

Developing institutional policies for health professionals' education reform: a case study of medical education in Viet Nam



Quang Cuong Le,^a My Hanh Bui,^{a,b,*} Quynh Long Khuong,^c Phuong Anh Le,^d Diep Tuan Tran,^e Quoc Huy Nguyen Vu,^f and Nu Viet Vu^g

^aHanoi Medical University, Ha Noi, Viet Nam

^bHanoi Medical University Hospital, Ha Noi, Viet Nam

^cUniversity of Pennsylvania, PA, USA

^dHarvard University, MA, USA

^eUniversity of Medicine and Pharmacy at Ho Chi Minh City, Ho Chi Minh City, Viet Nam

^fHue University of Medicine and Pharmacy, Hue City, Viet Nam

^gUniversity of Geneva Faculty of Medicine, Geneva, Switzerland



Summary

The Lancet 2010 Commission for Health Professionals' Education highlighted both instructional and institutional reforms to improve health professionals' training. While developed countries often have well-established policies to facilitate educational reform, such policies are limited in many developing countries, including Viet Nam. In this paper, we outline the development and implementation of three key institutional policies to enhance medical education in Viet Nam: (1) Establishing competency standards for the Medical Doctor (MD) program, (2) coordinating clinical training between medical universities and hospitals, and (3) setting up a national licensing examination. These policies were also evaluated against the Lancet Commission's recommendations. Decisive factors for Viet Nam's initial success include the pioneering mindset of its governmental leaders, close collaborations between academic and governmental institutions, and support from international organizations and experts. This paper may serve as a useful reference for low- and middle-income countries seeking to improve medical education and health professionals' training.

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Background

In 2010, the Lancet Commission on the education of health professionals for the 21st century recommended a comprehensive education system to strengthen the training of health professionals, emphasizing the interdependence between the health and educational systems.¹ The Commission outlined three important dimensions of educational reforms: the instructional reform, institutional reform, and projected educational outcomes.¹ The Commission proposed six instructional reforms, including: (a) competency-based curriculum, (b) interprofessional and transprofessional education, (c) information technology utilization, (d) adaptation of global knowledge to local needs, (e) resource enhancement, and (f) promotion of a new professionalism. The Commission also outlined four institutional reforms, which include: (a) aligning national stakeholders through joint planning, (b) extending academic learning sites into communities, (c) developing global

collaborative networks for mutual strengthening, and (d) promoting the culture of critical inquiry.¹ To achieve these reforms, the Commission called for four immediate and long-term enabling actions. Firstly, to mobilize leadership from academia, professional associations, and the government to discuss instructional and institutional reforms, and resource allocations. Secondly, to enhance investments in health professionals' training through public, private, and donor funding. Thirdly, to align accreditation, licensure, and certification with health goals. Lastly, to enhance global learning through defining and evaluating metrics on health professionals' education, and expanding research on this topic.¹

Since the Lancet Commission's report in 2010, numerous medical education reform efforts have been initiated. In 2021, 32 US medical institutions selected through the American Medical Association (AMA) Accelerating Change in Medical Education Consortium's grant awarding process, reported how they implemented, expanded, and modernized aspects of instructional and institutional reforms, the diverse challenges and lessons learned.² For example, competency-based teaching needs to be adapted to the

*Corresponding author. Hanoi Medical University and Hanoi Medical University Hospital, No.1 Ton That Tung Street, Ha Noi, Viet Nam.

E-mail address: bui-myhanh@hmu.edu.vn (M.H. Bui).

school's curriculum infrastructure and organization culture, and instructional and institutional reforms need to be closely interdependent to facilitate changes.³ Collaborative work across multiple individuals and medical institutions proved to be essential to each school's development and implementation of reforms.² A recent study also reported that some recommended instructional reforms were reinforced during the COVID-19 pandemic, particularly competency-based education, interprofessional education, and large-scale applications of information technology.⁴

In Viet Nam, the Lancet Commission's recommendations were also evaluated from the perspectives of a six-year curriculum reform at the University of Medicine and Pharmacy in Ho Chi Minh City, Faculty of Medicine (UMPFM).⁵ Overall, the Commission's recommendations were reflected in UMPFM's curriculum development and implementation, as well as in its reform planning strategy, coordination, organization, and governance.⁵

Health professionals' education reforms depend on each country's unique economic, political, and cultural context. In some countries, such as the United States, the federal government has the ultimate responsibility to protect people's health, but specific functions are delegated to professional councils, foundations, and independent organizations.⁶ These organizations provide advice to the federal government regarding all aspects of health professionals' education and generated many reform initiatives.^{1,7} Additionally, professional councils or associations, or private agencies have been entrusted with accreditation of medical curriculum and licensure for medical practice.⁶ In other countries, health professionals' education is often governed by their ministries or agencies created for that purpose.⁶ For instance, health professionals' education in Viet Nam has long been regulated by the Ministry of Education and Training (MoET) and the Ministry of Labor-Invalids and Social Affairs (MoLISA), in coordination with the Ministry of Health (MoH), all of which operate under the direct leadership of the Deputy Prime Minister in charge of the relevant sectors. Beginning in 2025, the MoET will assume full responsibility for governing health professionals' education, as the MoLISA has been dissolved. According to the Lancet Commission, these ministries, considered as governmental institutions, along with the academic ones, are part of the Commission's system framework to implement diverse functions within the medical education system. Despite the crucial role of a supportive policy environment, existing literature, as reviewed above, has focused more on reporting specific instructional, educational, and training reforms, and much less on institutional policy reforms.

Developed countries often have recognized professional organizations and established policies that facilitate health professionals' education reform and

development. However, in many countries, including Viet Nam, such enabling policies are lacking, partly due to a limited awareness of the importance of health professionals' education reform. Since the introduction of the "Doi Moi" (translated as "Renovation") policy in 1986, Viet Nam has transitioned from a centralized socialist system to a more market-oriented economy, sparking significant social and economic changes that have necessitated reforms in healthcare training and service delivery.^{8,9} Although decentralization measures were applied during the COVID-19 pandemic, national policies for reforming health professionals' training have remained largely centralized.¹⁰ As a result, developing and enacting policies that integrate educational reforms with broader health reforms is especially challenging within this centralized framework.

In this Personal View, we aim to share our perspectives and experiences in health professionals' training in Viet Nam, focusing on the development and evaluation of institutional medical education reform policies. First, we describe the current medical education situation in Viet Nam. Second, we give an overview of the multi-level policy making process. Third, we highlight three key policies. Using the "Personal View" approach, our method involves describing the content, development, and implementation of these policies while identifying and analysing achievements, challenges encountered, and lessons learned. We will also evaluate these policies based on the Commission's recommendations and enabling actions. Authors of this Personal View have either been directly involved in policy development at the government level, or in medical education reforms at various academic institutions. Hence, they are in a unique position to share their insights and experiences. Using Viet Nam as a case study, this article could serve as a useful reference for policy makers in developing countries wishing to initiate or currently reforming medical education. Furthermore, these insights could be potentially relevant and beneficial for the reform of other health professionals' training programs.

Current situation of medical education in Viet Nam

The medical doctor (MD) training program in Viet Nam has undergone continual evolution, as was previously described.^{11,12} As of 2024, 33 universities offer the 6-year MD undergraduate curriculum approved by the MoET, with guidance from the MoH. The number of graduates per medical school ranges from 100 to 900, with a total of 13,000 graduates nationwide—four times the number recorded in 2010.¹³ Overall, existing curriculum relies heavily on theoretical knowledge delivered through lectures while needed competencies are not clearly defined, rigorously reviewed, and nationally approved. Each academic institution can independently declare its own

competency standards, organize graduation exams, and grant the MD degree. Furthermore, MD graduates with an 18-month clinical internship following their graduation, are automatically licensed as General Practitioner (GP), although the internship does not have a recognized standard curriculum. Notably, starting in 2027, this clinical internship will be shortened to 12 months, according to the recent Law of Examination and Treatment.¹⁴ As a result, it is challenging to evaluate and ensure the quality of GPs and MD graduates.

Despite its distinct nature, the six-year MD training program is considered equivalent to a four-year bachelor's degree in any other disciplines according to Viet Nam's national qualifications framework.¹⁵ Unlike in many developed countries, the recognition of the MD degree in the Vietnamese society is not commensurate, which negatively affects physicians' remuneration and overall career after their graduation.

The graduate training pathway for MDs is a complex navigation between the research/teaching and clinical practice tracks, with both lacking clearly defined objectives and competencies.¹⁶ In Viet Nam, one needs to undergo specialist graduate training to practice a specialty, while a Master or/and a PhD degree is required to qualify as university lecturers. To commensurate for this, a 2-year "hybrid" clinical master program which contains some specialized clinical components, and some research components has been developed so that one could not only practice a specialty but would also be qualified to teach. Not surprisingly, graduates from this program are equipped with neither sufficient specialized clinical competency to practice nor necessary skills for research and teaching.

In response to the increased demand for healthcare at the grassroots level, a recent Degree required the establishment of a "basic specialist training", with the hope that these physicians could help treat some specialized diseases.¹⁷ However, the program's competencies are undefined. In addition, the career pathway for its graduates is unclear, especially as the program does not fit into Viet Nam's national qualifications framework.

As of 2024, medical universities in Viet Nam lack standardized accreditation. While the government has granted greater autonomy to educational institutions, this has led to a rapid increase in the number of medical schools and students without a robust quality monitoring and assurance system. Although some medical universities were accredited by the ASEAN University Network, none were accredited according to international medical education standards such as those set by the Liaison Committee on Medical Education,¹⁸ the Educational Commission for Foreign Medical Graduates,¹⁹ or the World Federation of Medical Education.²⁰ Therefore, medical training programs in Viet Nam are not well-recognized internationally. Additionally, Circular 5471/BYT-K2DT, issued by the MoH in 2024, has related concerns about the quality of medical education, as the rapid expansion

of medical schools has not been accompanied by a proportional increase in practice hospitals.²¹

In Viet Nam, the organization of medical training also differs from that of many countries. Tenured lecturers from universities bear the official responsibility for clinical training, while hospital-based physicians are predominantly considered guest lecturers. Access to clinical practice for medical trainees has relied largely on informal arrangements between leaders of medical universities and hospitals, with no specific regulations and official agreements. There are also no designated budget for the clinical clerkships, hence affecting the quality of training in hospitals. Overall, there is a lack of coordination between medical universities and teaching hospitals in developing and implementing training programs. As a result, hospital-based physicians are usually unsure of students' required competencies, and their commitment to teaching vary.

Overall, there is limited awareness about the importance of high-quality medical training, which has resulted in insufficient attention and investment in medical education in Viet Nam. Specifically, this results in inadequate financial resources, lack of enabling policy frameworks necessary for reform, and inadequate remuneration of physicians for their expertise and responsibilities.

To address some of the above limitations, Viet Nam has focused on introducing three key policies: (a) Setting competency standards for health professionals, including medical doctors.²²⁻²⁵ (b) Improving coordination of clinical practice training between academic institutions and teaching hospitals,²⁶ and (c) Introducing the national licensure requirement for medical practice.¹⁴

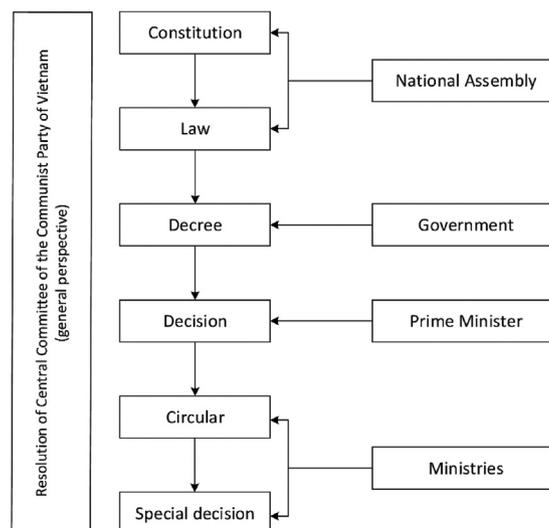


Fig. 1: Multi-level policy-making process in Viet Nam.

Multi-level policy-making process in Viet Nam

These reform policies were introduced and enforced through a multi-level policy-making process, as depicted in Fig. 1. The Constitution and Law issued by the National Assembly give the overall direction, followed by Decrees issued by the Government and Special Decisions by the Prime Minister, which in turn inform more detailed policies outlined in Circulars issued by various Ministries, particularly the MoH. All of these policies align with the Central Party's overarching guidance on improving people's health. Notably, developing policies for other health professionals' training programs follows a similar process.

In 2013, the Central Committee of Viet Nam Communist Party endorsed Resolution 29 which highlighted the need for educational reform, including the training of health professionals.²⁷ The Resolution emphasized a significant shift from mainly equipping knowledge to comprehensively developing learners' competency and values.²⁷ This regulation provided a critical foundation for subsequent reform policies. Subsequently, based on the MoH's proposal, the Deputy Prime Minister in charge of the health and education sector mobilized leadership at the MoH, the MoET, and the MoLISA to initiate a series of regular joint meetings to discuss and monitor regulations regarding health professionals' training.

To guide the elaboration of relevant policies, the MoH organized a series of workshops with the participation of national and international experts in health professionals' training, medical training institutions, hospitals, and relevant ministries, government departments, agencies, and committees of the National Assembly. These workshops were designed to deepen participants' understanding of the complex context of health professionals' training in Viet Nam and to provide an updated overview of the relevant experiences from countries in the Southeast Asian region and globally. Through active knowledge sharing and discussions, it is intended that participants also enhanced their understanding of their respective roles and responsibilities in improving medical training quality.

Reflecting on Viet Nam's reform, the direct leadership from high-ranking government officials has been pivotal in connecting all relevant ministries and sectors and achieving a consensus on policy formulation and promulgation. The government also sought technical and financial support from international organizations such as the World Health Organization and the World Bank. Additionally, experts from various countries such as the United States, Japan, Australia, France, Hong Kong, China, Korea, Thailand, and Switzerland have been invited to share their experiences and advice on the reform process. These practices align with the Lancet Commission's recommendations, which emphasize the importance of leadership mobilization at local, national, and international levels, joint planning across relevant

sectors (especially between health and education), engagement of all stakeholders in identifying the urgent needs for reform, development of global collaborative networks for mutual strengthening, sharing knowledge, and promotion of the culture of critical inquiry and public reasoning.¹

Development and implementation of competency standards

In 2015, following the Resolution 29, the Ministry of Health issued the Competency Standards for Medical Doctors.²³ A review of the MoH's development of these standards shows that it involved a wide range of stakeholders including medical training and recruitment experts, medical institution's managers, medical specialists, and social organizations.²³ During the development process, the Drafting Committee reviewed the medical competency standards from countries in the region and around the world and adapted them to Viet Nam's medical practice contexts. Subsequently, in 2016, the Prime Minister endorsed two Decisions which provided the necessary legal framework for medical universities to adopt these standards.^{24,25}

To support the implementation of the competency-based training programs, the MoH advised the Government to secure funding through the World Bank Official Development Assistance loan project entitled: "Health Professionals Education and Training for Health System Reforms Project."²⁸ This project not only provided financial resources but also facilitated technical support from both domestic and international health education experts for curriculum reform and implementation. Medical universities interested in this funding needed to submit detailed grant applications based on the World Federation for Medical Education's accreditation standards for medical curriculum. Through this process, medical universities familiarized themselves with the accreditation procedures and evaluated whether their institution has addressed the criteria. These include establishing the school's mission statement and self-evaluation report, ensuring the quality and suitability of proposed curriculum and organizational strategies, and assessing the feasibility and sustainability of the reform.

As of 2024, seven universities are at different stages of reforming their MD programs, with the University of Medicine and Pharmacy in Ho Chi Minh City, Faculty of Medicine (UMPFM) at the most advanced stage, along with Thai Nguyen University of Medicine and Pharmacy, Hai Phong University Medicine and Pharmacy, Thai Binh University of Medicine and Pharmacy, Hue University of Medicine and Pharmacy, Hanoi Medical University, and Vin University. Some other universities are still in the preparatory phase. Notably, UMPFM pioneered its reform project as early as 2013.⁵ With the World Bank's loan approval to MoH in 2014, UMPFM successfully introduced its integrated,

competency-based six-year curriculum in 2016 and graduated its first class in 2022.

A close collaboration between academic and governmental institutions could be one of the deciding factors for success in educational reform. For instance, from the beginning, UMPFM invited the MoH to its reform planning conferences and has received its full support. Similarly, the MoH involved UMPFM and other institutions in the development of the competency standards, which facilitated the implementation of these standards. Moreover, these standards were circulated internally and discussed at UMPFM to include faculty members not present at the MoH sessions. The “joint ventures” between the two institutions, with the support from organizations and individual consultants, allowed UMPFM to develop a solid curriculum reform proposal, which later served as a model for other academic institutions to follow. UMPFM’s reformed curriculum integrates many of the Lancet Commission’s recommendations, including an integrated, competency-based curriculum, hospital- and community-based clinical practice, and digital learning.⁵ It also includes the development of students’ clinical competencies and soft skills, such as professionalism, interprofessional teamwork, ethical behavior, lifelong learning, and their abilities in teaching, clinical research, and leadership.⁵ Additionally, the revised curriculum incorporates a comprehensive competency-based assessment program and establishes both internal and external quality assurance mechanisms to drive continuous improvement. To support and sustain these reform efforts, UMPFM also introduced institutional changes, such as the creation of the Advanced Training Center for Clinical Simulation (ATCS) and the Faculty Development Program. Some of these reforms, particularly interprofessional education, have since been adopted by other institutions in their training programs.²⁹

The processes of “joint planning”, “linking together”, “nurturing a culture of critical inquiry”, “mobilizing leadership”, and “enhancing of investments” have been applied throughout the reform, between and within academic and governmental institutions. This approach also extended to collaborations with national and international consulting organizations, and individual experts. The shared knowledge and technical support from these experts were particularly effective in the reform process. Prior efforts to introduce learning objectives in medical education have not succeeded,¹² possibly due to the lack of integration of each institution’s “bottom-up and top-down inputs”, inadequate involvement of stakeholders and motivational strategies, and insufficient favorable factors needed for curricular changes.⁵

Coordination of clinical training between medical universities and hospitals

The coordination between hospitals and medical universities in Viet Nam is complex due to separate

overseeing responsibilities—the MoH oversees hospitals while the MoET manages universities. To establish a “three-way” coordination between academic, clinical, and governmental institutions, a mandate at the Prime Minister level would need to be issued. Consequently, the government introduced Decree 111 on “Regulations on the organization of practical training in the health sector”.²⁶ This is the first document since 1975 to regulate the roles and responsibilities of institutions involved in medical education. Decree 111 emphasizes the essential roles of teaching hospitals, including community-level healthcare facilities, mandating that physicians must participate in curriculum development and the compilation of training materials.²⁶ Additionally, the decree mentions the diverse and multi-tiered structure of clinical training facilities. Degree 111 also outlined criteria for developing practical training programs, addressed financial responsibilities of involved parties, and required the coordination between the MoH, the MoET, and the MoLISA.²⁶

To implement this Decree, the MoH introduced a Decision in 2020 on the “Clinical teaching-learning method enhancement program for practice lecturers in health care training”.³⁰ This program, managed by the MoH, aimed to train hospital-based faculty in effective clinical teaching methods. In alignment with these policies, most medical schools have organized faculty development programs, with some institutions integrating simulation-based teaching methods for both their full-time faculty and visiting lecturers from clinical practice facilities.³¹ However, due to resource constraints, these programs have struggled to achieve long-term sustainability.

Despite its importance, the implementation of above policies remains incomplete. While aspects such as joint planning, linking together, nurturing a culture of critical inquiry, and mobilizing leadership have been initiated, they remain superficial across and within institutions. Overall, the directives are unclear, missing guidelines for implementation and monitoring, and hence are challenging to interpret and translate into tangible measures and organizational processes. Another barrier for implementation could be the lack of a defined common mission between academic institutions and affiliated hospitals regarding teaching, research, and clinical service. While universities prioritize teaching and research, hospitals focus on providing clinical services. For effective implementation of Decree 111, deeper and more comprehensive activation of processes such as joint planning and interprofessional knowledge sharing is necessary, both between and within ministries, hospitals, and academic institutions. Given Viet Nam’s current healthcare context, collaborative efforts and shared partnerships between medical universities and hospitals in teaching, research, and service are crucial for advancing and sustaining high-quality healthcare. The recommendations outlined by the

Lancet Commission should help to further secure the establishment of such partnerships.

National licensing examination

Over the past decade, Viet Nam has increasingly emphasized the importance of an independent and comprehensive assessment of physicians' competency as a requirement for licensure. In 2017, recognizing the need to regulate the certification process of healthcare professionals, including medical doctors, the Central Party issued Resolution 20 on the "Enhancement of citizens' health protection, improvement, and care in new situation".³² This Resolution mandated the establishment of a national medical council which administers qualifying examination to grant medical practice license and aligning with international standards. Following Resolution 20, the Law on Medical Examination and Treatment in 2023 required that the Viet Nam National Medical Council (VNMC) should be established as an independent organization for qualification of medical practice.¹⁴ According to this law, the VNMC should "preside over and cooperate with healthcare socio-professional organizations and other relevant agencies and organizations in developing a benchmarking toolkit for assessment and measurement of qualification for medical practice", as well as "implementing the qualification exam".

Since 2014, the Deputy Minister in charge of medical education at the MoH, together with leaders from academic institutions and teaching hospitals, has conducted study visits to the National Board of Medical Examiners in the United States and equivalent organizations in Japan, Korea, Thailand, China, Australia, and France to learn their experiences in organizing national licensing examinations. In 2025, a project between the MoH and Harvard Medical School has been established to train Vietnamese faculty on developing a multiple-choice examination item bank. As recommended by the Lancet Commission, the examination content, its development, implementation, and evaluation should be discussed and agreed upon by relevant parties.^{1,33,34}

Since the VNMC's leadership, membership, and governance are currently under elaboration and awaiting confirmation, Viet Nam's government is focusing on establishing a sustainable organizational structure for the VNMC, which is essential for organizing the first national licensing examination for MD by 2027, as required in the Law on Medical Examination and Treatment.¹⁴ The examination aims to assess medical knowledge, clinical reasoning, patient care, professionalism, and communication skills, based on Viet Nam's competency standards for MDs and reflecting the country's disease patterns. However, as of 2024, the overall framework and organization of the exam still remain undetermined, and discussions regarding its development, design, administration, and funding are underway.

Challenges in medical education reform in Viet Nam

Medical education reform in Viet Nam faces significant challenges. First, the policy-making process often takes a long time, and the issuance of inconsistent policies further delays reform efforts. Furthermore, policies are frequently adjusted in response to economic and social fluctuations, creating an unstable environment for long-term reforms. Second, there is limited awareness of the need for medical education reform, resulting in slow progress, with a limited number of early adopters and leaders in reform. Lastly, as a developing country, Viet Nam faces significant financial constraints. While the government has acknowledged the importance of improving the quality of medical education, limited resources often necessitate prioritization of other pressing and highly visible issues.

Limitations

There is a lack of a holistic review of the healthcare system's needs and a comprehensive assessment of the quality of medical education in Viet Nam. Such an evaluation would provide objective evidence to support meaningful reform. Additionally, these data are essential for determining whether reform policies are practical and well-suited to the Vietnamese context.

While our analysis focuses on policy development, implementation, and the initial evaluation of reforms, assessing their long-term effectiveness, particularly in improving the quality of medical doctors and healthcare service delivery, will require more time. A nationwide impact can only be measured once a sufficient number of medical schools have fully implemented curriculum reforms.

Conclusion

Medical education reform in developing countries is a challenging journey, especially as there is limited awareness of the importance of reform. Establishing an enabling policy environment is the most important first step to foster reform. Decisive factors contributing to Viet Nam's initial success include the pioneering mindset of its governmental leaders, close collaboration between relevant stakeholders, and high consensus within and between academic institutions and teaching hospitals. Additionally, the technical and financial support from international organizations and experts were valuable for the reform process.

Despite these achievements, Viet Nam's medical education reform continues to face significant challenges, including policy inconsistencies, limited funding, and difficulties in achieving inter-ministerial consensus. In this context, the role of the Prime Minister is crucial for coordinating different ministries, allocating sufficient funding, and facilitating the policy-making process that would enable medical education

reform. A comprehensive national-level strategy is essential for establishing a well-coordinated policy framework that strengthens education reform, particularly in the training of healthcare professionals.

Indeed, Viet Nam's experience in medical education reform aligns with the Lancet Commission's recommendations, demonstrating their practicality and effectiveness in reshaping medical education. While these recommendations are globally relevant, they should be adapted to each country's unique socio-economic context. Insights gained from Viet Nam's policy development for medical education reform could be helpful to other low- and middle-income countries seeking to enhance their own medical education systems, as well as the education of other health professionals.

Contributors

QCL: conceptualization, analysis and interpretation of data, and writing (original draft, review, and editing); MHB, QLK, PAL, DTT, and QHNV: writing (review and editing); NVV: conceptualization, analysis and interpretation of data, and writing (review and editing); all authors: read and approved the final manuscript.

Editor note

The translation in Vietnamese was submitted by the authors and we reproduce it as supplied. It has not been peer reviewed. Our editorial processes have only been applied to the original abstract in English, which should serve as reference for this manuscript.

Declaration of interests

All authors report no conflicts of interest.

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Appendix A. Supplementary data

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