperation. Moreover, there are few mechanisms for integrating activities of different NHTPs, particularly programs for the prevention and control of NCDs. Quality of health services at the grassroots level, especially at commune health centers, is limited. Commune health centers currently can perform only 52.2% of the technical services according to the national classification of technical services by level of facility (Medical Services Administration 2011). Apart from the inadequate facilities, equipment, and medicine, the limited expertise of health workers at commune health centers is considered a critical factor for commune health centers’ service quality, especially at commune health centers in mountainous areas (Trần 2011). While the number of human resources for health at the grassroots level is insufficient, health workers at commune health centers are also faced with a number of difficulties and shortcomings such as limited knowledge and poor practical skills due to inadequate links between training and required competencies of health workers (Ministry of Health 2016a).

**Solutions to Overcoming Health System Bottlenecks**

According to the Ministry of Health, strengthening the health system and professional capacity are a high priority for ensuring better service delivery (in both preventive and curative care) at the grassroots level (Ministry of Health 2016a). The ministry’s plan for people’s health protection, care, and promotion for 2016–2020 proposes restructuring community services to respond to the rise in NCDs (Ministry of Health and Health Partnership Group 2015). Additionally, the Viet Nam Health Financing Strategy for 2016–2025 sets out financing reforms including new payment mechanisms for PHC services, reallocation of funds for community health care, and prioritization of PHC services and NCD care in a cost-effective health service package (Ministry of
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Health and World Health Organization 2016). Importantly, in 2017, the Resolution 20-NQ/TW was issued, focusing on strengthening health protection, health care, and health promotion. This resolution emphasizes that health prevention and PHC will be covered by the government budget (Party Central Committee 2017). These reforms will improve grassroots infrastructure and staff availability as well as quality, which will indirectly strengthen the quality of PHC services (World Health Organization 2018) (see box on this page).

Conclusion

There is a striking concordance between the principles defining PHC in Article VII of the Alma-Ata Declaration and the principles that guided Vietnam’s post–civil war health system evolution. Vietnamese traditional culture and postwar politics resonated with the core principles announced in Alma-Ata. During the 1978 Alma-Ata Conference, Vietnam was preoccupied with postwar recovery. The Communist Party was ideologically predisposed to include health in its multisectoral development strategies, to build up preventive population-level strategies, and to embrace community involvement and

Orientation for Solutions toward Health Priorities at the Grassroots Level

- Implement strategies for comprehensive access including management and prevention of risk factors, screening for early detection of disease in the community for noncommunicable diseases, and intervention measures appropriate for each locality.
- Reform grassroots organizational models and primary health care (PHC) service delivery following an orientation toward comprehensiveness, continuity, and strengthened linkages between treatment and prevention and between the grassroots- and higher-level facilities.
- Continue to strengthen coherent and sustainable grassroots-level investments in physical facilities and human resources, particularly in disadvantaged regions.
- Strengthen surveillance systems for epidemics, ensure preparedness in terms of equipment and human resources to actively respond and control outbreaks, and continue to effectively implement the Expanded Program on Immunization.
- Strengthen capacity of the health sector and intersectoral collaboration for control of climate change, and master planning for industrial production, evaluating, and monitoring effects of pollution due to industrialization and urbanization.
- Implement Sustainable Development Goals, paying special attention to mothers, children, and the elderly. Study the mechanism and road map appropriate for integrating national health target programs into the routine PHC activities at the grassroots level.
consultation on local strategies. However, real progress on Vietnam’s PHC strategy occurred after the Doi Moi reforms of 1986.

From the Law on People’s Health Protection and Care in 1989 through a series of national health-related strategies and policies, the CPV has been consistently committed to improving population health, strengthening grassroots health care networks, and advancing PHC availability for all.

Vietnam’s comprehensive approach to health in development is part of why there has been simultaneous progress on literacy, life expectancy, and the reduction of poverty across the life course and across urban and rural settings. Vietnam’s health achievements were not the result of a small set of selective health interventions, and they were achieved with a health budget that was quite modest. Private sector health providers helped to provide services to those who could pay, freeing the public system to pursue a public health and PHC approach that could focus on those most in need. In an ironic refutation of Walsh and Warren’s (1979) thesis that good health at low cost can be had through selective interventions and without comprehensive PHC, Vietnam’s comprehensive PHC approach has led to the construction of a low-cost and sustainable system that has achieved great strides toward health for all.

Vietnam’s tremendous efforts to meet the complex health and development challenges of the twenty-first century require stronger focus on comprehensive PHC. Support for strong PHC has also expanded far beyond the group of early universal health coverage advocates, presenting a historic opportunity for action.

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