

Financing of NCD Prevention in LMICs: Vietnam Case Study

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Objective:

Prevention programs are increasingly seen as critical for tackling the rising burden of non-communicable diseases (NCDs), but tend to be under-prioritized and under-funded, particularly in low and middle income countries. The objective of this study is to estimate spending on NCD prevention in Vietnam and identify the enablers, challenges and dynamics underpinning population-level NCD prevention spending, with particular focus on tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity.

Methods:

Primary and secondary data collection was used to examine processes and organizational contexts that shape the formulation of policy and financial frameworks for NCD prevention. The methodology was categorized into three tiers; an academic literature review, scrutiny and analysis of official policy documents and budgetary data on health and NCDs, and in-depth stakeholder interviews with key government officials leading NCD programs. Government and government-routed donor spending on population level prevention was gauged to estimate NCD prevention spending. Where possible, impact of prevention programs on disease incidence and risk factors was gauged through available outcome indicators.

Results:

Vietnam spent an estimated VND 7,926 billion (US\$2.62 million) on population-level preventive healthcare in 2016, which amounts to less than 0.5% of the total state health budget, with much of it dedicated to infectious diseases. Spending on NCD prevention is not separately budgeted in health budgets. Challenges to NCD financing include low tobacco and alcohol taxation, lack of a comprehensive risk communication program for NCD risk factors, and inadequate multi-sectoral stewardship for NCD prevention and control.

Conclusion:

Vietnam has made progress in reorienting its health system to focus on NCDs, but continues to spend a minimal proportion of its substantial health budget on prevention. Vietnam needs to build on successes against infectious disease and enhance fiscal and policy prioritization of population-level NCD prevention.

1. Introduction

As a rapidly developing society, Vietnam has made impressive strides in public health with rising life expectancy (now at 76 years), reduced infant and maternal mortality, reduced communicable disease mortality and advances toward universal health coverage. Parallel with its economic growth, the country of 95 million has also experienced a fast and widespread process of urbanization, with a projected urbanization rate of 40% by early 2020. The rapid urbanization has been accompanied by environment deterioration, increased air pollution, emergence of new pockets of poverty and deterioration of lifestyle habits (including physical inactivity and diet changes).¹

These processes have brought about epidemiologic and demographic shifts with the disease burden increasingly dominated by non-communicable diseases (NCDs) like cardiovascular disease, cancers, hypertension and diabetes. While the proportion of deaths caused by communicable diseases has decreased (60% in 1986 to 20% in 2010), non-communicable diseases (NCDs) now comprise 75% of the total disease burden and 72% of deaths (up from 39% in 1986).²

Left unchecked, this problem is likely to get worse and lead to increased stress on the healthcare system. NCDs also exert an economic cost; while the total economic impact of NCDs for Viet Nam is not available, it is estimated that the direct and indirect costs to the economy from tobacco use alone are over USD 1 billion per annum.³ As the size of the elderly population climbs (now at 10% of the population), the population support ratio—the number of working age individuals per individuals age 65 and older—is forecast to decline from 9.3 in 2015 to just 2.6 in 2050 (UN DESA 2017). Unless action is taken now to ensure healthy ageing, the burden of caregiving will become unsustainable.

The government, building on its success with communicable diseases, has taken concrete steps to control NCDs. The country's national NCD strategy is aligned with global NCD targets and includes National Target Programs that respond to specific non-communicable diseases. It has enacted tobacco control taxes, policies and funds, alcohol harm reduction laws and nutrition programs to promote healthy eating, among others. While there has been progress in improving population awareness and improve treatment for and early detection of NCDs, there are still many areas where progress needs to be made. Premature deaths from NCDs remain high, there remains an inadequate focus on prevention programs, risk factors and primary care, numerous institutional shortcomings remain, from stewardship to coordination to communication, and inadequate control of alcohol, tobacco and unhealthy diet continues to be a problem, among other issues.

Limited availability and allocation of funds for financing NCD control and prevention are an important part of the reason for the continued persistence of chronic NCDs around the world. There is an established tendency for governments to provide more funding for treatment than prevention, almost in inverse proportion to potential impact – that is, while prevention is clearly the best use of limited resources it is often easier to secure resources for treatment instead. This is also the case in Vietnam and will require evidence, will and innovation to address.

This study will investigate the dynamics of NCD prevention financing in Vietnam to identify the key lessons, challenges and barriers from Vietnam's experience with financing and implementing NCD prevention. It will do so by first examining the socio-economic and institutional context of NCDs in Jamaica and the region, outlining the key policy responses and interventions of the Vietnamese government to the NCD crisis, and understanding how financing for NCD prevention is raised and spent, and what kind of

economic, social, political and institutional barriers stand in its way. The key lessons and challenges emerging from Vietnam's experience will then be discussed and summarized, and a set of actionable outcomes and recommendations will be presented.

2. Methodology:

The methodology for this assessment consisted of two parts: a review of academic and grey literature and budgetary data and data collection in the form of interviews with key informants. The study adopts the critical theory approach, which acknowledges reality as contextualized and shaped by various social, cultural, economic and political factors and sees the research process as a means to bring about change and transformation. In this study, the critical theory approach was employed to question existing frameworks, organizational hierarchies and red-tape, identify impediments arising from political, economic, systemic and bureaucratic, and largely regional and global contexts, before proceeding to present a set of actionable outcomes and recommendations.

Public financing was defined as resources allocated/mobilized indigenously (revenues) at the country level. This also includes the use of catalytic official development assistance as grants/loans and/or monies from philanthropic sources predicated on the understanding that these are meant to build country capacity and are a stop gap arrangement. This implies that funds from ODA loans and grants, as well as from philanthropic sources, need to go first into the government's resources. The World Bank definition of prevention was employed, as those preventative and "public health services ... designed to enhance the health status of the population as distinct from the curative services which repair health dysfunction."

The investigators used a search strategy involving Medline, Google Scholar, Embase, JStor and Web of Knowledge, databases to identify peer-reviewed articles that examined NCD prevention and financing. In addition, the first 20 pages of Google searches were examined to identify articles from the grey literature. The main search terms were 'NCD', 'prevention', 'financing' and 'Vietnam' or 'Viet Nam'. Additional search terms related to the topic were: 'health promotion', 'non-communicable disease', and 'budget'. Additional search terms related to policy were: tax, legislation, ban, intervention, labelling, law, and standards. Based on the information in the abstracts, those studies were selected for review that: a) were of an empirical nature; b) examined NCD prevention and its financing; and c) dated from late 20th century onward, when concerted policy efforts to counter NCDs began in the region.

The selected studies were reviewed and organized into categories of analysis that were refined based on the evidence emerging from the literature. Later, a specific search was undertaken for broader literature, including policy frameworks on NCDs in Vietnam and the region.

The investigators then reached out to the governments and relevant departments/bodies to procure reports, budget plans, policy guidelines and similar material. This data was analysed thematically, to further refine research questions and thoroughly revise interview guides. At the end of the second tier, the investigators shortlisted potential participants to be recruited for in-depth interviews. These included key stakeholders such as officials from the Ministry of Health, Ministry of Finance, planning ministry or staff from the office of the head of state.

3. The NCD burden in Vietnam:

The NCD share of the disease burden in Vietnam (measured in disability-adjusted life years - DALYs) grew rapidly from 51 percent in 1990 to 74 percent in 2017. NCDs now account for 73% of all deaths in Vietnam and 43% of NCD mortality took place before the age of 70.² In 2010, NCDs accounted for 318,000 deaths (72% of total deaths), 6.7 million years of life lost (56% of total YLLs), and 14 million DALYs lost (66% of DALYs lost) in Vietnam. Of these NCD-related deaths, cardiovascular diseases made up 40%, cancers 14%, chronic respiratory diseases 8% and diabetes 3%. NCDs occupy eight spots in the top ten causes of Vietnam’s disease burden.

What causes the most deaths?

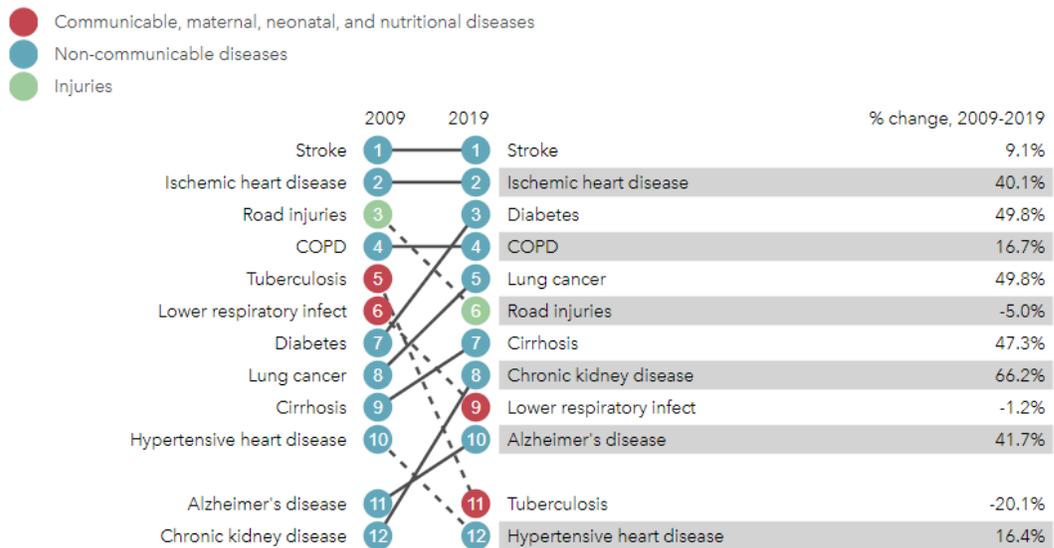


Figure 1 Top 10 causes of premature death in Vietnam and % change (2009-19). Source: Institute of Health Metrics and Evaluation (2020)

The single leading contributor to the disease burden is cardiovascular disease (CVD), accounting for 15% of all deaths and accounting for 10% of all DALYs, with stroke and ischemic heart disease being the biggest cause of mortality and morbidity within CVD. A recent systematic review in 2018 on hypertension – also a major contributor of CVD - in Vietnam indicated that the pooled prevalence of hypertension based on 3 national surveys was 21.1% and while only 11% of those who had been diagnosed with hypertension had it under control.⁴ Vietnam is also among countries that have the highest growth rate of diabetes patients worldwide. The prevalence of diabetes mellitus in Vietnam in 2012 was 5.7% among people aged 35 years old and over (compared to only 2.7% in 2001). The country is forecast to have between seven and eight million people suffering from diabetes by 2025. Moreover, a significant number of the Vietnamese population also lives with undiagnosed diabetes, estimated to be up to two million.⁵

4. NCD risk factors in Vietnam:

The epidemic of NCDs in Vietnam is driven by tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity. The country faces chronic issues of unhealthy dietary patterns, and increasing trends of overweight, obesity, and sedentary lifestyles. In the 2005–2015 period, the country's prevalence of overweight and obesity increased from 15.3% to 21.3% in urban areas and from 5.3% to 12.6% in rural areas. 45% of men in Vietnam use tobacco, 44% of men consume excessive amounts of alcohol while 25% of men were binge drinkers. There has been an increase on in the percentage of the population that are overweight or obesity from 12% in 2012 to 16% by 2016. Salt consumption is twice that of WHO-recommended levels and this has contributed to increasing levels of hypertension –currently 1 in 5 adults suffer from hypertension. About 80% of Vietnamese people were estimated to not eat healthy quantities of fruit and vegetables. Physical inactivity remains a huge problem, with 28.7% of people describing themselves as physically inactive.⁵

What risk factors drive the most death and disability combined?

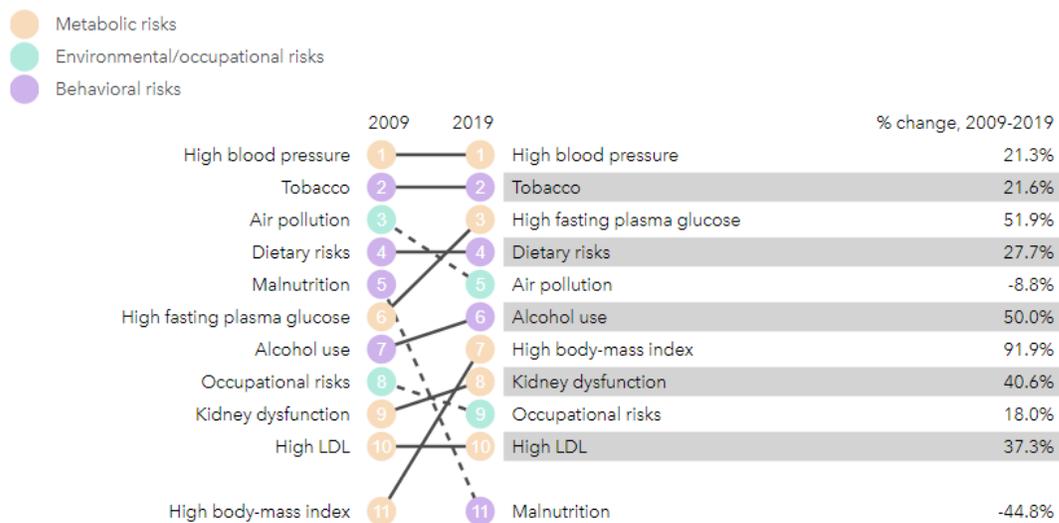


Figure 2 Top 10 risk factors contributing to DALYs in Vietnam and percentage change (2009-19) (Source: Institute of Health Metrics and Evaluation (2020))

4.1. Unhealthy diet:

Unhealthy diet is central to the growing burden of NCDs in Vietnam, where six of the eleven top risk factors driving death and disability are related to unhealthy diet. National nutrition surveys indicate that the Vietnamese are rapidly moving away from their healthier traditional diet, with increasing intakes of meat and poultry (from 11g daily per capita to 84g daily per capita). On the contrary, consumption of vegetables has gradually decreased from 214 g/capita/day in 1985 to 190 g/capita/day.¹ In a recent national survey, nearly 60% of the study population were consuming less than the WHO-recommended amount of fruits and vegetables, and average salt intake per day was almost double the recommended levels.⁶

4.2. Smoking:

According to the Vietnam STEPS survey 2015, the overall prevalence of current smoking was 25.8%. The prevalence was substantially higher among men than women (50.6% vs. 1.5%, respectively). This is nonetheless a slight but less than expected improvement over 2010. Current smoking was also more prevalent among people aged 30–49 years compared to other age groups. Current smoking was also more prevalent among people with lower educational attainment, informal sector workers, ethnic minorities, individuals with a lower wealth index, and individuals who lived in rural areas.

4.3. Alcohol use:

Vietnam has experienced a significant change in the consumption of alcohol that has grown in parallel to its economic growth. Vietnam is the third largest beer consumer in Asia and the per capita consumption of liquor has increased 90% between 2010 and 2017. The prevalence of current alcohol use in Vietnam is 43.8% and is much higher among men than women (77.2% vs. 11.1%, respectively). Heavy drinkers comprise 25.1% of Vietnamese males above the age of 15. The effects of heavy drinking in Vietnam can be witnessed in the high levels of liver cirrhosis and road traffic injuries. The prevalence of alcohol use is highest among people aged 30–49 years, people with a university/college education, government employees, ethnic minorities (among women), individuals with a higher income and residents of urban areas (among women).⁵

4.4. Overweight and obesity:

Among the most concerning risk factors in Vietnam is overweight and obesity; in the 2005–2015 period, the country's prevalence of overweight and obesity increased from 15.3% to 21.3% in urban areas and from 5.3% to 12.6% in rural areas.⁵ The prevalence of overweight is similar between men and women but slightly higher among women (14.9% in men and 16.4% in women). Overall and within sex strata, overweight was more common among older individuals (≥ 30 years), Kinh participants (Kinh being the major ethnicity in Vietnam, accounting for 86.2% of the whole population), and rural dwellers. Among men and women, the patterns of increased prevalence of overweight differed by educational status. Among men, the higher prevalence was observed among individuals with lower educational attainment (primary school) or with higher educational attainment (university/college), whereas among women, the highest prevalence was observed only among those with the lowest educational attainment.⁵

4.5. Physical inactivity:

Vietnam's urbanization has also affected its traditional life patterns that featured high levels of calorie expenditure through manual labour and rural work. Data from a survey from the Ministry of Health shows that 70% of adult Vietnamese do not engage in vigorous physical activity and that office workers walk, on average, only 600 steps a day, instead of the recommended 10,000. The problem is more pronounced among young people. Research also shows that new generations of Vietnamese have adopted a lifestyle characterized by high level of sedentary behaviour, with only 18% of fifth graders in Ho Chi Minh City meeting the physical activity guidelines.⁶

4.6. Hypertension:

Hypertension, itself a chronic disease, is also a risk factor for other NCDs, such as stroke, heart failure and chronic kidney disease. The prevalence of hypertension in Vietnam, according to the most recent STEPS survey, was 18.9% (23.1% among men and 14.9% among women). Hypertension was more common among older participants. Specifically, the oldest age group had the highest prevalence. In participants aged 50–69, nearly half the men, and about one-third of the women, had hypertension. The prevalence of hypertension was also higher among people with lower educational attainment, people having unstable jobs, Kinh participants, the wealthiest men, and women belonging to the 2nd and 3rd wealth index quintiles. There was a ‘significant and large increase’ in the prevalence of hypertension (from 15.3% in 2010 to 20.3% in 2015) among population aged 25-64.⁶

4.7 Air pollution:

Indoor air pollution from Solid Fuel Use (SFU) continues to be a problem with 70% of households using SFU, which causes 23,800 deaths per year. Outdoor air pollution also continues to be at unsafe levels, with annual average fine particulate matter (PM2.5) concentrations at 66 ug/m³, far higher than the WHO guideline of 10 µg/m³.⁷

5. Vietnam health system and financing context:

Like many low- and average-income countries in the world, Vietnam has a mixed health system. The health care administration in Viet Nam is organized at three-levels. The tertiary level is the Ministry of Health (MoH) – the main national authority in the health sector – which formulates and executes health policy and programs in the country. At provincial level are 63 provincial health bureaus which follow MoH policies but are in fact organic parts of the provincial local governments under the Provincial People’s Committees (PPCs). The primary level – or basic health network – includes district health centers, commune health stations, and village health workers. By 2013, there were more than 11,000 communal health stations and 1,040 hospitals. 93% percent of all the health service providers are decentralized to local levels.

The health financing system in Vietnam is a mixed system with multiple financing sources from the state budget, health insurance premiums, households’ out-of-pocket payments, aid and other sources. Out-of-pocket payments continue to account for a significant proportion (49%) of health spending. Around 43% of health expenditure in Vietnam comes from public resources (including 27% from the state budget and 16% social insurance premiums).⁸

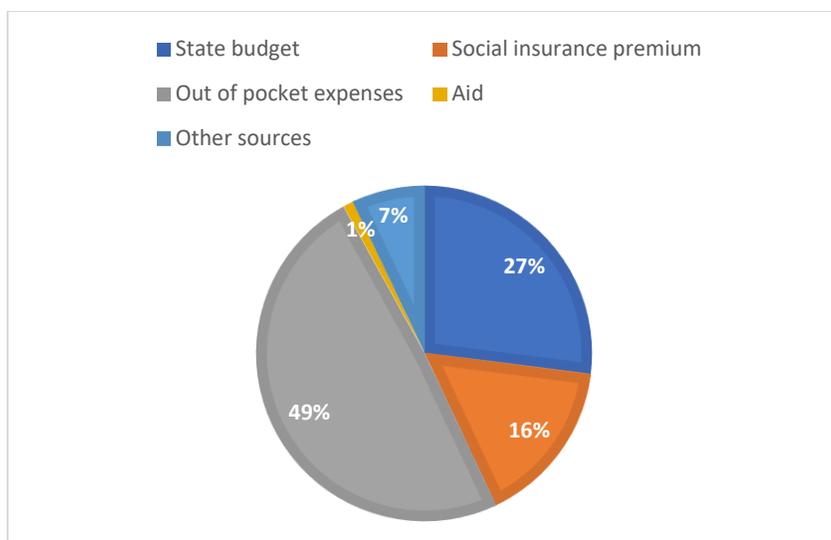


Figure 3 Sources of health financing in Vietnam. (IHME 2017)

Vietnam's total health expenditure has risen rapidly in recent years. Even after accounting for inflation and population growth, health spending in Vietnam has more than doubled between 2000 and 2016. Based on the latest available data (2016), Vietnam's healthcare expenditure was estimated at US\$16.1 billion in 2017, which represented 7.5 percent of the country's GDP, while total health expenditure per capita was US\$129 or VND 2.8 million.⁹ As a share of national income, Vietnam's level of health spending was slightly higher than average: in 2016, total health spending was 5.9 percent of GDP—just a touch higher than the 5.7 percent average for LMICs. Business Monitor International forecasts that healthcare spending will grow to \$22.7 billion in 2021, recording a compound annual growth rate (CAGR) of approximately 12.5% from 2017 to 2021.¹⁰

Public spending on health – including government spending, social health insurance contributions and government-managed external financing - has also increased significantly since 2000, though with a noticeable decline in 2014. From 2000 to 2016, public spending on health increased from VND 7.8 trillion to VND 125.6 trillion.⁹ In per capita inflation-adjusted terms, the increase has been threefold.

How much is spent on health -- now, and in the future -- and from which sources?

- Prepaid private spending
- Out-of-pocket spending
- Government health spending
- Development assistance for health

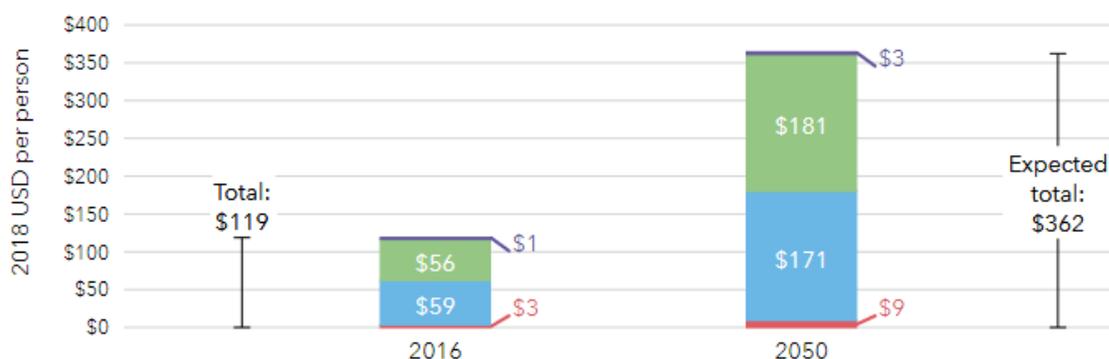


Figure 4 Current and future (projected) sources of health expenditure in Vietnam (Source: IHME 2017)

The increase in public spending on health has come from two main sources: direct government spending and social health insurance (SHI) expenditure. While per capita spending on health in Vietnam grew at a rate of 9% per year between 2000 and 2016, government spending on health (referred to in Vietnam as state budget spending on health) grew at an average of 10.4% per year. In real terms, total state budget spending on health increased from VND 25 trillion in 2006 to over VND 60 trillion in 2016 (see Figure 5).

The increase in per capita public spending on health was also bolstered by a notable increase in SHI expenditure. The government has tried to move toward a social health insurance (SHI) model since 1992 in part to curtail the growth of out of pocket (OOP) expenditure on health by increasing coverage among the poor. SHI has increased annually between 2000 and 2017 at an average of 9% (see Figure 6) and over 87% of the population had signed up for health insurance plans by 2017. While OOP expenditure continues to account for a large percentage of health expenses, Vietnam's expansion of social health insurance (SHI) has helped shield a significant part of the population from catastrophic health expenditures.¹¹

Despite policy intentions to reduce OOP spending by households, this source of financing continues to comprise the largest share of spending in the health system. The OOP share has remained persistently high at just under 40 percent since 2000; between 2011 and 2016, it increased further from 38 percent to 45 percent (WHO 2018a).¹¹ However, it appears that OOP spending on health is not concentrated among the poor, who spend about the same share of total household expenditure on health as other quintiles – about 6%, which attests to the government's success at increasing financial protection for the poor.¹

¹ Typically, an OOP share of total health expenditure of 15 to 20% is associated with lower incidence of financial catastrophe

Figure 5 Government budgetary spending on health (2006-2016). Source: WHO (2018a)

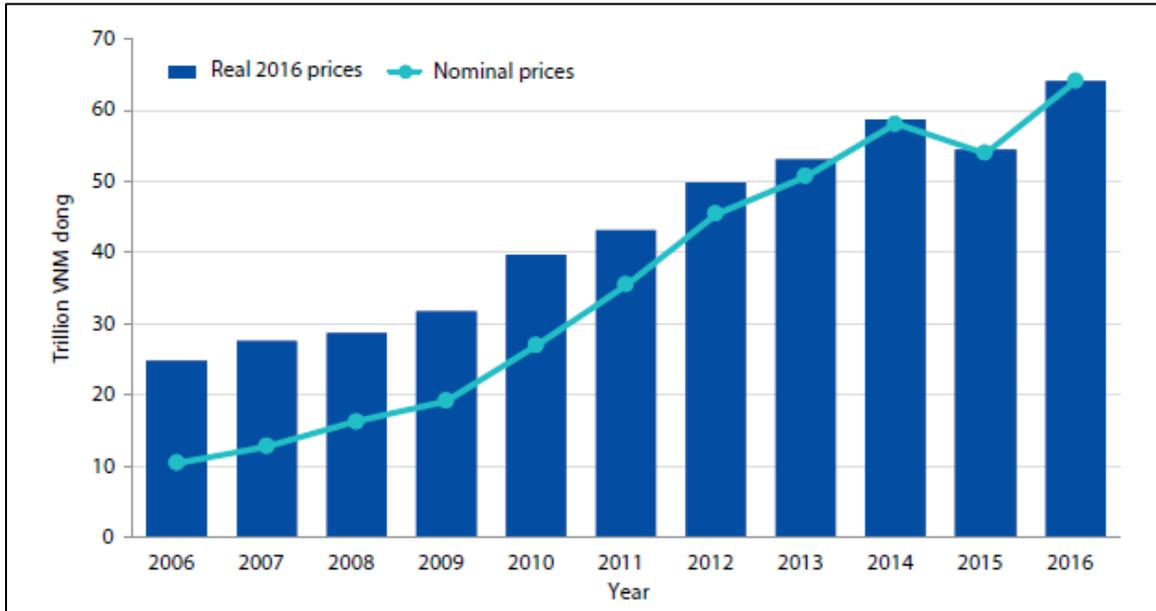
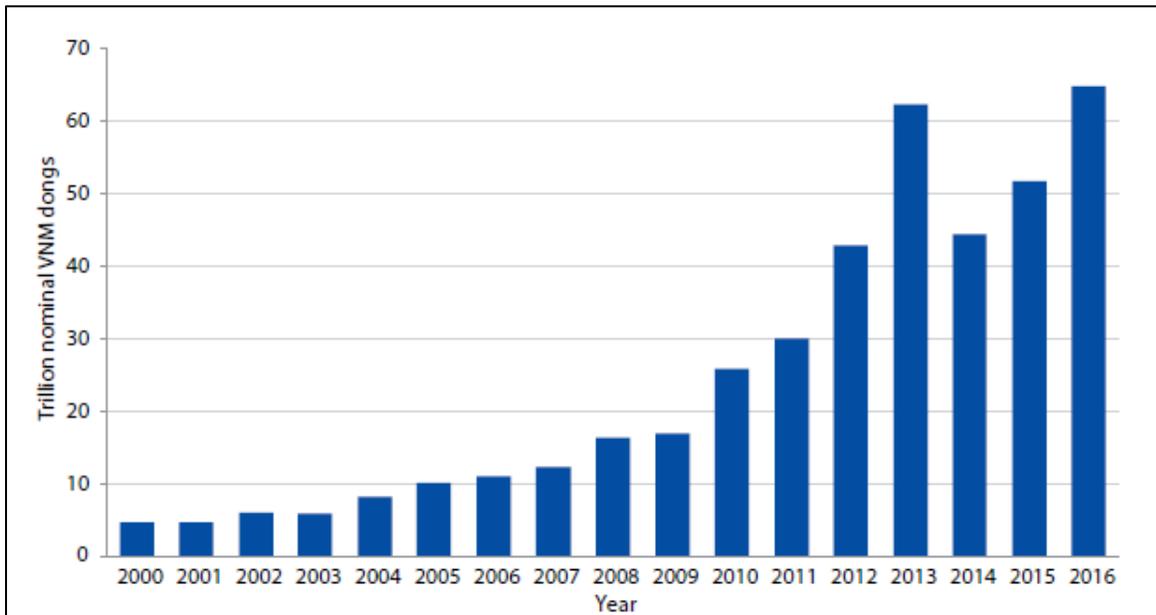


Figure 6 Social Health Insurance (SHI) Spending (2000-2016). Source: WHO (2018a)



These improvements in financial protection also point toward the good outcomes that have resulted from higher government spending on health and higher SHI coverage. Increases in public health spending have in part been due to an increase in population coverage and thereby higher service utilization, which implies people are accessing the care they need. However, this is also a consequence of Vietnam’s aging population and rise in the NCD burden, which is likely to contribute to rising expenditure.

Further, there is an imbalance of expenditure on health between prevention and treatment, as well as primary health care and specialist care. The bulk of expenditure on health – over 72% and rising - is

focused on treatment. There is also a mismatch of allocated and utilized resources, with many patients skipping the primary-to-tertiary spectrum of care and utilizing hospitals directly.

Other than screening tests for early diagnosis of some cancers, **most NCD preventive services – like tobacco cessation programs, counselling, nutrition examinations and screening - are not covered by the health insurance fund.**¹² The government's new Health Financing Strategy 2016-25 plans to expand coverage of the health insurance fund to include 'preventive services (including counselling) for individuals suffering from NCDs and chronic diseases.'

6. NCD Prevention in government policies and plans:

Vietnam has enacted several policies relating to the prevention and control of NCDs. The country was the first in Southeast Asia to establish a National Program on NCD Prevention and Control in 2002, including for cardiovascular disease, diabetes, cancer and mental health disorders. From this national program, the Ministry of Health created 4 National Target Programs (NTP) for specific NCDs. In addition, the government has enacted policies on healthy diets, nutrition (2012) and physical activity (various guidelines and regulations issued from 1989 to 2013), a law on Tobacco Control (issued in 2012), policies on control and minimization of the harmful use of alcohol (in 2014), and an Environment Law (in 2014).

Based on the Vietnam Annual Health Review 2014, these NCD programs have achieved some results such as successfully establishing a network of care from central to commune levels, training for health staff, development and strengthening for screening, diagnosis and management of treatment of diseases at different levels, and implementation of health information, education and communication (IEC) activities.¹³ However, multiple obstacles remain in the way of a well-coordinated, multi-sectoral and managed NCD prevention program.

6.1. National Target Programs:

Until 2015, the government's spending on NCDs was channelled through the National Target Programs (NTPs) for the prevention and control of NCDs. Initially for communicable diseases, the NTPs were later expanded to encompass NCDs, encompassing cardiovascular disease, hypertension, cancers, diabetes mellitus since 2006, and COPD/asthma since 2011. CHCs have traditionally been the institution responsible for implementing these NTPs in the community through funding from the central government.

In the period from 2011 to 2014, through projects under NTPs, 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; about 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 2012-2020.¹³

An independent review of the 4 NTPs in 2011 concluded that despite the political will for NCD prevention and control, the NTPs resulted in limited population health gains. The review identified 2 major limitations: one, that they were implemented as individual disease programs focused on treatment rather than prevention, and two, that the NTPs were centrally funded without incorporation into social health insurance or local financing, leading to long-term unsustainability.¹²

6.2. National strategy for the prevention and control of NCDs, 2015-2025:

The Vietnamese government promulgated a new NCD strategy in March 2015, with the objective of preventing and controlling cardiovascular diseases, diabetes, cancer, chronic obstructive pulmonary disease (COPD) and asthma, with action plans for each of these diseases. The strategy aims to contribute to protection, care and health quality, and reduce the premature death rate due to NCDs by 20% in 2025 compared to 2015.¹⁴

The targets of the NCD strategy include awareness of 70% of the adult population about NCDs, their impact on public health and socioeconomic development and prevention methods. The strategy also aims to reduce tobacco use by 30%, harmful alcohol use by 10% among adults, reduce the proportion of adults with hypertension to less than 30% and bring the diabetes rate to below 8% among people aged 30-69 by 2025.

In order to realize the targets for the prevention and control of NCDs, the strategy aims to strengthen the enforcement of legal frameworks and policies to control risk factors while encouraging healthier choices. It aims to undertake publicity campaigns to raise individual and population awareness and understanding of NCDs, enhance preventive services to control risk determinants and enable detection and emphasizes the need to improve skills and expertise in treating the diseases while expanding NCD-related healthcare services at businesses and schools.

6.3. Health and Population Program 2016-2020:

As part of the government's rationalization of the Target Programs, all priority health programs have been merged under a single Target program in 2016, the Target Program for Health and Population 2016-2020. This Program is aligned with the NCD strategy and employs the same target indicators extracted from the NCD strategy. The total budget for the whole program was projected at VND 20 trillion (approximately US\$ 1 billion), pending fiscal availability to be determined by the Ministry of Finance, with no specific budget allocation for individual sub-programs. The state budget share for the program was envisioned at 49%, while local government funds and lotteries were expected to contribute 25% and Overseas Development Assistance (ODA) was expected to contribute another 25%.² NCD indicators under the Health and Population Program include early recognition of at least 20% of prevalence of oral, breast, cervical and mega rectal cancer; 50% of people with hypertension to be detected, including 30% to receive management and care; 40% of people with diabetes to be detected, including 40% to receive management and care; 35% of people with chronic obstructive pulmonary diseases and bronchial asthma to receive early recognition and care by 2020.

6.4. Smoking Prevention and the Tobacco Control Fund:

In 2012, Vietnam adopted its first ever comprehensive tobacco control legislation in the country, the law on **Prevention and Control of Tobacco Harms** establishing smoke-free places, increases the size of graphic health warning labels, restricting tobacco advertising, promotion and sponsorship, and establishing a tobacco control fund. The key provisions in the included: designating health and educational settings, childcare and entertainment areas for children, indoor workplaces, areas at high risk of fire, restaurants, and public transport as smoke-free; introducing graphic health warning labels on cigarette packaging; banning advertising, promotion and sponsorship of tobacco products (with some exemptions for sponsorship); banning tobacco sales within 100 meters of childcare facilities, schools and health facilities; and banning sales of tobacco products to minors.¹⁵ However, Vietnam's current levels of tobacco taxation (40% of retail price) remain far below WHO recommended levels (of 70% of retail price).

Further, the legislation established a dedicated **Tobacco Control Fund** to provide financial resources for the prevention and control of tobacco use through smoking cessation programs, research projects, and educational and communication programs. The Tobacco Control Fund received compulsory contributions of 1% of the taxable price of all cigarette packs produced locally or imported for local consumption. This rate was increased to 1.5% from May 1, 2016, and to 2% from May 1, 2019. The fund is resourced through the state budget expenditure on health as well as contributions of enterprises producing or importing tobacco. **Annually, about 400-500 billion VND (US \$21.5 million) are contributed to the Fund** and used for smoking prevention and tobacco control activities, education and communication programs, and research and policy development.¹³

In 2013, Vietnam launched the National Strategy on Tobacco Control 2013-2020, which set specific targets for the reduction in the prevalence of smoking in the following groups: youth (ages 15–24 years), from 26% in 2011 to 18% in 2020; men: from 47.4% in 2011 to 39% in 2020; and women to less than 1.4% in 2020.¹⁶

6.5. Alcohol harm prevention legislation:

Low taxes and weak law enforcement and compliance have contributed to Vietnam's rapidly rising levels of alcohol consumption. It was only recently, in January 2020, that Vietnam enacted its first comprehensive legislation on alcohol harm prevention and control. The new law ensures stronger restrictions on alcohol marketing and sets limitations on the physical availability of retailed alcohol products, among others. The following 3 best-buys for preventing alcohol-related harms recommended by WHO were included in the new law: bans or comprehensive restrictions on exposure to alcohol advertising; restrictions on the availability of retailed alcohol; and a proposed excise tax on alcoholic beverages.¹⁷

The law bans advertising of alcohol products from 6:00 to 9:00 p.m. every day and mandates advertisements to carry warnings on alcohol-related harms. In addition, there will be a ban on marketing strategies that involve giveaways, images, logos, music, film talents, and other product brands targeting people under 18. In terms of limiting alcohol availability, the law prohibits establishing new on-site alcohol consumption businesses within 100 meters from health care facilities and schools. Selling alcohol to minors has also been banned.¹⁷

However, increased taxation of alcoholic beverages remains a difficult objective to achieve. The 2020 law stopped short of proposals to raise alcohol prices through taxation and the National Assembly postponed the discussion to a future consideration of taxation reform. The economic importance of Vietnam's alcohol industry (which produced 4 billion litres of Beer and contributed than VND \$43 trillion - US\$1.85 - in taxes in 2018) and widespread alcohol consumption hinders policymakers from raising excise or consumption taxes. Currently, Vietnam imposes excise taxes of 65% on beer and 35-65% on various types of alcohol. This is only 30% of the retail price on average, compared to 40% to 85% in other countries.¹⁸

6.6. Nutrition and healthy diet policies 2012-2020:

Vietnam's key food and nutrition policies were the National Nutrition Strategies (1996-2000, 2001-2010 and 2011-2020), food-based dietary guidelines and Plan of Action for Infant and Young Child Feeding. Vietnam introduced a new National Nutrition Strategy 2012-2020. While it remained focused largely on malnutrition, one of its six objectives was to 'effectively control overweight and obesity and risk factors of nutrition related noncommunicable chronic disease in adults'. The strategy aimed to control the

prevalence of overweight and obesity in adults to a rate of less than 12% by 2020, and the proportion of adults with elevated serum cholesterol (over 5.2 mmol/L) to less than 28% in 2015 and will remain relatively controlled with less than 30% prevalence in 2020. The strategy also aims to achieve a 30% reduction in salt consumption.¹⁹

Vietnam also initiated a National Action Plan on Nutrition in 2018, which included actions to implement a mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables and implement nutrition education and counselling in different settings (e.g. in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables. Vietnam's NCD strategy also includes the goal of reducing (though not banning) trans fatty acids and signals its intention to tax sugar-sweetened beverages (SSBs) though no steps have been taken in this respect other than a Ministry of Finance proposal to increase excise tax on SSBs.²⁰

The National Institute of Nutrition issued food-based dietary guidelines (10 tips on proper nutrition for period 2013–2020) in 2013, which were endorsed by the Ministries of Health, Education and Agriculture. Eat a range of meals that include all four food groups: carbohydrates, protein, fats, and vitamins and minerals. The messages included eating protein-rich foods from a balance of vegetable and animal sources, daily intake of vegetables and fruits, reducing salt intake (and using iodized salt), increasing physical activity, limiting consumption of alcohol and soft drinks, abstaining from smoking and maintaining an appropriate weight.²¹

Despite this progress, several diet-related policies in Vietnam continue to run counter to the needs of NCD prevention and control. A number of trade and import policies are aimed at protecting the domestic sugar industry with support to cane growers and sugar mill factories and the local food processing industry in its production 'of candy, cake, instant noodle'.²²

7. Preventive healthcare spending:

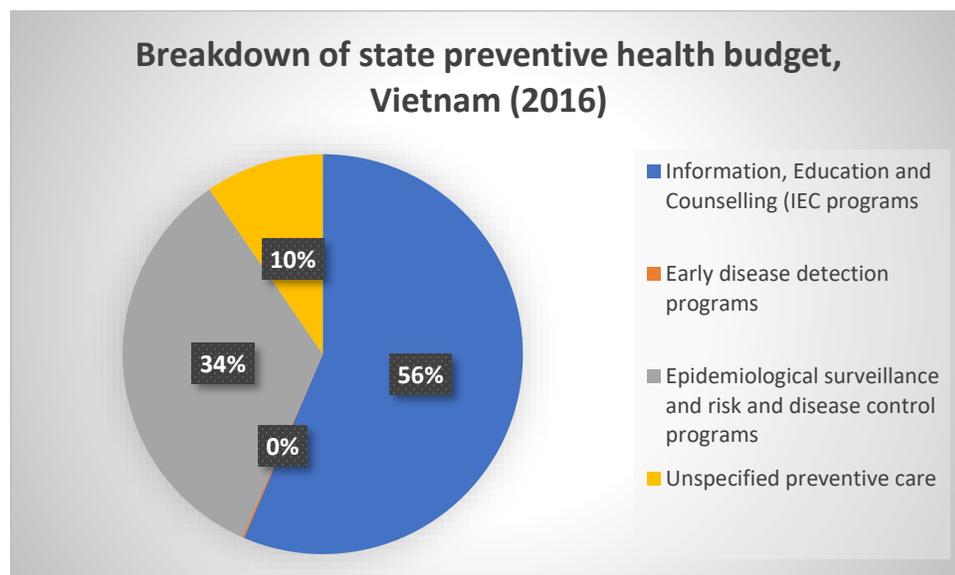
Separating out preventive spending in health is difficult as healthcare is usually delivered as an integrated service package, which may or may not be delivered on an organized programmatic basis. Thus, it may not be possible to separate each of the components of the system distinctly into NCD prevention or curative expenditure when they are not part of a program with specific expenditure records. The Vietnamese Health Accounts specify spending on preventive care based on a distinction between individual or collective consumption of healthcare.

According to the latest available National Health Accounts for Vietnam (2016), 68.35% of total expenditure on health in the country is for curative care activities, while preventive health accounts for only 7.13%. In 2015, this amounted to about 14,044,131 million VND (US\$606 million). The state budget itself contributes about 60% of total spending on preventive health (about VND 8.67 trillion), which amounts to less than 1% of total state health budget expenditure per annum of around VND 55 trillion. If only population level prevention expenditure is counted (IEC programs), this amounts to less than 0.5% of the total state health budget. Non-profit institutes serving households (NPISH) and donors contribute an estimated 38% to total preventive health spending.

Table 1 Vietnam preventive health spending (Calculated from Vietnam Health Accounts and Health Financing Strategy of Vietnam 2016-2025)

Spending area	Government (VND million)	NPISH (VND million)	Donors (VND million)	Households (VND million)	Total (VND million)
Information, Education and Counselling (IEC programs)	6,428,101	1,031,867	466,788		7,926,756
Early disease detection programs	8,193		14,235		22,428
Epidemiological surveillance and risk and disease control programs	1,095,749	2,407,690	1,217,439	27,818	4,748,696
Unspecified preventive care	1,147,912		198,339		1,346,251
A. Total state preventive health expenditure (VND million)	8,679,955	3,439,557	1,896,801	27,818	14,044,131
B. Tobacco Control Fund	500,000				500,000
Total dedicated spending on prevention (A+B)	9,179,955				14,544,131

Information education and counselling (IEC) programs account for about 56% of total preventive health expenditure and about 74% of the government's preventive health expenditure. Epidemiological surveillance and disease and risk factor control programs account for 34% of total preventive health expenditure.



8. Discussion:

As it has entered its epidemiological transition, Vietnam has made considerable progress in moving the focus of its health system toward NCDs, reflected in the gradually falling risk of premature death from NCDs (Figure 7). However, consumption and lifestyle changes due to rapid economic growth and urbanization have meant that many NCD risk factors continue to persist and worsen, leading to increased pressure on its health system in the coming years. Over the next few years, Vietnam needs to build on its progress and refine its health system to prioritize NCDs prevention, particularly through addressing risk factors.

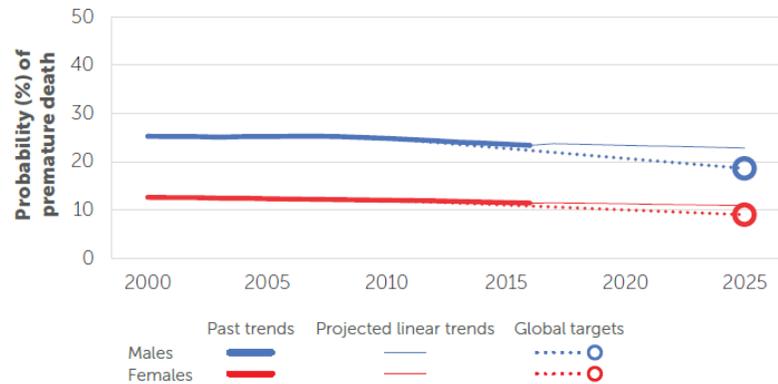


Figure 7 Risk of premature death due to NCDs in Vietnam (%) (WHO- NCD Country Profiles, 2018: Vietnam)

The priority interventions for Vietnam should be to reduce tobacco use, harmful use of alcohol and salt intake of the population, in order to prevent NCDs. This can be done by re-orienting NCD programs and enabling prevention at primary care levels, enabling stewardship and institutional coordination, generating resources for NCD prevention through taxing unhealthy consumption, reducing alcohol and tobacco use, and incentivizing a healthy diet and physical activity. Effectively implementing these measures requires political will from the top and a sustained whole-of-government and whole-of-society response, including support from political, social, professional and mass organizations in Vietnam.

8.1. Re-organizing NCD Target Programs

While Vietnam has had Target Programs the major NCDs in place for years, their fragmentation and lack of prioritization has limited health gains on NCDs, as per independent reviews. Among the key institutional reasons for this has been that the five target programs for the prevention and control of NCDs have been disease-specific and hence have been separately designed, managed and implemented by different organizations. According to health officials interviewed, *“this made them difficult to coordinate, integrate, and collaboratively implement”*

Among the key challenges is that of health information, considered crucial for health planning at the national level. However, information collected under the Target Programs was limited, fragmented and inadequate, since national target programs rarely collected data and even so, only sporadically and on a small scale. Furthermore, separate vertical disease programs led to a lack of integrated national guidelines on screening for early detection of NCDs and population-based monitoring of NCDs, making it difficult to monitor NCD status and progress of programs. According to national health staff, NCD reports were done

only through the national target programs, rather than the broader health information system, making NCD-related statistics and data limited, fragmented and inadequate.¹²

As multiple other countries have done successfully to organize their NCD response, Vietnam must **move from a focus on diseases to a focus on risk factors and organize its programs accordingly**. While steps have been taken toward this with the new Health and Population Target program, a focus on risk factors, their consequences, their inter-relatedness and mitigation needs to be reflected in guidelines, staff training, communication and education materials, resources, and reporting and monitoring. Further, Vietnam should develop national guidelines on screening for the early detection of NCDs and include screening cost into health insurance packages or subsidize the fees for those without the insurance to ensure detection of NCDs at earlier stages.

8.2. Enabling stewardship and multi-sectoral institutions:

In terms of multi-sectoral coordination, Vietnam already has committees on tobacco and alcohol control, and management board of the Tobacco Control Fund chaired by the Minister of Health and Vice Minister of Finance. However, strong stewardship and a long-term comprehensive, integrated approach for NCD prevention and control at the national level remains lacking. Officials interviewed also bemoaned the lack of strong public health champions among the political leadership, something that was critical to support NCD policies that had many powerful opponents.

There is a need to convert existing committees on tobacco and alcohol control into **one multi-sectoral and inter-ministerial Committee on NCD prevention and Control**, which encompasses all NCDs and targets all risk factors. According to Vietnamese health officials, *“it is important that the committee be chaired by a senior member of government in order to provide the strongest possible leadership for the multi-sectoral action that is required to combat NCDs.”*

This should be accompanied by the formation of a broader **multi-stakeholder NCD forum** to strengthen coordination and action across government and its partners, possibly by expanding the tobacco control working group. The forum should include NGOs, political, social, professional and mass organizations and academia. A key activity of this forum should be to convene regular national meetings between NGOs, academia and professional societies in order to encourage action from these groups in support of Vietnam’s NCD response.²

8.3. Re-orienting primary care for NCD detection and prevention:

Among the key shortcomings of Vietnam’s current NCD response is the widespread absence of NCD care and prevention services at the point of primary healthcare. A study of NCD service availability in Commune Health Centres (CHCs) in Vietnam found very limited prevention related activities were being carried out, other than for mental health. The study found that less than 25% of CHCs conducted NCD prevention programs focused on alcohol use, tobacco use, inactivity and healthy diets (mostly conducted in the form of mass communication of health information through loudspeaker broadcasts). The study also found that CHCs in the mountainous region conducted prevention activities less often than those in the other low-lying regions, even though the mountainous region has a greater percentage of smokers and people reporting drinking 1-4 days/week, putting them at greater risk for developing NCDs.²³

There is also a disconnection between CHCs and insurance payments. Social Health Insurance (which now covers over 80% of the Vietnam population) does not cover most NCD preventive services like tobacco cessation counselling or screening for early detection. According to officials interviewed, *“there is a*

budget ceiling on the percentage of health insurance fund that can be used at commune health level which is an obstacle for NCD management.” Those with health insurance still have to pay a large portion of the costs from their own pockets for NCD prevention, diagnosis and treatment. Staff capacity and training has also been identified as an obstacle; health staff at CHCs have also been found to not be aware of the national strategy for NCDs and face a lack of materials for NCD detection, management and planning.²⁴

The evidence suggests that an integrated primary care strategy to address NCDs that recognizes the epidemiological transition towards NCDs is critical to address the disease burden in a cost-effective way. There is an urgent need to **re-orient the primary health care delivery system** from the current focus on communicable diseases to one that prioritizes **health promotion and long-term continuum of care** for patients with NCDs and chronic diseases. Additionally, CHCs may require a fundamental re-design of their workflow, enabling them to move away from sites that implement vertical NTPs into clinics that horizontally integrate programs for preventing, diagnosing, and managing diseases to promote the health of the population they serve.²³ Importantly, the aim of primary care should be keeping people healthy via prevention and keeping them out of hospitals. To achieve this requires a shift in investment, budgetary and insurance allocations towards health promotion and preventive care.

8.4. Addressing abuse of tobacco and alcohol:

Abuse of tobacco and alcohol are among the key drivers of NCDs in Vietnam and among the areas in which the government has been unable to make substantive progress, with high consumption rates for both either unchanged (in the case of tobacco – Figure 8) or rising (in the case of alcoholic beverages – Figure 9).

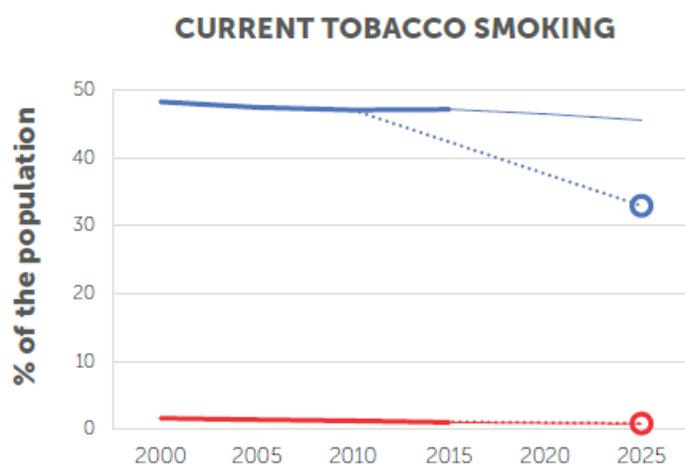


Figure 8 Tobacco smoking in Vietnam over time (WHO- NCD Country Profiles, 2018: Vietnam)

Alcohol per capita (15+) consumption (in litres of pure alcohol)

	2010*		2016*	
Recorded	2.2		3.1	
Unrecorded	2.5		5.3	
Total**	4.7		8.3	
Total males / females	8.2	1.3	14.5	2.5
WHO Western Pacific Region	7.0		7.3	

* Three-year averages of recorded and unrecorded for 2009–2011 and 2015–2017; **adjusted for tourist consumption.

Figure 9 Alcohol consumption in Vietnam (2010-2016) (WHO 2018, Global Alcohol Report: Vietnam)

Part of the reason for this is under-taxation. Vietnam has one of the lowest rates of tobacco taxation in the world and tobacco taxation policy over the last two decades has served to make cigarettes more affordable. While the revenue from tobacco taxes increased in 2008-2016, in real (inflation-adjusted) terms the revenue growth was smaller than the increase in cigarette sales.¹⁶ The Law on Prevention and Control of Tobacco Harms adopted in Vietnam in 2012 strengthened tobacco control policies in Vietnam, discouraged cigarette consumption, and some reduction of took place. However, smoke-free policies, health warnings and other curbs on smoking were not accompanied by effective taxation policies and tobacco consumption began to grow again in 2016-17.

Similarly, the prices of beer and alcohol remain considerably cheap to the low tax levels, which are far lower than those applied in countries like Thailand, New Zealand or Australia (up to 85% of retail price). This has resulted in average consumption of beer and liquor at 8.3 litres, far higher than the global average of 6.5 litres and the highest increase in per capita alcohol consumption in 2019. WHO has recommended that the Vietnamese government reduce the affordability of alcoholic beverages by raising special consumption tax. Other recommendations include a year-on-year increase in excise tax on all alcoholic beverages. Further, the licensing system on retail sales needs to be strengthened to implement the ban on underage sales and advertising and marketing regulations for alcohol, particularly to stop targeting to young and vulnerable groups, needs to be tightened.

In order to make substantive progress on NCD prevention, Vietnam needs to **increase taxes on both tobacco products and alcoholic beverages** to raise their prices and reduce consumption. The revenues from these taxes can also be used for financing health promotion (see following section).

8.5. Earmarking taxes on unhealthy products for health promotion:

Many countries have imposed taxes on products deemed to be bad for health and have earmarked these tax revenues to the health sector. Targeting products that are bad for health allows the policy to be introduced and the tax to be raised primarily as a public health initiative to curb consumption, and secondarily as a revenue collection measure. Earmarking taxes on cigarettes, alcohol, and more recently, sugar, has been used by many countries as a way of raising revenues for the health sector, from Jamaica to the Philippines. In many of these countries, the revenue has both facilitated increased revenue and improved health coverage and services.

Currently, Vietnam collects and earmarks taxes as part of its tobacco control effort, but the amount and scope of use of the Tobacco Control Fund are limited. The fund is collected through a surcharge – currently at 2% - on tobacco manufacturers and importers. While there are no published government data on the amount of tax revenue collected in the Fund, estimate put the figure at between VND 300-500 billion per year —less than 0.01 percent of GDP. Given Vietnam’s deeply inadequate spending on NCD prevention, there is a **need for increasing the quantum and scope of funds raised and allocated for the Tobacco Control Fund.**

The UNIATF programming mission to Vietnam has proposed the formation of a **Health Promotion Fund** through expansion of the Tobacco Control Fund. This could be resourced from other health-harming products such as alcohol and sugar-sweetened beverages (SSBs) in addition to the surcharge that has been funding the Tobacco Control Fund. Funds could also be generated by a year-on-year increase in tax on tobacco products to bring it to the WHO-recommended level of 70% of final retail price. As in other contexts, the Health Promotion Fund could be earmarked to finance a broad range of NCD prevention and health promotion projects.

8.6. Increasing fiscal space for health through SHI premiums:

There is also some scope to increase fiscal space for spending on healthcare (and thus free up fiscal space for spending on NCD prevention) through social health insurance premiums. One way to do so is increasing the number of contributing members in the SHI scheme and the average contribution rate therein. The health insurance fund could mobilize additional funds by providing coverage to the remaining 13 percent of the population that is not yet covered. Another option is to increase the maximum allowable premium rate: while the current SHI law allows for contribution rates up to 6% of salary (for formal sector workers), the current collection rate is 4.5 percent. There are some proposals to increase that maximum allowable rate to 8%. However, there is little political appetite to do so as government officials say higher premiums would affect business sentiment and create a disincentive for investment, thereby adversely affecting economic growth.²⁵ This may be a more feasible option for increasing spending on health and NCDs in the long-term.

8.7. Integrating NCD risk communication:

Vietnam has made considerable progress in improving population awareness of major NCDs – however, there is still insufficient awareness about how to mitigate the risks. In surveys, most people continue to consider medication as the primary response to prevent NCDs. While most people link smoking to respiratory diseases and lung cancer and alcohol with liver cancer, few people remain aware that smoking and alcohol consumption also result in cardiovascular disease and hypertension.²⁶

Part of the reason for this has to do with the coherence of the communication response. A recent research study observed that the Ministry of Health has not rolled out any comprehensive risk communication program for NCDs as per the National Strategy on Prevention of NCDs. At the district and commune levels, many officials have noted that while there have been instructions for implementing communication programs on NCDs in recent years, few activities have been carried out due to the lack of budget and time.²⁶

Persistent problems remain in Vietnam’s NCD risk communication interventions. Most of the communication programs still emphasize intervention, screening and management of patients while there is still no comprehensive communication program on disease prevention or promoting positive

behaviours such as changing diets, physical exercise, and avoiding risk behaviours like smoking or alcohol. The few communication programs on risk elements of NCDs that exist - such as those on smoking, alcohol abuse, hypertension and nutrition - are conducted unsystematically without any connection or coordination among them or other related sectors. There is also little application of behavioural change models, with most communication efforts mainly following the health communication and education approach. There is also an absence of monitoring and evaluation of NCD risk communication.

For prevention programs to be effective in the long-term, community interventions should focus on a comprehensive approach to improve understanding of and behavioural change for all risk factors. This could be done in the form of a **systematic campaign for national health promotion**. The UNIATF Joint Mission also recommends that a National Healthy Movement, which promotes a broad range of healthy activities from physical activity to improved nutrition - similar to the *Health Japan 21* movement - should be developed and implemented in Vietnam in the coming years in order to generate health promotion actions at community level in all provinces.² The Healthy Movement could also be financed from the Health Promotion Fund to be established based on the TC Fund.

8.8. Policies to enable healthy diets:

Achieving healthy diets is one of the areas in which considerable progress remains to be made. There are currently no policies for trans fatty acids and saturated fatty acids, nor policies on restrictions of marketing to children. While salt target levels have been set for foods and targets of 30% reduction in salt intake established, no strict regulations or laws have been enacted or enforced to ensure compliance and reformulation of food products to decrease salt. There have been some national communication activities on appropriate nutrition and healthy diet but more frequent campaigns are needed. Further, no subsidies or policies to encourage healthy vegetable and fruit production and consumption have been formulated.

The government needs to enact regulations to **minimize the consumption of salt, foods with trans fats, and SSBs** on a priority basis. In the case of salt, this needs to be carried out under the SHAKE Technical Package for Salt Reduction involving surveillance, reformulation, nutrition labelling and non-misleading marketing, public education and promotion of healthy levels of consumption in school, work and restaurant settings.

Importantly, policymakers need to reconsider its promotion of unhealthy sugar consumption through support to the domestic sugar industry and its products and **enact an excise tax on SSBs** as envisioned in the National NCD strategy and as proposed by the Ministry of Finance in 2017. Strong opposition from the industry, food manufacturers and other ministries and lawmakers is a major reason why this has not taken place yet.²⁰ According to officials interviewed, “a reason for the delay in the SSB tax was also a lack of human resource capacity at the Ministry of Health as, when asked by the Ministry of Finance, it could not provide a strong evidence base (in terms of impact on health, employment and the economy) for the enactment of such a tax.” Officials said the capacity to generate evidence is now improving and would be deployed for stronger measures in the coming years.

Further, the government also needs to encourage investment in healthier food formulations through **research partnerships among public, private and academic groups on new food and drink products** that provide consumers the option of accessing healthier foods with lower levels of salt, sugar and trans-fat. In the long-term, subsidizing healthier consumption – including vegetables and fruits – needs to be placed on the table as well.

9. Conclusion

Vietnam's progress in improving standards of living, life expectancy and health coverage of its population, including the poor has been substantive and impressive compared to countries with similar or even higher levels of economic development. This progress has been driven by the country's commitment to social development, universal healthcare and success in prevention and treatment of communicable diseases. However, as described earlier, this period has also seen rapid lifestyle changes toward an unhealthier pattern that are resulting in a rising NCD disease burden. The challenge for Vietnam is now to ensure its gains in life expectancy, morbidity and disability can be sustained – this can be done by avoiding the worsening of the lifestyle habits that are the major risk factors for NCDs.

Vietnam has taken substantive policy steps in recent years to reflect its changing disease burden and put in place strategies to address NCDs. These have included National Target Programs, smoking prevention measures, alcohol harm prevention, and nutrition and diet policies and guidelines. A new 5 year NCD prevention and control strategy (2016-2020) is now nearing completion. However, much remains to be done to address the growing NCD epidemic in the country and move from curative care to NCD prevention.

Vietnam has thus far largely followed a disease-specific approach to NCDs, with separate programs for CVD, hypertension, cancers and diabetes, among others. The bulk of the focus of these programs has remained on treatment and they have been insufficiently coordinated and integrated, which has limited their effectiveness. Vertical separation has meant separate information management systems, which has made it difficult to adequately monitor and respond to the NCD burden and its underlying risk factors. Communication efforts have also been fragmented as a result and have been conducted in separation from each other, ignoring the underlying commonalities of risks and the integrated response required. As Vietnam calibrates its NCD efforts, it needs to move from vertical and fragmented disease-specific efforts to horizontal, integrated NCD prevention with a focus on risk factors.

Primary healthcare needs to be the focal point of this re-orientation of the health system. Vietnam needs to continue the transition towards NCDs by re-organizing the primary healthcare system – particularly CHCs - to focus on preventive and long-term continuum of care for those with NCDs and chronic diseases. The government has already begun to undertake pilots in this regard to strengthen NCD prevention and care, which need to be expanded and rolled out. In particular, guidelines for integrated prevention and management of NCDs need to be implemented in all primary units, resources need to be allocated and staff trained in prevention activities, and financing barriers and caps for NCD detection and care at primary health units need to be removed.

Experience from other countries shows that the establishment of NCD-specific steering institutions can provide considerable advantages in steering effective prevention inter-sectoral, all-of-government responses. Vietnam still has separate committees for risk factors like alcohol and tobacco, which need to be merged into one multi-sectoral NCD steering committee, with strong ownership from the government and multiple ministries. This needs to be accompanied by the involvement of stakeholders, including NGOs, political, social, professional and mass organizations and other organizations in an NCD forum to support the government's response.

Vietnam's rising NCD problem is driven in large part by consumption of tobacco and alcohol, which is underpinned by long-standing under-taxation. Vietnam continues to tax both tobacco products and

alcoholic beverages at far lower rates than the global average, which is impeding efforts to control their use. A substantial annual increase in taxation of both tobacco and alcoholic beverages is critical to reducing their rising consumption in the country. In the case of tobacco, this needs to include an adoption of the proposal to increase excise tax in addition to ad valorem taxes, which should be equivalent to at least VND 2000 per pack. For alcohol this can be done both in the shape of excise tax and special consumption tax to bring it close to 70% of retail price.

Vietnam's inadequate financial focus on NCD prevention (currently at less than 0.5% of its health budget, which overwhelmingly focuses on treatment) continues to be one of its principal shortcomings and needs urgent rectification. While greater allocations from within the existing state budget or an increase in insurance contributions are one way to achieve increased preventive spending, part of the solution can involve hypothecation or earmarking of taxes on alcohol and tobacco for spending on prevention, which can have the twin effect of reducing unhealthy consumption while raising much-needed revenue for health promotion.

Vietnam also needs to act on proposals in the country's National NCD and Nutrition strategies to reduce consumption of salt, sugar and trans fatty acids. This needs to be done in the form of strict regulations or laws enforced to ensure compliance and reformulation of food products. In the case of sugar, this also needs to involve an end to subsidization of the sugar industry and an excise tax on SSBs, which can also contribute to the proposed Health Promotion Fund. Broader nutrition policies and agricultural and food policy incentives (including subsidies) can be considered to increase production and consumption of vegetables and fruits.

In tandem with tax policy changes, it will be crucial for policy makers in Vietnam to collect baseline data and track trends in consumption and government revenue as taxes and duties change. That would help establish a good evidence base to assess if policies are having the desired effect in terms of consumption of unhealthy products. The establishment of objective monitoring and evaluation frameworks for NCD taxes, duties and tariffs is critical to ensure their effectiveness. Evaluations of existing interventions and their impact on prices, import volumes and consumer behaviour needs to be planned before new ones are started.

Communication gaps in the government's NCD response continue to be a concern. While public awareness of NCDs has increased, there is still insufficient awareness about the relationship of various risk factors with disease and insufficient attention on how to mitigate the risks. The lack of a comprehensive and integrated NCD risk communication campaign is among the key shortcomings of the government response. To rectify this gap, a comprehensive campaign to address inter-related risk factors, and promote healthy behaviours from physical activity, to tobacco cessation to healthy nutrition - is critical. Learning from other country experiences, this can be implemented in the form of a systematic and integrated campaign for health promotion, like a Healthy Movement along the lines of similar campaigns in Japan and Jamaica.

10. Recommendations:

1. Reorient NCD target programs from a focus on diseases to a focus on risk factors
2. Increase spending on population-level NCD prevention to at least 2% of health spending
3. Reorganize the primary health care system from current focus on communicable diseases to one that prioritizes health promotion and long-term continuum of care for chronic disease.
4. Convert existing committees on tobacco and alcohol control into one multi-sectoral and inter-ministerial Committee on NCD prevention and Control, with high-level political ownership and stewardship.
5. Increase excise tax on tobacco to FCTC-recommended 70% of retail price through graduated tax increases per year.
6. Introduce special consumption tax on alcohol in line with alcoholic content of drinks and introduce a year-on-year tax increase
7. Strengthen licensing system on retail sales to implement the ban on underage sales.
8. Enact and enforce comprehensive bans on tobacco advertising, promotion, and sponsorship.
9. Increase the quantum and scope of funds raised and earmarked for the Tobacco Control Fund and consider the establishment of a broader Health Promotion Fund through expansion of the Tobacco Control Fund.
10. Explore the judicious use of Social Health Insurance funds for NCD prevention.
11. Establish objective monitoring and evaluation frameworks for NCD taxes, duties and tariffs to decide future fiscal policies.
12. Initiate a systematic campaign for national health promotion which promotes a broad range of healthy activities from physical exercise to improved nutrition.
13. Enact regulations to minimize the consumption of salt, sugar and food with trans fats.
14. Enact excise tax on sugar-sweetened beverages.
15. Create research collaboration among public, private and academic groups on new food and drink products that provide consumers healthier eating options.

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