

A HEALTH FINANCING REVIEW OF VIET NAM WITH A FOCUS ON SOCIAL HEALTH INSURANCE

**Bottlenecks in institutional design and organizational practice of health financing
and options to accelerate progress towards universal coverage**



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by

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Abbreviations

CHS	commune health station
DRG	diagnosis-related group
FFS	fee for service
GDP	gross domestic product
GGE	general government expenditure
GGHE	general government health expenditure
INN	international nonproprietary name
MoH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NHA	national health account
OOP	out-of-pocket (payment)
PHI	private health insurance
PPC	Provincial People's Committee
SHI	social health insurance
THE	total health expenditure
VND	Vietnamese dong (currency)
VSS	Viet Nam Social Security
WHO	World Health Organization

Acknowledgement

We thank the Ministry of Health (MOH) who approved and supported this study. We likewise are very grateful to MOH and VSS officials for their collaboration and fruitful discussions of health financing issues.

We extend our gratitude to WHO Representative of Vietnam as well as the whole WHO Country Office team for their great assistance both technically and organizationally.

Finally, thanks are extended to all respondents from the different organizations and departments who shared their insights and views on the Vietnamese health financing system.

Valuable research assistance was provided by Friedrich Wittenbecher

1. Introduction

1.1. Rationale and objectives of this report

Many countries are working to establish a health financing system that allows them to move towards universal coverage – defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost – thereby achieving equity in access and financial risk protection as well as in health financing (WHO, 2005). This is particularly challenging for low- and middle-income countries in light of their heavy reliance on out-of-pocket (OOP) payments for health care (WHO, 2010). The challenge is to improve the health financing system in order to achieve universal coverage as an overall policy goal.

The Government of Vietnam is clearly committed to universal coverage and has approved a number of important laws relating to health financing and health insurance. In addition to some good health indicators, there are impressive achievements as to Vietnam's health financing, namely a population coverage rate of about 60%, continuous commitment to state subsidized premium payments, and developments in the payment system. Viet Nam's health financing policy puts a strong emphasis on equity in health. Shifting from a tax-based health financing system, Viet Nam has been introducing social health insurance (SHI) since 1992. The country's health insurance law was promulgated in 2008, with the goal of universal coverage by 2014.

Yet, the goal of universal coverage with SHI is challenging. As in other developing countries, the majority of Viet Nam's population works in the informal sector. The share of household out-of-pocket (OOP) payments for health, despite its rapid decrease in recent years, is still very high and accounts for some 55% of total health expenditure (THE). Despite these successes and achievements, there are a number of bottlenecks in institutional design and organizational practice. These impede Vietnam from achieving the levels of health financing performance that the country could potentially attain, given its resources and priorities, and are therefore of great concern with regard to achieving universal coverage.

Based on the application of the OASIS¹ approach (Mathauer/Carrin, 2011), this report describes the findings of an assessment of the current health financing system in Viet Nam. The report provides a detailed analysis of Viet Nam's health financing system by assessing the system's institutional design and organizational practice in relation to the key health financing functions of resource collection, pooling and purchasing and how these affect the performance of the system. On this basis, it is

¹ OASIS: *Organizational assessment for improving and strengthening health financing; a practical tool for health financing review, performance assessment and options for improvement.*

possible to identify appropriate changes in institutional design and organizational practice that contribute to progress towards universal coverage.

The remainder of Section 1 outlines the analytical approach and methodology of this work. Section 2 provides a brief outline of the health financing system in Viet Nam, while Section 3 gives a detailed institutional–organizational analysis of Viet Nam’s health financing system and assesses its performance. The concluding section proposes policy options and changes in institutional design and organizational practice aimed at improving the performance of the health financing system.

1.2. Analytical approach and methodology

The analytical framework underlying this study was taken from Mathauer & Carrin (2011) and focuses on two core elements: i) the role of institutional design and organizational practice, and ii) the operationalization of health financing objectives into health financing performance indicators, as outlined in Annex Figure 1. Table 1 presents these indicators with their detailed operationalization and guidance on how these indicators could evolve in progressing towards universal coverage in a low middle-income country such as Vietnam. These indicative targets are based on the core values of equity and social justice, as well as on the rationale of using resources as efficiently as possible. The operationalization described below also takes account of the often limited availability of data in low- and middle-income countries.

Table 1. Possible indicators of health financing performance

Health financing performance indicator and operationalizations	Guidance for indicative targets
1. Level of funding	
- THE per capita	↑ for low and lower middle-income countries (i.e., the existing resource mobilization potential is realized) <i>Average THE as a share of GDP in lower middle-income and low-income countries is 4.8% and 4.6% respectively (Durairaj, 2010).</i>
- THE/GDP	
- GGHE/THE	
- GGE/GDP (fiscal space)	
- GGHE / GGE (fiscal space for health)	
2. Level of population coverage	
- Percentage of population covered by a financial risk protection mechanism. (This means that a person is not put at financial risk due to the costs of care.)	100% Equal population coverage across quintiles or population groups.
3. Degree of financial risk protection	
- Government funds prepayment ratio: GGHE/THE	≥ 70%

² Health care payments are at or exceeding 40% of a household's capacity to pay in any year (Xu et al., 2005).

- Percentage of households experiencing catastrophic expenditure in each scheme² 0%

4. Level of equity in health financing

- Total and specific health financing payments (e.g. taxes, contributions, insurance premiums, co-payments, out-of-pocket expenditure for health) as a share of household income Health financing payments as a share of non-food consumption is equal across all households.

5. Level of pooling across the health financing system

- Health care spending per pool member set in relation to overall health risks of pool members Equal health care spending per pool member across pools when set in relation to health risks of pool members.

6. Level of operational efficiency and equity in the delivery of a given benefit package at a given level of quality standards³

For each health financing scheme:

- Absence of over-provision (e.g. providing too many services and medicines, up-coding), under-provision (e.g. providing too few services and medicines, or of substandard quality), cost-shifting, cream-skimming No indications for and minimized incentives set by provider remuneration systems for over-/under-provision, cost-shifting and cream-skimming

7. Cost-effectiveness and equity consideration in the benefit package definition

For each health financing scheme:

Cost-effectiveness and equity considerations as part of benefit package definition logic.

8. Level of administrative efficiency

- Total administrative costs for all health financing schemes as a share of total health expenditure ↓
The average from National Health Accounts data for low- and middle income countries for 2008 is < 8%, with similar averages since 1995.

Source: adapted from Mathauer/Carrin (2011)

For the assessment of health financing performance, quantitative data were obtained from government and SHI sources, a household survey, and national health accounts, with secondary analysis being carried out. Latest available data are presented for each performance indicator. For the institutional–organizational analysis, the respective legal and regulatory provisions relating to health financing were analysed, and qualitative data were collected through interviews and discussions using key questionnaires with selected key health financing stakeholders from MoH, Vietnam Social Security and Ministry of Finance, as well as providers.

³ The assessment of this indicator requires a qualitative, institutional analysis and is thus dealt with in Section 3.

2. Overview of the health care and health financing system of Viet Nam

2.1. The structure of the health care system

According to preliminary results of the National Population Census of 2009, the population of Viet Nam is 85.8 million people. With such a large population, Viet Nam ranks third in South-East Asia and thirteenth in the world in term of total population size. Some 69% of the population live in the rural areas (GSO, 2009). The 2009 gross domestic product (GDP) was US\$ 1064 per capita (WHO, 2011).

Even before entering into the club of middle-income countries, Viet Nam has achieved significant improvements in all health areas. By 2005, Viet Nam’s age-specific death rates compared favourably with those of Malaysia – a far richer country – across all ages.

The health care administration in Viet Nam is organized in a three-level system (see Figure 1a and b). The tertiary level is the Ministry of Health (MoH) – the main national authority in the health sector – which formulates and executes health policy and programmes in the country. At provincial level are 63 provincial health bureaus which follow MoH policies but are in fact organic parts of the provincial local governments under the Provincial People’s Committees (PPCs). The primary level – or basic health network – includes district health centres, commune health stations and village health workers.

Figure 1a: The structure of the health care system in Vietnam

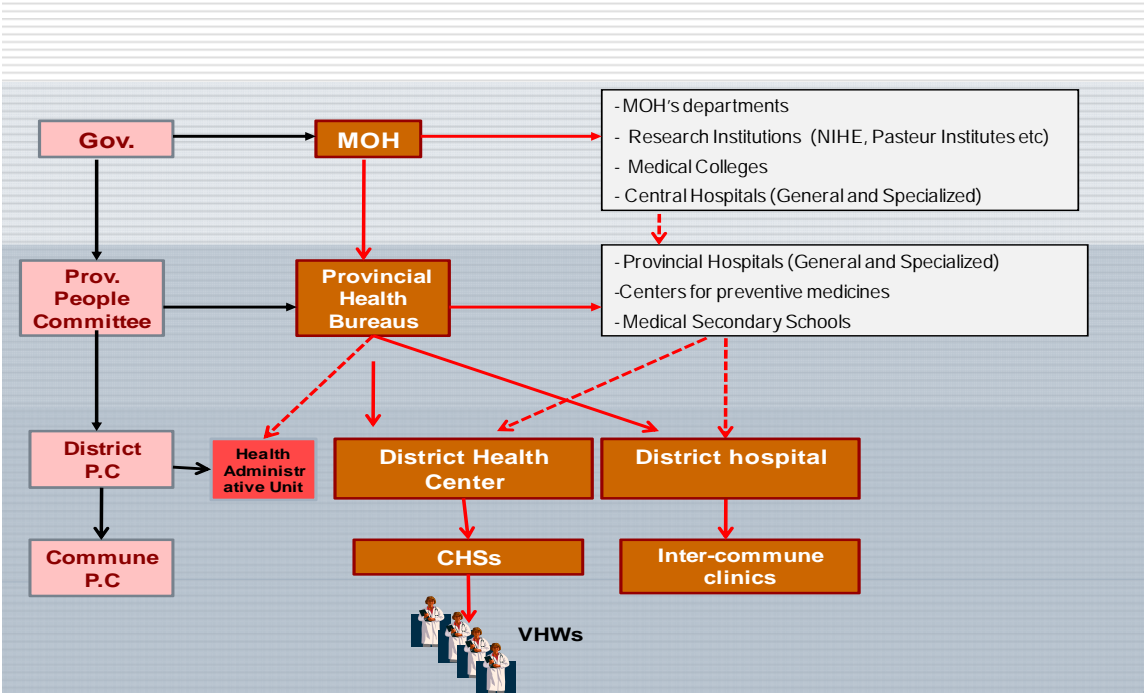
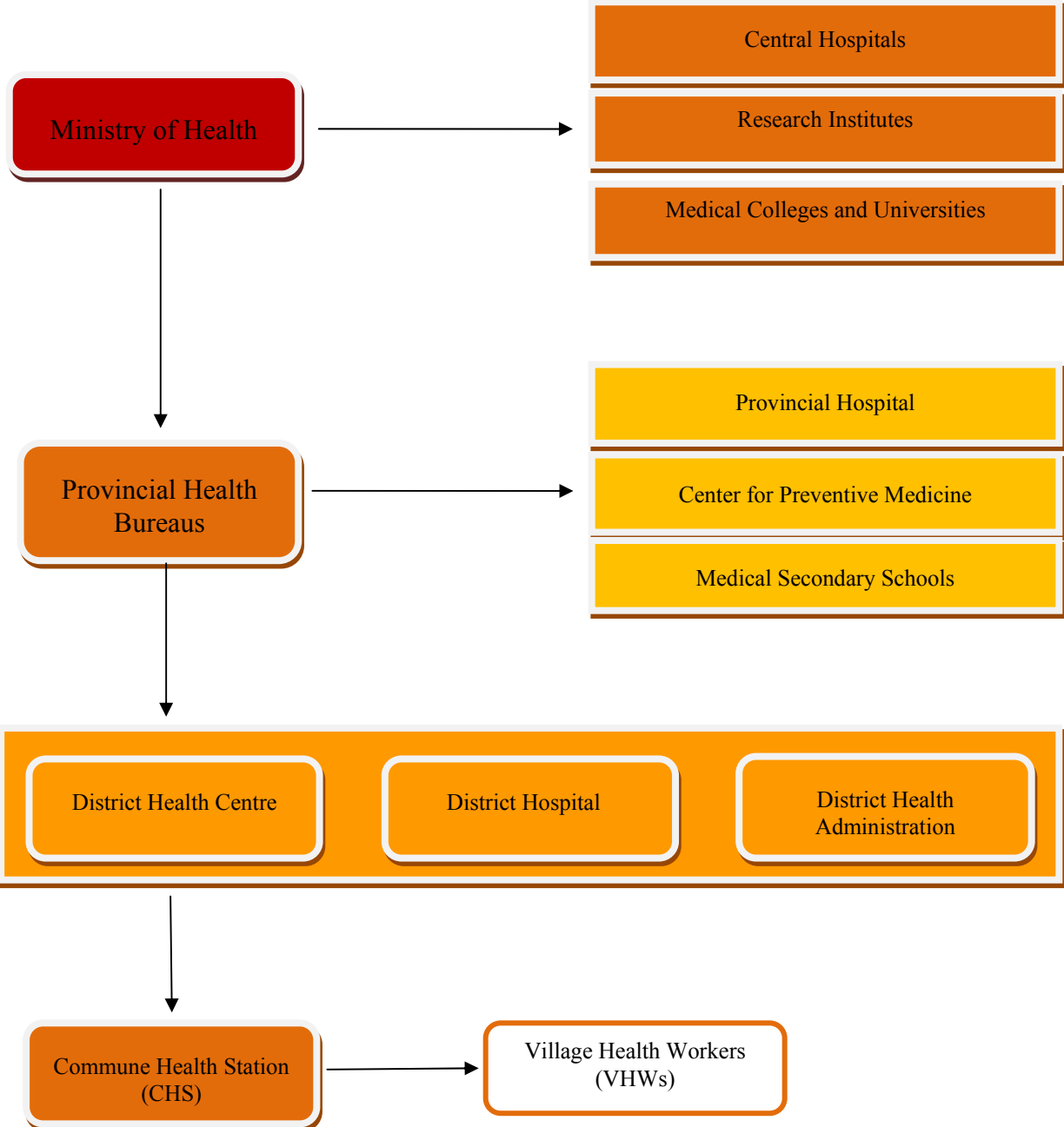


Figure 1b: The administrative structure of the health care system in Vietnam



Source: Central for Health System Research, Hanoi Medical University

The health service delivery system is undertaking a hospital autonomy reform that will help to improve performance but is also facing a number of unexpected effects that could undermine equity and cost-effectiveness of the health system.

2.2. Health financing policies and the evolution of social health insurance

Like the health financing systems of other socialist countries in the past, Viet Nam's health financing has been based on general government revenue. The health-care system has been successful in developing a health-care network that provides free primary health care and referral care services to all citizens. At the end of the 1970s, the country underwent a serious economic crisis and in 1986 the government launched its *Doi Moi* (or "renovation") reforms of the economy. In the health sector, four major reforms were introduced, namely: the introduction of user charges, the introduction of health insurance, permission for private practice in health care, and opening of the pharmaceutical market. As the reforms were implemented, OOP spending on health care increased dramatically, reaching 71% of total health spending in 1993 and continuing to rise to 80% by 1998 (Liebermann/Wagstaff, 2009).

After three years of piloting voluntary non-commercial health insurance schemes in some provinces in the period 1989–1992, the first government decree on SHI was promulgated in 1992 (Decree No. 299/1992/HĐBT, dated 15 August 1992 on the Article of Health Insurance). It was aimed at containing the growth of OOP spending and, via a mandatory scheme, at covering civil servants, workers in the formal sector in enterprises (both state-owned and non state-owned enterprises) with 10 or more employees, pensioners, socially aided people, staffs of international representative organizations.

The scheme was implemented in all provinces (i.e. nationwide), managed by provincial health insurance agencies and supervised by provincial health departments; the scheme covered all the eligible population in early 1993. It was a multiple fund structure, with one health insurance fund in each province and a national reserve fund. The level of the premium for formal-sector workers in the period 1992–2009 was 3% of their salary, of which employers contributed 2% and employees contributed 1%. During this period, a flat premium was applied to the informal sector, without a government subsidy.

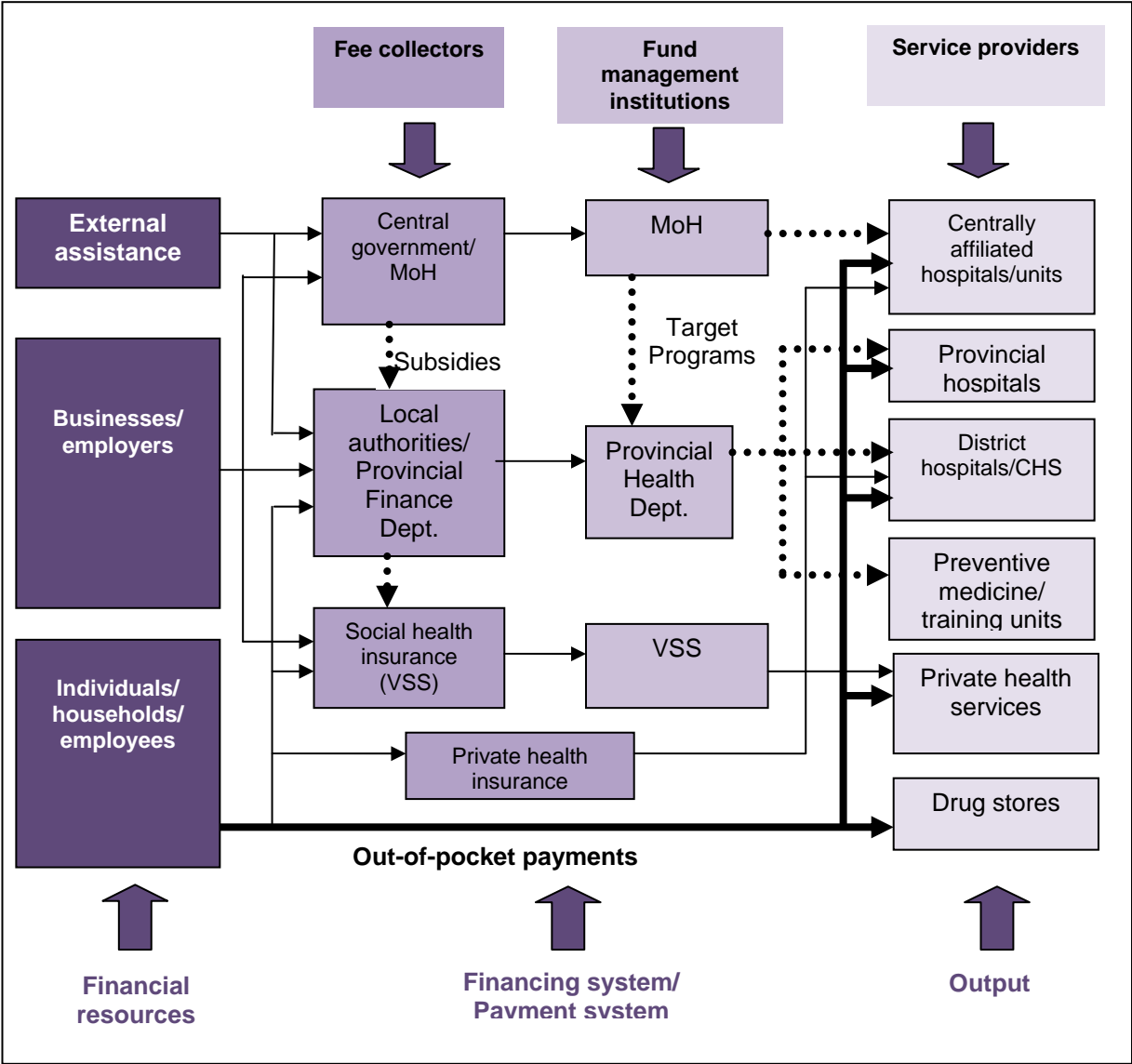
Five years later, in 1998, the government promulgated another decree on health insurance (Decree 58/1998/ND-CP) that unified all provincial health insurance funds into a single national health insurance fund and that enlarged the coverage of the health insurance scheme for members of the Congress and People Council; pre-school teachers, meritorious people, socially protected people, dependants of army officer and soldiers and foreign students in Vietnam. The merger of the agency for SHI with the agency for pension insurance and short-term allowance benefits (Viet Nam Social

Security, or VSS)⁴ in 2002 was a further major change in the organization of health insurance.

In order to improve accessibility to health care services for the poor and other vulnerable population groups, the Government issued several policies aiming at providing coverage to the poor, either by exempting the poor from paying user fees for services used or by covering them via health insurance. Over the time, these pro-poor policies evolved and were adapted. The first user fee exemption policy for the poor, Decree 95, was issued in 1994. The Decree stated that the poor should be exempted from paying user fees, however the government did not provide explicit funding for its implementation, i.e. health facilities did not receive extra funding for the loss of revenues when exempting patients. In 1999, Circular 05 stated that provinces should use budget funds in order to enrol at least 30% of the poor in compulsory health insurance. In 2002, Decision 139, in a further effort, led to the introduction of the Health Care Fund for the Poor (including ethnic minorities) in every province, to either enrol them in health insurance or to reimburse providers for health services free of charge for them. In practice, the provinces could choose either option or apply both options, i.e. some of the poor were enrolled in health insurance, whereas others were provided free health care without health insurance status. This policy, especially the direct fee exemption component, when put into practice, faced huge administrative difficulties, such as identifying the poor, issuing the card that certifies their status as "poor", enabling the poor to get free health care, defining benefits attached to the card holders, etc. Several studies revealed that the poor complained about being discriminated against and about not being able to enjoy the full benefits of the policy in reality. This was particularly the case for the direct exemption policy, whereas the health insurance coverage was perceived as a relatively better protection measure when seeking care. There was also evidence that some provinces tended to shift the sick among the poor to the health insurance, resulting in adverse selection and thus increasing average per capita expenditure of the insurance poor, whereas the preferred option for the healthier poor was to provide them with user fee exemptions (Liebermann/Wagstaff, 2009). In view of the weaknesses of this programme, the pro-poor policy has been further modified and from 2005, with the issuance of Health Insurance Decree 63, the direct exemption policy was no longer implemented. Decree 63 stated that all the poor have to enrol in compulsory health insurance with government funds subsidizing their premium. The health insurance law issued in 2008 continues to confirm that policy and by 2009, all provinces implemented it. Some 15 million poor and ethnic-minority people are now covered by subsidized health

⁴ Vietnam Social Security (VSS) is the government agency that is responsible for the implementation of national social insurance programmes such as pension, sickness and maternity allowances, and health insurance programmes.

Figure 2: Channels of financing sources for the Viet Nam health care system



Source: Ministry of Health (2008)

insurance.⁵ Clearly, this policy has reduced the risk of catastrophic spending on health care for the poor (Oanh et al., 2005; Wagstaff, 2007). Furthermore, in 2005, the National Assembly promulgated the Law on Education, Health Care and Protection for Children and following this Law, all children under 6 years of age were provided free health care, firstly through direct reimbursement to provider, later (from 2009) via SHI premium subsidization .

⁵ The process of identifying the poor is regulated by a circular of the Ministry of Labour, Invalids and Social Affairs (MOLISA). The list of poor households is based on the household economic survey (carried out each year), is discussed and voted on by members of each commune, and is submitted by the commune’s People’s Committee to the local district and the provincial Department of Labour, Invalids and Social Affairs for approval.

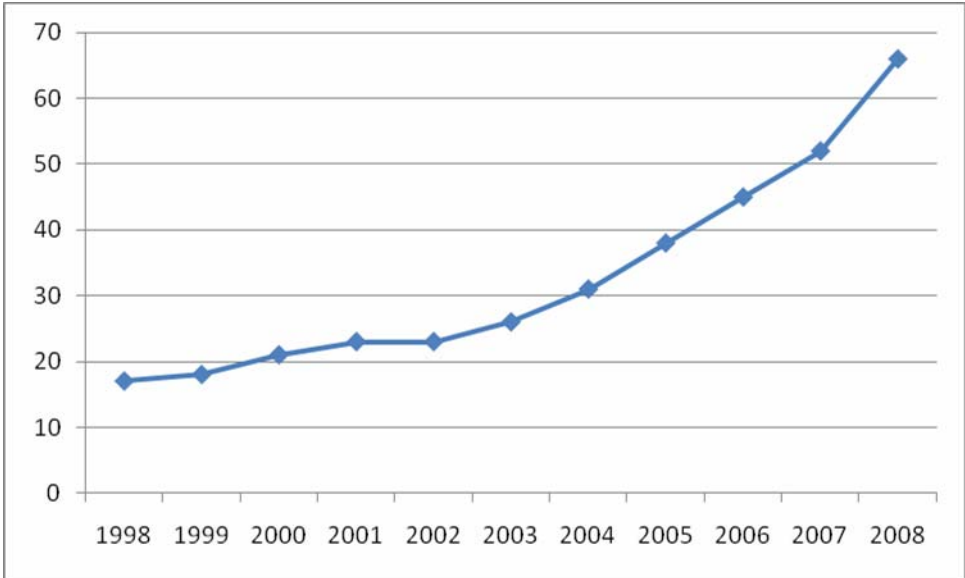
Due to the reforms during the implementation of the *Doi Moi* policies, Viet Nam health financing made a transition from a tax-based system to a system with multiple sources of financing. Today, the major sources of financing are general government revenues, SHI funding, and OOP payments of households. Other minor sources are external aid, overseas development assistance and private health insurance (4) (Figure 2).

2.3. Resource mobilization and health expenditure

The World Health Report 2010 considers that countries with high level of pooled funds, in the order of 5–6% of GDP, often have achieved universal access to health care for the entire population (WHO, 2011b).

In the last ten years, per capita health expenditure in Viet Nam has grown rapidly – increasing approximately four times over 10 years and reaching US\$ 66 in 2008 (Figure 3) (MOH/WHO, 2010). Thus, THE in Viet Nam has been increasing rapidly, and amounted to 6.4% of GDP in 2008. During the period 1998–2008, the annual rate of increase of THE amounted to 9.8%, which was higher than the annual rate of increase of GDP which was 7.2% (ibid.). Vietnam's THE as a share of GDP is higher than other countries of similar or higher income in the region such as Laos, Cambodia, Philippines, Thai Land, Indonesia, and China. However, pooled funds account for just around 40% of total health expenditure.

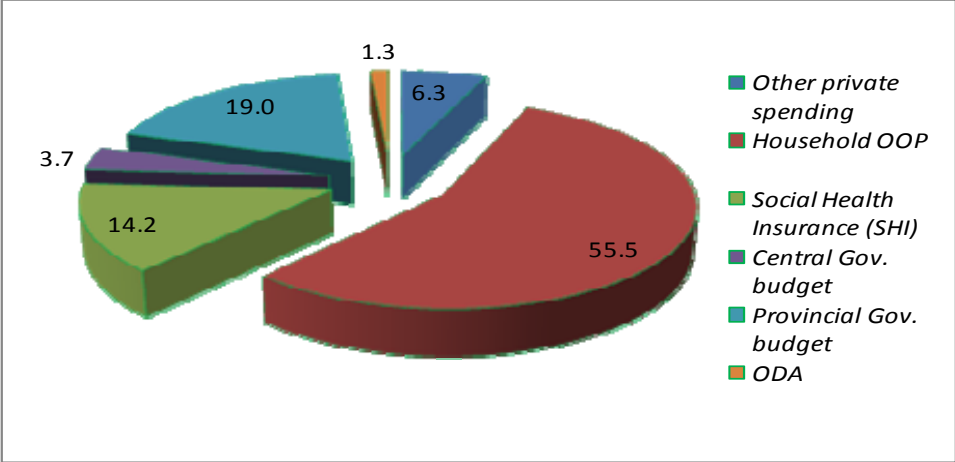
Figure 3: Per capita health expenditure in Viet Nam (US\$ current prices), 1998–2008



Source: MOH/WHO (2010)

The health financing reform due to the *Doi Moi* policy enabled multiple additional financial sources to be used for health care. The level of funding for health care has been increased, but the OOP spending of households has also increased and still accounts for the biggest share of THE. Spending from government budgets (at central and provincial levels) is the second largest share, while SHI contributes 14.2% of total health spending in 2007 (ibid.) (Figure 4).

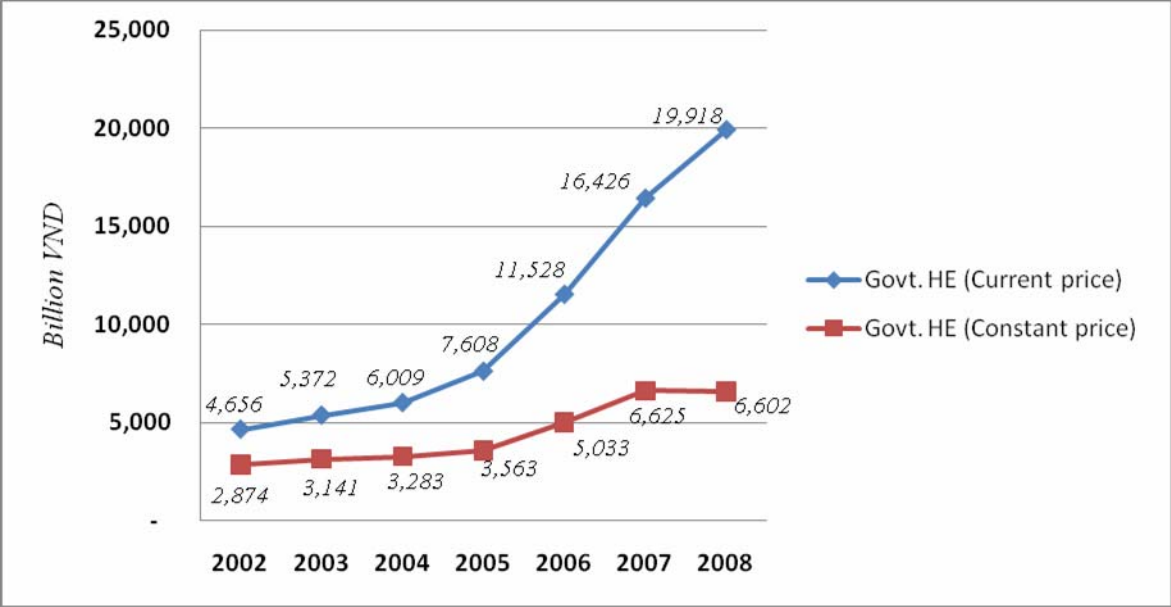
Figure 4: Share of sources of total health expenditure in 2007



Source: MOH/WHO (2010)

General government expenditure as a share of GDP was 32% in 2008 (WHO, 2011). As a developing country with low income, Viet Nam’s major source of revenue is indirect taxes (business tax, import and export taxes, and value-added tax), with a considerable part of the country’s income coming from oil production (24.2% of the total budget in 2006). In contrast, direct tax revenue – income tax – is extremely low, at only 1.8% of total budget revenue in the state revenue structure in 2006 (National Assembly of Viet Nam, 2006). The growth of annual GDP is fairly stable at 8% (GoV, 2011), which thus has also facilitated an increase in the state budget allocation for health. In 2008 the state budget granted for the health sector was 2.3 times higher than the 2002 allocation at constant prices (see Figure 5) (MOH/WHO, 2010).

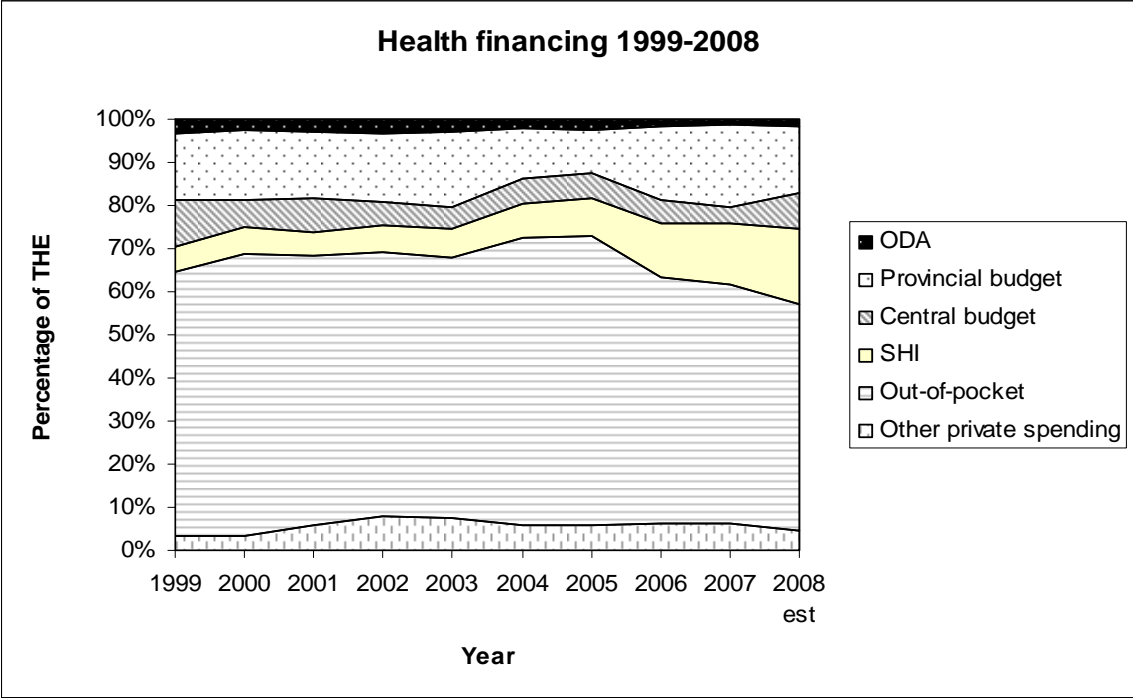
Figure 5: Tax-based financing for health (in current and constant prices) during 2002–2008



Source: MOH/WHO (2010)

The larger part of the government health expenditure is provided in the form of direct budget subsidy to health providers. Another part is channelled to the social health insurance in the form of premium subsidies for defined and targeted population groups such as the poor, children, and other vulnerable groups. This way of financing has become more significant since 2006. As shown in Figure 5, direct budget subsidy, consisting of central and provincial funds, and as percentage of THE, reduced between 1999 and 2005, but started to increase again in 2006 with substantial government investment in the upgrading of the local health care network. From 2006, spending on health insurance is also on a rise with the expansion of coverage to the poor and other subsidised groups. Also from 2006, with the implementation of hospital financial autonomy, the government signalled that from now on, direct budget subsidy to providers would be kept at a necessary level only, covering mainly essential public health and primary care, and certain parts of recurrent expenditures of tertiary care. The freed up resources from the government budget are spent on premium subsidies of vulnerable population groups in order to enrol them in SHI. Total government general spending on health is on gradual increase since 2006, which partly explains the slight reduction of OOP from 2006 onward (see Fig. 6). Overall, this is the result of a long policy development process since 2002.

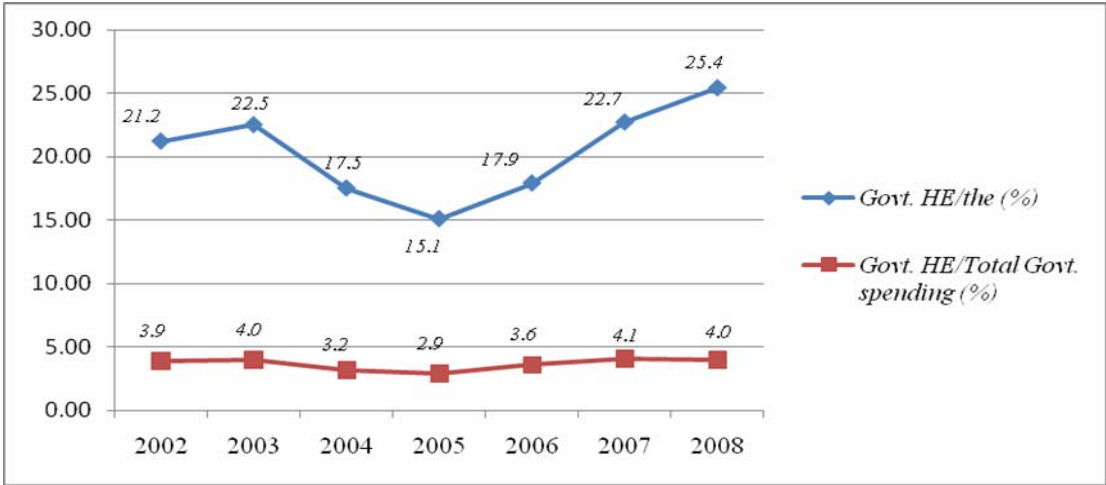
Figure 6: Trend in health financing, 1999 - 2008



Source: MOH/WHO (2010)

According to the National Health Accounts for 2002-2008, the proportion of government spending for health (excluding SHI fund) out of total health expenditure declined from 21.2% in 2002 to 15.1% in 2005 but increased to 25.4% in 2008. Government budget expenditure for health (excluding the SHI fund) as a proportion of total state budget expenditure fell from 3.9% in 2002 to 3.6% in 2006, but increased to 4.0% in 2008 (see Figure 7) (MOH/WHO, 2010).

Figure 7: Government expenditure for health (excluding SHI expenditure) compared to total health expenditure and total government expenditure



HE: health expenditure; THE: health expenditure

Source: MOH/WHO and General Statistics Office - GSO (2010)

In view of the financing health insurance premiums for the poor, other vulnerable groups as well as children, and due to significant government spending on upgrading district hospitals, commune health stations (CHSs) and provincial hospitals, the general government health expenditure (including direct budget subsidy and social health insurance spending), as a proportion of total government general expenditure, doubled from 5% in 2002 to 10.2% in 2008 (MOH/WHO, 2010). In 2008, the National Assembly decided to further increase the government budget allocation for health (Resolution No. 18/2008/NQ-QH12 of the National Assembly, 3 June 2008). As a result, the growth of the government budget for health care in 2009 was higher than the average growth of the total government budget.

Since 2008, the government has used the sale of government bonds to increase funding for upgrading health premises at the grassroots level and for district general hospitals in order to improve the quality of primary care (Decision No. 47/2008/QĐ-TTg dated 02/4/2008 of Prime Minister on approving the project investment for building, upgrading health premises at the grassroots level and district general hospitals using government bonds period 2008-2010). A project for upgrading district general hospitals received 3750 billion (US\$ 202 million) Vietnamese dong (VND) in 2008 and VND 3000 billion (US\$ 162 million) in 2009. In addition, in 2009, VND 500 billion (US\$ 26.9 million) from government bonds were allocated for building and upgrading specialist provincial hospitals and general hospitals in disadvantaged provinces.

Thanks to government efforts to increase government spending on health, in addition to the expansion of SHI coverage, the ratio of public financing in the total health expenditure has increased, and the OOP portion has decreased from 65% in 2005 to 52% in 2008 (MOH/WHO, 2010).

3. Health insurance in Viet Nam: institutional design, organizational practice, and challenges

This section analyses the institutional design and organizational practice of the three health financing functions, with a focus on the challenges of health insurance. Health financing performance is assessed with respect to the eight indicators outlined in Table 1, with a summary table being provided at the end of the section.

3.1. Social health insurance enrolment and collection of contributions

Contribution rates

Social health insurance policies as well as regulatory provisions relating to implementation are primarily the responsibility of the Ministry of Health. Enrolment procedures, eligibility regulations for premium subsidization, contribution rates, provider payment rates, etc. are all set at ministerial level. The Vietnam Social Security Agency on the other hand is the responsible implementing agency according to the regulations. This comprises enrolling members, collecting contributions, pooling and managing funds, contracting with public and private facilities, fund management, claims review as well as provider reimbursement.

The level of the premium for formal-sector workers in the period 1992–2009 was 3% of their salary, of which employers contributed 2% and employees contributed 1%. During this period, a flat premium was applied to the informal sector, without a government subsidy. The current health insurance implementation in Viet Nam is based on the SHI law approved in 2008, which became effective from 1 July 2009. From 2009, the level of premium for formal-sector workers increased from 3% to 4.5% (of which employers contribute 3%, employees contribute 1.5%). Whereas previously a differentiated contribution amount was applied, the premium for most groups outside the formal sector is now uniformly set at 4.5% of the minimum salary⁶ (Law on Health Insurance, 2008). This premium amounts to about 380,000 VND per person per year in 2010.

The government subsidizes 100% of premiums for the very poor and for children under six years of age, and subsidizes at least 50% of the premium for the "near-poor" and at least 30% of premiums for school children and students as well as the rest of the informal sector. According to the Law on Health Insurance, membership is mandatory for those who are eligible for full or partial premium subsidisation, however in practice, compliance is low and enforcement is lacking (see below). The near poor and the self-employed in the informal sector/ agricultural sector are reluctant to enrol in health insurance and to contribute their share of the premium.

Enrolment procedures and membership fragmentation

About 50.8 million people were covered by social health insurance in 2010, accounting for 60% of the population. As per the health insurance membership regulations, coverage is not family-based but individual-based, making membership

⁶ The minimum salary is set by the government and serves as a reference and calculation basis for many other purposes, such as salary levels for government workers. The minimum salary thus has no relation to a minimum wage in the sense of providing a decent minimum income. The minimum salary level in 2009 was equivalent to US\$ 35.

very fragmented and difficult to control, as described below. It is worth noting that a family-based membership was recommended during drafting of the health insurance law of 2008, as well as during the drafting of previous government decrees on health insurance, but this approach was not adopted.

In fact, membership of the SHI scheme in Viet Nam has been fragmented since its very beginning and it is now even more segmented. The first health insurance scheme launched in 1992 did not cover dependants of insured workers. The reason for this was that there was concern about the financial burden on contributors (at that time, the government was the major contributor to the health insurance premium since most enterprises were government-owned). Health insurance membership was divided into groups related to job or social background – such as civil servants, workers in government-owned enterprises, private enterprises, joint venture companies, foreign companies, social associations etc – excluding dependants of the workers.

Under the current health insurance law, there are 25 categories of membership, which are listed in Table 2. This means that a multitude of ministries and agencies, including the people committees at different administrative levels, VSS at all levels, as well as mass organisations, such as the Women Union, Youth Union, Farmer Association, are involved in this registration process. The Ministry of Labour, Invalids and Social Affairs, for instance, is responsible for enrolling the poor, those on low incomes and other socially assisted groups; the Ministry of Defence and the Ministry of Public Security is responsible for their personnel, the Commune people committee is responsible for identifying the poor, children under 6, and so on. Furthermore, the process of enrolling these targeted population groups is an administratively lengthy process, which involves identifying eligible persons, producing the list of eligible persons, certifying the list by the responsible agency, sending the list to VSS, printing health insurance cards, sending back the printed cards to the responsible agency, and distributing them to eligible persons. However, the inter-organizational relationships between the Department of Health, the Department of Labour, Invalids and Social Affairs and the VSS office at provincial level are not conducive for this collaboration, since insufficient communication and coordination hamper the enrolment process and thus affect the rate of enrolment and population coverage. Furthermore, the multiple membership groups also mean that some population groups fall into two membership categories, e.g. a child from a poor family falls into both the children category as well as the group of the poor. This overlap does not facilitate easy understanding of enrolment procedures, and more so, there is no priority and clarification on how to categorize a person. Finally, multiple membership groups make smooth shifting from one group to another more tricky, e.g., when a person previously working in the informal sector gains employment in the formal sector.

Table 2. Current health insurance membership categories

(Law on Health Insurance, 2008)

-
1. Workers, managers of enterprises, and civil servants.
 2. Officers of the Ministry of Public Security.
 3. Pensioners.
 4. Persons who are beneficiaries of a monthly social security allowance due to occupational injuries and occupational diseases.
 5. Workers who stopped receiving the disability allowance and who now receive a monthly allowance from the government budget; former rubber workers who receive a monthly allowance from the government budget.
 6. Retired commune civil servants who receive a monthly social security allowance.
 7. Retired commune staff who receive a monthly social security allowance from the government (according to the Government Decision No. 130/CP dated 20/6/1975 and No. 111/HĐBT)
 8. Unemployed persons who receive an unemployment allowance according to the law on unemployment.
 9. Persons awarded for revolutionary merit.
 10. Veterans who served before 30 April 1975; youth volunteers during the war against the French.
 11. People who directly served in the war against the United States.
 12. Members of the National Assembly and People's Committees.
 13. Persons who receive a monthly social protection allowance.
 14. The very poor and members of ethnic minorities living in disadvantaged areas.
 15. Dependants of persons awarded for revolutionary merit.
 16. Dependants of officers from the Ministry of Defence and the Ministry of Public Security.
 17. Children under six years of age.
 18. Organ donors.
 19. Foreigners studying in Viet Nam on Vietnamese government fellowships.
 20. Poor households.
 21. School children and students.
 22. Agriculture households.
 23. Dependants of formal-sector workers.
 24. Members of cooperatives and family enterprises.
 25. Workers on sick leave who need long-term treatment (the list of diseases is defined by the health minister)
-

Those who do not fall under compulsory insurance are all remaining informal-sector workers and their dependants who do not belong to one of the specific groups listed in Table 3. Workers' dependants will be covered in 2014, in the last year of the

universal coverage plan (dependants of military personnel and public security officers are already covered).

Fragmentation of membership and individual-based membership have several negative implications. First, the government budget subsidizes 100% of the premium for children under six years of age, many of whom are the dependants of salaried workers or informal-sector workers from better-off income quintiles and could easily have been covered by a family-based scheme. A similar point could be made for many of the elderly of 85 years or older. It could be argued that the government should use the spare resources to subsidize people in real need. In addition, a number of dependants are not yet covered by the compulsory scheme and have to wait until 2012 or 2014 to enrol in it. Second, members of the same family have to enrol in different health insurance membership groups, making implementation of enrolment and contribution collection more complex for both the family and for the VSS, which requires the assistance of different government agencies. Furthermore, some children above six years of age, but who have not yet entered school, fall outside the VSS scheme.

Enrolment compliance

While enrolment compliance in government-owned enterprises is nearly 100%, compliance in private enterprises is very low. Only about 50% of the estimated 16 million workers in the formal sector (including government-owned enterprises and private enterprises) have joined the SHI scheme. In addition to lack of organizational capacity in enrolment and collection of contributions, which is one major factor, other factors include inadequate monitoring and inspection, weak law enforcement, instability of officially registered private sector companies and the tendency of small enterprises to evade paying contributions, as described below.

Inadequate monitoring and inspection is an important factor. The VSS (the implementer of the health insurance scheme and other social insurance schemes, such as pension insurance) is not empowered by law to carry out inspections. The current legal framework assigns the inspection function only to government authorities (the government inspection office, the inspection office of the Ministry of Labour, Invalids and Social Affairs as well as the Ministry of Health, and the provincial government inspection bodies). They all can be involved in inspection of SHI compliance when and where appropriate. Despite of being a government agency, VSS is not authorized to undertake inspection, while on the other hand the designated government authorities at different levels lack resources (financial resources, human capacity) for inspection activities. The result is that private enterprises are not monitored and inspected as well

as intended. In many provinces the SHI compliance of private enterprises is only 20–30%.⁷

Instability of the private sector in a developing economy is a further factor in low compliance. Private enterprises quickly change the scope of their services and products to adapt to the rapidly changing business environment, and therefore the number of workers is changing each quarter. Many enterprises that are set up soon disappear from the market. Enrolment compliance in such companies is difficult to control.

Inadequate enforcement is also a factor since there has been no enforcement regulation so far. At the end of 2010, a draft government decree on penalties for violation of health insurance regulations was prepared and is likely to be issued soon, but the level of penalty charges in the draft decree seems insufficient to enforce compliance.⁸ It appears that the low penalty charge is an incentive for some employers to not enroll and to not contribute for staff or underreport salaries and instead accept the penalty charge if caught.

It is also important to note that VSS membership for social health insurance implies membership to VSS' pension scheme, i.e. contributions to the pension scheme. As outlined in further detail in Liebermann/Wagstaff (2009), the pension scheme provides rather unattractive benefits. Evading the payment of contributions to the pension scheme and thus avoiding VSS membership thus also affects health insurance coverage rates.

Furthermore, the mandatory scheme is also faced with *adverse selection*, especially for the private formal sector and persons with low incomes. The government subsidizes at least 50% of the premium for persons with low incomes, and in some regions the subsidy amounts to more than 80%, but even this high subsidy has not improved enrolment of these groups (MOH/DHI, 2009). The reason is that enforcement measures, even if they existed, cannot be implemented for those with very low incomes. Many such persons joined the health insurance scheme only when they needed to use health-care services.

Beside the compulsory health insurance scheme, there is currently also a voluntary non-commercial health insurance scheme, which is also operated by the VSS and pooled with the mandatory scheme, which offers insurance for those who are not yet eligible for compulsory health insurance. Out of the 18.5 million eligible people, only 3.9 million (i.e. 21%) have enrolled. Adverse selection has equally become a

⁷ During the period 2005–2008, only 20.9% of private enterprises in seven provinces paid health insurance premiums (Government Inspectorate, 2009). In the province of Tay Ninh, only 30% of private formal-sector workers enrolled (MOH/DHI, 2010).

⁸ There are different levels of financial penalty, depending on the amount of the unpaid premium. The maximum penalty is VND 20 000 000 (equal to US\$ 1,025) applied to an employer who has not paid employees premiums amounting to more than VND 80 000 000 (US\$ 4,102) (at an exchange rate of 19,500,000 VND per 1 US\$ on 31 December 2010 at Vietcombank).

serious problem for this voluntary health insurance scheme. Since 2008, when the government removed group enrolment conditions for the voluntary scheme, making it possible for anyone to join the scheme with a flat premium, the voluntary health insurance fund became a fund for people with high risks and was continuously faced with a deficit equivalent to hundreds of millions US dollars each year. Although the current health insurance law of 2008 stated that the current voluntary scheme will end by the beginning of 2014, after which everyone will be eligible for the mandatory scheme, so far there is no clear strategy on how to reach the un-reached population groups. Clearly, it is difficult to apply a contributory mechanism to a large informal sector like that in Viet Nam. Accordingly, enforcement measures will be very difficult to apply due to high administrative costs and a lack of resources. Even if the inspection had the resources, it seems that collection of penalty fees from the informal sector is very difficult.

Coverage rates of different membership groups

Fragmentation of the membership, mainly due to individual enrolment, low compliance both in the private formal sector and in informal sector, inadequate monitoring and enforcement, led to a situation where coverage rates among those with full premium subsidization are highest (94.3% for those whose premium is paid by the social security agency and 80.7% with government subsidized premiums) and above the coverage rates for the private sector employees (53.4%). Coverage of the "near-poor" with low incomes is low, but anyone from this group (i.e. up to 130% of the poverty line) is eligible to enrol in the SHI scheme in order to be protected against catastrophic spending. Table 3 provides a detailed overview of membership shares of the different population groups.

In this context it is noteworthy that also amongst those who are eligible for full premium subsidization (e.g. those who receive an unemployment, social protection or a social security allowance) coverage is not 100%. The same is true for dependents of meritorious persons and of officers of the Ministry of Defence and Ministry of Public Security as well as the large group of children below six years of age, in which about 20% of them are not covered. It is particularly worrying that this leaves many children unprotected from financial risk when falling sick. Moreover, it raises the question why this is the case and what kind of hurdles parents might encounter in the enrolment process. Delays in card issuance, poor services and inappropriate enrolment procedures could be one problem, as well as lack of knowledge where to apply for a card or how to get one's premium subsidized (Hohmann, 2011; UNICEF, 2011). Likewise, especially for larger households, the total amount to be paid in light of individual membership might not be affordable.

Table 3. Health insurance coverage 2010, by mode of contribution

Subgroups	Subgroup size (number of persons in millions)	Number of persons covered (in millions)	% of coverage	Share of total coverage (in %)
Subgroups with 4.5% of wage contribution	15.238	9.506	62.4	18.7
Workers in enterprises and other organizations (<i>employer 3%, employee 1.5%</i>)	11.911	6.361	53.4	12.5
Civil servants (<i>employer 3%, employee 1.5%</i>)	3.142	3.142	100.0	6.2
Foreign students on government fellowships (<i>premium: 4.5% of minimum salary, fully subsidized by the government</i>)	0.003	0.003	100.0	< 0.0001
Commune civil servants (elected) (<i>premium: 4.5% of salary, 30% subsidy by the government</i>)	0.182	0	0	
Subgroups whose contribution is paid by the social security agency (premium: 4.5% of provided allowance)	2.305	2.174	94.3	4.3
Pensioners	0.920	0.920	100.0	1.8
People who receive a monthly social security allowance	1.305	1.254	96.1	2.5
People who receive unemployment allowance	0.080	0	0	
Subgroups whose contribution is paid from the government budget (premium: 4.5% of minimum salary)	30.561	24.675	80.7	48.6
Commune civil servants	0.041	0.040	97.6	0.1
Persons of merit	1.791	1.791	100.0	3.5
Veterans	0.374	0.350	93.6	0.7
People who contributed to revolution, certified by the government	0.322	0	0	
Members of the National Assembly and People's Councils	0.123	0.119	96.7	0.2
People who receive a social protection allowance	0.843	0.384	45.5	0.8
The poor and minority ethnic groups	13.945	13.511	96.9	26.6
Dependants of persons of merit	0.869	0	0	
Dependants of officers of the Ministry of Defense and Ministry of Public Security	1.281	0.297	23.2	0.6
Children under six years of age	10.103	8.183	81.0	16.1
Subgroups with a partial government subsidy	19.879	10.499	52.8	20.7
(The "near-poor") (<i>premium: 4.5% of minimum salary, with at least 50% subsidy from the government</i>)	6.081	0.692	11.4	1.4
Schoolchildren and students (<i>premium: 3% of minimum salary, with 30% of premium subsidy from the government</i>)	13.798	9.807	71.1	19.3
Voluntarily insured members who do not receive any subsidy	18.552	3.917	21.1	7.7
Dependants of salaried workers and civil servants (<i>premium: 3% of minimum salary</i>)	6.820	0	0.00	0.0
Agricultural households, members of cooperatives, household enterprises (<i>premium: 4.5% of minimum salary</i>)	11.732	3.917	33.4	7.7
Total	86.866	50.771	58.5	100.0

Source: VSS (2011)

Contributions shares across membership groups

Collected contributions of subsidized members (70% of total membership, with 49% of the total fully subsidized and 21% partially subsidized) are based on the minimum salary and are thus, in comparison to their share as of total enrolees, very low in comparison to those of formal sector. There is thus a strong level of solidarity through the collection of contributions. Table 4 shows their shares of total contributions.

Table 4. Share of total SHI contributions by membership group

Membership group	As % of total enrolees (2005)	As % of total SHI revenues (2005)	As % of total enrolees (2009)	As % of total SHI revenues (2009)
Formal sector workers	25	57	16	39
Pensioners	8	20	4	9
Meritorious, elderly people	7	5	49	34
Children below six years				
The poor and others	21	6		
Students	33*	8	21**	9
Other voluntarily insured	7	4	9	9

Source: Liebermann/Wagstaff (2009; UNICEF (2011)

* includes the group of children

** includes the near-poor that benefit from subsidies

In summary, while there is a continuing increase in the government budget for health care, with a government subsidy of 100% for the poor and for children under six years contributing to improvement of the share of public financing in THE, the collection of revenue for SHI is below its potential. This is mainly due to the low coverage rate of the formal sector employees (about 53.4% in 2010), due to the individual-based and fragmented membership, weak inspection and enforcement, weak institutional design and implementation, and a high level of adverse selection. In addition, the voluntary health insurance scheme has had a serious impact on the deficit of the health insurance fund.

3.2. Pooling of funds

Fragmentation issues in the social health insurance fund

The current SHI system in Viet Nam is a single fund, which in principle ensures a maximum level of pooling. Contributions from all 25 membership categories in all provinces – from the higher-income group (e.g., parts of the formal sector) to the poor with government subsidized premiums – are pooled in one national fund. Yet, despite pooling through a single fund, there are some issues in the health financing system that limit the real level of pooling and undermine solidarity.

First, membership of the SHI scheme is based mainly on individual enrolment and excludes the dependants of workers from coverage. This is not only against cultural tradition but also reduces the element of solidarity.

Second, everyone who expects to need health care can join the SHI scheme and start benefiting from it after a waiting period of 30 days. This is also the case for the voluntary membership of the informal sector. As mentioned above, adverse selection occurs, since some people enrol only when they fall sick, thus affecting the health risk balance of the pool.

Third, it is important to note that while funds are pooled at national level in principle, the way the resources are allocated to the provinces and health facilities and specifically to individual membership groups severely contributes to fragmentation again, strongly affecting equitable delivery of the benefit package. Each of the 63 provinces monitors the revenues and expenditure for the six defined membership groups:

1. civil servants and formal sector workers;
2. pensioners, meritorious people, veterans and beneficiaries of social security/protection allowances;
3. the poor and near poor;
4. children under six years of age;
5. schoolchildren and students;
6. the remaining mainly voluntary members

The surplus of one province or of one membership group can be used to pay for deficits of other provinces/membership groups. However, the provincial membership group-specific capitation payment rates, originally calculated based on historical expenditure (see Section 3.3.2 for further explanation), perpetuate unequal spending between poorer and better-off provinces. In other words, poorer provinces due to their lower per capita expenditure subsidize better-off provinces. Also, since a provider's specific reimbursement ceiling is based on revenues collected by members registered at that provider, the principle of pooling income and sharing risks is equally

interrupted, thus in principle affecting cross-subsidization. Even more, the state premium subsidization payments for the poor actually cross-subsidize other population groups. This will be further elaborated in Section 3.3.2 below.

Finally, about 40% of the population are not yet covered by health insurance and have to make OOP payments for health care. They neither contribute to the pool nor benefit from risk-sharing. It is necessary to note that most of the uncovered 40% are in the informal sector and most of them are persons with low incomes, but their incomes are not low enough for them to receive the 50% or 80% premium subsidy from the government.

Duplicate private health insurance

Third, state-owned and private commercial health insurance companies operate a number of commercial health insurance schemes without adequate regulation. There are 11 domestic and foreign commercial life insurance companies operating in Viet Nam, providing different commercial health insurance schemes. Their revenue has increased about 20-fold in the past 10 years (from VND 485 billion in 1999 to VND 11 849 billion in 2009 (MOF, 2009). The top four insurers in 2009 were Bao Viet (Viet Nam Insurance), PVI (Petro Viet Nam Insurance), Bao Minh and PJICO. These schemes target the better-off population, many of them in the informal sector. The estimated number of schoolchildren and students enrolled in commercial health insurance schemes in recent years is about 10 million (i.e. 50% of this group) (GSO, 2010). Anecdotal evidence reveals that, because of the lack of regulation of commercial health insurance in Viet Nam, schoolchildren often pay double – once for SHI and again for private health insurance (PHI). This is because teachers encourage their students to continue paying PHI premiums, as the teachers wish to continue receiving commission from PHI companies. Commercial health insurance schemes are not supplementary or complementary, so that schoolchildren may pay twice - their contribution to VSS and a private health insurance premium - but cannot receive more or additional benefits. Millions of schoolchildren and their parents buy commercial health insurance each year without information about benefit packages that are often very limited. It is impossible to obtain information about specific commercial health insurance schemes on the Internet.⁹ The lack of regulation results in additional financial burden for households, who pay without getting respective benefits, and thus in additional profits for commercial companies. Some commercial health insurance companies target only schoolchildren for their business, as these are the healthiest population group and their health expenditure is minimal. No commercial health insurance company in Viet Nam is interested in providing health insurance schemes for the elderly or for households in rural areas. This “cream skimming” has a

⁹ In contrast, all legislation and regulations on SHI schemes in Viet Nam are available and easily accessible on the Internet.

fragmenting effect and contributes to undermining the national pooling and thus the solidarity basis of the social health insurance system.

3.3. Purchasing

3.3.1. Health insurance benefit package and financial risk protection

Insured members can use health services only from the commune health centre or district hospital where they are registered, or else be referred to higher care levels. In fact, in 2010, 20% of members were registered at community level, 61% at district hospital level, whereas 19% at a higher level (UNICEF, 2011). When seeking care in other commune health centres or district hospitals, their out-of-pocket expenditure will be reimbursed later at their place of residence, while emergency care is free of charge. The benefit package is regulated by the Social Health Insurance Law 2008 with the following features:

Inclusive list of health services. The SHI benefit package is based on an inclusive list and covers all ambulatory and hospital basic as well as advanced diagnostic curative health services and therapeutic services – including renal replacement therapy (peritoneal dialysis, haemodialysis, and spleen transplantation), organ transplantation, invasive cardiovascular treatment, computerized tomography scan, and magnetic resonance imaging etc. In addition, transportation costs in case of referral are covered for the poor, persons entitled to social assistance allowances and those in remote areas. In contrast, rehabilitation, home care, drug addiction treatment, prostheses, teeth, glasses and hearing aids are not covered, nor are treatment of occupational diseases and accidents at the workplace. In light of a large informal sector, the latter is of particular concern, as there is no formal employer to take responsibility of these charges, despite of the existence of some form of employment relationship in the informal sector.

Inclusion of expensive high-tech medical services in the benefit package. Nearly all high-tech medical services are included in the benefit package. The selection of new expensive high-tech services lacks appropriate health technology assessment procedures. However it is these cases that would create very high out of-pocket expenditure, due to high co-payment rate and reimbursement ceiling applied. In addition, the provision of services and treatments is based mainly on the opinion of clinicians and is neither evidence-based nor rationalised based on needs and cost.

Preventive health care, except for screening tests for early diagnosis of some cancers, is not covered by the health insurance fund. The government allocates a budget to preventive health so that basic preventive care is provided free of charge to all, insured and uninsured.

Copayment. Copayment was re-introduced in January 2010 under the new health insurance law and applies to the set price list for government health services at district, secondary and tertiary level as well as the drugs from the reimbursement list (see below). All insured members have to pay copayments, except of three specific member groups who are exempted, i.e. high ranking police officers; meritorious people, and children under six years of age. For referred patients, the level of copayment varies: 5% of copayment applies to pensioners, the poor and members who receive a social protection allowance, while 20% of copayment applies to the remaining membership groups. Insured patients who bypass lower referral facilities have to pay a higher copayment rate, depending on the level at which they access health care: it is 30% at district hospitals, 50% at provincial hospitals, and 70% at central and tertiary hospitals.

Under the current health insurance policy, copayment can be a financial burden for patients with high health-care costs, since there is no ceiling for copayment, and the accumulation of copayments – even at copayment rates of 5% or 20% of health-care costs – can become catastrophic expenditure for households. In addition, there is a ceiling on the maximum benefit that the health insurance fund covers for each episode requiring costly high-tech services. This ceiling is defined as 40 months of the minimum monthly salary, which is equivalent to US\$ 35 (as of 2010). In summary, the current copayment policy considerably limits the risk-protection function of SHI. Uninsured patients are particularly at risk, as they pay by user charges (fee-for-service), i.e. 100% of the price of the set price list.

List of reimbursement drugs. The list of reimbursement drugs covered by the social health insurance is issued by the Ministry of Health (Decision No.5/2008/QD-BYT (dated 01/02/2008) of the Ministry of Health). In 2008, the reimbursement drug list for health insurance members consisted of 750 medicines and 237 traditional herbal medicines. Recently, an additional 54 drugs for children under six years of age have been added to the list. The 750 medicines are listed by their international non-proprietary name (INN) and providers can prescribe generic and/or brand-name products. While this gives doctors some flexibility and medical autonomy, it makes them susceptible to pressure from pharmaceutical suppliers to prescribe more expensive brand-name drugs. Hospitals have the right to set up their own drug list according to the national drug list. There is a concern that the reimbursement drug list has not been sufficiently developed on the basis of evidence of cost-effectiveness; and some drugs that are rarely used even in some developed countries are included on the reimbursement drug list. The process for adding new drugs to the list or removing drugs from it does not have well defined steps that ensure selection according to evidence of cost-effectiveness. The biggest concern is, however, that the prices for drugs are not monitored nor regulated, in contrast to the price list with tariffs for health services determined by the Ministry of Health. It thus remains under the discretion of

the hospital to set prices. The copayment rates thus apply to unregulated, high drug prices. The root cause of this problem is caused by the fact that suppliers are allowed to set the drug prices on a competitive basis according to the Law on Pharmaceuticals.

High OOP payments for medicines. Despite the (in principle) very generous SHI reimbursement drug list, insured patients nevertheless have to buy many of their drugs themselves in private pharmacies. This is because hospitals frequently suffer from temporary shortages of drugs. Usually these drug costs are not reimbursed. Also, doctors may receive (financial and other) incentives from pharmaceutical companies and drug suppliers to prescribe drugs that are not on the reimbursement list. As a result, in view of high drug expenditure, the risk-protection function of SHI is undermined.

Another concern about the benefit package is the *tricky process of getting traffic accident related health care costs reimbursed*. According to the current regulation (Interministerial Circular No. 09/2009/TTLT-BYT-BTC), reimbursement of treatment costs following injury in a traffic accident requires an official statement saying that the patient did not violate traffic law. This regulation means that patients first have to pay directly (OOP) and then wait for the official statement which is issued by the police in order to get reimbursed. Many patients will not get reimbursed because the information on which an official statement can be based is lacking. Since traffic injuries are among the leading causes of the burden of disease in Viet Nam, the current regulation seriously undermines the risk-protection function of health insurance.¹⁰

3.3.2. Purchasing structure and provider payment mechanism

Before the 1990s the public health sector was fully financed by general tax revenue, and line-item budget was the only payment method the government used to pay providers. With the introduction of SHI, this changed. For a comprehensive understanding of the incentives that health providers face, we first present the purchasing and payment arrangements outside the social health insurance, before discussing in detail the provider payment mechanisms applied under social health insurance.

Budget allocation from the central government to provinces

Preventive care: In the Viet Nam health-care financing system, the government is the sole purchaser of preventive health care (provided by public health facilities). The central government's allocation to provinces of the budget for preventive health

¹⁰ A circular on adjustment of policy on reimbursement of expenditure of traffic injury treatment has been drafted in 2011 in order to provide better financial protection for insured patients.

care is based on capitation principles (i.e. the budget allocation for each province is based on the size of the province's population). However, using population numbers as the basis for budget allocations may be insufficient to respond to specific population needs across provinces. Some preventive care activities are under national vertical health target programmes, based on line-item budgeting. In contrast to programme-based or output-based budgeting, line-item budgeting restricts strategic purchasing.

Curative care: the government provides budget support to government health providers to cover part of their recurrent expenditures for curative care. The central government budget is based on available resources at the national level and also determined by historical spending (i.e. the amount spent in the previous year) and approved by the National Assembly. Specifically, the allocation to the 63 provinces is based on the capitation principle and is adjusted by a region-specific coefficient to reflect different geographical conditions and levels of economic development (according to Decision No. 59/2010/QĐ-TTg dated 30/9/2010 on Budget Allocation for recurrent expenditure in 2011). In 2011, the per capita allocation for health was VND 105 600 for urban areas, VND 142 700 VND for rural delta areas, VND 186 940 for ethnic minorities living in the river delta, and VND 261 140 for ethnic minorities living in the mountains and islands. Yet, these amounts change every year. Provinces with a population of less than 500 000 have an additional 12% per capita allocation, and provinces with a population of 500 000–800 000 receive an additional 10% per capita allocation. As the allocation is based on an adjusted capitation rate, the allocation mechanism of the central government ensures to a certain extent equity principles.

Budget allocation from provincial governments to government health facilities

Preventive care: The budget for preventive care is allocated to the respective government facility on the basis of the number of staff. However, staff are not distributed equally and according to need across provinces and hospitals, and therefore the resource allocation ultimately might not fully reflect health-care needs. Provincial governments provide an additional line-item budget for the treatment of epidemic outbreaks.

Curative care: Provincial governments do not allocate their budget to individual hospitals according to the central government logic, but on different principles, namely on the basis of the number of hospital beds for curative care. Yet, it is important to note that hospital beds, too, are not distributed based on population needs. However, hospitals enjoy some considerable degree of financial autonomy and, in contrast to preventive health programs, no line-item budget applies to curative care and hospitals can allocate resources according to their necessities and priorities.

Commune health stations are supposed to receive a flat fixed annual budget of about VND 10,000,000 per year, adjusted for each region. However, the implementation of this policy is not uniform across provinces due to the differences in available local resources and local government commitment.

Overall, at provincial level, the government budget for health is allocated on the basis of inputs and not of needs or even performance. This allocation mechanism does not incorporate explicit strategic purchasing principles and hence weakens efficient use of scarce resources. Moreover, as hospitals are implementing a policy of hospital autonomy since 2006 (Decree No. 43/2006/NĐ-CP dated 25/4/2006 of the Government specifying autonomy and accountability in terms of organization, staffing and financing in public entities), and in the absence of a national hospital plan with defined bed numbers, hospitals have the incentive to increase the number of beds to obtain more funding from the government budget. A study to assess the hospital autonomy policy, conducted in 2009 by the Health Strategy and Policy Institute (HSPI) among 18 hospitals of all levels, found that direct state budget subsidies account for around 10% of total revenues of central hospitals, whereas this share amounts to 17% for provincial and 35% for district hospitals (HSPI, 2010). This is considered as a direct result of the hospital autonomy policy implementation since 2006. With this policy, hospitals, especially central hospitals, tend to rely less and less on direct budget support, and more and more on revenues collected from health insurance and from user fees directly paid through out-of-pocket payments. Some hospitals are considered financially autonomous and do no longer receive any direct budget support. Other hospitals, such as mental health hospitals, TB hospitals and paediatric hospitals, still largely rely on government budget (ibid.).

Social health insurance provider payment mechanism

According to the SHI law, three types of provider payment mechanisms can be applied, namely fee-for-service, capitation, and payment by diagnosis-related groups (DRGs). Fee-for-service payment was officially introduced as a payment method for the social health insurance agency in 1995, after the collection of user fees had been legalised at government health facilities. Fee-for-service is now the dominant payment mechanism at all health facilities, both public and private and is used to pay provincial and central (tertiary) hospitals and referral health services, while capitation payment is used to pay for primary health care, i.e. outpatient and inpatient health care at commune health stations and those district hospitals that switched to capitation payment. Capitation had been piloted first in 2004 at low scale. By 2009, about 40 district hospitals (out of more than 600 district hospitals) were paid based on capitation. Payment by diagnosis-related groups, however, is so far only at the pilot stage. Since hospitals have the right to choose between capitation and fee-for-service, most hospitals still prefer payment based on fee-for-service. To contain cost, the MOH

issued a circular in 2009 that aimed at gradually expanding the implementation of capitation with the goal of applying this payment mechanism in all district hospitals and commune health stations by 2015.

Capitation

Health insurance members have to register either at a commune health station or a district hospital, but only the latter is contracted by VSS for capitation payment. SHI members are divided into six specific groups and a group-specific capitation rate is calculated for each group for each province. In other words, there are six specific capitation rates. The groups do not necessarily reflect homogenous health risks; moreover, the rationale for was not to establish *risk-adjusted* capitation rates..

Table 5. Capitation rates of the six SHI membership groups in Kien Giang Province, 2011

Member groups	Level of health risk within the group	Capitation rate (VND)
a) civil servants and formal sector workers	Rather low risk: young and healthy	534,258
b) pensioners, meritorious people, beneficiaries of social security/protection allowances, veterans	Rather higher health risks (older, sick, vulnerable people)	1,686,558
c) the poor and near poor	Relatively higher health risks	117,528
d) children under six years of age	Overall low health risks (young and healthy)	119,601
e) schoolchildren and students	Overall low health risks (young and healthy)	87,836
f) the remaining members (mainly voluntary members)	relatively high risk (due to adverse selection)	893,316

Source: Vietnam Social Security, 2011

In fact, the current calculation method of the capitation rate is not based on actual health care need but on historical expenditure of the previous year. Since ceilings are applied each year (see below), capitation rates are ultimately based on historical expenditure from earlier years. The expenditure thus reflects unequal (i.e. lower) utilization rates of the poor as well as use of less costly services, in contrast to their actual health care needs, which would imply higher utilization rates. This is due

to financial barriers in light of copayments unrelated to income and with no ceiling as well as due to poorer health infrastructure and lack of higher level services in poor and remote areas. Table 5 for the Kien Giang Province presents the capitation rates and shows that capitation rates for the poor and the near poor are significantly lower than for other adult population groups.

The capitation rate for each of the six member groups is calculated specifically for each province (there are 63 provinces) using the following formula:

$$R_{ij} = (\text{Exp}_{ij} / N_{ij}) \times K$$

R_{ij} is the capitation rate of group i in the province j ;

Exp_{ij} is the total health expenditure of group i for the province j for the previous year;

N_{ij} is the total number of group i members for the province j for the previous year

K is the adjustment annual coefficient

In principle, the capitation rate for a group is thus the average health care costs per capita in that group. Cost of some high cost health services (such as hemodialysis, organ transplantation, heart surgery, cancer treatment) are not included in the calculation of the capitation payment, but covered via fee-for-service. The total costs are adjusted for by an adjustment coefficient to account for fluctuations in medical care costs, inflation and changes in other related factors in the subsequent year. The coefficient applied in 2010 was 1.1. The Ministry of Health and the Ministry of Finance shall consider and adjust this coefficient upon occurrence of fluctuations in health care costs and changes in health insurance benefits.

One needs to keep in mind that the 2010 annual premium for the subsidized members is about 380,000 VND (4.5% of the minimum salary). For the example of the Kien Giang Province, children, schoolchildren and students, as well as the poor thus receive a capitation rate that is significantly below their contribution rate. It is important to note that provinces keep six sub-pools for the six membership groups and actually transfer the related sub-pool ceilings to the provider level. While there is no regulation that prescribes providers to provide services within the available sub-pool budget for each sub-group, there are indications that this is precisely happening. This suggests that providers might ration services to specific population groups when sub-pool funds are depleting. But even when facilities do not keep specific sub-pools for the six membership groups, still, health facilities with relatively more poor people receiving premium subsidies would thus more likely engage in under-provision due to the relatively lower capitation rates and due to the fact that their ceiling level is linked to the collection of premiums from their registered members. There is thus a need to analyse and monitor providers' behaviour as well as explore their rationale and incentives to do so.

As a result, this purchasing arrangement in combination with the provider behaviour described above seems to undermine the idea of pooling and solidarity through SHI (i.e., risk sharing and revenue pooling). Moreover, it would imply that the premium subsidization for the poor and schoolchildren as well as students cross-subsidizes the better-off. Above all, this refrains the poor from getting the needed access to care.

As per the Law of Health Insurance, in special cases, if providers run a deficit, the Vietnam Social Security shall make a report to the Ministry of Health and the Ministry of Finance for consideration and compensation. In practice, most capitated providers are running a deficit. This is because the capitation amount is to cover not only the cost occurred by the capitated hospital but also costs for patients referred to higher levels, where providers are reimbursed based on fee-for-service. In other words, the fee for service remuneration is deducted from the referring district hospital's capitation amount. Being paid on a fee-for-service- basis, the referral hospitals on the other hand have a tendency to apply new and high-tech (and thus allegedly more cost-intensive and more profitable) services to the referred patients. Thus, in the end, it is very hard for capitated district hospital to control and monitor the overall cost of health care.

In fact, capitation is not welcomed by the health-care providers. Many district hospitals and commune health stations complain that referral costs are high and that it is difficult to control them, so district providers have an incentive to limit referral to save their capitation funding. This might especially be the case for the sub-pools of the poor. Accordingly, many patients also complain that they are not accepted for referral to access higher-level care (MOH/DHI, 2009). So in case of need of higher-level care, patients might be forced to by-pass their district hospital and pay out-of-pocket on a fee-for-service basis at higher levels of health care. In sum, because of limited capitation funding, the needs of patients cannot be well met, OOP expenditure cannot be reduced, and thus the risk-protection function of SHI is undermined.

When a district hospital runs a deficit, i.e. exceeds the granted capitation amount, VSS can compensate up to 60% of the exceeded amount, which is very high initially. However, as a second ceiling, VSS cannot compensate more than 90% of total premium collection revenue of members registered at that district hospital (MOF/MOH, 2009).¹¹ This could be considered as some form of partial post risk-sharing between providers and the VSS, but it does not fully remove the disincentives for referring patients to higher levels. This arrangement also means that there is no

¹¹ The remaining 10% goes to a quasi-local reserve fund. In the rarer event of a health facility generating a surplus, it may retain some of surplus for its own use, but not more than 20% of the capitated amount. Any remaining surplus should be carried forward to health care capitated fund of following year.

risk-sharing/pooling mechanism across provider-based "sub-pools" (i.e. between districts hospitals). Thus, in practice, due to the way the ceiling levels are designed, the national pool is fragmented across the different health facilities, in addition to the fragmentation across the six membership groups: Clinics and hospitals with many registered members that receive state premium subsidies (i.e. with low contribution amounts) thus effectively have a much lower average per capita revenue, resulting in a lower ceiling and thus lower per capita expenditure. In addition, this ex-post risk sharing mechanism is administratively very burdensome since the VSS has to calculate revenues of registered members for each district hospital and commune health station.

Moreover, in view of the calculation method of the capitation rate - the province's previous year historical expenditure for each of the groups - the total capitation amount of some health facilities with mainly subsidized members in poor areas might come close to the second ceiling level anyway. Those health facilities would thus in no way benefit from this ex-post risk sharing mechanism. They would even have to control more rigorously their budget, in other words, ration referrals, if not even health care services delivered at their level.

Fee-for-service

Fee-for-service payment is used for: a) secondary and tertiary hospitals; b) providers who do not yet get paid via capitation; c) services for patients who are not registered at a given health facility; and d) services that are excluded from the capitation payment (e.g. high-cost services).

According to the regulations, individual hospitals (including both primary facilities that have not yet used capitation, and secondary and tertiary hospitals) make a contract with the SHI agency on the provision of health services to SHI patients and are reimbursed according to a fee schedule that has been approved by the local government and that is within the range provided in the national fee schedule. The national fee schedule was developed in 1995, approved by the Ministry of Health, the Ministry of Finance, the Ministry of Labour, Invalids and Social Affairs, and the State Committee for Prices. The prices of services in the 1995 fee schedule have not been updated, but in 2006 an additional 992 services (most of them advanced medical services) were added to the schedule.

The application of a fee schedule, which has not been updated for many of the services covered might result in insufficient funding for providers. As a result, providers may engage in several non-desirable practices. First, hospitals have an incentive to focus on the provision of those services that are most profitable. These are the services that were included after 1995 into the price list at current prices (and thus higher prices better reflecting costs); these are mostly high-tech services. This results in higher costs for VSS, higher out-of-pocket expenditure for patients as well as an

increasingly high-tech focused care. Second, providers tend to offer services that are not covered in the SHI benefit package, to generate revenues from higher OOP payments. Third, hospitals try to mobilize private resources to invest in new high-tech equipment in order to be able to provide those services that are more profitable. This leads to a continuous increase in the volume of health-care services provided by the health insurance, together with a growth of health expenditure.

To contain cost escalation due to fee-for-service payment, a double ceiling of payment was introduced. The first ceiling is called the “health-care fund” and is calculated as 90% of total premium revenues collected from an area covered by the district hospital. The remaining 10% goes to the central reserve fund. The second ceiling is the capitation amount. Although the capitation amount is calculated based on historical expenditure, it must not exceed that 90% ceiling for each primary health facility. The health-care fund of each facility is used to cover services provided by the relevant facility, and services provided by other (referral or emergency) facilities to the relevant facility’s registered members. If the expenditure of a facility is higher than the health-care fund, an additional payment could be made available of 5% of the actual premiums collected from registered members for outpatient care only or 10% if both outpatient and inpatient care are provided (MOF/MOH, 2009). Due to this regulation, health facilities with many subsidized members in poorer regions have much less money to spend per registered insuree than facilities with better-off insurees.

As in the case of facilities with capitation remuneration, primary health care facilities with fee-for-service payment equally have a problem with the cost of health-care services provided in referral facilities. Primary health-care facilities are not able to control these costs and therefore do not want to refer patients to other facilities. The consequence is the same: the quality of care might be affected and the patient has to pay a higher cost-sharing rate if he or she seeks treatment at a higher-level facility without a referral letter.

Another ceiling is applied to referral hospitals (provincial and national tertiary hospitals) and is calculated on the basis of the previous year’s average cost per admission (inpatient care) or per visit (outpatient care). The maximum payment (ceiling) is the average cost multiplied by the number of admissions or visits, multiplied by an adjustment coefficient (the current coefficient is 1.1 and can be changed every year). This ceiling can help to prevent high cost escalation but also creates a barrier to upgrading health facilities and to improvement of health care (MOH, 2009).

Facilities receive quarterly payments by VSS based on an expenditure plan agreed at beginning of each year between VSS and providers. An advance is made to start. Providers prepare and submit quarterly expenditure reports and get paid for subsequent quarters. In view of the above expenditure ceilings and constraints, towards the end of each quarter, some health providers might engage in some

rationing, under-provision or cream-skimming of patients, when they run short of funds. This might be especially the case for those groups with low capitation rates that are assumed to be below the expected costs of their actual health needs.

Another core challenge that hospitals face, particularly in light of their remuneration, is the fact that there is no central procurement agency for drugs. Each central and provincial hospital purchases drugs through a bidding process and has to negotiate directly with drug suppliers. The lack of bulk procurement means that each hospital pays much higher prices than would need to be paid through a central procurement system. Moreover, since suppliers are allowed to set the drug prices on a competitive basis, there is thus no drug price control in place, again inflating drug prices paid by hospitals. This situation contributes to high drug expenditure, particularly in a situation where the number of drug suppliers is limited.

Payment by diagnostic related groups (DRG)

Payment by DRG has been piloted in two hospitals in Hanoi City (one being rural, the other one being urban). The DRG pilot is applied for 4 conditions: acute pneumonia for adults, pneumonia for children, appendix operation, and normal delivery. The pilot project started in 2009, but there is no plan to expand yet. Although policy makers have realised the importance of replacing the current fee for service payment by other payment methods, such as a combination of capitation, DRGs and other payment mechanisms, up to now, there is no consensus among key actors, (MOH, VSS, MOF, and others) and no national plan on how to move forwards in this matter.

In conclusion, it is important to emphasize that the VSS has indeed established a good basis for cost-containment. The gradual move away from fee-for-service remuneration towards capitation is an important step in reducing incentives for overprovision. Likewise, the planned move to a DRG system needs to be acknowledged as an important and valuable policy decision. However, serious bottlenecks remain in this current system, as outline above. Now, there needs to be focus on avoiding a situation of under-provision, which forces patients to make higher OOP payments.

4. Summary of the health financing performance assessment

Viet Nam's achievement in the health financing performance indicators is summarized in Table 6 and is to be set against the indicative targets outlined in Table 1. As can be seen, performance is suboptimal in some indicators and below the country's potential.

Table 6. Actual achievement in health financing performance indicators

<p>1. Level of funding</p> <p><i>THE has been increasing rapidly in recent years. As a share of GDP, THE is 6.4% (in 2008) which is higher than the average of low income countries and comparable to that of middle-income countries</i></p> <p><i>THE per capita for 2008 was the equivalent of US\$ 66, which was higher than the average of countries in the Western Pacific Region. However, resource mobilization is below its potential due to low income tax collection and tax evasion as well as SHI collection difficulties in both the private formal sector and the informal sector.</i></p>
<p>2. Level of population coverage (% of population covered by a financial risk-protection mechanism)</p> <p><i>The whole population is covered for most preventive health care services through tax-based financing. For curative care, population coverage by SHI is about 60% (as of 2010).</i></p>
<p>3. Level of financial risk protection</p> <p><i>Some 44.6% of THE comes from prepaid contributions for health (government general revenue, health insurance contributions), which is still relatively low. OOP expenditure as a share of THE is more than 50%.</i></p> <ul style="list-style-type: none"> • The rate of households experiencing catastrophic expenditure in 2008 was 5.5% (HMU/WHO, 2011). This indicator has decreased considerably compared with 10.5% in 1997 (4). However, households from lower quintiles are still more likely to experience catastrophic expenditure. • 3.5% of households are impoverished through OOP payments for health care in 2008 (ibid.). Again, lower income quintiles are more likely to be impoverished. <p><i>It is necessary to note that the poorest are covered by SHI which reduces the danger of experiencing catastrophic health expenditure. Those who are facing high-cost health services and are from the informal sector can join the voluntary health insurance scheme to lower the chance of experiencing catastrophic expenditure; likewise the near-poor can benefit from subsidized premiums.</i></p>
<p>4. Level of equity in health financing</p> <p><i>Health financing payments (taxes and SHI) are regressive because of the flat health insurance contribution for the informal sector and the largest shares of taxes being indirect ones.</i></p>

<p>5. Level of pooling</p> <p><i>Health-care spending for SHI members is unequal between different catchment areas, as the providers' expenditure ceilings are linked to actual contribution revenue within that catchment area. Areas with many SHI members whose premium is subsidized by the state thus have considerably lower per capita average revenues.</i></p>
<p>6. Considerations of cost-effectiveness and equity in the benefit package definition</p> <p><i>The SHI benefit package, and specifically the reimbursement drug list and high-tech medical services, has not been developed on the basis of evidence of cost-effectiveness.</i></p>
<p>7. Level of efficiency and equity in delivery of the benefit package</p> <p><i>On the capitation principle, the central government budget allocation to provinces is to a certain extent related to health-care needs, but the provincial budget allocation to health facilities is related neither to health-care needs nor to performance and thus does not result in efficient use of resources.</i></p> <p><i>The combination of the current SHI provider payment mechanism, predominantly fee-for-service payments, with hospital autonomy creates incentives for overprovision and high-cost health services, thus undermining efficient use of resources.</i></p> <p><i>The implementation of hospital autonomy encourages providers to over-supply in order to generate more revenues. Inefficiencies in resource use are exacerbated by the VSS reimbursement policy for patients who bypass the referral system. Such patients can still be reimbursed, but have to pay a higher copayment rate. Thus provider-induced demand and the VSS reimbursement policy lead to over-supply and over-utilisation, especially of high tech costly services and higher level services.</i></p>
<p>8. Level of administrative efficiency</p> <p><i>Total administrative costs for all health financing schemes as a share of THE is 1.5% according to the NHA estimates of 2008. However, this may be an under-estimation. The administrative cost of health insurance is difficult to assess, since 100% of premium contribution goes to funding health care. The law allows the administrative cost to be covered by revenue from bank interest and investment interest on pension and health-care funds.</i></p>

At 55% of THE, OOP payment is very challenging for health financing in Viet Nam. Catastrophic expenditure has decreased in recent years (except a slight increase from 2006 to 2008), but it still ranks very high: Using WHO technical guidelines for calculation (Xu et al., 2005), catastrophic expenditure amounted to 5.8% in 1998, 7.6% in 2002, 8.2% in 2004 (Tran et al., 2004), 5.1% in 2006 and 5.5% in 2008 (HMU/WHO, 2011). However, the share of households facing catastrophic expenditure in the lowest income quintile is more than double that of households in the upper income quintile. In fact, the two lowest income quintiles face a high risk of being impoverished through the OOP payments (see Table 7).

Table 7. Catastrophic expenditure and impoverishment by socioeconomic status, data for 2008

Expenditure quintile	Share of households facing:	
	Catastrophic expenditure (%)	Impoverishment (%)
1st quintile	7.8	7.5
2nd quintile	6.0	8.6
3rd quintile	5.5	1.5
4th quintile	4.5	0.1
5th quintile	3.6	0.0

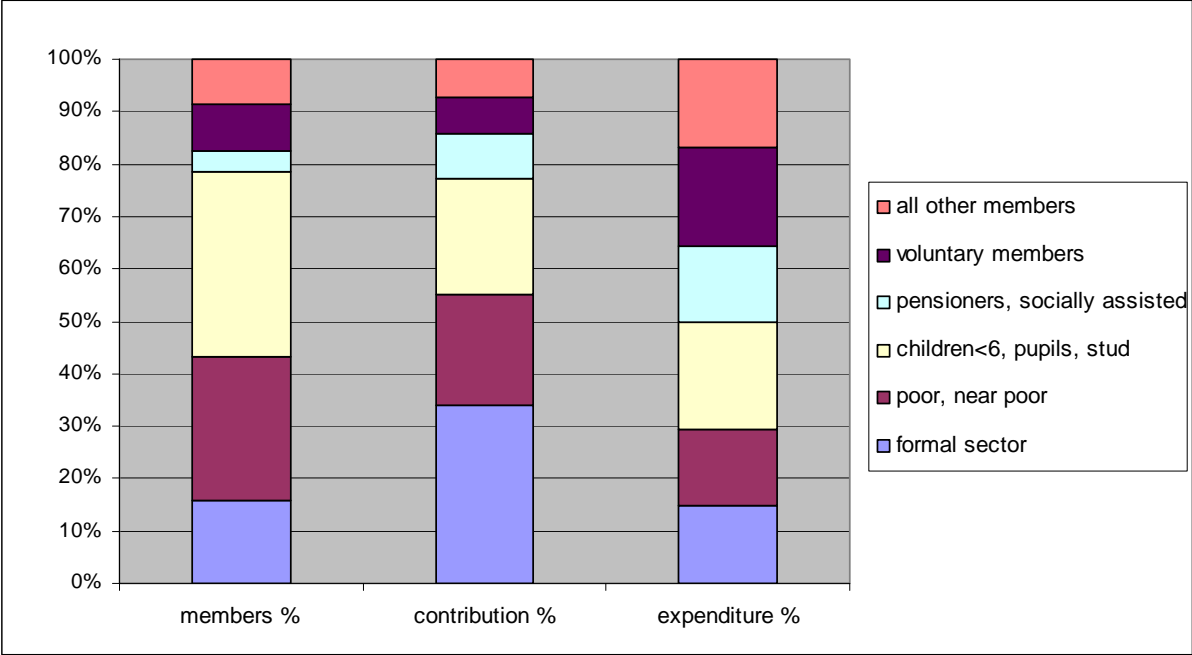
Source: HMU/WHO (2011)

Statistics show that, although current health insurance coverage is only 60% of the population, most patients treated in hospitals are insured (MOH, 2009). People without health insurance have a lower utilization rate of outpatient and inpatient care because of the high user charges. As public health facilities receive government funds to cover part of current spending and investment, the health insurance patients, including the better off and the poor, benefit both from the government subsidy for their premium as well as from government funding for public hospital services, while the non-insured receive no premium subsidy and because of financial barriers also have no access to government funded hospital care.

A recent study by Bales/Chinh (2010) on a benefit-incidence analysis of the government budget support for curative care has shown that the distribution of support received was highest in the decile with the highest income. One of the explanations is that most curative health-care services are provided at provincial and tertiary hospitals, to which better-off people have better access than persons with lower incomes due to the concentration of better-off people in urban areas and the higher cost-sharing in tertiary care (which lower-income groups cannot afford).

Figure 8 also reveals that the poor and near-poor with assumingly health care needs as high as those of the formal sector employees, reveals that the poor/near-poor consume relatively less health care services. As outlined above, the purchasing arrangements (calculation of expenditure ceilings for hospitals that is related to the members' revenues of that hospital as well as very unequal capitation rates) explain this to a large extent, in addition to the still high user charges and other opportunity costs that might hinder the poor to use more expensive services at referral and higher health care levels.

Figure 8: Membership group share, their contribution and expenditure share (2010)



5. Conclusions and recommendations

Vietnam shows strong political commitment for the development of a health care system aimed at equity, quality and efficiency. A further advantage to achieve these objectives lies in the fairly high and stable economic growth rates over the last decade. The Social health insurance law of 2008 set the goal to reach universal coverage of social health insurance in 2014. Political commitment and a conducive economic environment are necessary conditions, but not sufficient to achieve universal coverage. There is need to overcome the bottlenecks revealed in this analysis of institutional design and organizational practice of the health financing system. Based on the above assessment, the following changes in institutional design and organizational practice of health financing are made in order to further improve the performance of the health financing system and to ultimately progress towards universal coverage.

5.1. Increase tax-based financing to increase funding for social health insurance

Government budget allocation for health care should be increased in order to raise the number of vulnerable people covered with state subsidized health insurance premiums. The near poor and other economically in-active population (e.g., the elderly below 85 years of age without a pension, people with disability) are considered

vulnerable, but are currently not covered by the health insurance. At the same time, the government subsidized premium rates should be increased.

There is room to expand fiscal space for health by increasing the share of general government health expenditure (GGHE) in the total general government expenditure (GGE). In order to mobilize additional resources, specifically, the government could explore innovative health financing mechanisms, such as by introducing sin tax on tobacco and alcohol trade and use.

5.2. Allocation of government budget based on performance instead of input

Current allocation of provincial government of budget to hospitals should not be based on bed numbers, but based on performance as well as demand-side factors. Risk-adjusted capitation could also be an option.

5.3. Adequate coverage mechanism for informal sector

Based on previous unsuccessful experience in covering the informal sector population as well as the reality of very low compliance of highly subsidized scheme for the near poor, and having taken into account of the large share of the informal sector, an alternative covering mechanism for informal sector should be considered to complement the contributory mechanism.

5.4. De-fragmentation of membership

A family or household approach should be taken instead of individual coverage. Mandatory enrolment of dependants from 2014 according to the Law on Health Insurance will be still very fragmented, if each member in a family is categorized in a different group of membership. Such fragmentation will make both member registration and revenue collection difficult and costly for the system.

Family membership also implies that children are insured via a principal insurance member. Further evaluation is necessary to develop family membership. A decision on the contribution mechanism would need to be taken: for instance, will children and spouses who generate no income be covered by one family membership contribution rate, or will contributions have to be made for each individual family member? In the latter case, low-income households could be exempted from the contribution payments for their children which could be paid by state subsidies.

5.5. Monitoring, inspection and enforcement

VSS should be legally empowered to undertake monitoring and inspection and impose penalty fees and other enforcement measures in order to enhance compliance,

particularly of the formal private sector. This would imply an adjustment of the current health insurance law as well as the prevailing inspection legislation.

5.6. Cost effectiveness of benefit package

The benefit package should be improved and developed based on cost effectiveness criteria. Procedures for developing the lists of drugs and high-tech medical services for reimbursement should equally be based on evidence of cost-effectiveness. A National Health Technology Assessment Committee should be established in order to provide recommendations for the selection of appropriate medical technologies.

5.7. Costing of health services

Prices of health services should be updated on the basis of appropriate hospital costing methods, and not just on “guesstimates”. Hospital costing would provide the necessary inputs for calculation of capitation and of DRGs.

5.8. Cost sharing without catastrophic expenditure

Regulations on copayment should be amended and an income-related ceiling on copayments should be introduced to prevent catastrophic expenditure by insured patients. The total copayment and other OOP payment amounts should not exceed the household capacity to pay. It is worth exploring the financial and other implications of whether the very poor, persons on low incomes, and minority ethnic groups living in economically disadvantaged areas could be exempted from copayments.

Catastrophic expenditure could also be reduced by changing the reimbursement rules regarding coverage of medical services for traffic accidents.

5.9. Refining provider payment mechanism along with preventing profit making tendency of providers to optimize use of resources

The current payment mechanisms should be amended; specifically capitation should be refined in order to meet the actual health-care needs of the insured and in order to overcome the negative effects. For example, uncontrolled costs of referred treatment should not be deducted from the capitation fund of primary health care facilities, and secondary hospital care should not be paid by capitation, but by other payment mechanisms. The facilities' budget ceilings should be based on an average premium contribution instead of actual premium contribution. Viet Nam may consider an approach that combines different payment methods of capitation, DRGs and fee-for-service, so that to mitigate shortcoming of each single method while promoting

efficiency and quality of care. Central procurement and price regulations of drugs would also contribute to efficiency, by ensuring lower prices.

Capacity-building is needed for the development of DRG payment as well as consensus building across players (Ministries of Health and MOF, VSS, providers). As the development of DRGs will need time, temporary provider payment mechanism provision (such as bed-day payment for different type of wards or hospitals) should be used to reduce current (and unintended) dominant fee-for-service payment. The hospital autonomy regulations should be revised in order to remove all unintended impacts of the hospital autonomy policy. Hence, this requires a cohesion between health financing policies and policies made by other sectors that affect health.

5.10. Regulation of the role of private, commercial health insurance

The role of commercial health insurance as a supplementary health insurance should be defined and regulated in order to avoid the double financial burden for the insured and to ensure that the cost of health-care services outside of the SHI package can be covered by commercial insurance.

5.11. Improvement of primary health care and referral system.

The capacity of primary health care should be improved, and should be adapted to the epidemiological transition whereby 70% of the disease burden is due to noncommunicable diseases. The referral system should be rebuilt and reimbursement rates for patients who bypass it should be modified to avoid economic inefficiency and overload at secondary and tertiary levels of care.

5.12. Capacity building for the social health insurance agency

The health insurance agency should improve its technical and management capacity, especially in management information systems. A Social Insurance identity code should be issued to each person at birth.

The VSS should be reorganized to provide for an independent and professional health insurance system instead of the current mixed pension and fund and health insurance agency.

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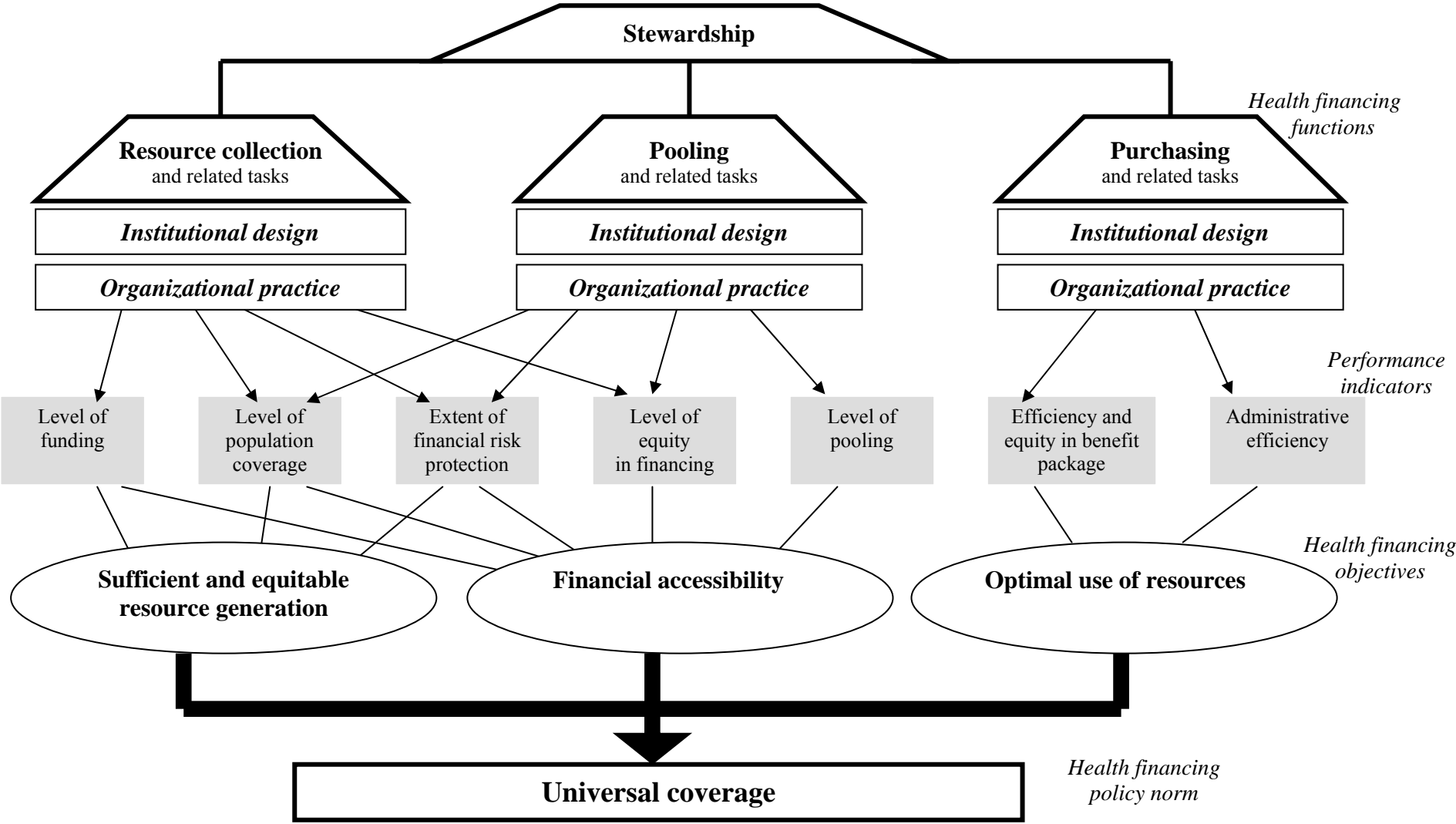
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Annex 1: Overview of the analytical framework



Source: Based on Mathauer & Carrin (2011)