VIETNAM CASE STUDY

Financing of NCD Prevention in LMICs: Vietnam Case Study

Ammar Rashid, Kassim Nishtar, Saba Amjad

Abstract

Objective: To estimate spending on non-communicable diseases 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 programmes. Government and government-routed donor spending on population level prevention was gauged to estimate NCD prevention spending. Where possible, impact of prevention programmes 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 programme 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.

Keywords: Noncommunicable Diseases, Tobacco, Behavior, Employees, Incidence, Risk Factors, Diet, Communication, Tobacco Use, Health Care, Taxes

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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. Rapid urbanization has been accompanied by the deterioration of the environment, rise in 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 (now at 10% of the population) climbs, the population support ratio—the number of working age individuals per elderly individuals—is forecast to decline from 9.3 in 2015 to just 2.6 in 2050.[4] Unless action is taken now for ensuring healthy ageing, the burden of caregiving will become increasingly 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 Programmes that respond to specific non-

[1-3]Heartfile, Islamabad, Pakistan

Correspondence: Ammar Rashid. **Email:** Ammar@Heartfile.org

ORCID ID: 0009-0003-9287-2032

communicable diseases. It has enacted tobacco control taxes, policies and funds, alcohol harm reduction laws and nutrition programmes 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 programmes, 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.

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 money 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

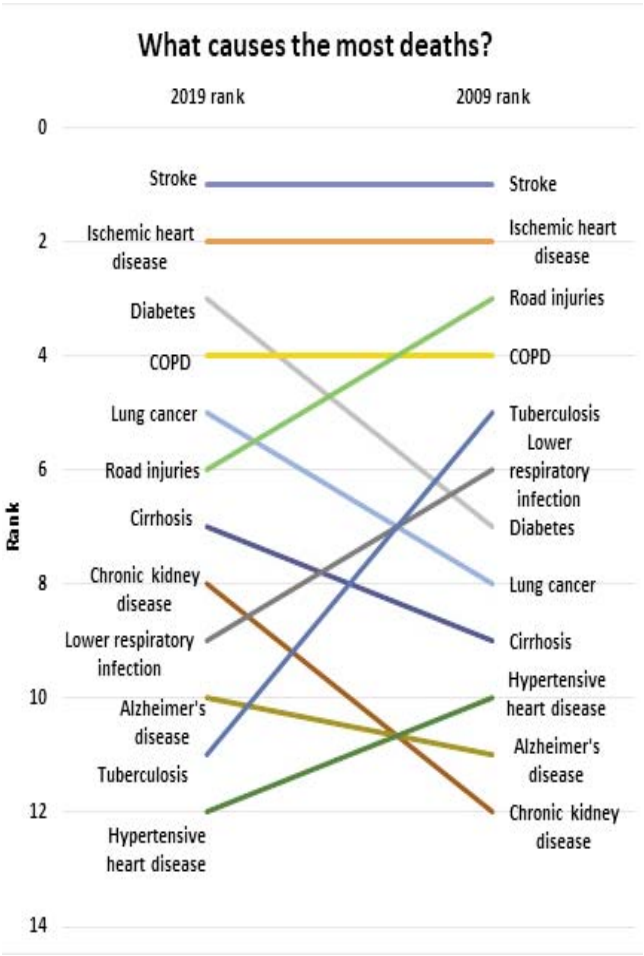


Figure-1: Top 10 causes of premature death in Vietnam and % change (2009-19). Source: Institute of Health Metrics and Evaluation (2020).

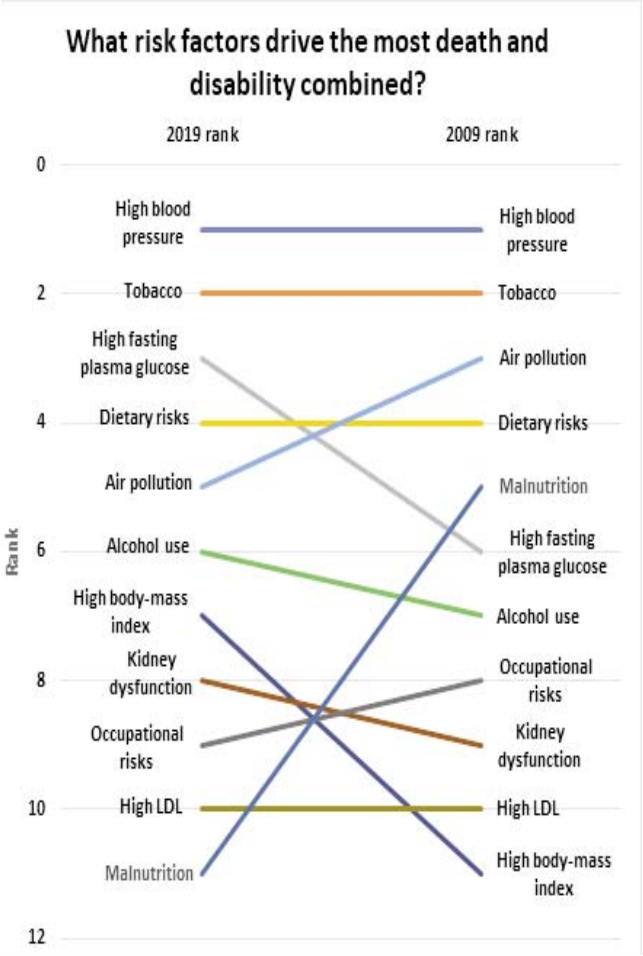


Figure-2: Top 10 risk factors contributing to DALYs in Vietnam and percentage change (2009-19) (Source: Institute of Health Metrics and Evaluation (2020).

state.

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.[5] 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.[6] 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 (IHME 2019).

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 ischaemic 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.[7] Vietnam is also among countries that have the highest growth rate of diabetes patients worldwide.[8] 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). By 2025, the number of people suffering from diabetes in the country is forecast to be between seven and eight million. Moreover, a considerable part of the Vietnamese population - estimated to be up to two million - is living with undiagnosed diabetes.[8]

NCD risk factors in Vietnam

The epidemic of NCDs in Vietnam is driven by harmful use of alcohol, tobacco use, 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'.[8] 44% of Vietnamese men consume excessive amounts of alcohol while 25% of men were binge drinkers. Further, the population suffering from overweight or obesity increased from 12% in 2012 to 16% in 2016 and the number is growing.[2] Salt consumption is also twice that of WHO-recommended levels and is contributing to increasing levels of hypertension; currently around 18% of Vietnamese adults (including 23% of men and 15% of women) suffer from hypertension.[8] 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.[8]

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 other hand, vegetable consumption has decreased from 214 g/capita/day in 1985 to 190 g/capita/day in 2010.[6] 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.[9]

Smoking

According to the Vietnam STEPS survey 2015, the prevalence of current smoking was 25.8%.[8] The prevalence was considerably higher among men (50.6%) than women (1.5%) respectively. This is nonetheless a slight but less than expected improvement over 2010. Current smoking was also more widely prevalent among people aged 30–49 years, people with lower educational attainment, informal sector workers, ethnic minorities, individuals with a lower wealth index, and individuals who lived in rural areas, compared to other groups.[8]

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.[1] The prevalence of current alcohol use in Vietnam is 43.8% and was much higher among men (77.2%) than women (11.1%), respectively.[8] 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).[8]

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.[8] The prevalence of overweight is slightly higher among women (16.4%) vs men (14.9%). Overweight was also 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.[8] Among men, 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.[8]

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.[1] 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.[1]

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).8 Hypertension was more common among older participants, with the oldest age group having 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 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'.[8] 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.[9]

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.[10]

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 central Ministry of Health (MoH) – the main national authority in the health sector – which formulates and executes health policy and programmes in the country.[11] There are 63 provincial health bureaus at the provincial level, which follow MoH policies but are organic parts of 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.[11] By 2013, there were more than 11,000 communal health stations and 1,040 hospitals. 93% percent of all the health service providers

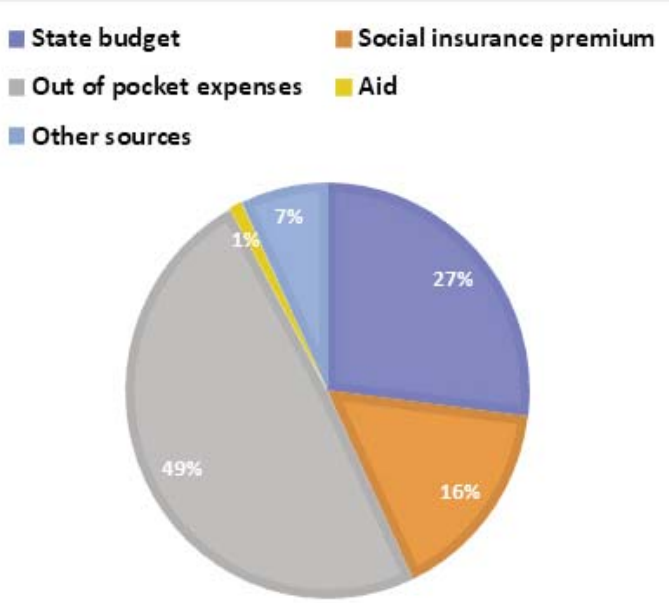


Figure-3: Sources of health financing in Vietnam. (IHME 2017).

are decentralized to local levels.[12]

The health financing system in Vietnam is a mixed system with multiple financing sources including the state budget, health insurance premiums, out-of-pocket payments by households, development assistance 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

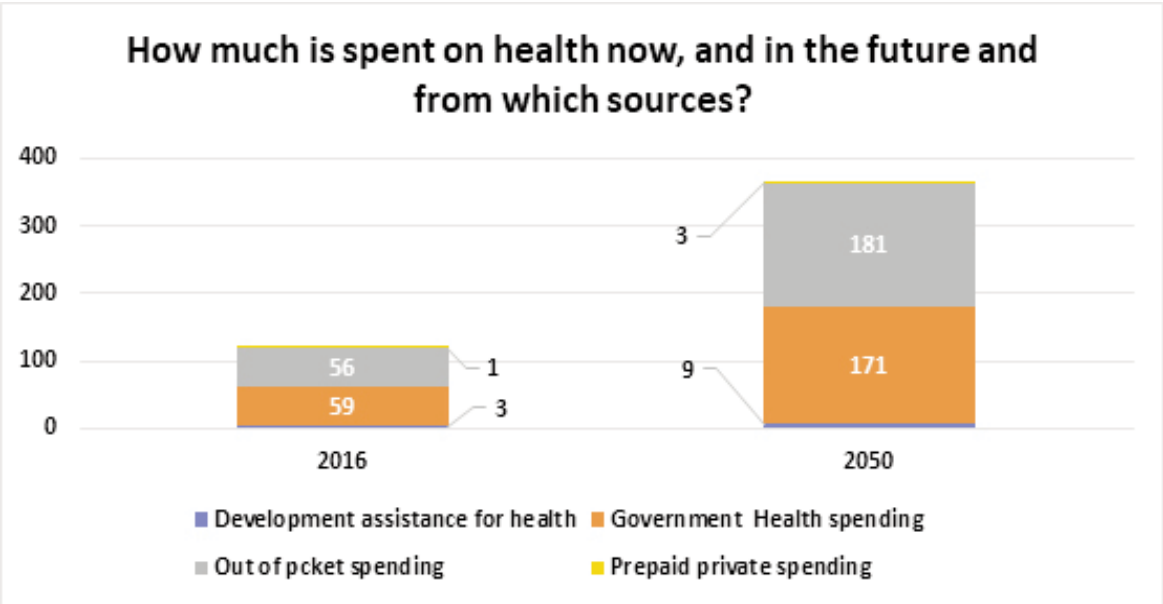


Figure-4: Current and future (projected) sources of health expenditure in Vietnam (Source: IHME 2017).

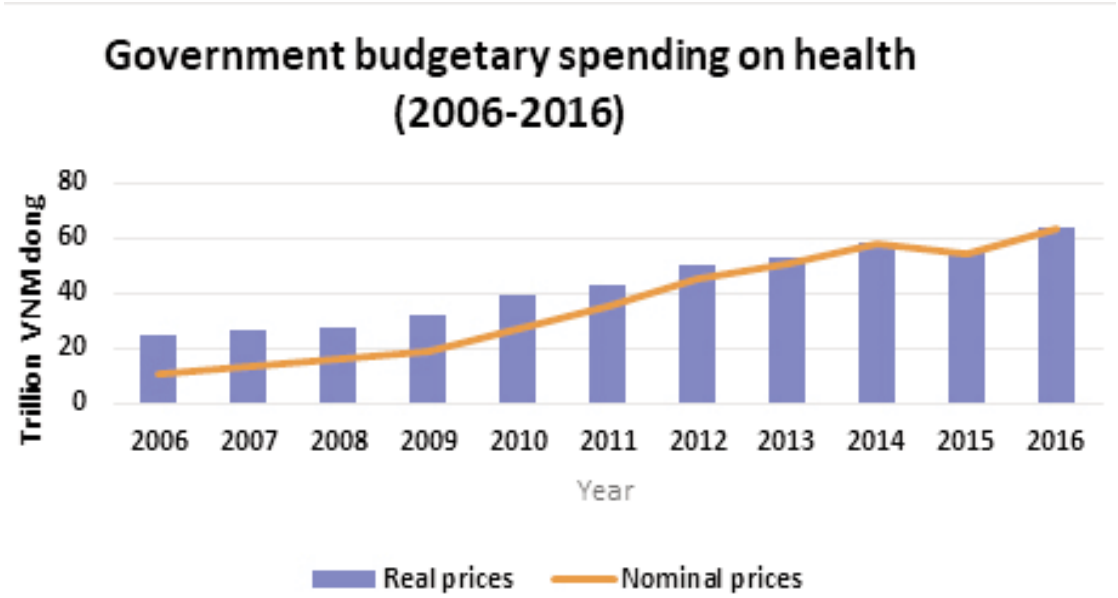


Figure-5: Government budgetary spending on health (2006-2016). Source: WHO (2018a).

comes from public resources (including 27% from the state budget and 16% social insurance premiums).[13]

Vietnam's total health expenditure (THE) 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.[5] Based on the latest available data (2016), Vietnam's healthcare expenditure was estimated at US$16.1 billion.[14] This represented 7.5% of the country's GDP, while total health expenditure per capita was US$129 or VND 2.8 million.[15] 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.[5] 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.[14]

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.[5] In per capita inflation-adjusted terms, the increase has been threefold.

The increase in public health spending 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.[5] 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 significant 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 increased annually between 2000 and 2017 at an average of 9%[5] (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.[16]

Despite policy efforts to reduce OOP spending by households, it continues to comprise the largest share of spending in the health system. The share of OOP has remained consistently high at just under 40% of THE since 2000; between 2011 and 2016, it increased further from 38% to 45%.[5] 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%. This attests to the

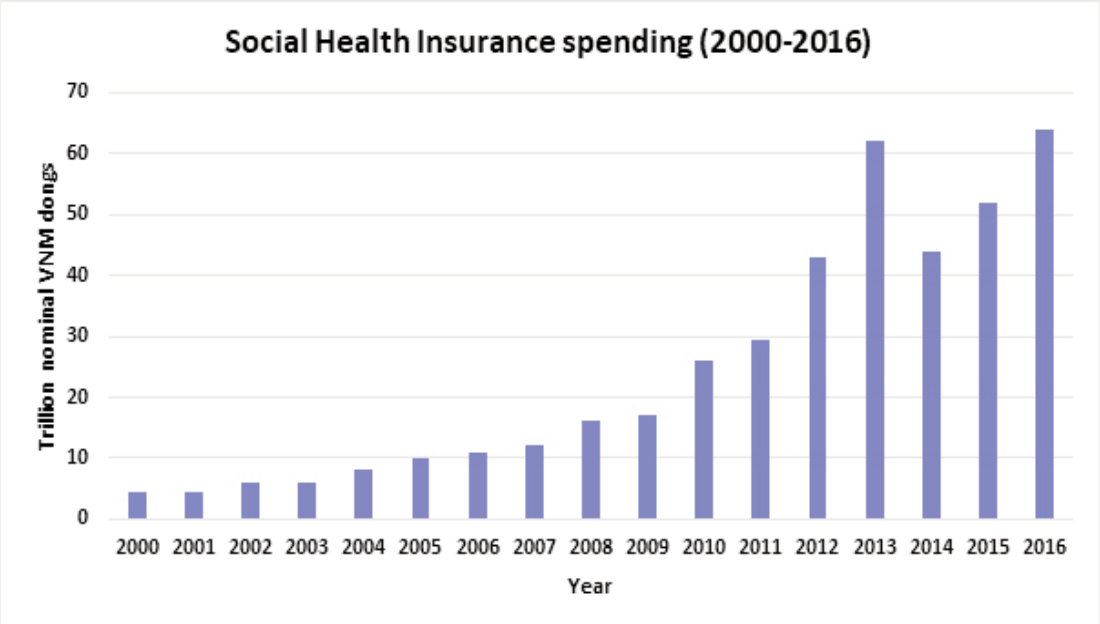


Figure-6: Social Health Insurance (SHI) Spending (2000-2016). Source: WHO (2018a)

government's success at increasing financial protection for the poor.[1]

These improvements in financial protection stem from efforts to increase government spending and SHI coverage. Health spending increases have been driven in part by increases in population coverage and higher service utilization, suggesting people are accessing the care they need. However, this is also a consequence of Vietnam's ageing 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 programmes, counselling, nutrition examinations and screening - are not covered by the health insurance fund.[6] 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.'

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 Programme on NCD Prevention and Control in 2002, including for cardiovascular disease, diabetes, cancer and mental health disorders.[17] From this national programme, the Ministry of Health created four National Target Programmes (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).[17]

Based on the Vietnam Annual Health Review 2014, these NCD programmes 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'.[6] However, multiple obstacles remain in the way of a well-coordinated, multi-sectoral and managed NCD prevention programme.

National Target Programmes

Until 2015, the government's spending on NCDs was channelled through the National Target Programmes (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 NTPs in the community, via financing from the central government.

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 COPD and asthma from 2011 to 2014. Further, the Ministry of Health (MoH) and the Ministry of Education and Training signed a collaborative Programme and Plan on children and students' health protection, education, and care for public educational institutions for 2012-2020.

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.[17] The review identified 2 major limitations: one, 'that they were implemented as individual disease programmes 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'.[17]

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.[18]

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'.[18] It aims to undertake publicity campaigns to raise population awareness and understanding of NCDs, enhance preventive services to control risk determinants and enable detection and emphasize the need to improve skills and expertise in treating the diseases while expanding NCD-related healthcare services at businesses and schools.[18]

Health and Population Programme 2016-2020

As part of the government's rationalization of the Target Programmes, all priority health programmes have been merged under a unified Target programme in 2016, namely the Target Programme for Health and Population 2016-2020. This Programme is aligned with the NCD strategy and employs the same target indicators as the NCD strategy. The total budget for the Programme was VND 20 trillion (approximately US$ 1 billion), pending fiscal availability to be determined by the Ministry of Finance, with no specific budget allocation for the sub-programmes under it.[2] The state budget share for the programme 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 Programme include the following: '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'.[2]

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, which established smoke-free places, increased the size of graphic health warning labels, restricted tobacco advertising, promotion and sponsorship, and created a tobacco control fund.[19] 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'.[19] However, Vietnam's current levels of tobacco taxation (40% of retail price) remain far below WHO recommended levels (of 70% of retail price).

The dedicated Tobacco Control Fund established under the legislation was intended to provide financial resources for the prevention and control of tobacco use through smoking cessation programmes, research projects, and educational and communication programmes. The Tobacco Control Fund received compulsory contributions of 1% of the taxable price of all cigarette packs produced locally or imported for local consumption starting from May 2013. This rate was increased to 1.5% from May 1, 2016, and to 2% from May 1, 2019.[20] 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 programmes, and research and policy development.

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'.[21]

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'.[22] 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'.[22]

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 targetting people under 18'.[22] 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, and bans sales of alcohol to minors'.[22]

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.[23]

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 non-communicable chronic disease in adults'.[24] 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'.[24]

Vietnam also initiated a National Action Plan on Nutrition in 2018, which included actions to implement a mass media campaign on healthy diets, encompassing social marketing to reduce the intake of total fat, saturated fats, sugars and salt, promote the intake of fruits and vegetables and implement nutrition education and counselling in different settings to promote healthy eating.[25] 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.[25]

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

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 programmes)	6,428,101	1,031,867	466,788		7,926,756
Early disease detection programmes	8,193		14,235		22,428
Epidemiological surveillance and risk and disease control programmes	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
Total state preventive health expenditure (VND million)	8,679,955	3,439,557	1,896,801	27,818	14,044,131
Tobacco Control Fund	500,000				500,000
Total dedicated spending on prevention (A+B)	9,179,955				14,544,131

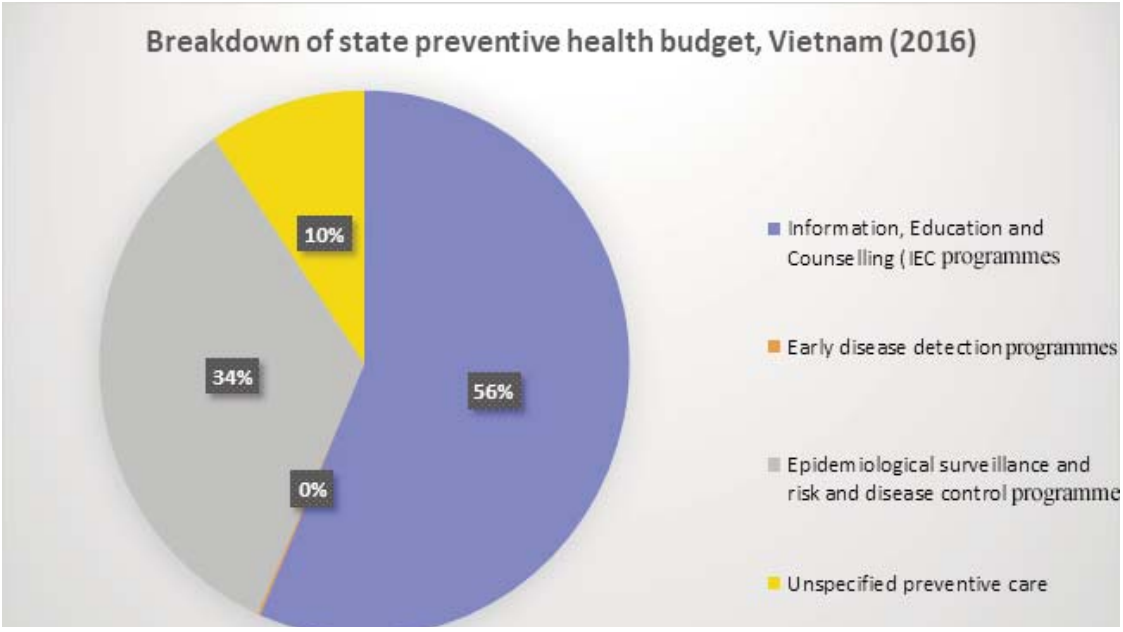
smoking and maintaining an appropriate weight'.[26]

Despite this progress, several diet-related policies in Vietnam continue to run counter to the needs of NCD prevention and control. Several trade and import policies are aimed at protecting the domestic sugar industry with support to cane growers, sugar mill factories and the local food processing industry in its production 'of candy, cake and instant noodle'.[27]

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 programme 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 programmes), 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.

Information education and counselling (IEC) programmes 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 programmes account for 34% of total preventive health expenditure.

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.

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 programmes 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 whole-of-government and whole-of-society response, with a Health in All Policies (HiAP) approach, that mobilizes support from political, social, professional and mass organizations in Vietnam.

Re-organizing NCD Target Programmes

While Vietnam has had Target Programmes 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 programmes 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 Programmes was limited, fragmented and inadequate, since national target programmes rarely collected data and even so, only sporadically and on a small scale. Furthermore, separate vertical disease programmes led to a lack of integrated national guidelines on screening for early detection of NCDs and population-based

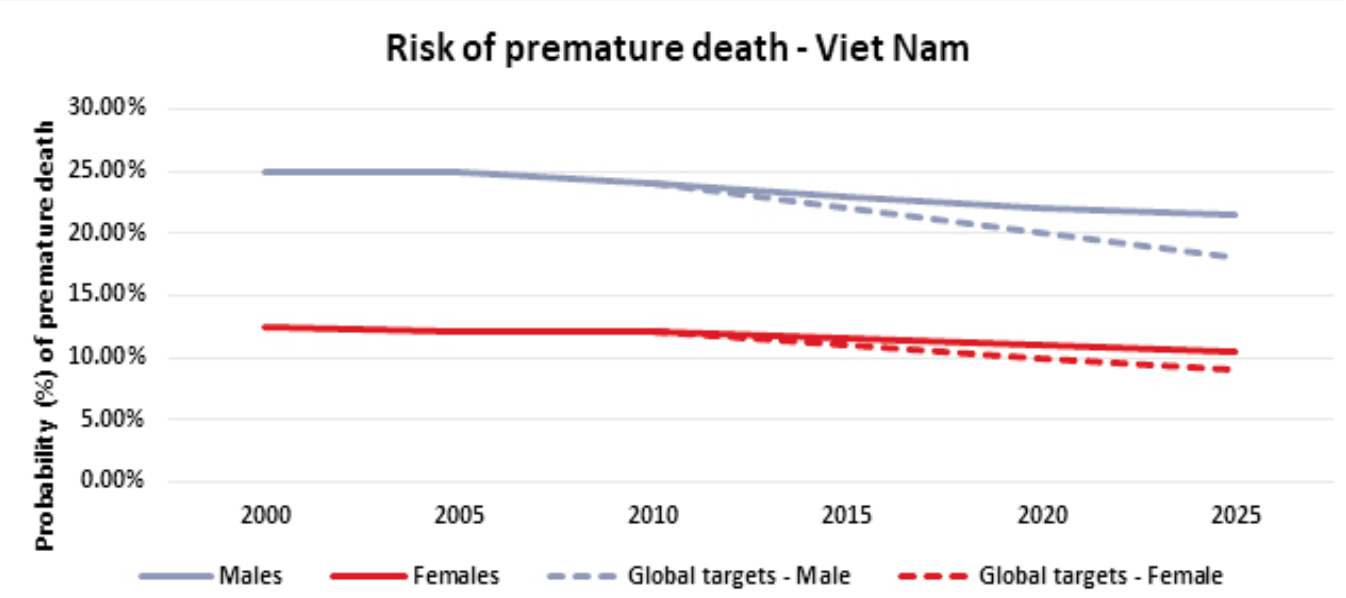


Figure-7: Risk of premature death due to NCDs in Vietnam (%) (WHO- NCD Country Profiles, 2018: Vietnam).

monitoring of NCDs, making it difficult to monitor NCD status and progress of programmes. According to national health staff, NCD reports were done only through the national target programmes, rather than the broader health information system, making NCD-related statistics and data limited, fragmented and inadequate.

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 programmes accordingly. While steps have been taken toward this with the new Health and Population Target programme, 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, as argued by Nguyen and Hoang (2018), Vietnam needs to 'develop national guidelines on screening for 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'.[6]

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.[2] However, despite promising progress, what remains absent is strong stewardship and a long-term comprehensive, integrated approach for NCD prevention and control at the national level. 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.

As proposed by the UNIATF (2016), 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.[2] This should be accompanied by the formation of a broader multi-stakeholder NCD forum to strengthen coordination and action across government and its partners, including NGOs, political, social, professional and mass organizations and academia. The forum would take up the responsibility of convening national meetings to follow up on Vietnam's NCD plan.[2] A Vietnamese health official interviewed agreed that "*political leadership was essential to create a robust NCD response, hence it was essential that a senior government official chair the national NCD committee*."

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 programmes focused on alcohol use, tobacco use, inactivity and healthy diets'[17] (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'.[17]

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'.[6] According to a Vietnamese health official interviewed, "*the budgetary limit placed on the proportion of SHI funds that can be utilized at commune levels acts as an impediment for effective NCD control.*" Those with health insurance still have to pay a large portion of the costs from their own pockets for NCD prevention, diagnosis and treatment at commune level.[6] 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.[28]

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-organize the primary health care 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, as argued by Duong et al (2019), '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 programmes for preventing, diagnosing, and managing diseases to promote the health of the population they serve'.[17] Importantly, the aim of primary care should be keeping people healthy via prevention and keeping them out of hospitals. To achieve this

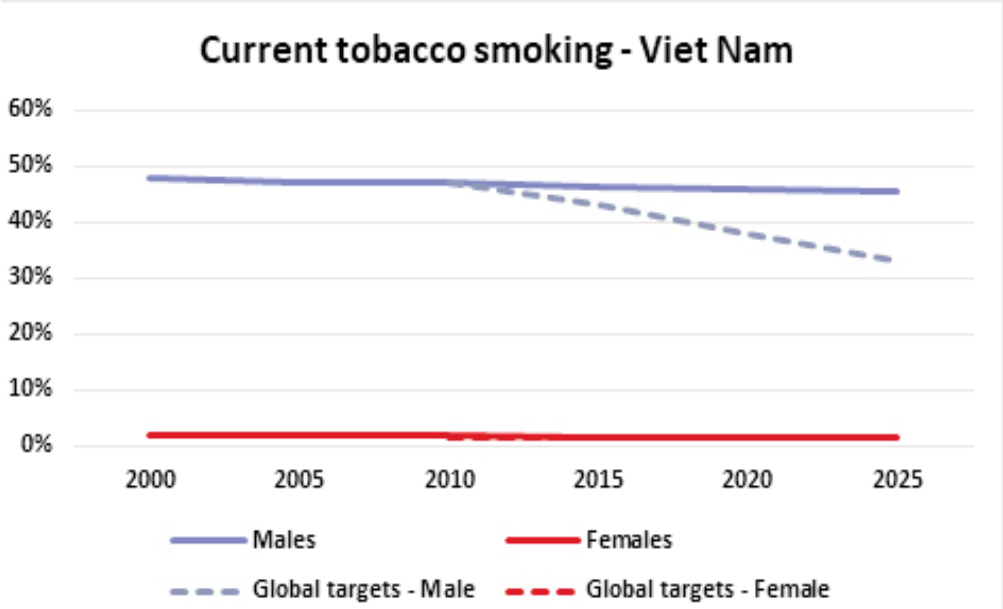


Figure-8: Tobacco smoking in Vietnam over time (WHO- NCD Country Profiles, 2018: Vietnam).

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.[20] The 2012 Law on Prevention and Control of Tobacco Harms strengthened tobacco control in Vietnam, discouraged cigarette consumption, and resulted in some reduction of consumption. However, the absence of effective tobacco taxation polices

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).

requires a shift in investment, budgetary and insurance allocations towards health promotion and preventive care.

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).

Part of the reason for this is under-taxation. Vietnam has one of the lowest rates of tobacco taxation in the world meant tobacco consumption began to grow again in 2016-17.[20]

Similarly, the prices of beer and alcohol remain considerably cheap due to low taxation levels, which are far lower than those applied in countries like Thailand, New Zealand or Australia (up to 85% of retail price).[29] 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'.[29] WHO has recommended that the Vietnamese government reduce the affordability of alcoholic beverages by raising special consumption tax and enact a year-on-year increase in excise tax on all

alcoholic beverages.[29] 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 targetting to young and vulnerable groups, needs to be tightened.

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

Earmarking taxes on unhealthy products for health promotion

Many countries impose taxes on products deemed to be bad for health and earmark these tax revenues to the health sector.[5] Such targeting of unhealthy products enables the introduction of the policy and the raising of tax revenue primarily as a public health initiative and only secondarily as a revenue collection measure. Earmarking taxes on products including cigarettes, alcohol, and sugar, has been used by multiple countries, from Philippines to Mongolia to Jamaica as a way of raising revenue for public health while improving health indicators.[5]

Vietnam currently earmarks taxes as part of its tobacco control policies, but the quantum 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, which is estimated to raise between VND 300-500 billion a year - less than 0.01 percent of GDP.[5] Given Vietnam's insufficient 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.[2] Funds could also be generated by an annual 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.

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, as suggested by Teo et al (2019) is 'increasing the number of contributing members in the SHI scheme and the average contribution rate therein'. The health insurance fund could be used to 'mobilize additional funds through the provision of coverage to the remaining 13 percent of the population that is not yet covered'.[5] Another proposal 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), there are 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'.[5] This may be a more feasible option for increasing spending on health and NCDs in the long-term.

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.[30]

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 programme 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 programmes on NCDs in recent years, few activities have been carried out due to the lack of budget and time.[30]

Persistent problems remain in Vietnam's NCD risk communication interventions. Most of the communication programmes still emphasize intervention, screening and management of patients while there is still no comprehensive communication programme on disease prevention or promoting positive behaviours such as changing diets, physical exercise, and avoiding risk behaviours like smoking or alcohol. The few communication programmes 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 programmes 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 proposed Health Promotion Fund.

Policies to enable healthy diets

Achieving healthy diets is one of the areas in which considerable progress remains to be made. Policies to reduce trans fats or saturated fats remain absent as do policies for restricting children-focused marketing. 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 campaigns on appropriate nutrition and healthy diet but there is a need for greater frequency and breadth in campaigning. Further, no subsidies or policies to encourage healthy vegetable and fruit production and consumption have been formulated.

The government needs to urgently 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.[25] 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.

Conclusion

Vietnam's progress in improving standards of living, life expectancy and heath 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 Programmes, 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 largely followed a disease-specific approach to NCDs, with separate programmes for CVD, hypertension, cancers and diabetes, among others. The bulk of the focus of these programmes 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 add 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 is critical for Vietnamese policy makers to collect baseline data and track trends in consumption and revenue to measure the effectiveness of changes in taxes, duties, and policies at large. This would help establish a base of evidence to assess if policies are having the desired effect in terms of consumption and revenue. 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.

Recommendations

1. Reorient NCD target programmes 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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