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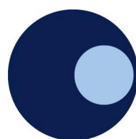

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FIRST DRAFT

Strategic Options for Financing Health System Modernization and Development: what can Vietnam learn from international experiences?

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Preface / Acknowledgements

This study was commissioned by the UNDP to provide input into the development of the 2011-2020 Socio-Economic Development (SED) Strategy and also recommendations on implementation steps.

The study was undertaken during the period of January – April 2011.

Special thanks to….

Executive summary

This study was commissioned by UNDP to inform the process of drafting the Vietnam SEDS, 2011-20 and other health sectoral policies. It aims to highlight some of the main health financing challenges facing Vietnam and to draw on international literature to produce recommendations as to how the country should respond to them.

The study was conducted in January to April 2011. It is based on a review of the literature for health financing in Vietnam and in selected neighbouring and comparable countries, as well as secondary data from Vietnam, key informant visits and one field trip to Vinh Phuc Province. It is structured along the lines of the four key health financing functions – i) revenue collection; ii) risk pooling; iii) purchasing; and iv) provision of services.

Vietnam has a legacy of good coverage with health infrastructure and relatively good health indicators. However, it faces escalating health care expenditure (total health expenditure was over 6% of GDP in 2008 and heading towards 8-9% by 2015, which is high for a low-income country) and weak capacity to extend health insurance to all groups. Health insurance contributes only limited additional funding, despite covering 58% of the population. It contributes 17% of overall expenditure, but the bulk of this (75%) comes from public subsidies.

Overall, the government contributes 43% and household out of pocket payments contribute 52%. Increasing the public contribution in order to reduce out of pocket payments will be needed, if Vietnam is to reach towards universal coverage (not just breadth of population covered but also in relation to width of services covered and height of costs per service). Evidence on catastrophic spending also suggests that Vietnam should aim to reduce household out-of-pocket contributions below the level of 30-40% of total health expenditure. Studies on health insurance suggest that it may have had a limited effect on reducing households costs overall. Drugs spending alone over 2000-7 has doubled, now absorbing 40% of total health expenditure.

Increasing public contributions must be combined with measures to reduce cost escalation – especially, reformed provider payments and the development of better mechanisms for managing and regulating the health care market. The current total health spend is adequate to cover essential health care, if well used.

Increased coverage will raise demand for services, which in other countries has increased the need for investment in infrastructure and staff. Given the extensive network in Vietnam, that is unlikely to be a short-term need, though the imbalance in use of primary and hospital services – which is already skewed towards the latter – may be exacerbated.

Given this analysis and based on experiences of some other countries, the report makes the following recommendations.

Moving towards universal coverage with effective financial protection

- There is an urgent need to develop detailed plans and projected resource requirements for insurance expansion at province level up to the end of 2014. This analysis will be important to manage expectations regarding health insurance coverage uptake. How feasible is universal coverage by 2014? The international literature highlights that the bulk of those currently without insurance in Vietnam are notoriously difficult to enrol and hence considerable effort and resources will be required to increase coverage of the remaining groups. Whilst the Ministry of Health has undertaken some initial exploratory work with provinces to understand the feasibility of reaching universal coverage by 2014 (MoH, 2011) it is important to quantify the

resource requirements needed for the VSS to manage the process over the period up to 2014. Some analysis of expected enrolment using different implementation tactics should be explored further. There are likely to be initial investment costs associated with enrolment coupled with recurrent costs. The development of annual business plans and annual reports outlining projected coverage should be encouraged.

- The experience from Thailand and China shows that increasing state subsidies can provide the impetus towards achieving universal coverage. Currently, the bulk of funding for insurance comes from general taxes paid into state budget and passed to the VSS (75%). The costs of subsidising universal coverage have been estimated in a recent World Bank study (Liebermann and Wagstaff, 2009). An updated analysis of the feasibility of covering the remainder of the population via the state budget and the fiscal implications of this approach should be produced in alignment with the proposed roadmap for achieving universal coverage.

- Clear guidelines should be produced for roles and procedures for identifying the near poor at the provincial level.

- Once the resource implications of enrolling the remaining groups have been elaborated, funding mechanisms should be agreed for each province. Vietnam might want to adapt from the approaches used in some FSU countries. In the Czech Republic, for example, there is a monthly central budget transfer for the economically inactive population set at 13.5% of the average wage. Another example is the Republic of Moldova, where the health insurance law specified that the per capita contributions from the budget on behalf of state-insured individuals must be equivalent to the estimated average per capita cost of the benefits package.

- Support should be given to each province to develop an action plan, which starts from a problem diagnosis (who is uncovered and why). Factors depressing demand for health insurance need careful discussion at each level, and actions to address them. If the service is perceived as cumbersome or of low quality or inaccessible, then clearly voluntary membership will remain low.

- For private companies, a carrot and stick approach might be adopted, with companies enrolling their employees on a regular and comprehensive basis given a discount (and those resisting facing some form of sanction, such as a fine)

- Since 2003 the VSS has been responsible for collecting premiums for private sector enterprise workers and this has proved problematic, as witnessed by the low number of private enterprise workers currently enrolled in health insurance. Alternative mechanisms for premium collection should be considered, including the use of the existing tax collection system. This has been successful in a number of the FSU countries, such as Estonia. An analysis of the efficiency of existing VSS premium collection needs to be undertaken and a review of alterative premium collection mechanisms should be undertaken.

- Vietnam should learn from the experience of countries where high coverage has achieved significant reductions in household spending. Thailand is one such example

Reforming provider payment systems

- A strategic decision needs to be made whether the longer term goal is to unify purchasing into a single payer (the VSS), with the MoH refocusing on policy setting and market regulation. This will have implications for the process of implementation of provider payment reform and for the development of the relationship between the MoH and the VSS. One model for integrated purchasing might be Kyrgyzstan, where the state budget transfers most of the funds for health

from general revenues to the Mandatory Health Insurance Fund (MHIF) to provide a basic package on behalf of the entire population. In addition, payroll taxes are transferred to the MHIF, in order to achieve a complementary contributory entitlement for the insured population.

- Considerable capacity building of the VSS will be needed if it is to be effective as an active purchaser of the bulk of health care services.

- If Vietnam moves towards a single payer, based on real costs of care, then user fees should be reformed, set either as a small fixed amount (co-payment) or proportion (co-insurance) of each treatment. Other informal and supplementary payments should be eliminated.

- Vietnam should move towards the payment mix which may other countries have moved towards, which includes capitation payments for primary care, case-based (or DRG) payments for hospital care, and target payments for some high-priority and preventive services.

- The new payment systems should be monitored in relation to quality of care and cost control. They should be based on real costs and linked to rational care guidelines (see below). These could be incorporated in service contracts.

- Based on the international evidence on provider payment reform, an incremental approach to reform is recommended, based on the piloting currently underway. An incremental approach gradually shifts financial risk to hospitals, allowing them time to adapt to the new incentives, and provides the opportunity to establish information systems and accumulate the data necessary to refine the payment system. In many countries there is an incremental inclusion of hospitals, diseases covered, and also an incremental inclusion of costs included in the payment as the system involves.

- As with insurance coverage, it will be important to develop a more detailed plan for provider payment reform at the national level and the development of implementation guidelines at the province level. Even if piloted approaches are successful, they will not automatically be adopted by all providers. Some form of transitional benefits may be needed to encourage adoption (as used in South Korea, where a generous margin was allowed at the time of switching from fee for service). The benefits to providers of simpler and more transparent charging can be emphasised. A study tour to areas of China which have successfully reduced costs through provider payment reform might help to convince hospital managers.

- Reform of pay for providers, and its streamlining, must ultimately be accompanied by streamlining of pay for medical staff, who currently draw on a wide range of sources, formal and informal, which again creates mixed incentives in terms of patient care.

- Provider payment reform is one tool which can be used to improve the balance in the Vietnamese system between hospital and primary care – the former being overutilised at present and the latter under-utilised. Management of the growing burden of NCDs can best be handled at primary level, and payment systems for providers and staff can incentivise this work, and reduce the flow of patients and staff to hospitals. In the Czech Republic and Slovenia, a portion of the (capitation) rate is paid in the form of a bonus if cost containment or health promotion targets are met. The case of Kyrgyzstan is also instructive, where payment reform was used as a tool for addressing over-capacity in hospitals, and generating savings to reinvest in primary care.

Managing and regulating the health care market

- The experience of other countries in relation to health technology assessment should be studied. In particular, there needs to be an agency which assesses new technologies both prospectively (when should the specific technology be used?) and retrospectively (i.e. how did the technology impact decisions on patient care). This would be linked to licensing of technology for use in specific settings.

- The ability of clinicians and managers to profit from private investment in equipment produces a conflict of interest and should be forbidden, with appropriate sanctions applied for any infringement.

- Linked to a streamlined purchasing function, the use of a limited number of core clinical guidelines (for the most common conditions) should be reinforced. The process of their production should be speeded up, simplified and they should be widely disseminated. Payments should be based on and costed on the basis of compliance with the guidelines. Experience from China and Taiwan suggest that considerable cost savings can be generated through increased use of clinical guidelines.

- A range of quality control measures should be developed, including accreditation of all providers and the piloting of clinical auditing. Borrowing from China's experience, independent quality reviews by expert panels or routine monitoring of high-tech services could be considered.

- Patient voice should also be encouraged to report any abuses, including poor conduct and over-charging.

- The mechanism for pharmaceutical procurement needs to be reformed to ensure lower drug prices, while strengthening checking and monitoring of the tendering process for drugs in hospitals.

- Experience of contracting services from the private sector could gradually be developed in Vietnam, using experiences from countries like Australia. The contracting skills developed in the process can be applied to public and private sector alike, particularly if the current trend towards autonomisation of public hospitals continues.

- The balance of investments in primary versus hospital care need to be reviewed. A recent analysis (Wagstaff and Bredenkamp, 2011) found that only 2.5% of government spending was received by CHC and polyclinic level, compared to 97.5% by hospitals. This reinforces the need to rebalance the system.

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Abbreviations

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1 Background

1.1 Study objectives

Health sector development and modernisation efforts are gathering pace in Vietnam. A number of key health financing strategies have recently been defined (see, for example, the health section within the SED Strategy 2011-2020), or are currently being finalised (draft MoH Health strategy 2010-2020). There have been detailed discussions on implementation plans (e.g. the JAHR 2010 report focuses on implementation of the five year plan for the period 2011-2015). In these documents there are, amongst other policy developments, commitments to increasing the state budget for health care; a roadmap for universal coverage, and broad strategies and plans to reform the current provider payment system for health care in Vietnam.

The study was commissioned by the Development Strategy Unit with funding from the United Nations Development Programme. The terms of reference state that the paper should provide clear recommendations for all levels of the Vietnamese health system and include:

- a review of regional and international experiences in financing the modernization and development of health services, highlighting the strengths and weaknesses of alternative approaches;
- an assessment of Viet Nam's current health sector and financing arrangements; and
- recommendations for future health sector development priorities and financing channels in Viet Nam.

The study focuses on the four key health financing functions – i) revenue collection; ii) risk pooling; iii) purchasing; and iv) provision of services. It draws on selected international experience to explore how countries in the region and beyond have designed and implemented policies to address key health financing and delivery challenges. It then considers what lessons Viet Nam might learn from these experiences as the country moves forward with implementation of key health system modernisation and development strategies.

1.2 Data and research methods

The study was undertaken between January and April 2011. It was based on a structured literature review of health financing in Vietnam and international experiences on selected health financing themes which emerged as most relevant for the Vietnamese context. This was supplemented by a visit to Vietnam to interview key local policy makers, health officials and workers and international partners and the collection of secondary data from a number of sources.

Health financing reform in Vietnam has been the focus of a number of detailed assessments by the World Bank, Asian Development Bank, International Labour office and others in recent years (e.g. Liebermann and Wagstaff (2009), Long (2008), Ekman and Bales (2008), Castel, (2010)). A recent UNICEF report has also focused on health equity in Vietnam, with specific focus on maternal and child mortality (UNICEF, 2009). The Joint annual Reviews for 2008 and 2010 (MoH/HPG, 2008/2010) provide detailed analysis of the health financing and delivery challenges, as well as a comprehensive description and recommendations in other areas of the system.

Finally, a recent report by the Ministry of Health (MoH, 2011) is widely cited as it provides the most recent situation analysis of health insurance uptake and challenges for universal coverage.

The international literature review was limited mainly to countries in the region, particularly China and Thailand, which are seen as offering relevant experiences. The study however has attempted to explore experiences further afield, including the former Soviet Union and central and eastern Europe. The remainder of this section provides a brief overview of health sector development in Vietnam and places this into context with other countries in the region. It then moves on to consider key health policy goals and how health financing strategy can be used to align with these goals. The following sections of the report focus on (1) revenue collection, (2) risk pooling, (3) purchasing, and (4) provision. The sections that follow address a number of questions that came out of discussions with local stakeholders. First, what are the key implementation challenges that need to be addressed in order to move towards universal coverage? Second, what are the respective roles of the MoH and insurance agency as insurance develops, particularly where the purchasing function is taken on predominately by the insurance agency. Third, how have countries moved from a fee for service, or norms-based provider payment system, to one based on performance or outputs? Fourth, how can hospital autonomy be effectively regulated and how best to develop public private partnerships?. Fifth, is there an appropriate role for private health care provision and if so what is this role? Sixth, how can pharmaceutical prices be better regulated? These are significant questions, each one warranting more than a section in this report. It is anticipated however that the sections that follow offer some insights to discussions on implementation.

1.3 Socio-economic context

The socio-economic context strongly influences health sector development and therefore provides a useful starting point for the analysis that follows. Analysis of countries in the region shows considerable differences in population size, proportion of the population living in urban areas, income per capita, poverty rates and human development indexes (Table 1.1). Socio-economic indicators for selected countries

	Pop ('000s)	% living in Urban areas	Gross National Income per capita (PPP Int. $)		Population living off < $1 (PPP Int $) a day (%)	Human Development Index[1]
Country	**2008**	**2008**	**2000**	**2008**	**2000-2007**	**2007**
Vietnam	87,096	28	1,390	2,700	21.5	116
Thailand	67,386	33	4,610	5,990	< 2.0	87
Philippines	90,348	65	2,430	3,990	22.6	105
Rep. of Korea	48,152	81	17,050	28,120	Na	26
Indonesia	227,345	52	2,240	3,830	Na	111
Singapore	4,615	100	32,880	47,940	Na	23
Malaysia	27,014	70	8,350	13,740	<2.0	66
China	1,344,920	43	2,330	6,020	16	92

Source: ADB (2010)

For example in 2008 Gross National Income per capita (measured by PPP Int. $) ranged from $47,940 in Singapore to $2,700 in Viet Nam. However, it should be noted that income per capita nearly doubled in Viet Nam between 2000 and 2008.

[1] The Human Development Index is constructed by combining proxies for three important aspects of human welfare: health, education, and a decent standard of living. Health is represented by life expectancy; education by literacy and school enrolment; and standard of living by GDP per capita. UNDP's latest index covers 182 economies (1=highest ranking, 182=lowest ranking)

Vietnam and Philippines have similar levels of poverty - 21.5% and 22.6% respectively (defined as the proportion of population living off less than $1 (PPP Int. $) per day). The proportion of population living in urban areas is high in Singapore (100%) and Republic of Korea (81%) compared with Viet Nam (28%).

The global downturn has impacted Vietnam's economy with a decline in GDP growth from 8.8% in 2005 to 6.2% in 2008 and an increase in inflation from 8.4% to 22.9% over the same period (Son et al., 2010). Castel (2010) states that as a result of food price rises the number of people under the poverty line increased from 19.3 million at the end of 2008 (12.1% of the population) to 20.3 million at the end of 2009 (15.7% of the population). The increase in the number of poor has important implications for health financing policy as it increases the potential number of population requiring a health insurance subsidy by government. Furthermore, given the limited depth of insurance coverage (that is the level of health benefits offered to the insured) increasing poverty leaves families vulnerable to the financial consequences associated with accessing (or not accessing) health care. This issue is addressed in the section on risk-pooling, but in summary the equity implications of the economic downturn require further analysis and suggest that during periods of economic turbulence careful attention to vulnerable groups is required.

Table 1.1 Health Status Indicators for selected countries

	Life Expectancy at birth (2008)			Infant Mortality Rate (per 1000 live births)	Maternal Mortality Rate (per 100,000 live births)
Country	Male	Female	Both	2008	2000-2009
Viet Nam	70	75	73	12	75
Thailand	66	74	70	13	14
Philippines	67	74	70	26	162
Rep. of Korea	76	83	80	5	15
Indonesia	66	69	67	6	307
Singapore	79	83	81	2	8
Malaysia	71	76	73	6	28
China	72	76	74	18	34

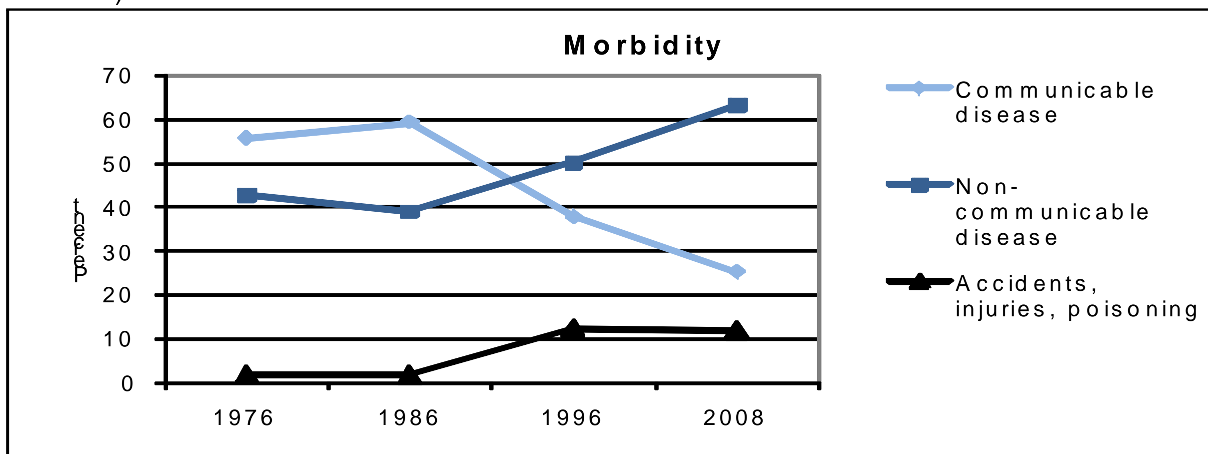
Source: WHO (2010)

Viet Nam's commitment to improving health is well documented (e.g. Ekman and Bales, 2008, Lieberman and Wagstaff, 2009). Life expectancy and rates of infant mortality are comparable to those of countries with substantially higher per capita incomes (Table 1.2). For example, in 2008, combined male/female life expectancy at birth in Viet Nam was 73 years, whereas in the Philippines and Thailand it was 70 years. Infant mortality rates for Viet Nam are slightly lower than China (12 and 18 per 1000 live births respectively). Maternal mortality rates in Viet Nam (75/100,000) are much lower than the Philippines (162/100,000) and Indonesia (307/100,000), but higher than both Thailand (75/100,000) and China (34/100,000).

The disease pattern in Vietnam is reflected by a mix of communicable and non-communicable disease (Figure 1.1). Non-communicable diseases such as cardio-vascular disease, cancers, mental illness and injuries due to accidents have increased in recent years and communicable diseases have decreased. It should be stressed however that although the morbidity patterns have moved towards greater prevalence of non-communicable diseases, communicable diseases continue to exhibit complex dynamics. Many dangerous communicable diseases are at risk of re-emerging such as cholera, dengue fever, HIV, TB, malaria etc.

Communicable diseases accounted for 55.5% of total morbidity in 1976, but had fallen to 25.2% by 2008. Non-communicable diseases have shown continuous increases from 42.7% in 1976 to 63.1% in 2008 (MoH/HPG 2010). Variations in morbidity and mortality across the country have important equity implications. A recent UNICEF report highlights variations in maternal and child mortality by income group (UNICEF, 2009).

Figure 1.1 Morbidity trends 1976-2008 (communicable and non-communicable disease)



Source: JAHR, 2010

1.4 Health policy goals and health financing strategy

Health policy goals in Vietnam are reflected in a number of documents, including the draft SED strategy 2011-2020, and align with the four basic health system goals defined by the World health Organisation (WHO 2010b) which are i) to improve the people's health; ii) to improve system responsiveness; iii) to protect the people from financial risks; and iv) to raise the efficiency of the entire system. Health financing strategies can promote these goals through the following measures (MoH/HPG 2010):

- ensuring that per capita health expenditure is maintained at a reasonable level, through appropriate mobilisation of social resources;
- guaranteeing that public financial resources account for a larger proportion than private funds in total national health expenditure;
- reducing the percentage of households falling into poverty due to expenditures on health care; and
- improving the effectiveness in allocation and use of health financial resources, increasing both efficiency (lowering costs) and service quality.

1.4.1 The Socio-Economic Development Strategy (2011-2020)

The SED Strategy (2011-2020) is at an advanced stage of development and includes a section dedicated to health and the health sector. The section is brief but makes references to a large number of strategies. Table 1.3 provides a summary of the key strategies outlined in the draft document. Emphasis is placed on consolidating grassroots care and enhanced capacity of

commune health centres; preventative care with reference made to both HIV and child malnutrition; renovation and building of hospitals at different levels; expanding health insurance, and increasing state and "socialisation" efforts and targeting the poor. Ensuring the equity, efficiency and quality of the delivery system is also a stated strategy, as is ensuring doctors are available at the level of the rural commune.

Table 1.2 Draft SEDS strategy

No	Health Strategies outlined in the Draft SEDS document
1	Increased state investments coupled with increased socialisation efforts
2	Consolidate grassroots health care. Enhance capacity of commune health centres.
3	Complete the building of district hospitals and upgrade provincial and national hospitals
4	Encourage all sectors to build high-quality specialised medical facilities
5	Tackle overload in hospitals
6	Further develop autonomy, openness and transparency of state health facilities
7	Ensure delivery of equitable, efficient and quality health services
8	Standardise quality of health services and hospitals towards gradually reaching regional and international standards
9	Refine and improve policies related to health insurance, medical examination and treatment, and fees for health care
10	Work out road map towards universal insurance
11	Improve implementation of policies related to targeted priority groups (poor, children and the elderly)
12	Improved training of health workers
13	Ensure doctors are available in rural communes and urban wards
14	Develop preventative care, including HIV prevention, reduction of child malnutrition, food hygiene.
15	Develop rapidly pharmaceutical and medical industries.
16	Develop strongly traditional medicine in combination with modern medicine
17	Develop and implement national strategy for raising physical health of the Vietnamese people, through sport and exercise

Source: GoV, SED Strategy Draft 2010-2020

1.4.2 Draft Health Strategy 2010-2020 (Forth Draft)

The draft Health Strategy 2010-2020 focuses on strengthening the health care network, promoting preventative care, population and family planning, curative care, development of human resources and the pharmaceutical sector. Specific health financing strategies referred to in the document include the continued increase in investment for health, particularly for priority groups; allocation of budget based on results / outcomes; movement towards universal health insurance which is affordable; mobilisation of other sources of investment ("socialisation") for the sector; continued implementation of hospital autonomy policies whilst addressing overuse of high-tech services; incremental reform of provider payments (capitation, case based or DRGs); and ensure financing policy supports priority groups (poor, near poor, children under 6, elderly, minority groups) to ensure access.

1.4.3 The Joint Annual Health Review (2010) focussed on 5-Year Plan (2011-2015)

The health financing chapter of the document proposes "appropriate solutions that can be included in the health sector's 5-year plan for 2011-2015" (MoH / HPG 2011) and includes a number of recommendations relating to i) increasing the share of public financing for health; ii) raising the

efficiency in the allocation and use of health financing resources; and iii) strengthening medical cost controls. Reference to these proposals will be made in subsequent sections.

1.5 Summary of health sector strategies and implementation plans

There is recognition that private spending on health care is too high and that government spending needs to increase. Further strategies focus on attaining universal health insurance by the year 2014 and a roadmap has been defined to achieve this. Provider payment reform is also a high priority, with a number of local documents highlighting the impact that current FFS and norm-based budgets are having on health sector efficiency and cost containment.

The following sections focus on these strategies, considering some of the implementation issues to be tackled. They are structured according to the four key health financing functions (revenue generation, risk pooling, purchasing and provision).

2 Revenue Generation

2.1 Overview

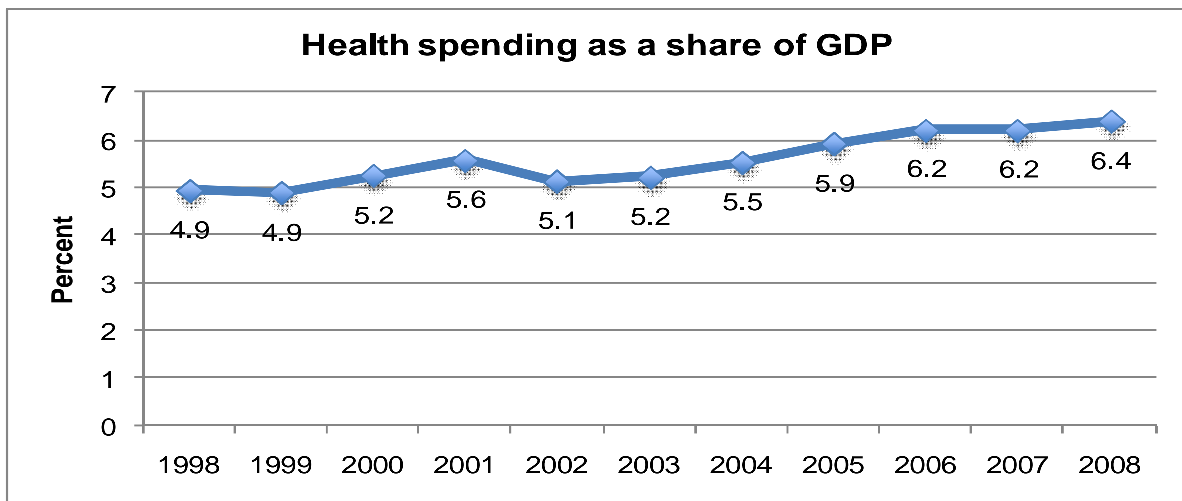
This section examines trends in health financing in recent years in Vietnam and includes a review of sources and type of expenditure. A comparative regional review of expenditures is also presented. As will be shown, the bulk of spending in Vietnam is from private out-of-pocket spending. This section considers some of the main drivers of health expenditures and considers projections for future funding based on international experiences.

2.1.1 Health spending trend and future projections

Total health expenditure, as a proportion of gross national product (GDP) has risen steadily over the past ten years. In 1998 the figure was 4.9% and it stood at 6.4% in 2008 (Figure 2.2 below).

Per capita health spending in Vietnam in 2008 was VND 1.1 million, which when calculated in purchasing power parity terms is equivalent to US$PPP 178. Per capita health spending has increased rapidly when calculated in current prices, there was an increase of 4.6 times between 1998 and 2008.

Figure 2.1 Health Spending trend 1998-2008



Source: MoH / HPG (2010)

Forecasts indicate that, in 2015, total health expenditures could amount to 8.8% of GDP and public health expenditures to 3.4% of GDP (Castel 2010). From a health insurance funding perspective Castel suggests that if in 2015 the state budget finances half this budget, to match the rest, health insurance must raise the equivalent of about 1.7% of GDP in 2015.

2.1.2 Sources of funding and spending by activity

A review of funding sources for health care shows an increase in public funding for health in recent years, which in 2008 amounted to 43% of total health spending (MoH/HPG 2010). The 2010 Joint annual Health Review states that according to preliminary results, the rate of growth of state spending on health in 2009 is higher than the average growth in the state budget. The share of

total state budget spent on health increased from 4.8% in 2002 to 7.4% in 2007 and preliminary estimates for 2008 put this share at 10.2% (MoH/HPG 2010).

The health sector has also received funds mobilized from state treasury bonds to invest in infrastructure for district general hospitals and inter-district regional hospitals. In 2008 and 2009 VND 3.7 trillion and VND 3.0 trillion were allocated to upgrading projects from treasury bonds (MoH/HPG, 2010).

With the increase in the public finance share out of total government spending, household out-of-pocket spending has fallen. In Vietnam, household out-of-pocket spending as a share of total health spending has fallen from 65% in 2005 to 52% in 2008 (MoH/HPG, 2010).

Increased priority has been given to preventative medicine over the past few years. National Assembly Resolution No. 18/2008/QH12 (GoV, 2008) directs that “at least 30% of state budget health spending be reserved for preventive medicine”. According to data from the National Health Accounts 2004-2007, the share of spending on preventive medicine out of total state budget spending on health increased rapidly in 2006, reaching 30.7%, compared to the 2005 share of 23.9% (MoH/HPG, 2010).

The state transfers for health insurance are expected to increase from about 0.36% of GDP in 2009 to 0.5% of GDP in 2010 and to remain stable as a share of GDP in the years to 2020 (Castel 2010). The author states that two factors explain the increase. First, starting in 2010, the state budget will cofinance half the cost of students’ health insurance cards. Second, in 2010 the official poverty line will be adjusted and the lists of the poor will be totally revised. With the current poverty line, households with per capita income lower than VND200,000 per month in rural areas, and VND260,000 in urban areas, are defined as “poor.” These thresholds are likely to be increased in 2010 to VND300,000 and VND390,000, respectively (Check have they been increased). ILSSA projects that with these new levels, the number of registered poor may reach 12.3 million in 2010. This larger number should lead to an increase of about VND1.1 billion in state subsidies for the poor.

2.2 Regional comparisons

As with many countries of a similar socio-economic level, private in Viet Nam is high relative to public spending (Table 2.4). There has however been a notable reduction in private spending in Vietnam in recent years. In 2005% private spending stood at 65% whereas in 2008 the figure was reduced to 52% of total spending (MoH/HPG 2010).

The level of private spending is still considerably higher than Thailand, which has seen a reduction in private payments from 43.9% in 2000 to 26.8% in 2007 over the same period. Vietnam’s private expenditure is now slightly lower than China (55.3%) and Malaysia (55.6%) and higher than the Republic of Korea (45.1%), Indonesia (54.5%) and the Philippines (34.7%).

Table 2.3 Health Financing Indicators, Selected countries

Country	Total expenditure on health as % of gross domestic product (GDP)	Government expenditure on health as % of total expenditure on health	Private expenditure on health as % of total expenditure on health	Per capita total Spending on health (PPP - int. $)	
	2007	2007	2007	2000	2007
Viet Nam	6.2	39.3%	60.7	76	183
Thailand	3.7	73.2	26.8	159	286
Philippines	3.9	34.7	65.3	79	130
Rep. of Korea	6.3	54.9	45.1	809	1688
Indonesia	2.2	54.5	45.5	48	81
Singapore	3.1	32.6	67.4	1167	1643
Malaysia	4.4	44.4	55.6	304	604
China	4.3	44.7	55.3	108	233

Source: WHO, 2010

The continued high level of private payments highlights a lack of protection from the financial consequences of illness. Liebermann and Wagstaff (2009) report that in 1997-98, over 15% of the Vietnamese people recorded out-of-pocket health expenses that exceeded 25% of their discretionary income (measured as non-food consumption).

The World Health Organisation Health Financing Strategy for the Pacific Region (2010-2015) propose that if progress towards universal coverage is to be made out-of-pocket spending should not exceed 30%–40% of total health expenditure (WHO, 2010)

Table 2.4 Table: Tax Revenue as % of GDP, Selected Countries

Country	1990	2000	2009
Viet Nam	11.5	18.0	20.3
Thailand	16.6	13.2	14.6
Philippines	14.1	13.7	12.8
Korea, Rep. of	14.8	17.9	15.5
Indonesia	17.8	8.3	11.6
Singapore	14.6	15.1	…
Malaysia	17.8	13.2	15.7
China	15.1	12.7	17.7

Source: ADB (2010)

Tax clearly plays a substantial role in subsidising health care in Viet Nam. Tax subsidies are used on both the demand side (to pay for premiums for specific groups) and on the supply side (budgets for health providers and salaries for health workers). Viet Nam's tax revenue collection as a proportion of GDP almost doubled in the period 1990-2005 from 11.5% to 22.8% (Table 2.5). Revenue collection declined in 2009 but Viet Nam still manages to collect more tax revenue than any of the countries in the review.

2.3 Is there a funding gap?

Vietnam's total health expenditure stood at 6.4% of GDP in 2008 (MoH/HPG 2010). Forecasts suggest that spending could rise to 8.8% of GDP by 2015 (Castel, 2010). There are likely to be a number of factors which are driving increased health expenditures. For example, there is a correlation between income and health spending. As Vietnam moves towards middle income country status, based on international experience health expenditures are predicted to increase. However there are other important factors relating to changing demographics, disease profile, and importantly the provider payment system and provider regulation (e.g. increased autonomy).

It is argued that the rise in non-communicable diseases has led to a rapid escalation in health care costs, because the costs of treatment are 40 to 50 times higher than treatment of communicable diseases (due to the requirement for high technology diagnostics, drugs and prolonged treatment periods). For example, heart surgery can cost from 100 to 150 million VND and a course of treatment for hypertension from 20 to 30 million VND (MoH/HPG 2010). A recent survey of the average costs of outpatient and inpatient treatment for insured patients in 16 hospitals in 2005 and 2008 found that the average cost for one outpatient visit had increased in all hospitals and was between 2.3 to 3 times higher in 2008 than in 2005. The increases were highest in district and provincial hospitals. Average costs for inpatient admissions during the same period were 2 times higher in 2008 compared to 2005 (MoH/HPG 2010).

It is highly likely that the strong promotion of social mobilization, joint ventures, business partnerships in public hospitals and fee-for-service payment system also play an important role in driving expenditures, given the incentives associated with the fee for service payment system. The results of the 2007 Hospital inventory indicates that the main source of revenues for hospitals is user fees (accounting for 59.4% of the total) and this has increased 26.5% compared with 2006 (Liebermann and Wagstaff, 2009).

The nature of health care benefits provided as part of an insurance benefit package will determine costs. A recent estimate of the cost of providing key health services suggests that low-income countries would need to spend just less than US$44 per capita on average in 2009, rising to a little more than US$60 per capita by 2015. This estimate includes the cost of expanding health systems so that they can deliver all of the specified mix of interventions. It includes interventions targeting non-communicable diseases and those for the conditions that are the focus of the health-related Millennium Development Goals (MDGs) (WHO, 2010). Viet Nam currently spends $183 (PPP Int. $) per capita on health which suggests that the country can afford key services. The challenge however is how resources can be pooled to ensure those individuals who require health services are able to access them, and also how these resources can be channelled to key services, rather than care which may yield little benefit. These are the subject of the next sections of this report.

2.4 Summary

The international experience shows that the revenue collection challenge for health is two-fold: 1) how to raise overall general government revenues; and 2) how to raise new funds that could go directly to health in a way that reduces the financial barriers to care such as the burden of out-of-pocket (OOP) expenditures on health. The obligation to pay directly for services at the time of need presents a barrier to people seeking care when they do not have the financial means at hand; this has a particularly dire impact on the poor. New sources of funds should aim to increase the proportion of prepaid contribution mechanisms over OOP expenditures.

Vietnam appears to be making good progress in relation to increasing government expenditure and reducing private expenditures. There are concerns however about the sustainability of funding.

Whilst some of these concerns relate to the changing socio-demographic and health profile, much is also driven by the way in which services are purchased, resources allocated and providers are paid and regulated.

3 Risk Pooling

3.1 Introduction

The achievement of universal coverage by 2014 is a key strategy for Viet Nam. To date, 58% of the population are enrolled in either the compulsory or voluntary schemes. Approximately 36 million people are currently not covered (MoH, 2011). The aim is to incrementally increase coverage between 2011-2014 to attain universal coverage and to ensure that the risk related to financing health care is borne by all groups of the population and not by specific groups or individuals. Liebermann and Wagstaff (2009) state that expanding coverage to a larger section of the population; deepening coverage so that patients pay a smaller fraction of the cost out-of-pocket; and cost containment are three main challenges facing the system.

The World Health Organisation Health Financing Strategy for the Pacific Region (2010-2015) proposes four target indicators to monitor and evaluate overall progress in attaining universal coverage (WHO, 2010b); i) out-of-pocket spending should not exceed 30%–40% of total health expenditure; ii) total health expenditure should be at least 4%–5% of the gross domestic product; iii) over 90% of the population should be covered by prepayment and risk pooling schemes; and iv) close to 100% coverage of vulnerable populations with social assistance and safety-net programmes. As was shown in the previous section, out-of-pocket spending is well over the WHO target and this section also highlights gaps in total coverage and in coverage of vulnerable groups. Whilst total health spending exceeds the WHO target, the bulk of funding is sourced from out of pocket spending.

This section reviews Viet Nam's progress in moving towards universal coverage and begins with a brief overview of trends in insurance coverage by groups in the compulsory and voluntary schemes, highlighting current gaps in coverage. This is followed by an assessment of how health insurance status impacts on access to care, health expenditures and financial protection. The government has outlined a roadmap for universal coverage with sequencing of group expansion. The section continues with a review of international experience in expanding coverage. A number of countries in the region have achieved universal coverage or have a high proportion of their population covered by insurance. The Republic of Korea (Xu et al., 2010) and Malaysia (Yu, 2008) have achieved universal coverage; Thailand has achieved near universal coverage (98% of its population) (Wibulpolprasert and Thaiprayoon, 2008), and China covers 87% of its population (Meng and Tang, 2010), albeit with concerns about the depth of this coverage. The experiences of these latter two countries and the countries of the former Soviet Union and Central and Eastern Europe will be reviewed. Specifically, the financing of expansion to universal coverage is reviewed and issues relating to implementation and impact – in terms of access and financial protection - are assessed. The final section considers these lessons within the Viet Nam context.

3.2 Overview of Health Insurance

As with many other countries in the region, the development of health insurance in Viet Nam has followed an incremental approach. Introduced in 2003 following the issuance of Decree 299, the compulsory scheme initially covered state officials and civil servants, state enterprise workers, those receiving social security allowance and employees working in non-state enterprises (where greater than 10 employees were registered. Decrees 58 (1998) and Decree 63 (2005) provided the legal framework for further enrolment of a number of other groups including the elderly, foreign students, kindergarten teachers, relatives of military personnel and the police, the poor and army veterans. A Health Insurance Law was passed in 2008 and came into effect in July 2009 which extended compulsory insurance further to cover children under 6 years old and near-poor.

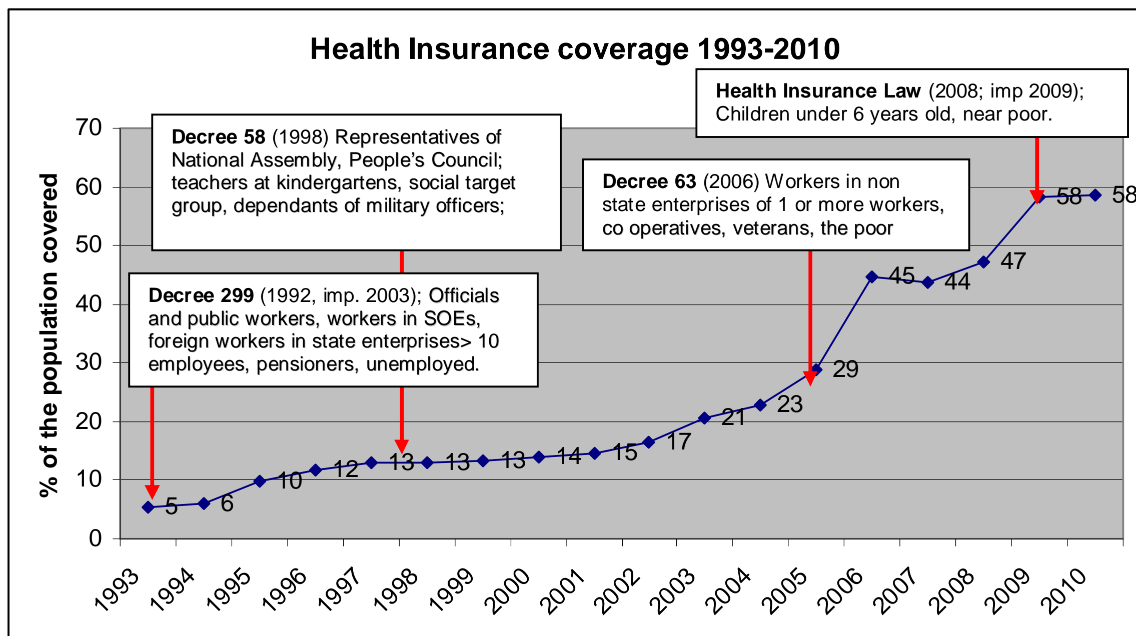
Students, dependents of the compulsory insured and those working in the informal sector are currently to be covered via the voluntary scheme[2]. The compulsory and voluntary schemes are administered by the Viet Nam Social Security (VSS) and currently cover approximately 58% of the population (see figure below). Approximately 36 million individuals currently remain uninsured.[3]

The proportion of total health spending from health insurance fund was 17.6% in 2008 (MoH/ HPG 2010).

3.2.1.1 Trends in health insurance coverage

Health insurance coverage increased steadily between 1993 and 2003 with approximately 20% of the population covered by the end of this period (Figure 3.3. Between 2003 and 2010, the figure increased to 58% as large numbers of the poor and children under six were incorporated into the scheme. Even though the contributions for both these groups are covered by state subsidies, 100% coverage is still to be attained. It is important to note that the government subsidised health insurance contributions for 11 out of 24 categories in 2010 (JAHR 2010).[4]

Figure 3.2 Trend in health insurance coverage (1993-2010)



Source: MoH (2010)

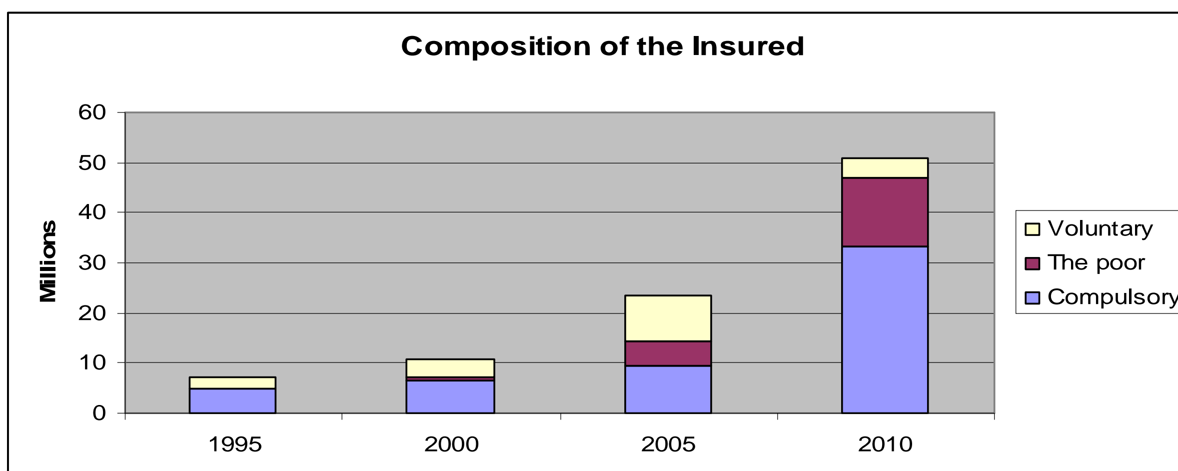
3.2.1.2 Composition of the insured

The bulk of the insured are either covered by the compulsory scheme or classified as "poor" with subsidies paid by the state (Figure 3.4). From 2006, the number of poor people issued with health

[2] See the recent report by the MoH (2010) on the possibility of implementing universal health insurance and the Joint Annual Health Review 2008 (MoH/HPG, 2008) for a detailed history of the development of health insurance.
[3] See Annex C for a detailed breakdown of insured by group and region.
[4] The precise number of categories requires confirmation. The recently published "Viet Nam Social Security" document recently published by the VSS (2010) lists 28 categories.

insurance cards increased very rapidly, tripling compared to 2005. By 2010, the total number of poor people who had been issued with health insurance cards was 13.5 million people, accounting for approximately 27% of all people with health insurance (see annex C for detailed breakdown of numbers insured by population group).

Figure 3.3 Composition of the Insured (1995-2010)



Source: MoH (2011)

The majority of individuals enrolled in the voluntary scheme are full time students who are generally enrolled en masse by the insurance agency who collects contributions at schools or colleges. Premiums are paid by the student's family, and it has been stated that typically there is little that is voluntary about the enrolment process (World Bank, 2009).

3.2.1.3 Coverage by Region

Health insurance coverage rates vary across the country. Table 3.6 presents a breakdown by region and also includes rates for Hanoi, Ho Chi Minh City (HCMC) and the provinces with highest and lowest cover to illustrate variations.

Table 3.5 Health Insurance Coverage by region

Area	Population (mns)	Insured (n, mns)	Proportion (%)
Viet Nam	86.0	50.1	58.2
Red river delta	19.6	10.8	55.1
Midland and northern mountainous	11.1	7.1	64.2
North and south central coast	18.9	11.4	60.1
Central Highland	5.1	3.2	63.2
South East	14.1	8.3	59.1
Mekong region	17.2	9.2	53.6
HCMC	7.1	4.6	63.8
Hanoi	6.5	3.7	57.1
Bac Kan – High cover	0.3	0.3	96.5
Pho Tho - Low cover	1.3	0.4	29.0

Source: Adapted from MoH (2010) data

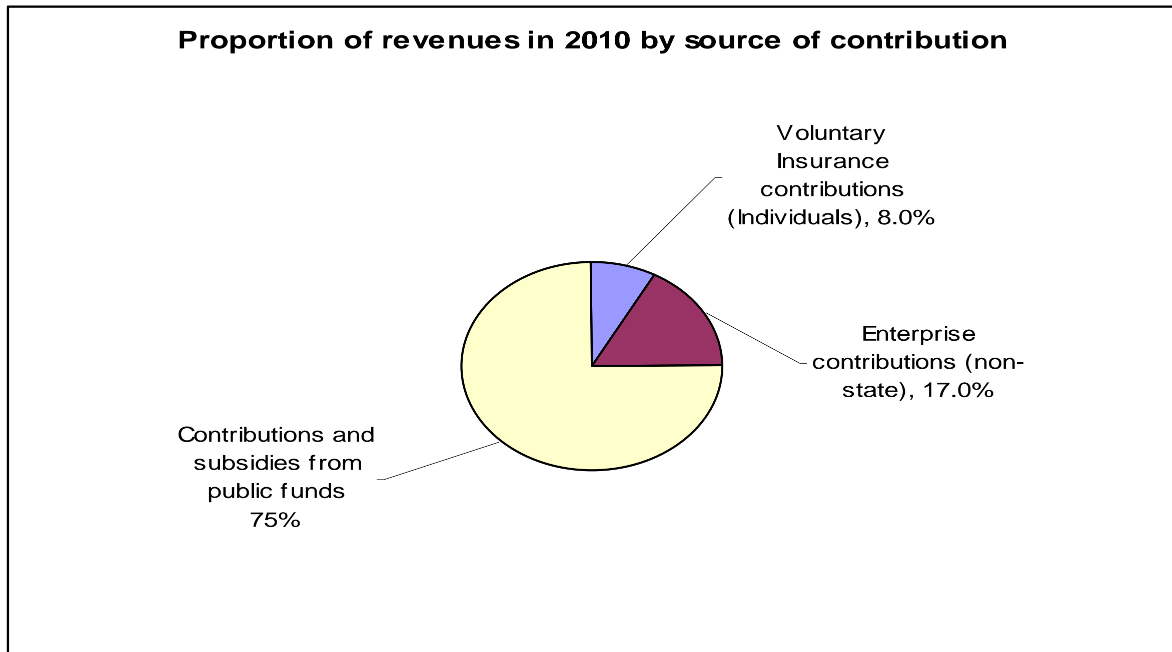
In the Mekong region 53.5% of the population are enrolled, whereas in the Midland and northern mountainous region over 64.2% of the population are covered. Coverage is higher in HCMC (63.8%) compared to Hanoi (57.1%). At the province level enrolment is highest in Bac Kan (96.5%) a province with a very small population, and lowest in Phu Tho province (29%).

The reasons for differing regional coverage include population characteristics (e.g. numbers of poor, near poor, informal, state worker) and also VSS administrative capacity at province and district level.

3.2.2 Premiums and benefit package

Premiums are set at 4.5% of salary (increased in Jan 2010), pensions or benefits depending on the insurance group. For those not earning a salary (e.g. the poor) the health insurance premium is equivalent to 4.5% of minimum salary. The state paid VND 394,200 (4.5% of the minimum wage) per premium in 2010 for the poor (MoH/HPG 2010). Since 2008, the state budget has also subsidized 50% of the health insurance premium for members of near poor households who participate in voluntary health insurance, part of the premiums for health insurance of students, and the entire premium for children under six years. Figure 3.5 shows that contributions and subsidies from public funds represented 75% of all health insurance revenue in 2010.

Figure 3.4 Proportion of health insurance revenues in 2010 by source of contribution



Source: Adapted from MoH 2010 data (p.32)

Premiums of individuals enrolled in the voluntary health insurance scheme differ. In urban areas the premium is VND 320,000/person/year and in rural areas it is VND 240,000/person/year. The premium for students enrolled in the voluntary health insurance scheme is VND 120,000/person/year in urban areas and VND 100,000/person/year in rural areas.

Benefits are similar for voluntary and compulsory health insurance members. The benefit package covers most outpatient and inpatient care received at government facilities. In addition, some health insurance members are now entitled to reimbursement of their transportation costs, in case they are referred to a different level of care. Exclusions include interventions covered by vertical programs such as HIV/AIDS prevention and treatment programs, drugs not on the MOH list, treatments not yet approved by MOH, various “luxury” interventions such as cosmetic surgery, dental care, treatment of self-inflicted injuries, and treatment for drug addiction.

For high-tech, high-cost medical services insured patients (except for a few designated insured groups) are only entitled to partial refund of the costs by the health insurance agency, with the rest to be paid for out of their own pocket. High health care costs of VND 7 million or more will be reimbursed up to 60%, but only to a ceiling of VND 20 million per health service use, with the remainder to be paid out of the patient’s pocket to the health service provider.

People covered by voluntary health insurance pay 20% of the treatment costs (the co-payment is eliminated if outpatient care costs are less than VND 20,000). For people who have been covered by voluntary health insurance continuously for 24 months or more, the VSS will pay 50% of some drugs which are not on the regular list of drugs covered by health insurance, for example some drugs for cancer or for prevention of rejection of organ transplants. The amount covered by health insurance will not exceed VND 12 million per year. The poor must pay a 5% co-payment (MoH/HPG 2008).

3.2.3 Factors impacting uptake of health insurance

The Ministry of Health recently completed a study which assessed some of the key challenges in enrolling different groups to health insurance, particularly those working in private enterprises and the near poor for which health insurance coverage rates are very low (MoH 2011). The MoH presents enrolment figures for private enterprises in 7 provinces between 2005 and 2008 which show that approximately 20% of private enterprises were covering their workers. Enrolment is higher in Hanoi with 30 private enterprises reporting that 60% of workers were covered (MoH, 2011). The main issues relating to low enrolment are that private enterprises are either unaware of their obligations regarding health insurance for their workers or they evade making contributions as the administrative structure for health insurance implementation is weak. Employees of private enterprises do not want to be insured because they consider the premiums to be too expensive; the administrative hurdles for accessing treatment once insured are high and take time; the drugs included in the benefit package are limited and of poor quality’.

Efforts to cover the near poor are also proving a challenge and relate to the inability or unwillingness to pay for health insurance and also the lack of clear guidelines relating to roles and responsibilities for implementing health insurance at the local level. Feedback from the provinces is that the aggregate premium for near poor households is too high, the near poor need to pay 20% of health care costs, and services are often some distance away. Near poor individuals often wait until they fall sick, or get defined by the local authority as a “poor household” to get free insurance.

Whilst some local households wish to purchase health insurance, the premium is too high, costing millions dong for a family even with a 50% subsidy (MoH 2011). Even higher subsidies to the 50% near poor have not encouraged large increases in insurance coverage among the near poor. For example, in Ben Tre province, as part of a health sector project over 59,000 cards were purchased and the near poor were offered a further 30% subsidy (80% total subsidy) in efforts to enrol them. The study found that just over 5% of the near poor purchased cards and the feedback was even at 20% of the premium the price was too high. In another province - Tay Nihn - only 1.5% of near poor households are currently insured.

In 2010, approximately 650,000 near poor people enrolled in health insurance across the country (MoH, 2011). In the Mekong region alone, 439,157 near poor were enrolled in health insurance. This region is supported by the Mekong Health Support Project which funds communications, identification and drawing up lists of near poor households. In addition to the 50% state subsidy, the project also subsidies 30% of the premium. Beneficiaries thus contribute only 20% of the premium. According to the roadmap to achieve universal health insurance, according to the Health Insurance Law, coverage of the near poor should be implemented starting in 2010.

Most provinces have not yet prepared master plans for implementation of health insurance as set forth in the roadmap. Local authorities argue that implementation of health insurance is the responsibility of the health sector and social security, thus expansion of beneficiaries is facing enormous difficulties. A common problem for enrolment is that the agencies responsible for implementation do not have clear guidelines for implementation: they do not have lists of near poor nor a budget to implement health insurance. Whilst there is a steering committee for poverty reduction at the district level, the Department of Labour, Invalid and Social Affair has not produced any guiding documents regarding the process of defining near poor households and therefore commune leaders cannot develop lists for implementing health Insurance (MoH 2011). There is also little communication about health insurance. In previous years (up to 2002) health insurance was communicated to the community but this is not currently common place.

Castel's (2010) simulations indicate that if universal coverage is achieved, the policy that links the basic premium for health insurance to the minimum wage (and thus to general income growth) will be successful in balancing health insurance finances in 2015 and, probably, in supporting the growth of the health sector in the following 5 years. If half the workers in the informal sector do not follow the health insurance regulation or if formal employment in the enterprise sector does not grow as expected, the revenue shortfall could hit 0.3%–0.5% of GDP.

3.3 Impact of Insurance on access and financial protection

A number of studies have examined the impact of health insurance on access and expenditures for different groups and income categories. Liebermann and Wagstaff (2009) state that the evidence from Vietnam suggests that insurance reduces the financial risk that people incur, especially large amounts of spending over the year, although the effect is small—a reduction in the risk of catastrophic spending of 1 percent to 3 percent. The same authors suggest that, on balance, insurance lowers out-of-pocket payments—the higher costs caused by extra utilization are not enough to outweigh the lower costs per contact. However, the reduction in out-of-pocket spending attributable to insurance is relatively modest (25 percent). Liebermann and Wagstaff (2009) state that this finding is broadly consistent with previous studies, with most finding a limited impact of insurance on out-of-pocket payments, the exception being a study of the voluntary program in Hai Phong (Jowett et al. 2003) which found a very large impact. Two studies (Wagstaff and Pradhan 2005; Sepehri et al. 2006a) find an impact in the range -20 percent to -35 percent, and another (Trivedi 2003) found a zero impact. A recent study of the scheme for the poor (Wagstaff 2007b) also found a zero effect. Ekman and Bales (2008) conclude from their review of health insurance studies that they "provide strong evidence of a positive and causal impact of this type of insurance on key policy outcomes".

Approximately 30% of poor people with health insurance still encounter catastrophic health spending (measured as health expenditures exceeding 10% of non-food expenditures) (MoH/HPG 2010). This reflects the reality that people with health insurance use health services more, yet health insurance does not cover all health care costs, such as purchase of medicines that are not on the list covered by health insurance, health care in private facilities, food and transport costs

related to health care seeking, etc. Thus, besides expansion of coverage of the population, there is a need to pay attention to the depth and height of coverage, increasing the package of benefits to reduce out-of-pocket health spending of people with health insurance. The application of 5% co-payments for poor people with health insurance is also causing difficulties in terms of financial access for the poor, especially the poor and ethnic minorities in disadvantaged areas.

There are concerns that the goal of pooling and risk sharing in the health insurance scheme has been affected by the health insurance fund management mechanism in the past few years. People with health insurance in some poor or mountainous provinces tend to use health services less (due to many factors, including limitations of the health provider system, geographic factors/transport, culture, and especially financial ability of the poor to pay fees not covered by health insurance), so the health insurance fund in these provinces is in surplus, while the health insurance funds in large cities and provinces with more developed socio-economic conditions usually have a severe deficit in their health insurance fund. This has led to the health insurance funds in poor areas cross-subsidizing care for large cities in some provinces (MoH / HPG 2010).

3.4 Moving towards universal coverage

The passing of the Health Insurance Law in 2008 reaffirmed the goal of universal health insurance coverage and laid out the roadmap to reach this goal by 2014. Table 3.7 provides a breakdown of the key groups required to join to achieve the goal of near universal coverage and the numbers requiring enrolment. Approximately 5.6 million workers employed in non-state sector enterprises need to be enrolled. There have been challenges enrolling this group as private enterprises are not keen to enrol workers and systems to enrol them are also lacking. The other key groups include the near poor, pupils and students, relatives of employees and farmers and other professions working in the informal sector.

Table 3.6 Breakdown of key groups currently not covered by health insurance in Vietnam

Participants	Number in Group (mns)	Covered by HI (mns)	% covered by HI	Currently not covered by HI (mns)
Enterprises Workers	11.9	6.4	53.4	5.6
Near Poor	6.1	0.7	11.4	5.4
Pupils and Students	13.8	9.8	71.1	4.0
Relatives of employees	6.8	0.0	0.0	6.8
Informal Sector	11.7	3.9	33.4	7.8
Total	50.3	20.8	58.7	29.6

Source: Adapted from MoH (2010)

Table 3.8 provides a roadmap for group enrolment. By the end of 2009 all children under six years of age should have been enrolled in health insurance. According to the MoH data there are still 1.9 million children under six who are yet to be enrolled. By the end of 2010 5.4 million “near poor” and 4 million students require coverage if the roadmap timelines are adhered to. The final two groups - including relatives of employees and farmers/ informal sector workers - totals 14.6 million people.

Table 3.7 Milestones for enrolling specific population groups into health insurance

Year	Group to be covered by health insurance
2009	Children under six years
2010	Near poor, pupils and students
2012	People in agricultural, forestry, fishery and salt making households
2014	Dependents of workers, cooperative members, family enterprises and other groups.

Source: MoH 2010

3.5 Lessons from other countries

International evidence highlights how some countries have attained, or are close to, universal coverage. This section reviews the experiences of Thailand, China and the countries of the former Soviet Union and Central and Eastern Europe, focussing on how these countries funded universal coverage, implementation challenges, and the impact of insurance coverage on access and health expenditures.

3.5.1 Funding Universal Coverage: Experiences from Thailand and China

A key policy dilemma is how to fund insurance contributions of those who are not employed in the formal sector. Thailand and China have both had success in expanding coverage to include informal workers and their families. Governments in both countries have invested considerable resources to attain universal / high levels of coverage.

Thailand provides an important regional example of how universal coverage has been achieved with the addition into the scheme of informal sector workers. The country has three main health insurance schemes covering i) civil servants and their dependents (CCS), ii) private sector employees and temporary public sector employees (Civil Service Scheme); and iii) population not covered by schemes (i) and (ii) (the Universal Health Care Coverage Scheme (UCS)). Near universal coverage has been attained with the expansion of the UCS. The number of uninsured decreased from 20% of the total population in 1998 to 2% in 2007 (Wibulpolprasert and Thaiprayoon, 2008). The UCS currently covers approximately 75% percent of the population with a comprehensive package of care, including both curative and preventive care. An important feature of the UCS scheme is the source of funding for enrolees, which is financed solely from general tax revenue. The additional state funding commitment to finance universal coverage is evident by the figures which show that government spending on health (as a proportion of total spending on health) rose from 56.1% to 73.2% between 2000 and 2007. It is widely acknowledged that political and financial commitment to universal coverage in Thailand was key to its attainment.

China, like Thailand, has three key insurance schemes which in 2008 covered 87% of the population and has also moved towards universal coverage in an incremental fashion. The Urban Employee-based Basic Medical Insurance scheme (UEBMI) covers 15% of the population, the Urban Resident-based Basic Medical Insurance scheme (URBMI) covers 4%, and the New Rural Cooperative Scheme (NCMS) covers 68% of the population. In 2008, nearly 90% of the rural population was covered by the NCMS, while 65% of the urban residents were covered by urban health insurance schemes. After the NCMS was set up in 2003, its rural coverage expanded rapidly, increasing from 8 million in 2003 to 833 million in 2009. Over the past few years, an average of 80% of premiums has been subsidized by the government, with 20% coming from individual farmers (Meng and Tang, 2010).

The expansion of health insurance in China has been supported by government subsidies through a medical assistance program (MFA) for the poor. Both the NCMS and MFA were introduced in 2003 and designed to close the health security gap between rural and urban areas and between the rich and the poor (Meng and Tang, 2010). Target populations are identified by the county (district in urban areas) Department of Civil Affairs in collaboration with community government organizations. By the end of 2009 approximately 93 million poor residents were covered by the MFA. Government subsidies to the MFA have continuously increased since it was first started. In 2003, the urban MFA received US$ 31 million from the central government, increasing to US$ 62 million in 2006.

3.5.2 Funding Universal Coverage: Experience from the former Soviet Union and countries of Central and Eastern Europe (FSU/CEE)

The countries of the FSU/CEE have adopted different approaches towards covering their respective populations with health insurance. In some countries, the eligible nonworking population is covered through transfers from central or regional budgets, or from dedicated funds, such as employment funds (Slovakia) or pension and unemployment funds (Kyrgyzstan prior to 2004). In most countries, transfers from the central budget are used, although mechanisms vary regarding the basis for calculating these transfers. It is often a matter of budgetary negotiations, with governments paying what they deem they can afford. In Serbia, for example, despite contributions on behalf of vulnerable groups being based on the minimum wage, general revenue allocations have been based on historic levels and are ad hoc in practice (Kutzin et al., 2010).

In some cases, however, there is a specific liability on the budget that is enforced. In the Czech Republic, for example, there is a monthly central budget transfer for the economically inactive population set at 13.5% of the average wage, as defined by the Ministry of Finance. Another example is the Republic of Moldova, where the health insurance law specified that the per capita contributions from the budget on behalf of state-insured individuals must be equivalent to the estimated average per capita cost of the benefits package, leading to annual increases in these transfers. Estonia is notable for its near-complete reliance on payroll taxation, with very minor transfers to the Estonian Health Insurance Fund for non-contributing individuals entitled to coverage, and in Croatia subsidies for the non-working population were made implicitly by retroactively covering shortfalls, rather than these being budgeted and paid prospectively.

General revenues continue to play an important role in health system funding, even in many of the FSU/CEE countries that rely on payroll tax as the predominant revenue collection mechanism. This may take the form of explicit subsidies for the non-contributing population. In the Republic of Moldova, over 65% of the funds managed by the National Health Insurance Company (NHIC) took the form of transfers from the central budget to cover the premium of defined state-insured non-contributing individuals. Alternatively, in Kyrgyzstan, the state budget transfers most of the funds for health from general revenues to the Mandatory Health Insurance Fund (MHIF) to provide a basic package on behalf of the entire population). In addition, payroll taxes exist and central budget transfers to the MHIF take place, in order to achieve a complementary contributory entitlement for the insured population. Hence, public funding for both the Moldovan and Kyrgyz systems comes predominantly from general revenues, although each has something called an "health insurance fund". In all countries, general revenues also are used to directly fund population-based and public health-oriented programmes, such as those for tuberculosis (TB), psychiatric care, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and substance abuse.

Returning to the Viet Nam context the feasibility of covering the remaining uninsured population via government subsidies was explored in a recent World Bank report. Liebermann and Wagstaff (WB, 2009) estimate the fiscal implications of extending health insurance coverage in Viet Nam to attain universal coverage. The authors put forward an alternative option to the current insurance system,

whereby all contributory and non-contributory insurance payments are funded via tax subsidies. They explore the fiscal implications of one scenario in which universal coverage is achieved by increasing the fiscal deficit (3.8% of GDP to 4.4% of GDP at the time of the study). Liebermann and Wagstaff argue that as (insured) households would spend less on out-of-pocket payments, there is a case for raising taxes as a quid pro quo.

3.5.3 Implementing universal coverage: Experience from Thailand

Important lessons relating to rapid implementation (investment in infrastructure and human resources) need to be considered, and importantly whether the coverage is sustainable in the long term. Following the increase in coverage in Thailand, a survey found that more than 70 percent of health personnel claimed that their workload increased as a result of the UCS (WB, 2010). A comparison of service utilization between 2002 and 2007 revealed that the utilization rate of public health care services increased more than 20 percent for outpatient care and nearly 20 percent for hospital admissions (WB, 2010). The findings from Thailand suggest that movement towards universal coverage requires planned investment in the health service infrastructure, not least health workers; that creating unrealistic expectations and demand amongst the insured needs to be avoided; that there is a risk of underestimating the effect of universal coverage on the growth of the private sector, particularly those services that cater for the urban rich and the foreign patients; and that countries should balance the use of financial incentives to solve the problem of human resources for health with non-financial incentives, like social recognition, and greater fairness in personnel management.

3.5.4 Insurance coverage and financial protection: Experience from China

There has been considerable emphasis on extending the *breadth*[5] of health insurance coverage in countries across the region, however there are concerns in many countries about the depth and height of coverage. Whilst policy has focussed on the aim of developing a universal risk pool, equally important is the nature of cover for those individuals in the risk pool, as there is little point in being insured if the benefits are limited and significant additional spending is associated with any episode of health care.

Depth of insurance coverage is a current concern in Viet Nam. Currently, the proportion of total health spending sourced from health insurance was 17.6% in 2008 (MoH/ HPG 2010). Given that approximately 58% of the population are covered with insurance, this figure appears very limited, suggesting a limited benefit package associated with either compulsory or voluntary health insurance.

Evidence from China suggests that health insurance coverage does not necessarily guarantee financial protection for individuals who access health care. Wagstaff and Lindelow (2005) find increased out-of-pocket payments with insurance coverage in China; however they suggest the welfare implications of this finding are obvious. Individuals are likely to weigh any extra risk of large out-of-pocket payments against the additional health gains from being able to receive more extensive and more sophisticated medical care once insured. The authors state that on balance, people may be better off despite facing a higher financial risk. They add however that if providers exploit their informational advantage and take the opportunity of insurance coverage to deliver more expensive medical care that the individual would not have chosen, had he been fully aware of the magnitude of the additional health benefits and additional out-of-pocket expenses, then the welfare gains associated with insurance are less clear.

[5] height = extent of costs covered; depth = which services included; width = population covered)

However in Thailand, Vasavid et al. (2004) reported that household health expenditures decreased after UCS implementation. They find that in 2002 household savings on health care services among those currently insured by the UCS were approximately US$253.95 million and a year later the figure was US$334.89 million. Evidence from three low-income provinces found that enrolment in the UCS would ease the burden on household expenditures only if UCS beneficiaries seek care from facilities operated under the UCS. The proportion of people facing catastrophic health expenditures was also been reduced significantly from 5.4 percent in 2000 to 2.0 percent in 2006. It is also reported that the UCS has also brought at least one million Thais out of poverty.

3.5.5 Collecting health insurance premiums: Experience from the countries of the former Soviet Union and central and Eastern Europe (FSU/CEE)

The collection of insurance premiums from those working in private enterprise has been difficult in Vietnam. The VSS has responsibility for collecting revenues as part of its wider collection of social security revenues. There has been a lot of discussion internationally about the best way to collect health insurances revenues. It is insightful to understand how premium collection has evolved in the countries of the former Soviet Union and countries of Central and Eastern Europe. These countries have made different choices as to whether to make new purchasing agencies (typically compulsory insurance funds) responsible for the collection of dedicated taxes (integrated approach), or to have a separate body – typically either the general tax collection agency for the country or an agency with specific responsibility for collecting payroll "social taxes" – take on this function and then transfer the funds to be pooled by the purchasing agency (functional specialization approach). Both approaches have potential theoretical advantages and disadvantages.

In 2001 in the Russian Federation, payroll tax collection for compulsory health insurance was shifted from the Federal and Territorial Compulsory Health Insurance Funds to the general tax authority. The tax authority collects the "uniform social tax", which covers payroll contributions for health, pensions and other social security items. A specified portion of the uniform social tax is transferred to the compulsory health insurance funds. The rationale for this institutional change was to streamline the collection of all types of tax within a general budgetary framework to promote transparency. Similarly in Estonia, following years of lobbying by the health insurance agency, responsibility for revenue collection was shifted from the health insurance agency to the central tax administration. The rationale was that the switch in functional responsibility to the tax administration would allow the health insurance agency to focus on purchasing arrangements, or expenditure flows.

Countries have also experienced difficulties with the implementation of the integrated approach. In Bosnia and Herzegovina, for example, collection rates varied from 30% to 84% across health insurance funds (each of which was responsible for collecting its own payroll tax), due to such factors as different levels of unemployment, the extent of the informal sector and urbanization. Overall, the analysis found that only approximately 50% of what could be collected from formal sector workers was actually being obtained, and much of this was due to an unclear division of responsibilities – despite the apparent responsibility of the health insurance funds for revenue collection – for collection and enforcement between the health insurance funds and the general tax authority (Sanigest 2005).

It is recognized that revenue agencies and social security organizations have different requirements regarding data needs, record retention, and other related aspects of core processes. Also, there are generally differences in taxpayers covered, taxable income bases, and related items that must be taken into account. While such differences add complexity to implementation of integration projects, they are manageable issues that do not obviate the fact that the core

processes are common in both systems even as details may differ. Placing responsibility for collections with the tax administration eliminates duplication of core functions that would otherwise occur in the areas of processing, enforced collection of returns and payments, and audit of employers.

Placing responsibility for collections with the tax administration could also significantly reduce compliance costs for employers, with less paperwork as a result of common forms and record-keeping systems, and a common audit program covering VAT, income and payroll taxes, and social contributions.

A careful assessment needs to be made of the readiness of the tax administration to take on the new responsibility for collection of social contributions in Vietnam. The tax administration must currently have the capacity to take on this new role, or, the transfer should be incorporated into a modernization program being undertaken by the tax administration. A tax administration that is not well structured, has existing tax collection fragmented across different agencies, is not organized with effective processes for collection and audit, has poorly trained staff, and has ineffective management, will not be in a position to achieve the significant potential benefits of improved collection levels—and any transfer in these circumstances may in fact damage collections in the short term. In these cases, integration should be undertaken in conjunction with a modernization of the tax administration's structure and core collection processes.

3.6 Summary

No country has yet been able to guarantee everyone immediate access to all the services that might maintain or improve their health. They all face resource constraints of one type or another, although these are most critical in low-income countries. Hence whilst countries have moved to universal coverage - a key strategic goal - it is important to understand the content and quality of coverage. International evidence shows that most reforms towards universal coverage have been gradual. Social health insurance systems, for example, usually start by covering formal sector employees and slowly expand to other population groups - often starting with dependents of the employees. In most European countries that have achieved universal coverage, the transition took place over many decades, often taking more than 50 years. More recently, in Costa Rica, the Republic of Korea and Thailand, reform took between 20 and 30 years (Kutzin et al., 2010).

The 2010 Joint annual Health review suggests that three factors will strongly influence Viet Nam's roadmap towards achieving universal health insurance. These include:

- *The structure of Viet Nam's workforce*. Current targets for the year 2010 envisage that the agricultural workforce will account for less than 50% of the total labour force, falling to 30% by 2020. The high number of casual rural and urban labourers remaining in 2014-2015 is a hindering factor for ensuring participation in the health insurance scheme.

- *Capacity of the state budget:* With 40% of the population unable to afford health insurance premiums, the state budget needs to fund approximately USD 2.8 billion to ensure their health care needs.

- *Trend in development of the public health service delivery:* The JAHR stresses the importance of regulating hospital autonomy.

- *Strengthened capacity of the health insurance management institution.* Currently the health insurance system does not yet have software and unique individual ID numbers to manage health insured patients, as well as health care costs reimbursed by health insurance. The health insurance fund is managed and administered together with other types of funds,

such as the pension fund, in the Vietnam Social Security scheme, so there is a lack of professional specialization and specific health insurance skills.

Finally, It is important to note that during the transition process to universal coverage, population coverage often remains incomplete and sometimes may even become more unequal, with the poorest groups the least likely to be protected and often the last to benefit from extended coverage. It is here that existing community, cooperative and enterprise-based health insurance, as well as other forms of private health insurance, might have a role to play, protecting as many people as possible.

4 Purchasing and provider payments

4.1 Overview

Providers in Vietnam receive their income from three main sources: the budget, out-of-pocket payments by patients, and income from the health insurance agency. Concerns relating to the health policy impact of the current provider payment system relate mainly to the payment of hospitals and focus on the efficiency and cost escalation consequences associated with incentives introduced by fee for services (health insurance payments and out of pocket payments by patients) and norm-based state budgets paid within the context of increasing hospital autonomy. It is argued that the VSS currently plays a very limited role as an informed "purchaser" of health services: It acts largely as a passive payer of bills and in any case picks up only 17 percent of total health expenditures. Furthermore, neither VSS nor the states exercise much financial control over providers (Lieberman and Wagstaff 2009).

Hospital outpatient visits and inpatient admissions have increased by an average of 5 percent a year since 1998 (Lieberman and Wagstaff, 2009). Referring to the FFS system, the authors state that: "what can safely be said is that insurance in Vietnam has probably encouraged some overuse of services, but exactly how much is not known and nor will it be known how much of the increase is caused by patients too keen to seek care and how much is due to the provider being too keen to deliver care, incentivised by higher revenues". Lieberman and Wagstaff (2009),

The proportion of income hospitals receive from either FFS or the state budget is likely to depend on a number of factors and will be determined by the numbers of insured registered with a facility, the types of service provided in a facility, the charges for services, and the ability and willingness of patients to pay for services. Informal payments are also prevalent in Vietnam. In some higher level facilities the bulk of funding comes from FFS payments – be they from VSS, the uninsured or user charges for services not covered by the VSS. Conversely, at lower levels of the system where insurance uptake has been limited and where patients do not have the ability to pay, the bulk of funds will come from state subsidies.

Over the last past 10 years, the state budget has gradually been reduced as a source of revenue for many hospitals, and health insurance income has increased. As both fee-paying patients and health insurance pay providers on a FFS basis, there has been a gradual shift away from budgets toward FFS in the hospital sector as insurance coverage increases.

4.2 Strategy and JAHR 2010 implementation recommendations

A recent decree (62/2009/ND-CP) states that capitation payment should be introduced in all primary health care facilities. Capitation payments have been piloted since 2001, and to date there are 43 providers implementing capitation, mainly district general hospitals (MoH/HPG 2010). The 2010 JAHR refers to the preliminary results of capitation piloting which highlight that problems have been encountered as capitation funds have been significantly overspent in almost all hospitals. Furthermore, average costs of care through health insurance have not fallen, but have actually increased for both inpatient and outpatient services.

Hospital provider payment reforms (case-based payments) are also being implemented on a pilot basis at Ba Vi district hospital and Thanh Nhan municipal hospital. The 2010 JAHR argues that further implementation of case-based payments will require investment in hospital costing, the application of procedure codes and the adjustment of relative weights for diagnostic groups being

used internationally to make them appropriate for the Vietnamese context. The report also states that the Ministry of Health is developing a concrete roadmap for applying case mix payments.

Forthcoming government policy and implementation documents outline strategies and plans to tackle the unintended consequences of the existing system of payments (e.g. MoH Draft Health Strategy 2010-2020, MoH/HPG 2010). Whilst the broad provider payment strategy is defined, implementation plans are currently being discussed. Table 4.9 provides the provider payment recommendations outlined in the 2010 JAHR document.

Table 4.8 Provider payment reform recommendations (2010 JAHR)

Priority Issue	Short Term (2011)	Long term (2015)	Goal by 2011
Effectiveness in allocation and use of health financing resources remains limited	Develop a roadmap for applying new provider payment mechanisms including capitation and case-mix. Research to refine the capitation mechanism applied to curative care. Strengthen the reporting system and analysis of state budget reconciliation reports for the health sector in order to have accurate information for financial planning in the health sector. Set up a sectoral reporting system on state budget spending for health.	The Ministry of Health develops guidelines for performance based state budget allocation in both preventive and curative care. Bring into full play the role of the contracting mechanism for health service provider payments. Estimate costs for curative and preventive care to have a basis to estimate cost-effectiveness, and for estimation of the resources needed to serve as a basis for state budget allocation. Set up a mechanism for monitoring and evaluating efficiency and equity in allocation and use of state health budget spending.	Share of state health budget spent on preventive medicine increases. Share of state budget spent at the district and commune level increases. Projects for piloting capitation and DRG payments to providers in place. Set of indicators and state budget reconciliation report is widely disseminated.

Source: MoH/HPG 2010

The following section reviews how countries have reformed their provider payment systems and attempts to provide insights into some of the important implementation steps that need to be considered.

4.3 International lessons

4.3.1 Overview of International experience

The region offers an extensive literature on provider payment reforms. This section consider how countries have approached reform and considers two case studies to illustrate in detail two approaches, one from Thailand and the other from Kyrgyzstan. The section starts with an overview of regional experience.

Many countries (e.g. China, Thailand, Taiwan and Korea) appear to be moving towards mixed payment systems which including capitation and case-based payments. A key message from these countries is the incremental approach towards payment reform. For example in Taiwan, a pilot experiment with case payment initially included 28 frequent procedures, such as appendicectomy and haemorrhoidectomy and in Korea case payments began with pilot reforms on just a few conditions and have subsequently expanded to more conditions and more voluntarily participating institutions (Eggleston, 2008).

Jiujiang (China), one of the original pilot cities for Basic Medical Insurance (BMI), started out using FFS to pay hospitals, but in late 1996 switched to a fixed charge per inpatient day, having experienced a high rate of growth of medical expenditures under FFS. In 2001, the city switched again in an attempt to further stem expenditure growth, this time to capitation. After the switch to

capitation, medical expenditure per insured inpatient fell and the share of drug spending as a proportion of total spending fell from 76.5 to 59.8% (Eggleston, 2008).

Zhenjiang, the other BMI pilot city, started out using a fixed charge per inpatient day, but in 2001 started to experiment with a diagnosis-related group (DRG) payment method for 82 diseases. Rates were fixed – hospitals could retain any savings but bore the loss if actual expenditures exceeded the fixed rates. Reimbursement rates for each disease were set according to average expenditure incurred over the previous three years in treating the disease in question, less any expenditures deemed unreasonable. In 2003, the average expenditure for diseases using DRG payment was 25% lower than the province average in the same level hospitals. In subsequent nationwide implementation of BMI, many cities followed the leads of Jiujiang and Zhenjiang in switching to payment methods other than FFS. Many have adopted a fixed charge per inpatient, but not all. For example, in Guangdong Province in 2002, 13 of the 18 municipal cities used this method, two used FFS, two used capitation, and one used a fixed charge per inpatient day (Eggleston, 2008).

The experience from China highlights that case-based payments or DRGs can focus initially on a core group of diseases. One city where evidence has recently emerged of DRGs being used to pay insured patients admitted with 13 specific or 'target' diseases is Shanghai (Eggleston, 2008). DRGs were used in the last three months of 2004 and again in the same period in 2005. The results suggest that the hospital reduced its length of stay during the DRG test periods on patients with the target disease (irrespective of whether the patient was insured or not).

An important point is how to overcome provider reluctance in moving from FFS to case-based services. In Korea generous margins (on average 23.8%) above the FFS reimbursements for nine selected services (which together account for 25% of inpatient cases) helped to overcome provider reluctance to accept the perceived infringement of professional autonomy.

In China, some steps have been taken to promote quality and deter misconduct by hospitals or other providers. For example, in Qingdao, where a global budget has been used, payments to hospitals have been reduced if they admitted fewer than 95% of the number of patients they had admitted the previous year (Eggleston, 2008). Some Basic Medical Insurance schemes have set up independent quality reviews by expert panels or routine monitoring of high-tech services. Most NCMS schemes have also established contracts that specify the package of services providers are to deliver, payment methods, quality standards, and other criteria. In some cases, contract with providers have included provisions for terminating the contract if, for example, patients were not charged in accordance with the established price schedule.

Some providers in China have of their own initiative moved away from FFS. For example, some hospitals have introduced DRGs for fee-paying patients. By the end of 2000, 16 hospitals in Ha'erbin had started using DRGs. Since then, similar use of DRG pricing has been reported in many other parts of China. The stated objectives for charging self-paying patients a bundled case rate include attracting more business by developing a reputation for transparency in pricing. This interesting pricing strategy, undertaken as hospitals compete for patients, might be encouraged further by purchasers as providers compete for their insurance contracts. Arguably the importance of this development lies in demonstrating that China can move toward prospective payment even while insurance coverage remains far from universal.

Preliminary evidence suggests that the adoption of DRGs has brought down spending in ways consistent with theoretical predictions. In the Red Cross Hospital of Ha'erbin, total expenditures for acute appendicitis decreased after implementation of DRGs, and the proportion of drug expenditures in total expenditures decreased from 50 to 15%. In Jining Medical College Hospital, for the five diseases monitored, total expenditure per case decreased by 30–50% following

implementation of DRGs, drug expenditure per case fell by 34–64%, and average length of stay fell by 0.4–2 days. It is unclear how many of these changes stem from the payment reform itself rather than other contemporaneous trends.

In Hainan province the introduction of prospective payment in six hospitals is associated with a slower rate of growth of overall expenditures and patient co-payments per inpatient admission, compared to FFS (>50% less per admission) (Eggleston, 2004). Whilst these findings highlight the potential benefits of moving towards a prospective system the authors urge caution in interpretation since the expenditure decrease could stem from some combination of reduced quality of care, risk selection, and cost shifting to the uninsured.

There have also been some experiences in China with alternative provider payment methods for outpatient care. For example, Shanghai's government insurance program switched to capitation payment for outpatient care. While findings indicate a slowdown in spending growth, reform design and available data do not permit a rigorous assessment. In many cases, provider payment reforms have been introduced in conjunction with other health system reforms, and evaluations have focused on the overall impact of the package. In the rural sector, alternatives to FFS have also been tried, although no evidence on impacts appears to exist. In two counties of Xinjiang, the county government – through the NCMS fund – paid 40–50 yuan per month to each village practitioner. In return, the village doctors provided free diagnosis and treatment, except for certain items – such as a delivery – for which they received additional fees. In Kuanyang township of Guizhou Province payment of village practitioners included three parts: a basic salary, an indicator based bonus (indicators included the number of home visits and patient satisfaction), and a performance-based bonus that included cost containment.

Within the countries of the former Soviet Union and Central and Eastern Europe the countries of the region typically have implemented a simple per capita payment system for primary care, adjusted based on the age and sex composition of the enrolled population and geographic differences or some hybrid of the per capita payment for primary care. For example, in Bosnia and Herzegovina PHC providers are paid a mix of capitation and salary, and in Albania the Health Insurance Fund pays a base salary to GPs with a per capita supplement based on location and the number of registered patients (Kutzin et al, 2010). A number of countries have modified the per capita payment system to reduce the potential incentive for under-provision of services. In the CE countries, for example, PHC providers typically are paid by capitation, with fee-for-service payments for preventive and other priority services (Croatia, Estonia, Hungary, Lithuania, Romania, Slovenia, Slovakia). Some countries have included monitoring systems (such as Kazakhstan and the former Yugoslav Republic of Macedonia) or performance-related payments along with the per capita system in order to improve the efficiency incentives of the payment system. In the Czech Republic and Slovenia, a portion of the (capitation) rate is paid in the form of a bonus if cost containment or health promotion targets are met (Kutzin et al.).

Most countries of the region have implemented, or are moving toward, case-based hospital payment systems (Kutzin et al, 2010).

4.3.1.1 Implementing DRGs in Thailand

Initially implemented in 1993, a system of 100 DRGs was created using paper records in 10 hospitals and focused on injury and emergency care (Bales, undated). In 1995, the set of DRGs expanded to 500 groups covering all cases, but still based almost entirely on paper records. In 1996, researchers began using electronic patient records from hospitals where they were available and used "Grouper" software to group diseases such that a diagnostic group consisted of a combination of ICD-10 disease code and procedure codes for which the treatment costs were similar. In 1997, the Ministry of Health set up an essential minimum data set that they required

each hospital to provide in electronic form. This research formed the basis of establishing the Thai DRG relative weights.

Commencing in 1999, DRGs (500 groups) were used as the basis for topping up the capitation for inpatients with severe conditions in a scheme for the poor (later replaced by the UC scheme). In 2003 when the Universal Coverage Scheme was established, diagnostic groups had expanded to 1,200 groups, and the DRG payments were applied for severe inpatient cases for which the relative weight was over 4. By 2008, there were 1,920 DRGs, and enough evidence had been accumulated on disease mix and health seeking patterns to allow estimation of a global budget (number of visits times average cost per visit), and to use the relative weights in the DRG to allocate this budget across facilities based on their reporting of diagnostic groups treated. By 2010, there are more than 2000 DRGs applied to acute, sub-acute and mental illness cases.

The impact of DRG implementation was carefully monitored. The use of electronic forms of information allowed detailed data analysis to identify fraudulent behaviour of providers, to identify diseases accounting for a large share of costs that could be prevented, or treated with less expensive methods. Initially renal dialysis was not included in the package of services covered by insurance, but analysis of household poverty of households with renal failure patients led to the decision to find a way to include dialysis into the DRG, but at the same time to find more effective ways to prevent renal failure, or less expensive alternatives than facility-based renal dialysis (Bales, undated).

With specific reference to Vietnam, Bales argues that estimation of the capitation amount is not complicated, but requires consideration of the frequency of visits, the costs per visit, inflation in treatment costs and labour costs. In addition, there needs to be an objective measure of severe illness for which topping up payments can be made to reduce the risk on hospital finances. The impact of applying capitation on hospitals, patients, quality of care, and the health insurance fund needs to be monitored and evaluated thoroughly so adjustments can be made.

4.3.1.2 Implementing purchasing reforms in Kyrgyzstan

Kyrgyzstan used a step-by-step implementation approach and built practical operational capacity directly throughout the sequencing of purchasing reforms. The first step was the implementation by the Mandatory Health Insurance Fund (MHIF) of new provider payment systems: a case-based system for hospitals (all 66 general hospitals) and a per capita payment system for PHC (all 740 new Family Group Practices nationwide). For hospitals, the MHIF selected a case-based payment system as an initial mechanism aiming towards the restructuring and rationalization of excess capacity, and tying payments to services delivered to the population. This approach introduced some competition, enabled provider autonomy and facilitated the strengthening of health information systems.

The new case-based hospital payment system was innovative to the extent that it reimbursed hospitals for variable costs directly related to patient care, while the government budget continued to pay for fixed costs. With the incremental financing from the MHIF, hospitals could finance drugs, supplies and food, as well as giving staff bonuses. This led to strong population (especially pensioners') support for health insurance, as co-payments for drugs and supplies could be reduced. Limited competition and patient choice emerged, as patients assessed and selected hospitals at which drugs, supplies and food were more readily available.

The natural evolution of the process resulted in health care providers beginning to demand more refined provider payment systems. The simple case groups were refined from 108 groups to 139 groups to improve the fairness of the payment system, which was demanded by the hospitals and made possible by the collection of better data, through operation of the system. The information system was refined by adding an integrated financial management module. In addition, based on

requests from health care providers, changes in labour laws and regulations allowed contracting with health care workers and performance-based payment. Steps that were perceived as difficult at the onset soon became the demands of health care providers, as the process acquired its own momentum.

Step two came about in reaction to the conflicts between the new payment systems rewarding productivity and the former budgeting process with incentives to expand rather than rationalise facility capacity. The incentives of the budget system were winning, as they were still driving provider decisions. To solve this problem, the MHIF was incorporated under the MoH as an independent entity. The MHIF was assigned responsibility for purchasing services with both budget funds and payroll tax funds using the new provider payment systems. This approach was piloted in two regions in 2001 and rolled out (step-by-step) to be nationally implemented in 2005, and the MHIF evolved into a “strategic” health care purchaser by shifting the savings from rationalising the hospital sector to PHC, increasing its funding by more than 30%. An outpatient drug benefit was also introduced.

4.4 Purchasing Reforms: the respective roles of the MoH and VSS

Reforming the delivery system with the aim of containing costs and improving quality is a major challenge facing the government. How the health system is best reformed depends crucially on the future development of the health insurance system. Liebermann and Wagstaff (2009) consider two reform scenarios for provider payments within the insurance context. The first is a scenario where coverage expands toward 100 percent and there is a policy commitment that VSS will fund a large proportion of the cost of care. In this scenario, supply-side state subsidies would be largely redirected to the demand side in the form of greater tax-financed revenues for VSS. The authors argue that in this scenario VSS would exert a significant leverage over providers. It would have a strong incentive and a mandate to develop a more rational payment system for providers, as well as a quality assurance mechanism that would in itself help to lower costs by curbing unnecessary care.

The second scenario is one which maintains the status quo. The VSS would cover less than half of the population and fund an even smaller share of total health spending. The VSS would be a minor payer of health care bills in Vietnam, and would lack the leverage, incentive, or mandate to develop new payment methods and quality assurance mechanisms. These tasks would fall to MoH. Supply-side subsidies would need to continue in order to keep out-of-pocket payments down for the uninsured. Liebermann and Wagstaff argue that payment reform could still occur. The MoH could, for example, develop a case-based payment system for hospitals, and this could apply for all patients, insured and uninsured. The MoH could pick up a given percentage of the case-based payment for all cases (including insured ones) from the state budget. The authors conclude that the second scenario suffers from providers facing too many payers, and the limited influence in terms of expenditures of the two third-party payers, MOH and VSS. Payment reform in this scenario is likely to be “messier” and less effective and therefore “*any strategy of improving provider performance must involve moving to a single payer model*”.

4.5 Summary and Lessons

Much theoretical work suggests that the optimal provider payment system mixes pre-payment with some cost reimbursement. Indeed, an optimal payment system almost surely involves mixed levels of both supply-side and demand-side cost sharing (Eggleston 2000). Langenbrunner et al. (WB 2009) find that a consistent finding from the literature is that mixed provider payment systems are necessary to optimally balance multiple objectives such as cost and quality. The authors find that most of the EU 15 countries use fee-for-service for “priority services” such as preventive care and

selected primary care services, and prospective per capita payments for other types of primary care. These countries then use prospective payments to set rates and cap expenditures for inpatient care services, but adjust for case mix, variations in severity and variations in resource use across facilities (Langenbrunner et al. 2009).

The evidence above highlights that many countries have implemented provider payment reform in an incremental fashion (particularly for hospital payments) because of the potentially large effects on resource allocation between hospitals relative to historical patterns, and because of the time needed to accumulate the data necessary to design more sophisticated payment systems. An incremental approach gradually shifts financial risk to hospitals, allowing them time to adapt to the new incentives, and provides the opportunity to establish information systems and accumulate the data necessary to refine the payment system.

The review highlights that it is often best to pilot a new payment system first as a safe “paper system” without any real change in the flow of funding. This is part of the process of organizational learning for both the purchaser and providers, and may help gain the understanding and support of key stakeholders. The pilot paper system is useful to model the changes and benefits that will be brought about by the new way of working. It also puts the information systems in place and begins collecting hospital case data to simulate the changes in resource allocation that will occur in a case-based payment system. The paper system can be used to show hospitals how their budgets will be affected if the new payment system is introduced, so they can begin to adapt their internal management to the new system before facing any actual financial risk.

After the pilot system, the new payment system may be implemented incrementally in several ways. For example, introducing the new system in some hospitals and gradually adding other hospitals, or introducing the system in all hospitals in one administrative or geographic area and gradually adding other areas; reimbursing a subset of hospital costs through the system initially and gradually increasing the types of costs reimbursed; reimbursing a subset of cases on a per case basis initially and gradually including other types of cases; introducing hospital-specific adjustors to the base rate to maintain historical allocation between hospitals and gradually shifting to a single base rate for all hospitals in the system.

If Vietnam does intend to move towards a DRG system it might make sense to take a DRG system that has been developed for another country and modify it to the Vietnamese setting (Liebermann and Wagstaff 2009). This is also the case for other payment systems such as capitation. Over time, as clinical pathways are developed in Vietnam, the DRG rates could be modified accordingly. Finally it is worth highlighting that whilst critics often highlight the limitations of simple case payment arrangements, simplicity can be a virtue (Eggleston 2008). The administrative costs of complex payment mechanisms can outweigh their nuanced incentive benefits, especially when only basic informational and managerial infrastructure supports implementation.

5 Service Delivery

5.1 Review of current public and private provision

Recent documents provide detailed assessments of the health delivery system in Vietnam (MoH/HPG 2010; Liebermann and Wagstaff, 2009). In summary, the tiered structure of health care, reaching down to the commune level has helped to ensure broad coverage of preventive interventions and access to basic curative interventions for the bulk of the population. There are a total of 10,866 commune health stations covering 98.6% of all communes/wards throughout the country. Health workers are operating in 99,409 villages throughout the country accounting for 84.4% of all villages (MoH/HPG, 2010). Grassroots healthcare consists of the district, commune and village levels and has been identified as a priority because it is the level of care closest to the people, and is easiest to access in terms of finance and geography. Almost all districts have district general hospitals and some areas also have regional polyclinics or regional maternity clinics. It is stated that increased use of the delivery system is responsible for impressive recent achievements in reducing mortality at all ages, and for bringing age-adjusted mortality rates on par with those of Malaysia, a much richer country (Liebermann and Wagstaff, 2009) .

Table 5.10 shows the number of hospital beds per 10,000 people by region in 2008, which stood at 16.9 beds/10,000 people nationally, higher than the average in other low-income countries (12) and middle income countries (16) - higher than Indonesia (6), and the Philippines (13), yet lower than Thailand (22) and China (22) (MoH/HPG, 2010).

Table 5.9 Availability of curative care services by region, 2008

	Hospital beds /10 000 people	Medical workers / 10 000 people
Total	16.9	28.6
Red River Delta	15.5	23.3
Northeast	18.4	32.2
Northwest	19.4	38.0
North Central Coast	14.3	24.9
South Central Coast	17.0	26.9
Central Highlands	13.9	27.1
Southeast	23.4	29.2
Mekong River Delta	14.3	22.8

Source: MoH/HPG (2010)

The government is promoting private sector development (MoH/HPG, 2010). Thuan et al. (2008) find that use of private facilities in Vietnam is common and that patients tend to use private services before accessing state care. To date, the country has 74 private hospitals with a total of 5,600 beds (accounting for just over 3% of the total hospital beds nationally), over 30,000 private clinics, and over 21,600 private pharmacies. In addition, 22 private hospitals have been licensed and are being constructed. In order to promote development of private health care services, the Government has directed localities to prioritize private health facilities through allocation of land for development, setting more favourable tax rates, providing investment credit, and ensuring greater equity between the public sector and private sector in the public recognition of service and training of health staff (MoH/HPG, 2010).

5.2 Hospital autonomy

Since 2002, the implementation of the policy financial autonomy in state hospitals has led many hospitals to diversify the forms of health services they provide. Joint ventures and business collaborations have led to the purchase and upgrading of medical equipment, especially high tech equipment which has been welcomed by providers within the context of state funding constraints.

A recent study found that in most hospitals, the number of items of medical equipment valued at more than VND 10 million is now considerably higher than before the financial autonomization policy was introduced (MoH/HPG 2008). The 2008 Joint annual Health review states that up to 2008 the government reported that public hospitals raised approximately VND 3 trillion for investment in high technologies. The extent and form of investment vary considerably between hospitals. Hospitals with a high level of financial autonomy often rely on joint ventures and business collaborations in which the investor installs the equipment at the hospital and the two sides share profits or Build Operate Transfer (BOT)[6] arrangements to obtain new and high tech equipment.

There are concerns relating to the inadequacy of existing guidelines relating to hospital autonomy policy. Feedback from health facilities indicates that the lack of concrete guidelines creates confusion for public hospitals when implementing joint ventures or business collaborations for use of medical equipment. Some of the confusion is related to the extent and scope of their financial autonomy and right to enter joint ventures or business collaborations related to equipment (types of equipment as well as profit share allowed) (MoH/HPG 2008). The 2008 JAHR states that many believe that the Government should invest using a more uniform approach to modernizing public hospitals through use of state budget and other legitimate resources. At the same time, there is a need for policy to strongly promote the development of private hospitals, to overcome the mixing up of public and private assets. This is a problem that should continue to be evaluated in greater depth and comprehensiveness.

Another issue of concern comes from findings of an assessment of medical equipment in a sample of provincial general hospitals, which indicated that about 20% of medical equipment was not used to full capacity. This implies that effectiveness in the use of funding through social mobilization is not high as reflected in the uncoordinated investment in equipment, sometimes exceeding actual demand, or lack of coordination in training (MoH/HPG 2008). Finally, because hospital managers have received little management training, the methods used to create incentives and ensure supervisory monitoring have not been used well between the equipment operators and clinical practitioners (resulting in an even greater need to overuse diagnostic equipment to compensate for losses).

In summary there are various concerns over the increasing trend towards hospital autonomy. Given the profit motive underpinning private investment, concerns relating to over-servicing and increased costs to patients are well founded and the public private partnerships currently in place require care scrutiny to assess whether they align with broader health policy objectives related to equity, efficiency and sustainability.

[6] The investor builds and operates the facility (or piece of equipment) for a certain period of time and on expiration of the investment period, transfers, without refund, the facility (or piece of equipment) to a public service facility.

5.2.1 International experience: Public private partnerships

Public-private partnerships can take many forms, each with a different degree of private sector responsibility and risk (Table 5.11). These are differentiated most critically by whether the private firm manages medical services, owns or leases the facility, employs the staff, and finances and manages capital investments. A government's decision on the most appropriate option will depend on the hospital's needs and circumstances, the government's capacity to regulate and effectively control the quality of care, and the public consensus on the need for reform.

Table 5.10 Options for private participation in hospitals

No.	Option	Private sector responsibility	Public sector responsibility
1	Co-location of private wing within or beside private hospital	Operates private wing (for private patients). May provide only accommodation services or clinical services as well.	Manages public hospital for public patients and contracts with private wing for sharing joint costs, staff, and equipment.
2	Outsourcing nonclinical support services	Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services	Provides all clinical services (and staff) and hospital management.
3	Outsourcing clinical support services	Provides clinical support services such as radiology and laboratory services.	Manages hospital and provides clinical services
4	Outsourcing of specialised clinical services	Provides clinical support services (such as lithotripsy) or routine procedures (cataract removal)	Manages hospital and provides most clinical services
5	Private management of public hospital	Manages public hospital under contract with government or public insurance fund and provides clinical and nonclinical for services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.	Contracts with private firm for provision of public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance.
6	Private financing, construction, and leaseback of new public hospital	Finances, constructs, and owns new public hospital and leases it back to government	Manages hospital and makes phased lease payments to private developer.
7	Private financing, construction, and operation of new public hospital	Finances, constructs, and operates new public hospital and provides non-clinical oe clinical services or both	Reimburses operator annually for capital costs and recurrent costs for services provided.
8	Sale of public hospital as going concern	Purchases facility and continues to operate it as public hospital under contract.	Pays operator for clinical services and monitors and regulates services and contract compliance.
9	Sale of public hospital for alterative use	Purchases facility and converts it for alternative use, depending on sales agreement.	Monitors conversion to ensure adherence to contractual obligations.

Source: Taylor and Blair, 2007

The following case studies provide an international perspective on public private partnerships for hospitals specifically, although it should be noted that PPPs cover a broad range of non-hospital services.

In northeast Brazil the Bahia state government entered into contracts with private firms for the management of 12 new public hospitals, constructed and financed by the government. The government's aim was to increase efficiency, improve quality, and transfer operational risk. The private operators recruit the staff and manage the facilities (including all medical services) under annual funding contracts that can be extended for five years. The operators must treat all public patients who come to the hospitals. The government pays for the medical services based on a target volume of patients. The operators must achieve 80 percent of the target to receive payment but are not reimbursed for volumes above the target. Nevertheless, they have routinely exceeded the target by 30 percent (Taylor and Blair, 2007).

In Australia the government selected a private operator to design, build, own, and operate a new, 153-bed hospital under a 15-year contract (Mildura hospital contract). The existing public hospital was closed, and its employees transferred to the new hospital. The operator must provide appropriate clinical services to all patients who come to the hospital without charging them. The provider receives from the government annual payments based on the forecast mix of clinical patients (with funding capped at a specified number of patients) plus a small block grant to cover such costs as teaching. For quality control purposes, the provider is required to maintain the hospital's accreditation (by an independent agency), provide monthly reports on clinical indicators, and have high-volume treatments reviewed by external peers. The contract includes penalties for noncompliance (including the ultimate sanction, "step-in rights" for the government). And it requires the operator to provide a performance bond of about 5 percent of its annual revenues. Mildura's results have been impressive. Capital costs for the new hospital came in 20 percent below those for public sector comparators, and the hospital provides clinical services at lower cost than government-operated hospitals. Moreover, all performance targets have been met, patient volumes increased by 30 percent in the first year, and the operator made a profit (Taylor and Blair, 2007).

The U.K. government has used public-private partnerships in financing, construction, and facility management for many public hospitals over the past decade. Under its programme a regional health district tenders for a private firm to finance and construct a new hospital, maintain the facility, and provide nonclinical services such as laundry, security, parking, and catering. The operator receives annual payments for 15–25 years as reimbursement for its capital costs and its recurrent costs for maintenance and services. In this model of public-private partnership, unlike those adopted in Australia, Brazil, and Sweden, the public sector remains responsible for all medical services (Taylor and Blair, 2007).

To be continued – the need for public sector negotiation and contracting skills, ability to set and monitor performance standards, information on cost structures, as well as private sector capacities. Should we make a judgement about how far these preconditions are fulfilled in VN?

5.3 Retention and remuneration of health workers

The overall supply of health workers in Vietnam (0.56 doctors per 1,000 population, 0.77 nurses and 0.3 pharmacists) is close to the Southeast Asian average but below the regional averages for Western Asia. In comparison with the Africa region, it has more than twice as many doctors per population and five times as many pharmacists, but fewer nurses. The main challenge is the distribution of health staff. Its urban population accounts for 27% of total national population but the majority of university pharmacists (82%), doctors (59%), and nurses (55%) work in urban areas. Remote areas – such as the Northern Uplands provinces or Central Highlands – have fewer health workers per capita, relative to Ministry of Health (MOH) staffing norms, and relative to funded positions. In Lai Chau province, for example, only 3% of community health stations have a doctor, while in Dien Bien the proportion is 16%, 22% in Son La and 24% in Cao Bang (all remote provinces). The shortage is also severe for highly skilled cadres and district level facilities. For

example, only 23% of medical staff are graduates in the Central North coastal area (the rest having secondary education or less) (Witter et al. 2010).

Witter et al. highlight the complexity of funding sources for doctors in Vietnam, and the extent to which these work against retention at lower levels has been (Witter et al, 2010). The authors argue that four typical 'directions of travel' are identified for Vietnamese doctors – from lower to higher levels of the system, from rural to urban areas, from preventive to curative health and from public to private practice. Substantial differences in income from formal and informal sources all reinforce these preferences. While non-financial attributes are also important for Vietnamese doctors, the scale of the difference of opportunities presents a considerable policy challenge. Significant salary increases for doctors in hard-to-staff areas are likely to have some impact. However, addressing the differentials is likely to require broader market reforms to control some of the exploitative informal charging practices, as well as regulatory measures which mandate a period of rural practice as a necessary step on the path to public employment and promotion.

5.4 Clinical Guidelines

Clinical guidelines have the potential to improve quality of care for inpatients and ambulatory care patients. But they also have the potential to reduce costs by curbing unnecessary care. A multi-country systematic review of the effect of using clinical pathways on length of stay (LOS), hospital costs and patient outcomes found that clinical pathways appeared to be effective in reducing LOS and costs Rotter et al. (2008).

In 2007 and 2008, the Department of Health worked with senior clinical colleagues from the NHS and Royal Colleges to develop condition-based (and symptom-based, where appropriate) commissioning pathways for each of the highest volume specialties reflecting national good practice, in order to challenge existing practice, utilise service improvement tools and techniques, maximise opportunities for transformational change, provide a catalyst for local discussion and challenge, support commissioners to deliver local services within maximum waiting times and improving patient experience of their care pathway (DoH). These were developed for cardiology, pain management, ENT, dermatology and other service areas.

The Ministry of Health in Vietnam has developed and issued more than 1,000 technical guidelines for hospitals. Clinical guidelines can lead to improved health care, but many guidelines are not effectively implemented (Livesy and Noon, 2007).

In February 2010, the Minister of Health issued a decision to set up a steering committee to compile treatment guidelines in order to promote more rapid development of up-to-date treatment guidelines for each disease.

Detecting noncompliance is difficult with typical clinical guidelines, which are usually lengthy documents that are not always easy to follow. Clinical pathways can be used as they are a simpler document. Pathways are a simple document—a single form that shows the steps to be taken treating a patient with a given diagnosis and how soon after admission the steps should be taken. Clinical pathways thus provide considerable scope for operationalizing clinical guidelines in a way that facilitates transparency in the relations between providers and patients, and providers and payers. They have been used in a number of countries, including other transition economies and Asian health systems. A study, for example, of the introduction of a clinical pathway for transurethral prostatectomy in a Taiwanese hospital found that after the introduction of the pathway, mean length of stay and admission charges both fell, in part due to a reduction in laboratory tests and drugs.

Clinical pathways are being developed specifically for Vietnam by the MOH, with technical assistance by experts in the field and funding from the international donor community. To date, work on pathways has started for only a few diagnoses. The approach has been a bottom-up consultative process involving just a few large hospitals in Vietnam, and as yet there does not appear to be consensus on what the definitive Vietnamese clinical pathway for these conditions should look like. While this consultative approach has the merit of ensuring maximal buy-in from hospitals, it has the disadvantage of being slow. At this rate, it will be decades before Vietnamese pathways are available for the conditions that account for the bulk of hospital inpatient admissions.

It might make sense, therefore, to begin with pathways developed in other countries, and have committees of experts (including representatives from senior hospital management) adapt them to the Vietnamese setting. It is also important that VSS be involved in the process, so that it can start to develop a pathway-based auditing system.

5.5 Health Technology Assessment and Priority setting

One main challenge for health care systems is that resources are limited, making it impossible to provide everyone with every effective intervention they might need or want. Scarcity raises questions of justice and efficiency: how should limited health care resources be allocated? What health services should be publicly funded? How should indications for particular interventions be defined.

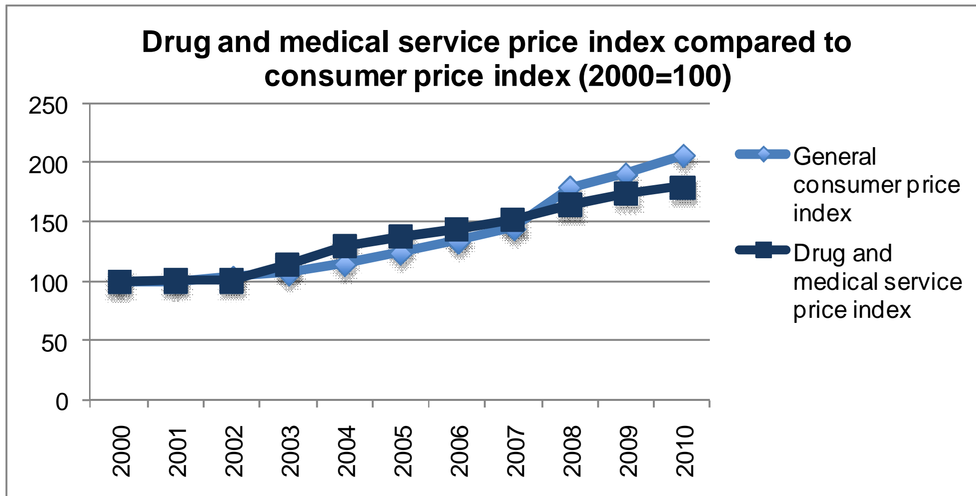
There has been an increasing demand for technology, especially in relation to medical devices, due to increasing awareness of the availability of technology among healthcare providers and the public and increasing competition among private hospitals.

5.6 Pharmaceutical Pricing Regulation

Drugs account for a very high share of total spending in Vietnam. According to National Health Accounts data in 2007, total spending on drugs was VND 28.4 billion. In constant prices this is equivalent to a doubling of drug spending between 2000 and 2007. Drugs account for 40% of total health spending. Per capita drug spending has increased rapidly reaching a level of USD 17 per capita per person in 2008.

The Drug Administration of Vietnam collaborates with the Ministry of Finance and Ministry of Industry in its responsibility for implementing and setting up regulatory mechanisms to control drug prices. The State uses drug price stabilization methods in the market to respond to the need for drugs to serve care, protection and promotion of the people’s health. Facilities supplying drugs must implement all guidelines on price declaration and price re-declaration, posting prices and sale prices of drugs. State agencies in charge of managing drug prices (Drug Administration of Vietnam and Provincial Health Bureaux) are responsible for considering the reasonableness of drug prices, not for approving drug prices declared or re-declared by suppliers. Management of drug prices is decentralized with price management at the central level and in each locality.

Figure 5.5 Drug & medical services and general consumer price index, 2000- 2009



Source: MoH/HPG 2010

To be continued: The mechanism for pharmaceutical procurement needs adjustments to ensure lower drug prices, while strengthening checking and monitoring of the tendering process for drugs in hospitals

5.7 Lessons

Hospital autonomy Pharmaceutical pricing Clinical pathways Public private partnerships

To incorporate:

Human resources for health, Infrastructure Planning, Rebalancing primary and hospital sectors, Quality assurance, Regulation of the health care market

6 Conclusions and recommendations

Vietnam has moved swiftly in the last two decades from an integrated, tax-funded health system towards an insurance-based model with provider payments based largely on fee for service. A range of issues are thrown up by the current situation, many of them interconnected. Some of the most important challenges currently facing health financing in Vietnam include:

- How to enrol the remaining hard-to-reach populations into health insurance
- How to ensure that health insurance provides an adequate degree of financial protection for its members, especially the vulnerable groups
- How to dovetail funding from budgetary sources and health insurance to ensure adequate resources and appropriate incentives for facilities and health staff
- How to modify payment systems to encourage rational, effective, high quality care while constraining cost escalation
- How to regulate providers, public and private to achieve equity, efficiency and quality of health outcomes

In relation to these challenges, experiences in neighbouring countries and countries further afield can provide useful lessons, not just on reform directions but on implementation steps and sequencing. This report has tried to draw out some of these. They are summarised here in a number of recommendations.

6.1 Risk pooling: moving towards universal coverage and effective financial protection

Challenge

The Government has set an ambitious target of 2014 for attaining universal coverage and it has also laid out a roadmap for the inclusion of groups into the scheme. Currently 36 million people are without insurance and the main groups to be enrolled include the near poor (5.4 million), informal workers (7.8 million), dependents of workers (6.8 million), students and pupils (4 million) and workers in private enterprises (5.6 million). The review highlights a number of reasons why insurance for these groups is not purchased, including inability or unwillingness to pay for insurance, but also importantly a lack of implementation guidelines and motivation at lower levels to collect premiums.

The government has attempted to make health insurance affordable for vulnerable and priority groups. Health insurance is free for the poor and subsidised by at least 50% for the near poor. However it appears that at the household level the aggregate total premium is still too high for many households, even with the reduced premium for households with large families. Even for individuals and their families employed in the informal sector the evidence suggests that premiums are high (MoH, 2011). Currently premium levels for the voluntary insured differ according to whether a person lives in an urban (VND 320,000/person/year) or rural area (VND 240,000/person/year). Whilst large families receive reductions in premiums, the total amount per year for a large family could be over 1 million VND.

Enrolment of private enterprises into the compulsory scheme is also proving problematic. The VSS is unable to effectively enrol this group with companies easily able to evade registering their employees. Discussions with central and local stakeholders suggest that the VSS does not have the resources to effectively seek out and enforce compulsory insurance for this group. Furthermore there does not appear to be strong sponsorship at province and central levels to enable and support the VSS in their health insurance role. The international literature highlights the importance of strong sponsorship at a high level to ensure local level implementation.

Continuing high rates of out of pocket payment and catastrophic payments suggest that increasing health insurance, while an important component, will not be sufficient on its own to provide financial protection for the population.

Recommendations

- There is an urgent need to develop detailed plans and projected resource requirements for insurance expansion at province level up to the end of 2014. This analysis will be important to manage expectations regarding health insurance coverage uptake. How feasible is universal coverage by 2014? The international literature highlights that the bulk of those currently without insurance in Vietnam are notoriously difficult to enrol and hence considerable effort and resources will be required to increase coverage of the remaining groups. Whilst the Ministry of Health has undertaken some initial exploratory work with provinces to understand the feasibility of reaching universal coverage by 2014 (MoH, 2011), it is important to quantify the resource requirements needed for the VSS to manage the process over the period up to 2014. Some analysis of expected enrolment using different implementation tactics should be explored further. There are likely to be initial investment costs associated with enrolment coupled with recurrent costs. The development of annual business plans and annual reports outlining projected coverage should be encouraged.

- The experience from Thailand and China shows that increasing state subsidies can provide the impetus towards achieving universal coverage. Currently, the bulk of funding for insurance comes from general taxes paid into state budget and passed to the VSS (75%). The costs of subsidising universal coverage have been estimated in a recent World Bank study (Liebermann and Wagstaff, 2009). An updated analysis of the feasibility of covering the remainder of the population via the state budget and the fiscal implications of this approach should be produced in alignment with the proposed roadmap for achieving universal coverage.

- Clear guidelines should be produced for roles and procedures for identifying the near poor at the provincial level.

- Once the resource implications of enrolling the remaining groups have been elaborated, funding mechanisms should be agreed for each province. Vietnam might want to adapt from the approaches used in some FSU countries. In the Czech Republic, for example, there is a monthly central budget transfer for the economically inactive population set at 13.5% of the average wage. Another example is the Republic of Moldova, where the health insurance law specified that the per capita contributions from the budget on behalf of state-insured individuals must be equivalent to the estimated average per capita cost of the benefits package.

- Support should be given to each province to develop an action plan, which starts from a problem diagnosis (who is uncovered and why). Factors depressing demand for health insurance need careful discussion at each level, and actions to address them. If the service is perceived as cumbersome or of low quality or inaccessible, then clearly voluntary membership will remain low.

- For private companies, a carrot and stick approach might be adopted, with companies enrolling their employees on a regular and comprehensive basis given a discount (and those resisting facing some form of sanction, such as a fine).

- Since 2003 the VSS has been responsible for collecting premiums for private sector enterprise workers and this has proved problematic, as witnessed by the low number of private enterprise workers currently enrolled in health insurance. Alternative mechanisms for premium collection should be considered, including the use of the existing tax collection system. This has been successful in a number of the FSU countries, such as Estonia. An analysis of the efficiency of existing VSS premium collection needs to be undertaken and a review of alterative premium collection mechanisms should be undertaken.

- Vietnam should learn from the experience of countries where high coverage has achieved significant reductions in household spending. Thailand is one such example where expanded coverage has also included a strategic allocation of resources to levels of health facilities that are better accessed, especially by the poor. In the Thai health system context, DHS is the most crucial strategic hub to perform comprehensive and integrated services covering curative, prevention and promotion services.

6.2 Reforming provider payments

Challenge

Providers currently receive payments and budgets from three main sources – the VSS in the form of fee for service payments, the state budget (norm-based budgets) and fee for service from patients. This provides incentives to providers which are not aligned with public interest and which are hard to control. The combination of FFS and norm-based budgets has been described as a “toxic mix” of incentives (WB, 2010). The reform of this system is a priority to improve efficiency and control cost escalation.

Recommendations

- A strategic decision needs to be made whether the longer term goal is to unify purchasing into a single payer (the VSS), with the MoH refocusing on policy setting and market regulation. This will have implications for the process of implementation of provider payment reform and for the development of the relationship between the MoH and the VSS. One model for integrated purchasing might be Kyrgyzstan, where the state budget transfers most of the funds for health from general revenues to the Mandatory Health Insurance Fund (MHIF) to provide a basic package on behalf of the entire population. In addition, payroll taxes are transferred to the MHIF, in order to achieve a complementary contributory entitlement for the insured population.

- Considerable capacity building of the VSS will be needed if it is to be effective as an active purchaser of the bulk of health care services.

- If Vietnam moves towards a single payer, based on real costs of care, then user fees should be reformed, set either as a small fixed amount (co-payment) or proportion (co-insurance) of each treatment. Other informal and supplementary payments should be eliminated.

- Vietnam should move gradually towards the payment mix which many other countries have adopted, which includes capitation payments for primary care, case-based (or DRG) payments for hospital care, and target payments for some high-priority and preventive services.

- The new payment systems should be monitored in relation to quality of care and cost control. They should be based on real costs and linked to rational care guidelines (see below). These could be incorporated in service contracts as such as those used in Kyrgyzstan which monitors prescribing practice for conditions such as hypertension (Kutzin et al, 2010)

- Based on the international evidence on provider payment reform, an incremental approach to reform is recommended, based on the piloting currently underway. An incremental approach gradually shifts financial risk to hospitals, allowing them time to adapt to the new incentives, and provides the opportunity to establish information systems and accumulate the data necessary to refine the payment system. In many countries there is an incremental inclusion of hospitals, diseases covered, and also an incremental inclusion of costs included in the payment as the system involves.

- As with insurance coverage, it will be important to develop a more detailed plan for provider payment reform at the national level and the development of implementation guidelines at the province level. Even if piloted approaches are successful, they will not automatically be adopted by all providers. Some form of transitional benefits may be needed to encourage adoption (as used in South Korea, where a generous margin was allowed at the time of switching from fee for service). The benefits to providers of simpler and more transparent charging can be emphasised. A study tour to areas of China which have successfully reduced costs through provider payment reform might help to convince hospital managers.

- Reform of pay for providers, and its streamlining, must ultimately be accompanied by streamlining of pay for medical staff, who currently draw on a wide range of sources, formal and informal, which again creates mixed incentives in terms of patient care.

- Provider payment reform is one tool which can be used to improve the balance in the Vietnamese system between hospital and primary care – the former being over-utilised at present and the latter under-utilised. Management of the growing burden of NCDs can best be handled at primary level, and payment systems for providers and staff can incentivise this work, and reduce the flow of patients and staff to hospitals. In the Czech Republic and Slovenia, a portion of the (capitation) rate is paid in the form of a bonus if cost containment or health promotion targets are met. The case of Kyrgyzstan is also instructive, where payment reform was used as a tool for addressing over-capacity in hospitals, and generating savings to reinvest in primary care.

6.3 Managing and regulating the health care market

Challenge

With the growth in the private sector and the increasing autonomy given to public hospitals in Vietnam, there is an urgent need for the MoH to develop regulatory tools to ensure that services meet public goals, including delivering appropriate, high quality, cost-effective services.

Whilst the promotion of hospital autonomy has resulted in the attraction of private investment into the sector, there are concerns that current implementation is encouraging investment in expensive technologies that yield revenues for the hospital but may not necessarily be required on clinical grounds. Whilst it appears that strategy and implementation guidelines for private investment are elaborated, there appears in practice to be considerable flexibility on private investment in hospitals.

The current process of the development and use of clinical guidelines (also known as treatment protocols / treatment pathways) requires review. There are literally hundreds of guidelines

developed, however it is very difficult to locate copies of guidelines and understand how they are used.

Recommendations

- The experience of other countries in relation to health technology assessment should be studied. In particular, there needs to be an agency which assesses new technologies both prospectively (when should the specific technology be used?) and retrospectively (i.e. how did the technology impact decisions on patient care). This would be linked to licensing of technology for use in specific settings.

- The ability of clinicians and managers to profit from private investment in equipment produces a conflict of interest and should be forbidden, with appropriate sanctions applied for any infringement.

- Linked to a streamlined purchasing function, the use of a limited number of core clinical guidelines (focussed initially on the most common conditions) should be reinforced. The process of their production should be speeded up, simplified and they should be widely disseminated. Payments should be based on and costed on the basis of compliance with the guidelines. Experience from China and Taiwan suggest that considerable cost savings can be generated through increased use of clinical guidelines.

- A range of quality control measures should be developed, including accreditation of all providers and the piloting of clinical auditing. Borrowing from China's experience, independent quality reviews by expert panels or routine monitoring of high-tech services could be considered.

- Patient voice should also be encouraged to report any abuses, including poor conduct and over-charging.

- The mechanism for pharmaceutical procurement needs to be reformed to ensure lower drug prices, while strengthening checking and monitoring of the tendering process for drugs in hospitals.

- Experience of contracting services from the private sector could gradually be developed in Vietnam, using experiences from countries like Australia. The contracting skills developed in the process can be applied to public and private sector alike, particularly if the current trend towards autonomisation of public hospitals continues.

- The balance of investments in primary versus hospital care need to be reviewed. A recent analysis (Wagstaff and Bredenkamp, 2011) found that only 2.5% of government spending was received by CHC and polyclinic level, compared to 97.5% by hospitals. This reinforces the need to rebalance the system.

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Annex A Terms of reference

TERMS OF REFERENCE (TOR)

Research paper on "Strategic Options for Financing Health System Modernization and Development: what can Viet Nam learn from international experiences?"

II. BACKGROUND AND RATIONALE

In an attempt to support Viet Nam to review implementation of the Socio-Economic Development Strategy (SEDS) 2001 – 2010 and formulate SEDS 2011 – 2020, MPI and UNDP have jointly developed "Support for the Formulation of Socio-Economic Development Strategy 2011-2020" project. The project will provide technical assistance to the Drafting Team – and hence the Sub Committee for the formulation of SEDS -- to (i) analyse and assess the development situation of the country comprehensively and (ii) propose to the Sub Committee strategic development directions and options for the nation for the next ten years. The project plans to conduct a number of studies in 2009. One of the planned studies is a research paper (with its presentation to the Sub Committee's SEDS 2011-2020 Drafting Team) on "Strategic Options for Financing Health System Modernization and Development: what can Viet Nam learn from international experiences?". The project is seeking an international institution/sub-contractor to undertake the research work.

III. OBJECTIVES AND SCOPE OF WORK

1. Objective

To produce a research paper to help MPI/DSI formulate Viet Nam national socioeconomic development strategy for the period 2011-2020.

2. Scope of work

The institution will develop a high quality research paper that includes (i) a review of regional and international experiences in financing the modernization and development of health services, highlighting the strengths and weaknesses of alternative approaches; (ii) an assessment of Viet Nam's current health sector and financing arrangements; and (iii) recommendations for future health sector development priorities and financing channels in Viet Nam. The research paper should synthesize and build on ongoing health sector work in Viet Nam, including the Government's health sector development strategy (2006-2010), ongoing drafting of a national health sector development strategy and various donor supported initiatives1. The paper should not duplicate these efforts, but provide a synthesis of this work, with concrete strategic options for financing health sector modernization and development. The paper should provide clear recommendations for all levels of the Vietnamese health system. The assignment duration is specified in Section I. Within this time frame, a detailed work schedule will be worked out by MPI/DSI and the institution (in cooperation with UNDP), upon signing contract.

IV. SPECIFIC TASKS OF THE ASSIGNMENT

Discuss with MPI/DSI/the project management and UNDP and agree on, among others, (i) expectations for this assignment and the subcontractor, (ii) research methodologies/approaches (based on the methodologies/approaches proposed in the technical bidding document), (iii) detailed research plan (which is proposed in the technical bidding document), and (iv) payment schedule.

Collect information necessary for the preparation of the paper

Prepare the paper as specified in this TOR, including consultations with DSI, UNDP, and other national partners (during the process of conducting the research) to ensure the research work will be built on sound knowledge of Viet Nam's context as well as its relevance and applicability.

Send the first draft research paper (in English and Vietnamese) to project management for circulation to relevant stakeholders and experts for peer reviews and comments

Prepare, based on the comments and feedback, a second draft of the paper (in English and Vietnamese) and present it to the Sub-Committee's SEDS Drafting Team members and representatives from relevant sectors; facilitate or take active roles in

The team should draw on any documentation from Government-donor partnership on health (a cooperation accord with international and domestic partners to increase the efficiency of international health assistance to Viet Nam was signed on 31 March 2009). Other potential English sources of information are WB, 2009, Health Financing and Delivery in Vietnam: Looking Forward: ADB, Health Human Resource Sector Development Program Documents. SIDA and WHO have also been actively involved in health sector planning and policy development in Viet Nam. the discussions on the research topics (in a one-day workshop or in 1-2 other roundtables, including with the selected SEDS Sub-Committee members, on these topics as DSI/project management may find necessary).

Revise and finalise the paper (in English and Vietnamese) after consultation and submit it (in both hard and soft copy) to the Project Management Board and UNDP.

V. EXPECTED DELIVERABLES AND QUALITY INDICATORS

1. Expected deliverables

A research paper that (i) reviews regional and international experiences in financing the development and modernization of health services, highlighting the strengths and weaknesses of alternative approaches; (ii) provides a comprehensive assessment of Viet Nam's current health sector and financing arrangements; and (iii) sets out recommendations for future health sector development priorities and financing channels in Viet Nam.

2. Quality criteria

The research paper should include at least the following sections:

1. A review of major approaches in regional and international strategies and institutional arrangements (including private-public linkages) for financing the development and modernization of health systems, including, including a detailed review of options for developing health insurance.

2. Comprehensive assessment of Viet Nam's current health sector and existing financing sources, including:

Hospitals (health examination and treatment establishments)

Preventive health care

Human resource

Health care science and technology

Ability to meet the demand for health care services

Population's accessibility to health care services, focusing on that of the group of poor people (against the objective of ensuring equity and efficiency in provision of and access to health care services)

Sources of health sector financing: state budget, private investment

(domestic and foreign), hospital fees, health insurance, and ODA.

3. Commonly used effective health sector financing instruments (including insurance) from international experience and good practices

4. Recommendations for future health sector development priorities and financing channels in Viet Nam:

District hospitals (issue of government bonds has been decided, but not sufficient to meet the demand. New reliable and sustainable sources of financing required)

Expansion and modernization of provincial general hospitals in provinces with large population, or regional or inter-provincial hospitals (to provide directly high quality health services to local people, reducing overcapacity in hospitals in Ha Noi in Ho Chi Minh City while enabling the people to save money by no longer needing to go to these cities for health services)

Upgrading or new establishment of a number of specialised hospitals that are highly demanded (cancer, cardio-vascular, lung, eye examination and treatment)

Options to establish some regional class modern hospitals to provide high quality health services to the Vietnamese people in need (to discourage them from going abroad for health examination and treatment services) and to foreigners (who live in Viet Nam or who go to Viet Nam for tourism or convalescence purposes. (Singaporean and Bangkok models may be relevant)

Modernisation of preventive health care system

5. Recommended policies to achieve equity and efficiency objectives in health care provision and easy access (for everyone) to quality health care services

6. Other contents may be suggested by project management.

Concrete evidence and information sources should be presented in the paper to support the analysis.

The paper should be written clearly, logically, and understandably with a short executive summary of key research findings and recommendations. The paper can be written in English and translated into Vietnamese.

VI. MONITORING AND QUALITY CONTROLS

The detailed work plan agreed between the institution and the project management/UNDP and the quality criteria above will serve as the basis for monitoring and evaluating work progress of the institution.

The project will cooperate with UNDP in instituting quality controls.

The project will be responsible for providing the institution and its experts with national information, materials, documents, contact details, etc. as deemed necessary for the assignment.

Annex B Key Informant Visits

No	Organization	Objectives	Data Requirements	Time	Note
	UNDP: SEDS Project	Clarify objectives of the mission, understand the role of UNDP, and collect context information on the health sector.		9h-10h, 14/2 Monday.	Confirmed Ms. Lan Anh: 0439421495/2 81 or 0903209059 Room 204, Ministry of Planning & Investment. 65 Van Mieu, Hanoi
	UNICEF Tel: 3.942.5706 - 11	Discuss about current situation of Health sector, especially focus on Health care Financing Strategy in Vietnam	-Documents related to Health sector and Health Care Financing	15h30-16h30, 14/2 Monday.	Confirmed Mr. Thien: 0936893808 Fl 7, Mr. Jean Dupraz, 81A Tran Quoc Toan, Hoan Kiem, Hanoi
	MOH: Department of Planning & Financing	Understand current situation of Health Care Financing in VN (Revenue & expenditure, Payment mechanisms, ...) and Health Financing Strategy 2010-2020	- % of consolidated (central and province) budget allocated to hospitals and PHC: 2006 - to most recent year available, by province -Breakdown of consolidated budget expenditure by input (e.g. staffing / medicines...), by province for the most recent year - Assessment of implementation of Health Financing reforms such as Autonomy and socialization in Hospitals	8h-10h00, 15/2 Tuesday.	Confirmed Mr. Lien: 0913211531 62732273/1515 Ms Nga MOH, 138 Giang Vo, Hanoi
	MOH: Policy Unit Sarah Bales – External Consultant 0913598420	-Discuss about Health Financing Lessons from region and comparable countries		10.15-11.30 15/2 Tuesday.	Confirmed, Sarah Bales – External Consultant 0913598420 138 Giang Vo
	WORLD BANK Minh	Discuss about current situation of Health sector, especially focus on	- Documents related to Health sector and Health Care Financing	14h-15h, 15/2 Tuesday	Confirmed 8th floor, 63 Ly Thai To Street. Mr.

	39346600/228	Health care Financing Strategy in Vietnam			Tomas Palu, Human Development Sector Coordinator
	Health Strategic & Policy Institute 38234167	Discuss about current situation of Health sector, especially focus on Health care Financing Strategy in Vietnam	-Provider payment mechanisms between Health Insurance & Health care providers -Roadmap to Universal HI -Experience from International	10h15-11h30, 16/2 Wednesday	Confirmed Mr. Tien: 0903454155 138 Giang Vo, Hanoi
	MOH: Administration of Medical Care	Discuss about current situation of Service Provision & Quality of Care	- Results of Hospital Inventory from 2006 up to now	8h30-10h, 17/2 Thursday	Confirmed Mr. Khoa: 0913395903 138 Giang Vo, Hanoi
	MOH: Department of Health Insurance	-HI policies -Implementation of HI law -Roadmap for Universal HI -Reform in Payment Mechanism		10h-11h, 17/2 Thursday	Confirmed Hương: 0913252280 138 Giang Vo, Hanoi
	Viet nam Social Security Org. 39347965; 39344160	-HI policies -Implementation of HI law -Roadmap for Universal HI -Reform in Payment Mechanism	- Health Insurance coverage and revenue collection at the national and province level by group. - Insurance sustainability through comparing the revenue and expenditure data by insurance group over time (e.g. 2006 to most recent year) - Utilization of services by the insured by group over time	14h-15h, 17/2 Thursday	Confirmed Van: 0912176038 2, Trang Thi, Hanoi
10	WHO	Discuss about current situation of Health sector, especially focus on Health care Financing Strategy in Vietnam	-Documents related to Health sector and Health Care Financing	15.30-16.30, 17/2, Thursday	Confirmed. Ms. Kim Phuong 63 Tran Hung Dao Ha Noi, Tel 4 3943 3734/5/6 Ext. 83834

11	Ministry of Finance (MOF): Dept. of State Budget	Understand the current situation (Tax revenue, government budget for Health…) and Health Financing strategy for the time coming (2010 – 2020)	-Total central and province government tax revenue collected via direct and indirect taxes - 2006 to most recent year, by province (if possible) -Central and province budget allocations allocated to health - 2006 to most recent year, by province -Government budget allocation to health insurance fund to cover contribution shortfall	8h-10h,18/2 Friday	Will be confirmed by next Tues. 22202828/3161; 0912272667 Mr. Phuong 28 Tran Hung Dao, Hoan Kiem, Hanoi
12	Bạch Mai Hospital 38693731/2014 Lâm	Site visit Feedback on current health financing mechanisms/policy -Recommendations for future		14h-16h, 18/2 Friday	Processing
13	Provincial Health Bureau; Provincial Hospital; District Hospital; Commune Health Station & Health Insurance Office in Vinh Phuc Province	-Site visit -Feedback on current health financing mechanisms/policy -Recommendations for future		21-22/2 Monday & Tuesday	Confirmed by Xuân – Tel. 0912666755
14	DSI – Nguyen Ba An	-Summary on Main Results -Discuss about Report		9h-10h; 24/2 Thursday	Processing

Annex C Health Insurance coverage in Viet Nam

C.1 Trends in health insurance coverage (1993-2010)

Year	Average Population	Total		In which		
		No of people	% compared with population	Compulsory	The poor	Voluntary
1993	70,185	3,790	5.40	3,470	-	320
1994	71,671	4,260	5.94	3,720	-	540
1995	71,996	7,100	9.86	4,870	-	2,230
1996	73,157	8,630	11.80	5,560	-	3,070
1997	74,307	9,540	12.84	5,730	-	3,810
1998	75,456	9,892	13.11	6,069	134	3,689
1999	76,597	10,232	13.36	6,355	493	3,384
2000	76,734	10,622	13.84	6,394	841	3,387
2001	77,655	11,340	14.60	6,685	1,214	3,441
2002	78,587	13,032	16.58	6,975	1,665	4,392
2003	79,530	16,471	20.71	8,118	3,254	5,099
2004	80,484	18,356	22.81	8,190	3,772	6,394
2005	81,450	23,434	28.77	9,574	4,726	9,133
2006	82,427	36,866	44.73	10,568	15,178	11,120
2007	83,416	36,545	43.81	11,667	15,499	9,379
2008	84,417	39,749	47.09	13,529	15,530	10,690
2009	86,025	50,069	58.20	19,609	15,113	15,347
2010	86,866	50,771	58.45	33,343	13,511	3,917

Source: Ministry of Health (Feb, 2011)

C.2 Health Insurance Coverage, by region (2009)

Province/City		Population	No.of insured	%
Total		**86,024,500**	**50,069,998**	**58.20**
1. Red river delta		***19,631,556***	***10,814,642***	***55.09***
1	Hà Nội	6,466,497	3,691,441	57.09
2	Vĩnh Phúc	1,003,579	586,442	58.44
3	Bắc Ninh	1,026,956	440,825	42.93
4	Quảng Ninh	1,147,515	712,443	62.09
5	Hải Dương	1,708,157	900,937	52.74
6	Hải Phòng	1,842,333	1,039,443	56.42
7	Hưng Yên	1,131,793	507,046	44.80
8	Thái Bình	1,785,831	1,168,112	65.41
9	Hà Nam	787,207	427,807	54.34
10	Nam Định	1,830,771	855,335	46.72
11	Ninh Bình	900,919	484,811	53.81
2. Midland and northern mountainous		***11,094,748***	***7,123,730***	***64.21***
12	Hà Giang	726,337	434,467	59.82
13	Cao Bằng	512,283	467,985	91.35
14	Bắc Kạn	295,467	285,211	96.53
15	Tuyên Quang	727,454	426,548	58.64
16	Lào Cai	614,754	510,350	83.02
17	Yên Bái	742,934	437,309	58.86
18	Thái Nguyên	1,127,866	862,532	76.47
19	Lạng Sơn	733,891	382,106	52.07
20	Bắc Giang	1,559,980	734,676	47.10
21	Phú Thọ	1,317,524	381,539	28.96
22	Điện Biên	492,391	468,530	95.15
23	Lai Châu	371,149	320,907	86.46
24	Sơn La	1,083,600	945,262	87.23
25	Hoà Bình	789,119	466,308	59.09
3. North central coast and south central coast		***18,887,064***	***11,357,632***	***60.13***
26	Thanh Hoá	3,409,550	2,217,200	65.03
27	Nghệ An	2,921,032	1,604,041	54.91
28	Hà Tĩnh	1,230,916	717,724	58.31
29	Quảng Bình	849,243	514,944	60.64
30	Quảng Trị	599,623	402,442	67.12
31	Thừa Thiên Huế	1,090,557	773,292	70.91
32	Đà Nẵng	889,498	671,235	75.46

33	Quảng Nam	1,423,390	955,871	67.15
34	Quảng Ngãi	1,220,492	718,367	58.86
35	Bình Định	1,490,012	928,695	62.33
36	Phú Yên	864,353	445,122	51.50
37	Khánh Hoà	1,160,071	578,028	49.83
38	Ninh Thuận	565,674	268,848	47.53
39	Bình Thuận	1,172,652	561,823	47.91
4. The Central Highland		***5,121,423***	***3,235,472***	***63.18***
40	Kon Tum	431,215	307,357	71.28
41	Gia Lai	1,276,277	854,096	66.92
42	Đắk Lắk	1,733,113	1,137,095	65.61
43	Đắk Nông	490,782	276,910	56.42
44	Lâm Đồng	1,190,036	660,014	55.46
5. South East		***14,063,794***	***8,307,968***	***59.07***
45	Bình Phước	877,357	315,632	35.98
46	Tây Ninh	1,069,322	529,368	49.51
47	Bình Dương	1,486,696	1,007,516	67.77
48	Đồng Nai	2,490,011	1,163,567	46.73
49	Bà Rịa - Vũng Tàu	997,561	732,249	73.40
50	TP.Hồ Chí Minh	7,142,847	4,559,636	63.83
6. The Mekong region		***17,225,914***	***9,230,554***	***53.59***
51	Long An	1,440,849	903,073	62.68
52	Tiền Giang	1,674,790	804,205	48.02
53	Bến Tre	1,258,025	725,902	57.70
54	Trà Vinh	1,003,674	807,522	80.46
55	Vĩnh Long	1,031,181	624,711	60.58
56	Đồng Tháp	1,669,981	959,132	57.43
57	An Giang	2,150,645	976,107	45.39
58	Kiên Giang	1,687,758	977,249	57.90
59	Cần Thơ	1,190,340	563,356	47.33
60	Hậu Giang	758,697	316,835	41.76
61	Sóc Trăng	1,292,972	685,918	53.05
62	Bạc Liêu	858,595	461,074	53.70
63	Cà Mau	1,208,408	425,470	35.21

Source: Ministry of Health (Feb, 2011)

C.3 Breakdown of health insurance, by Group (2010)

TT	Participants	Target groups	With HI	Percentage (%)	Without HI
	Total	**86,866**	**50,771**	**58.45**	**36,095**
I.	***Compusory groups***	***67,114***	***46,854***	**69.81**	***20,260***
1.	Enterprises and other organizations	11,911	6,361	53.40	5,550
2.	Administrative	3,142	3,142	100.00	0
3.	Foreign students studying in Vietnam	3	3	100.00	0
4.	Part-time commune officials	182	0	0.00	182
5.	Persons on pension	920	920	100.00	0
6.	People on monthly social insurance allowance	1,305	1,254	96.09	51
7.	People on unemployment allowance	80		0.00	80
8.	Commune officials from the state budget allowance	41	40	97.56	1
9.	Merit persons with revolution	1,791	1,791	100.00	0
10.	Veterans	374	350	93.58	24
11.	People who personally participated in the war	322	0	0.00	322
12.	Representatives of National Assembly, People's council	123	119	96.75	4
13.	Social protection	843	384	45.55	459
14.	The poor, ethnic minority people	13,945	13,511	96.89	434
15.	Relatives of merit people	869	0	0.00	869
16.	Relatives of police, army	1,281	297	23.19	984
17.	Children under 6 years old	10,103	8,183	81.00	1,920
18.	Members of households living just above the poverty line	6,081	692	11.38	5,389
19.	Pupils and Students	13,798	9,807	71.08	3,991
II.	***Voluntory groups***	***18,552***	***3,917***	**21.11**	***14,635***
20.	Relatives of employees	6,820		0.00	6,820
21.	Farmers with average living standards up, members of cooperatives…..	11,732	3,917	33.39	7,815

Source: Ministry of Health (2010)

C.4 Breakdown of coverage by source of contribution

Participants	Target groups	With HI	Percentage (%)	Without HI
Total	**86,866**	**50,771**	**58.45**	**36,095**
1. Contributed by Employee&employer	***15,238***	***9,506***	***62.38***	***5,732***
Enterprises and other organizations	11,911	6,361	53.40	5,550
Administrative	3,142	3,142	100.00	0
Foreign students studying in Vietnam	3	3	100.00	0
Part-time commune officials	182	0	0.00	182
2. Contributed by Social securities Fund	***2,305***	***2,174***	***94.32***	***131***
Persons on pension	920	920	100.00	0
People on monthly social insurance allowance	1,305	1,254	96.09	51
People on unemployment allowance	80	0	0.00	80
3. Contributed by the State budget	***30,561***	***24,675***	***80.74***	***5,886***
Commune officials from the state budget allowance	41	40	97.56	1
Merit persons with revolution	1,791	1,791	100.00	0
Veterans	374	350	93.58	24
People who personally participated in the war	322	0	0.00	322
Representatives of National Assembly, People's council	123	119	96.75	4
Social protection	843	384	45.55	459
The poor, ethnic minority people	13,945	13,511	96.89	434
Relatives of merit people	869	0	0.00	869
Relatives of police, army	1,281	297	23.19	984
Children under 6 years old	10,103	8,183	81.00	1,920
4.State budget group health insurance premium support	***19,879***	***10,499***	***52.81***	***9,380***
Members of households living just above the poverty line	6,081	692	11.38	5,389
Pupils and Students	13,798	9,807	71.08	3,991
5. Paid by Individuals	***18,552***	***3,917***	***21.11***	***14,635***
Relatives of employees	6,820	0	0.00	6,820
Farmers with average living standards up, members of cooperatives…..	11,732	3,917	33.39	7,815

Source: Ministry of Health (Feb 2011)