



## Key Takeaways of Viet Nam Workshops

7<sup>th</sup> April 2021

*The quest to achieving sustainable healthcare in Asia Pacific cannot be achieved alone. It requires multi-stakeholder collaboration to make a difference. In that spirit, Sanofi and KPMG, with the support of the World Economic Forum (WEF), are producing a position paper surrounding the theme of “**Sustainable Healthcare in APAC: Financing & Delivery Models**”, with the objective of identifying and unlocking financing and delivery models in APAC to achieve better health outcomes with a more efficient use of resources.*

*This report will inform programming and high-level dialogue on global health system resiliency at relevant World Economic Forum-hosted events and other country/ regional platforms. To ensure the report offers insightful and actionable solutions, three co-creation workshops were organised in Viet Nam on 15<sup>th</sup>, 16<sup>th</sup> and 19<sup>th</sup> March 2021 to collaborate together with stakeholders across the public and private sectors.*

*The workshops covered three different thematic areas: Life-course Immunisation, Diabetes Management and Rare Disease. Each workshop was attended by approximately 10-15 participants, consisting of government associated institutes, public and private health practitioners, NGOs and multilateral organisations, patient advocacy groups, banks, private insurers, pharmaceutical companies and others.*

*Chatham House rule was observed during the workshops. The insights and solutions gathered during the workshops have been summarised in this report, with no direct attribution to any participants. However, contributing participants and organisations would be credited as a contributor to the position paper.*

*We thank all workshop participants for their valuable contribution.*

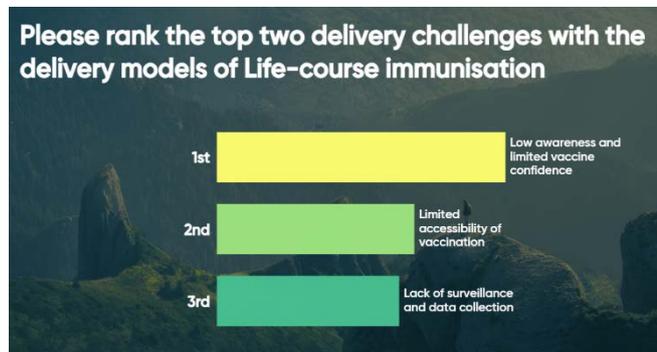
### Life-course Immunisation Workshop

Immunisation prevents 2-3 million deaths per year and is widely recognised as one of the most cost-effective public health interventions. However, life-course immunisation uptake rate remains low in Viet Nam. The country has achieved high vaccination coverage for children but not for adults.

#### *Despite the benefits, why are people not getting vaccinated?*

Awareness and vaccine confidence are ranked by workshop participants as the top delivery challenge for life-course immunisation, due to reasons such as:

- Awareness of boosters required are shrinking among preschool kids, adolescents and adults
- The country has yet to establish National Immunisation Schedule for adults



Apart from awareness and vaccine confidence, accessibility of vaccination is recognised as the second biggest challenge. Subsidised immunisation services are only provided at [Commune Health Centers for 1-3 days per month](#), often resulting in long queues for immunisation. In addition, highly regulated registration and variation approval processes could lead to delayed arrival of innovations and supply bottlenecks.

#### *How can we raise the awareness & confidence of vaccines?*

**Multi-stakeholder awareness:** Policy makers and healthcare practitioners play an important role in increasing general population's awareness and vaccine confidence. Through the strategic use of Behavior Change Communication (BCC), they could change the public's attitude towards life-course immunisation. For instance, the centralised government media in Viet Nam could be leveraged to disseminate positive stories to promote life-course vaccination, and to collaborate with social media giants to rectify misrepresentation of information quickly. Even beyond, policy makers and healthcare practitioners could adopt behavioural sciences to understand patients' biases, thereby repositioning life-course immunisation as a social norm.

**Adult vaccination schedule:** Vaccination is made a priority for children in many ASEAN countries including Viet Nam but not for adults. For paediatrics vaccines, many countries have adopted both carrot and stick approaches to motivate the uptake of the vaccines. For example, Australia implemented ["No Jab No Pay"](#) which withholds certain payments for parents of children who are not fully immunised.

Such an approach could be applied to promote the uptake of adult vaccination. For example, listing important vaccination like tetanus booster and influenza vaccine (influenza activity observed throughout the year) as one of the pre-requisites for employment and ability to attend big scale events such as Olympics could drive higher uptake rate among adults. Similarly, employers could include vaccination as part of employees' annual health check-ups. Some corporates like Honda and Emirates have mandated their employees to receive vaccination such as flu shots, while covering the cost too.

For this measure to be scalable, one of the key enablers would be to establish a centralised platform which allows individuals to opt in to have their vaccination history recorded, enabling relevant stakeholders such as healthcare practitioners to assess and give recommendations accordingly.

Once awareness and vaccine confidence are established, what comes next is to enhance the accessibility of vaccines to increase chance of conversion.

#### *How can we enhance the accessibility and availability of vaccines?*

**Expanded access points:** The administration of vaccines needs to be expanded beyond health centres and into other touchpoints like vaccination centres and pharmacies so as to enhance accessibility. Mapping out the customer journeys of various segments would help identify the relevant touch points for expansion.

**Streamlined supply chain:** While stringent regulatory requirements help to maintain the quality of vaccines assures public's trust towards vaccination, the complex processes could lead to delayed launch of products and supply bottlenecks. Close conversations between industry players (for example, in the form of vaccine alliances) and policy makers would be instrumental to bridge the understanding of the challenges faced by multiple stakeholders in the ecosystems, thereby helping to streamline the processes and reduce unnecessary barriers. The COVID-19 pandemic has accelerated the development and approval process of COVID-19 vaccines, could the same be applied to other vaccines?

Another element required to streamline the supply chain is the availability of data for demand forecasting. Presently, the lack of centralised immunisation data has made it challenging for manufacturers to forecast demand, which could result in supply chain disruption or wastages.

Accessibility is both a function of availability and affordability. Unfortunately, vaccines which are widely available but the lack of affordability will lead to limited adoption.

### *How can we ensure adequate funding for Life-course Immunisation?*

**Cost benefit analysis:** The quick win is to demonstrate the cost and benefits of life-course immunisation initiatives in order to create compelling reasons to garner more resource allocation from the health system.

The underlying enabler of cost-benefit analysis is data collection. Several measures could be undertaken to gather data, for example: (1) Private sector could partner with provinces to pilot programmes to gather data, which helps to prioritise the financing needs among provinces. (2) Enabling data sharing across multiple agencies such as Ministry of Health and Ministry of Education to form the full picture. (3) Leveraging digital tools to gather new sources of data to complement existing sources of data.

**Tax creativity:** There are rooms to further maximize the utility and efficiency of existing financing mechanisms. Taxation has been a traditional source of funding but often they are not fully utilised for healthcare purposes. Viet Nam could take reference from countries such as Taiwan and the Philippines which earmark sin-taxes<sup>1</sup> for healthcare purposes such as financing the national immunisation program.

**Collaboration with private sector:** Relying on public sector alone will not be enough. The collaboration between public and private sector can open up more creative possibilities. Presently, the government has collaborated with private players to offer discounted HPV vaccines in certain provinces to encourage uptake. Such a program could be further expanded to cover wider range of vaccines like influenza vaccines.

In addition, Viet Nam government is in the midst of revising health insurance law to strengthen the collaboration between public and private health insurers to complement coverage. Tapping on this trend, one idea worth exploring is to partner with private insurers to offer insurance coverage specifically for vaccination, which in the long run can help insurers achieve lower insurance claims, a win-win solution.

Last but not least, creative financing mechanisms such as using outcome-based contracting to spread risk between government and private players, and providing tax incentives to employers to enforce vaccination at workplaces, could be explored.

COVID-19 pandemic has undoubtedly brought many challenges to the healthcare systems. Yet, it has heightened the awareness level of immunisation and spurred global initiatives to strengthen the vaccine delivery system. The time is ripe to ride on this momentum to impact spill over effect to life-course immunisation as a whole. Let's do this together now.

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<sup>1</sup> Sin taxes are typically added to liquor, cigarettes, and goods that are considered morally hazardous.

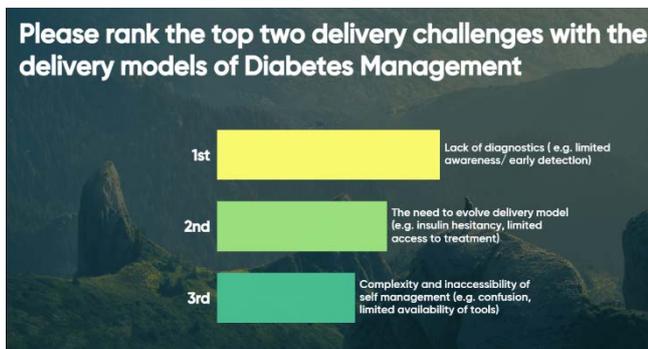
### Diabetes Management Workshop

Diabetes is a leading cause of death in most countries. As the most populous region in the world, the Asia-Pacific (APAC) represents a disproportionately large share of the Diabetes burden. In Viet Nam in particular, [1 in 20 Viet Nameese adults](#) are estimated to live with diabetes, with Type 2 Diabetes being the dominant condition. Viet Nam must rise to the challenge to tackle this epidemic.

#### *What are the greatest challenges with the delivery models of Diabetes Management?*

The top ranked challenge was the lack of diagnostics — screening and early detection mechanisms, as evident from the significant amount of [undiagnosed Diabetes cases \(~70%\)](#) in the country. Many of the primary care facilities do not possess the capacity to diagnose, especially in the mountainous areas.

The second ranked challenge was the need to evolve the care delivery model. Limited patients seek treatment as many are required to travel to district, provincial or national level hospitals for help. Late initiation of insulin, in turns, leads to complications such as 35% amputation of diabetic foot.



#### *How can we improve the access of diagnostics?*

**National-level priority:** The first and foremost step is to assign national level priority to diabetes management, which would enable and encourage various federal and grassroots initiatives. This could be done by leveraging the rich imbursement data captured by Viet Nam Social Security to quantify the impact of failing to diagnose and treat diabetes early. Nation-wide campaigns, akin to the “War against Diabetes” program launched by Singapore, could be adopted to raise national awareness. Patient stories from network of influential Diabetes ambassadors could also be leveraged to increase the awareness of Diabetes and to promote the benefits of effective interventions.

**Dialling up the role of district hospitals and community health centres:** The healthcare services provided by Viet Nam district hospitals and community health centres are excellent, but many lack the necessary capability in detecting and treating populations living with Diabetes. To tackle that, policy makers and private players could facilitate knowledge transfer and trainings from central hospitals down into district hospitals and community health centres.

Private players could also run initiatives with community health centres to educate healthcare workers to identify high risk population, and share the importance of regular check-ups and screenings. Similar initiatives have been adopted by non-for-profit organisations such as FHI 360, which collaborated with policy makers to strengthen the capacity and systems in HIV prevention and care across provinces in the country.

**Proactive and innovative diagnostics:** To uncover undiagnosed Diabetes cases, both “pull” and “push” strategies are required. Instead of waiting for the general public to seek diagnosis, policy makers and healthcare practitioners could proactively screen populations who are at risk. For instance, interviewing patients or mandating them to fill out details about family history so as to identify high risk cohorts.

This additional process step might be challenging for overcrowded hospitals, hence there is a need to rethink how the patient journey is organised. Instead of the traditional linear patient journey (e.g. registration → speaking to nurses → consulting doctors), hospitals could adopt patient centric journey (e.g. registration → family history filling → sent for diagnostics if patients present high risk) to streamline processes and better address their needs.

In addition, creative tools could be adopted to digitise diabetes screenings to save manpower and time to alleviate the overloaded healthcare system.

Solving the access to diagnostics is the very first part of the journey, next is to pair it with the appropriate delivery model to provide the necessary treatment.

### *How can we evolve the delivery model?*

**Dialling up the role of district hospitals and community health centres:** Extending on the point above about diagnosis, the central or provincial hospitals could moreover equip district hospitals and community health centres with the know-how to treat Diabetes. Examples include measuring insulin sensitivity for prescription, and providing the appropriate insulin dosage to avoid addiction which is a key concern among healthcare practitioners and people living with Diabetes.

**Compliance empowered by digital tools and high human touch:** Adherence to treatment is key to managing Diabetes. Digital apps could be utilised to enable patients to monitor blood sugar level and enforce proper nutrition in-take etc. However, digital tools should only serve to complement human interactions, and not to replace. The role of human touch in enforcing compliance is indispensable. For example, digital tools (existing or new players) could be used to collect data about patients which in turn empower personalised care from healthcare practitioners — nurses could call non-compliant patients daily to remind insulin intake based on the data captured.

**Increased reach:** Equity is one important pillar of healthcare; however, the access of treatment is often unequitable between the urban and rural areas in Viet Nam. Policy makers could partner with third parties such as Reach52 to reach out to less developed or mountainous areas to deliver treatment.

The aforementioned solutions could fill the gaps of the delivery models, but not without the backing of funding.

### *How can we ensure adequate funding for Diabetes Management?*

Unlike the nature of infectious diseases which can be prevented with life-course immunisation or cured with anti-viral treatments, Diabetes management requires consistent day-to-day behavioural changes which raise the importance of:

**Personal incentives:** Offering incentives for long term behavioural changes can be a win-win solution for stakeholders such as policy makers and private insurers. When the population achieve better health outcomes, the government or insurers incur lower medical expenses in the long run. Tools such as mobile apps and fitness tracker could be leveraged to track behaviours and link to schemes or programmes that support the reimbursement or incentive aspects. Viet Nam could also take reference from the “Carte Vitale” healthcare bank card concept in France to offer a Diabetes-specific “Carte Vitale” fintech healthcare card that collects information, enables payment & reimbursement and pays out financial incentives to users when exhibiting desirable behaviours such as adhering to insulin intake.

One key enabler to monitor users’ behaviours for the necessary incentives is to digitize healthcare records and enable data sharing across stakeholders such as private insurers. This is because Diabetes is associated with a large number of comorbidities and its implications can span across aspects. Doing so would help forming holistic benchmarks or baselines to monitor users’ improvement in health. Taiwan, for instance has adopted such an approach. The integrated information collected enabled healthcare practitioners to detect Diabetes, initiate insulin treatment and coordinate care early, resulting in better management of the condition and significant cost savings in the long run.

**System wide incentives:** Data is king. The established data baseline in the previous recommendation could also lay the foundation for novel contracting mechanisms such as the “pay for performance” or “Social Impact Bond” models, which could complement taxation as an alternate source of funding. Policy makers could tap on private investors to fund Diabetes Management initiatives and only repay diverse stakeholders in the ecosystem with principal and a rate of return once the measurable social outcomes or cost savings are achieved collectively.

Another system wide changes that government could implement is to encourage employers to provide holistic programs and annual health screenings to their employees to help detect and manage Diabetes early. Early diagnostics and intervention could delay the onset of condition, resulting in less productivity loss at work, which is another win-win solution.

**Disease-specific private insurance:** Another financing mechanism worth exploring to plug the gap is for policy makers like Ministry of Health and Ministry of Finance to devise Diabetes-specific insurance which is currently not present in the country. In line with government's existing initiatives to strengthen the collaboration between public and private health insurers to complement coverage, policy makers could partner with local insurance companies and private players to execute the plan.

Alternatively, a bottom up approach could be considered — private players could collaborate with government-owned entities in the healthcare system such as state-owned hospitals and pharmacies to devise a plan for policy makers' consideration.

To increase the uptake of Disease-specific private insurance, incentives like income tax exemption could be offered to individual diabetic employees who subscribe to the private insurance.

While the whole world is fighting against the COVID-19 pandemic, let's not forget that Diabetes is not relaxing its grip. In fact, people with Diabetes have a higher chance of serious complications from COVID-19. However, the risk could be lowered if Diabetes is well-managed. Let's not slow down, but rather accelerate our effort to care for people living with Diabetes.

### Rare Disease Workshop

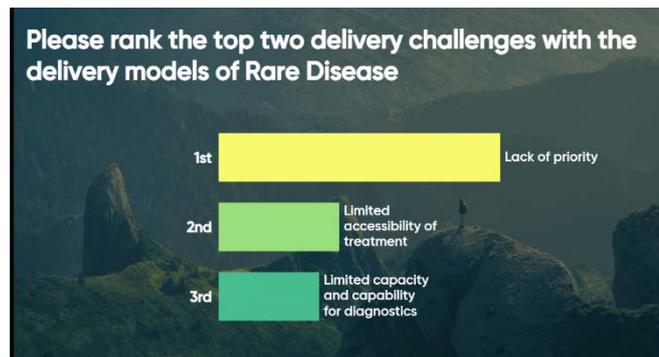
Rare Diseases, also referred to as orphan diseases, are characterised by having low prevalence (typically 1 in 2,000 people) yet being chronically debilitating and severely life threatening. Viet Nam in particular, has case from about [100 out of more than 7,000](#) rare diseases reported from across the world. Unfortunately, due to the low prevalence for each individual instance of disease, such cases are often not prioritised. Viet Nam must address Rare Diseases head-on so as to realize the goal of Universal Health Coverage – leave no one behind.

### *What are the greatest challenges with the delivery models of Rare Diseases?*

Expectedly, the lack of priority was ranked as the first and foremost concern. A Rare Disease Committee has been formed in Viet Nam, but the country still lacks a national strategy such as patient registries, guidelines for specific Rare Diseases, and conducive regulatory environment for orphan drug approval.

Limited accessibility of treatment was ranked as the second top challenge. For instance, there is only [one hospital that provides treatment for lysosomal storage disorders in North Viet Nam](#) ; indeed highly specialised and coordinated medical care can be

challenging for hospitals with lower-resource settings, further compounded by the lack of home infusion therapy.



### *How can we increase the priority assigned to Rare Diseases?*

**Enhancing awareness across levels:** There is a need to raise the awareness of Rare Diseases across segments of the ecosystem, including policy makers, healthcare practitioners and the general public. Each requires a tailored strategy.

Policy makers need to recognise that while the prevalence of a single Rare Disease might seem low if viewed in isolation, when combined, the collective economics and societal impact of the cohort of Rare Disease types is significant. They consume a disproportionate amount of healthcare resources relative to their prevalence, and detecting and treating them earlier would result in significant savings.

On the healthcare practitioners' front, awareness and knowledge towards Rare Diseases could be enhanced via trainings in medical school, which in turn could be funded by the private sector. Such an approach has been adopted in countries like UK, where Rare Disease is covered in undergraduate and postgraduate medical trainings.

In addition, the awareness level among the populations could be elevated too via network of champions and friendlies. The enhanced awareness among populations and patient groups would effect a change in attitude towards the disease area at the national level.

**Establishing patient registries via international programs:** The lack of patient registries affects proper development of Rare Disease health policy, as well as leading to a gross underestimation of the problems and consequences burdened by individuals and wider society. However, establishing patient registries can be challenging in and of itself due to barriers such as geographically dispersed communities and limited funding support for research. Not to mention, developed countries like Australia were only able to push through the barriers and establish national Rare Disease Registry in the recent years.

An alternative for Viet Nam is to leapfrog by tapping on international programs for patient registries. For example, Viet Nam could leverage WHO initiatives as an alternative to creating national registries, or collaborate with countries like France with established Rare Disease patient registry, to glean insights.

Viet Nam could furthermore explore collaborating with private players such as pharmaceutical companies and various key opinion leaders to form privately fund registries and to drive national studies.

**Strengthening patient advocacy programs:** Rare Disease patient groups' existence in Viet Nam is limited as they are legally required to be linked with hospitals or associations that are considered as legal entities. One way to broaden the existence is to actively engage policy makers, healthcare practitioners, and key opinion leaders so as to increase awareness and rally for the change in legislation. This would allow for greater independence to form bigger patient groups for advocacy.

Viet Nam could take reference from the patient advocacy structure in Australia. The country features both national level patient alliance groups as well as grass root communities. National level patient alliance groups are funded by government and located in the compound of hospitals with experienced healthcare practitioners and researchers. They serve to facilitate studies and resource sharing among individual patient groups. In addition, Australia also has multiple groups formed by families of Rare Disease patients, mushrooming at the grass root levels of advocacy.

Viet Nam could also leverage the expertise and resources of other established networks in the region, such as the Asia Pacific Alliance of Rare Disease Organisations (APARDO), to strengthen its patient advocacy programs.

The lack of national priority is the greatest hurdle to overcome for Rare Diseases. Once it is resolved, efforts could be trickled down to enhance the accessibility of treatment.

### *How can we enhance the accessibility of treatment?*

**Shared international responsibility:** Extending on the point above about international collaboration and given the constrained resources in the country, Viet Nam could join consortiums that are looking at facilitated regulatory models and alliances to bring treatments into markets without the high HTA costs being borne by each market independently.

**Leveraging diagonal therapeutic expertise:** Viet Nam is leading in certain therapeutic areas, playing a major role in various international studies. One of the areas is In Vitro Fertilization (IVF). As most of the Rare Diseases have genetic causes and could be detected or treated from pre-natal screening and advanced new-born monitoring, Viet Nam could potentially leverage its expertise in IVF to expand into Rare Diseases so to develop pathways to adopt more advanced diagnostics and treatment options.

Another aspect of accessibility of treatment is affordability of the orphan drugs. However, often, the residual medical expenses of patients with Rare Diseases exceeds three times their household incomes.

### *How can we ensure adequate funding for Rare Diseases?*

**Establishing financing needs:** Data speaks louder than words. The rich data captured by Viet Nam Social Security program could be leveraged to estimate the impact of known Rare Diseases and the financial implications of failing to properly initiate diagnostics and treatment early. It could be used to showcase the disproportionate amount of healthcare resources Rare Diseases consume in relation to its prevalence, as compared to other disease areas, which then provides a compelling reason for policy makers to assign higher financing priority.

The data to be analysed in conjunction with referencing other countries in the region, could be used to anticipate the budget needs for Rare Diseases 2 to 3 years in advance for proper planning.

**Shaping reimbursement policy:** Unlike other countries which have established a defined "Rare Disease Act", Viet Nam still lacks a proper policy that details the definition of Rare Disease, its care pathway, and, importantly, the end to end financing needs of specific Rare Diseases and the associated reimbursement frameworks.

One way to gather inputs to shape such a policy is to pilot privately funded small scale programs like early assess frameworks, to generate epidemiology data and establish reimbursement needs in certain provinces which could be extrapolated to other regions. Another way is to tap on the established reimbursement frameworks by organisations such as the APEC Rare Disease Network.

Establishing a “Rare Disease Act” is futile if it does not translate to actual actions that are backed by a right-sized level of investment. Private sector and government such as Health Authorities need to work hand-in-hand on all the initiatives.

**Minimising wastage:** There are two ways to look at future-proofed health system financing: one is to minimise wastage of existing resource allocation, and second is to establish new sources of funding. For the former, there is still room to further streamline the existing care packages for Rare Diseases in Viet Nam so to minimise wastage. One idea is to learn from Prostate Cancer programs — establishing a centre of excellence that serves to consolidate expertise across hospitals and streamline provision of care (i.e. resource utilization). On average it takes a Rare Disease patient seven years to be diagnosed correctly; the level of ineffective resource consumption that occurs should be a financial driver in and of itself to take rapid action on this cause.

**Raising funds via innovative financing mechanisms:** Extending on the point above, the second way to achieve financial sustainability in healthcare is to establish new sources of funding. Novel financing mechanisms like crowdfunding at the community level (a tactic deployed by the Singapore government), using gamification platforms to drive donations for Rare Diseases, transferring the social impact bond concept driven by banks in Viet Nam’s green energy space to the healthcare sector, and reallocating sin taxes or taxes extracted from mature drug products to Rare Diseases could be further explored in order to create additional financial capacity for the mission ahead.

One thing to note is that while sin taxes on tobacco, alcohol and gambling could be an additional source of funding for healthcare, they lack sustainability as the desired behavioural changes would eventually be achieved, resulting in gradual tax revenue decline. Instead, new taxes could be targeted at more sustainable areas such as green energy initiatives.

A disease may be rare, but hope should not be. Rare Diseases are often not treated as a priority in resource-constrained countries such as Viet Nam. We need to rethink how we perceive Rare Diseases. The cost of diagnostics and treatments are high but the cost of neglection is even higher. What’s more, developing countries such as Viet Nam have the privilege to stand on the shoulders of giants to learn from developed countries, and leapfrog. There are no excuses, let’s push the boundaries together.