



# THE FUTURE OF HEALTH FINANCING IN VIETNAM:

Ensuring Sufficiency,  
Efficiency, and Sustainability



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# **THE FUTURE OF HEALTH FINANCING IN VIETNAM:**

Ensuring Sufficiency, Efficiency, and Sustainability

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June 2019



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# Abbreviations

|         |  |
|---------|--|
| ARV     | Antiretroviral   |
| CPI     | Consumer price index                                     |
| DALY    | Disability-adjusted life year                            |
| DRG     | Diagnostic-related group                                 |
| EPI     | Expanded Program on Immunization                         |
| FFS     | Fee-for-service  |
| GDP     | Gross domestic product                                   |
| GHED    | Global Health Expenditure Database                       |
| GNI     | Gross national income                                    |
| GSO     | Government Statistics Office                             |
| HCI     | Human Capital Index                                      |
| HIV     | Human Immunodeficiency Virus                             |
| IHME    | Institute for Health Metrics and Evaluation              |
| IMF     | International Monetary Fund                              |
| LMIC    | Lower-middle-income country                              |
| MOF     | Ministry of Finance                                      |
| MOH     | Ministry of Health                                       |
| MPI     | Ministry of Planning and Investment                      |
| NCD     | Noncommunicable disease                                  |
| NHA     | National Health Accounts                                 |
| NTP     | National Targeted Program                                |
| ODA     | Overseas Development Assistance                          |
| OECD    | Organization for Economic Cooperation and Development    |
| OOP     | Out-of-pocket  |
| PCV     | Pneumococcal Conjugate Vaccine                           |
| SDG     | Sustainable Development Goal                             |
| SHA     | System of Health Accounts                                |
| SHI     | Social health insurance                                  |
| STEPS   | Stepwise Approach to Surveillance                        |
| TB      | Tuberculosis   |
| UHC     | Universal health coverage                                |
| UN DESA | United Nations Department of Economic and Social Affairs |
| UNICEF  | United Nations Children's Fund                           |
| UNFPA   | United Nations Population Fund                           |
| WHO     | World Health Organization                                |
| VSS     | Vietnam Social Security                                  |



# Executive Summary

**Vietnam is a country in transition.** Its development story over the past 30 years has been remarkable, characterized by high economic growth and a shift toward an open market economy. Rising income, government revenue, and expenditure have led to substantial investments that have furthered economic development and human capital improvements. While the economy is still expected to grow at a steady pace in the medium term, the Government of Vietnam has, in recent years, had to shift gears toward fiscal consolidation, to reduce the high levels of public debt that had arisen from high government spending. The focus on expenditure controls and improving efficiency of spending is a government-wide concern, including in the health sector.

**An epidemiological and demographic transition is also under way.** The burden of disease in Vietnam is dominated by noncommunicable diseases (NCDs) such as cancers, hypertension, and diabetes. Vietnam is also one of the most rapidly ageing countries in Asia. These trends will have important implications for future health care demand, health spending, and health outcomes.

**A “health financing transition” has been occurring in parallel with these changes.** Generally speaking, that financing transition is characterized by increases in a country’s total spending on health as national income rises. At the same time, the composition of sources of financing for health also changes. Domestic sources of financing usually increase as a share of total resources for health, while eligibility for development assistance for health declines. A gap may emerge if domestic sources do not increase substantially or quickly enough, and private out-of-pocket (OOP) spending ends up filling the void. This has been the experience in many countries; Vietnam is no exception.

**Vietnam’s total health expenditure is comparable to that of countries of similar income levels, both as a share of gross domestic product (GDP) and in per capita terms.** In 2016, total health spending in Vietnam was 5.9 percent of GDP, or VND 2.8 million (US\$129) per capita. Both total and public spending on health have increased significantly since 2000, rising approximately threefold in real per capita terms. The increase in public expenditure on health has been due to substantial increases in state budget spending on health and social health insurance (SHI) expenditure.

**Despite the increase in health spending, the composition of health spending has not changed significantly.** Between 2000 and 2016, public spending on health as a share of total health expenditure has increased gradually but remains around the 40 percent range. Likewise, the share of OOP spending has remained persistently high at around 40 percent since 2000; between 2011 and 2016, it increased further from 38 to 45 percent. Despite this high share of OOP spending, Vietnam has seen substantial improvements in households’ financial protection against large health expenditures. External financing for health has stayed at less than 5 percent of total health spending for many years, though it continues to comprise a large share of resources for priority disease programs.

**Health financing policy, too, has undergone substantial changes in recent years.** The implementation of a policy on full cost recovery has seen a rapid shift from supply-side subsidies to demand-side financing for curative health services, paid for by SHI. User fees for curative care were increased as part of this policy to ensure that public hospitals would be able to recover costs that were previously funded through government subsidies, and to support the move toward financial autonomy for hospitals. With a sharp increase in

administrative prices of health services in recent years, there is a risk that the SHI fund will soon run into deficit. These changes are occurring in the context of a health service delivery system that remains geared toward the provision of and payment for curative care in tertiary and secondary care facilities, rather than preventive care and health promotion. This system is increasingly incompatible with the burden of disease and the health needs of the Vietnamese population.

**The combined effects of these transitions pose some risks to the sustainability of essential public health services and will continue to put upward pressure on health spending.** The role of public financing for health thus becomes increasingly important. A higher level and larger share of public financing for health will be needed to sustain past health gains, meet new demands, and cope with the various contextual and policy pressures that the health system is facing.

**In this context, this paper aims to evaluate the different sources of financing that might be available for increasing public spending on health.** “Fiscal space for health” refers to the ability of governments to increase spending for the health sector, without jeopardizing the government’s long-term solvency or crowding out expenditure in other sectors. This analysis is one tool to assess, monitor, and predict the sources and level of public resources available for the health sector. This paper will also detail the various transitions that Vietnam is facing, to highlight the complexity of issues and the range of reforms that will be needed in the health sector in the coming years. Additional fiscal space for health, alone, is not the solution.

**This paper analyzes the prospects for increasing fiscal space for health from various sources.** Key findings from each pillar of fiscal space are summarized in the following table.

**Table 1: Fiscal Space for Health, Sources and Prospects**

| Source of fiscal space for health | Key information  | Prospects for fiscal space (Good, Moderate, Low) |
|-----------------------------------|--|--|
| Economic growth                   | <p><b>There are moderate prospects for additional fiscal space for health, given steady economic growth and increases in public spending on health that are more than proportionate to economic growth.</b></p> <ul style="list-style-type: none"> <li>▪ Vietnam’s growth rate is projected to be high and steady in the medium term, at 6.5 percent per year.</li> <li>▪ On average, since 2000, for every 1.0 percent increase in GDP per capita, public spending on health in Vietnam increased by 1.7 percent.</li> <li>▪ <b>If income elasticity of public spending on health remains positive, Vietnam could expect additional fiscal resources for health of up to 0.4 percent of GDP by 2023.</b> Public spending on health would increase from 2.8 percent to 3.2 percent of GDP. This projection is based on Vietnam’s good growth prospects and takes into consideration potential economic risks.</li> <li>▪ Even if public spending on health as a share of GDP remains unchanged at 2.8 percent, by 2023 it would increase to VND 196 trillion in real terms.</li> </ul> | Moderate   |

| Source of fiscal space for health  | Key information  | Prospects for fiscal space (Good, Moderate, Low) |
|--|--|--|
| Additional fiscal resources, through increased aggregate public spending | <p><b>Overall, the fiscal position is tight.</b> There are low prospects for increasing aggregate public spending.</p> <ul style="list-style-type: none"> <li>▪ <b>Public spending as a share of GDP will not increase:</b> Vietnam is undergoing a period of fiscal consolidation. This comes after many years of increases in government revenue but even faster increases in government expenditure, contributing to high levels of public debt and budget deficits.</li> <li>▪ <b>External financing for health</b> has been less than 5 percent of total health spending for many years. It continues to comprise a large share of resources for priority disease programs, but even this will not be sustained in the medium term.</li> <li>▪ <b>Social health insurance (SHI):</b> SHI coverage, revenue, and expenditure have increased substantially in the last decade. The Government of Vietnam is considering options on how to increase membership and contribution rates. This is a viable source of fiscal space in the medium term; however, political will to increase contribution rates in the short term is low. Preliminary projections show that the SHI fund will soon go into deficit. There are ongoing efforts to control costs, including implementing provider payment reform, identifying fraudulent claims, improving treatment guidelines, and establishing rules for eligible reimbursement.</li> <li>▪ <b>Taxes on tobacco and sugar-sweetened beverages:</b> The Government of Vietnam is deliberating tax increases, but it is unlikely that these revenues will be earmarked for health.</li> </ul> | Low  |
| Increase in prioritization of health in government spending              | <p><b>State budget spending on health as a share of total government spending is unlikely to increase significantly. Local budgets are expected to assume a greater role in public spending on health, but local prioritization of health is variable.</b></p> <ul style="list-style-type: none"> <li>▪ Vietnam currently allocates 9.3 percent of its budget to health. This share has roughly held steady over the past 10–15 years, despite (soft) expenditure earmarking through government pronouncements that the health budget should increase faster than the rate of increase of general government spending.</li> <li>▪ The outlook for increases in prioritization of the central state budget to health is especially low. The intent is for local budgets to assume a greater role in paying for public sector health services.</li> <li>▪ Local budget contributions to health can be variable. There is currently no good way of assessing adequacy of local budget availability for health needs. It is also difficult to track health spending at the local level due to the variety of reporting lines, in the context of fiscal decentralization.</li> </ul>  | Low  |
| Efficiency gains   | <p><b>Potentially large efficiency gains related to public hospitals.</b> A large share of total health spending in Vietnam (73 percent) occurs at hospitals. Five key areas where substantial efficiency gains are possible:</p> <ol style="list-style-type: none"> <li>Fee-for-service provider payment mechanism</li> <li>Overreliance on hospital-centered service delivery at central and provincial levels</li> <li>Inefficiencies in hospital investment decisions</li> <li>Excessive spending on pharmaceuticals</li> <li>Weaknesses in monitoring and accountability mechanisms</li> </ol>  | Good   |

Source: Authors

**In summary, additional fiscal space for health is limited in the short to medium term.** There are moderate prospects for additional resources for health resulting from economic growth and through increases in SHI enrollment and contributions. However, in the context of a tight fiscal position, prioritization of health—including, importantly, within local budgets—is uncertain. With total health spending at 5.9 percent of GDP, increasing the prioritization of health may also be unlikely given the perception that this level of spending is sufficient.

**Additional resources will be better spent if Vietnam can first improve efficiency of existing spending on health.** Indeed, increasing resources to the health sector in the current financing and service delivery arrangements, where the bulk of spending is at hospitals, will not be efficient. A more productive health sector—one that produces health rather than just consuming health care services or inputs—is also more likely to attract additional resources.



# A: BACKGROUND AND COUNTRY CONTEXT

## 1. Introduction

**Vietnam has made remarkable progress in improving the health outcomes and overall welfare of its people over the past few decades.** Economic and political reforms, starting in the early 1990s, have ushered in a period of sustained economic growth, leading to rising incomes and a decline in poverty. Health outcomes have improved in tandem with rising living standards. Life expectancy now at 76 years<sup>1</sup> is the highest in the region for countries at a similar income level. Access to health services has also expanded rapidly, and coverage of essential services is high. Today, Vietnam performs well in global indexes of human capital and universal health coverage (UHC), especially for a lower-middle-income country (LMIC).

**Since the early 1990s, domestic resource mobilization for health has been favorable, accompanied by policy reforms that provide financial protection.** Total health spending has increased significantly since 2000 and is now 5.9 percent of GDP. From 2000 to 2016, public spending on health increased from VND 7.8 to VND 125.6 trillion in nominal terms, or almost threefold in real per capita terms. Social health insurance (SHI) coverage has increased rapidly: today, 87 percent of the population has insurance coverage, including most of the poor and vulnerable groups, whose premium contributions are covered through government subsidies. Even though out-of-pocket (OOP) spending on health is relatively high at 45 percent of total health spending, households are by and large sufficiently protected against the financial risks associated with large health care costs.

<sup>1</sup> As reported in the World Development Indicators database. National estimates published by Vietnam General Statistics Office report life expectancy in 2017 as 73.5 years.

**However, looking ahead, the combination of upward pressure on health care spending on the one hand, and a constrained fiscal environment on the other, brings into question Vietnam’s ability to maintain the level of public spending on health needed to address remaining and new health challenges.** Vietnam’s population is ageing rapidly, and the burden of disease has shifted to comprise primarily noncommunicable and chronic diseases. Rising expectations of a growing middle class who will demand better quality and more technological sophistication in health care will also put pressure on health care demand and financing. Ongoing reforms in fiscal consolidation mean that availability of funds for government spending will be limited. In the health sector, in line with a policy on hospital autonomy, the Government of Vietnam has reduced state budget financing for hospitals and increased user fees. The objective is for hospitals to recover operating costs through SHI reimbursement and user fees.<sup>2</sup> However, these fee hikes have not been accompanied by an increase in health insurance premiums, jeopardizing the sustainability of the health insurance fund. External financing for health is rapidly being phased out, putting at risk priority health programs that continue to rely on donor resources.

**From the financing perspective then, the key question is how Vietnam can maintain a sufficient level of public spending on health to sustain and further advance good health outcomes and respond to new health challenges.** To address this question, this paper analyzes health financing trends and patterns in Vietnam, assesses the current and likely future effect of relevant policies and reforms, and identifies the financing potential of different sources of fiscal space for health.

**“Fiscal space for health” refers to the ability of governments to increase spending for the health sector, without jeopardizing the government’s long-term solvency or crowding out expenditure in other sectors.** Broadly, there are five key sources of fiscal space: (1) conducive macroeconomic conditions, such as economic growth and increases in overall government revenue that, in turn, might lead to increases in government spending for health; (2) reprioritization of health within the government budget; (3) increase in health sector-specific resources, such as taxes that are earmarked for health; (4) increase in grants and foreign aid specific to the health sector; and (5) increase in the efficiency of existing government spending on health. This paper will look at each of these potential sources of fiscal space and highlight the prospects of raising additional sources of financing for health from each one. The paper also identifies relevant data gaps that affect the certainty of predicted outcomes.

This paper is organized as follows: the remainder of Section A presents an overview of Vietnam’s performance on key health outcomes and access to care. Section B describes health financing trends over the past 17 years. Section C analyzes each of the five potential sources of fiscal space for health. Section D concludes with a discussion of the findings and offers some recommendations to the Government of Vietnam.

## **2. Health outcomes and access to care—What Vietnam has achieved so far with its health-related spending**

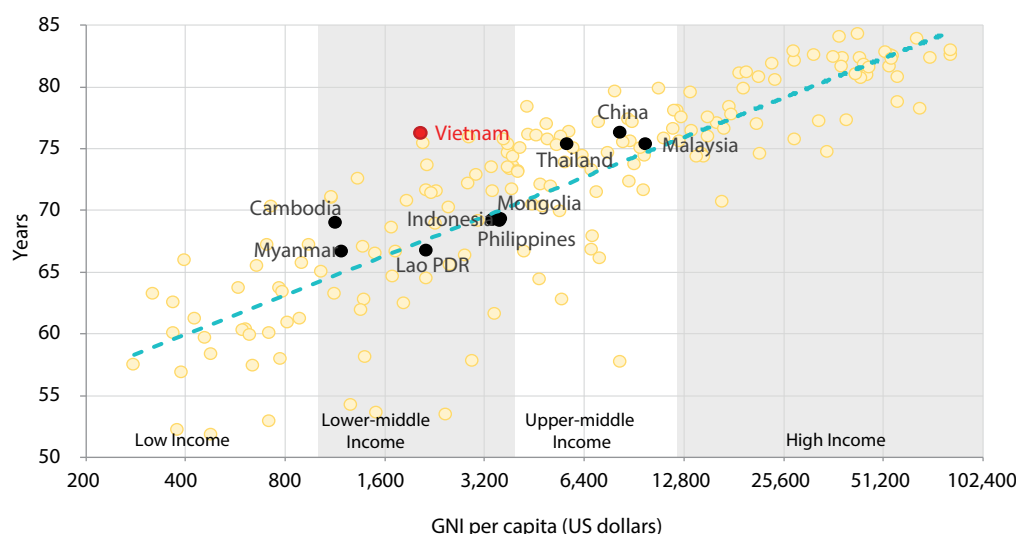
**Vietnam has made remarkable progress in health outcomes over the past two-and-a-half decades.** Life expectancy is now 76 years and is higher than for most other countries in the region and among countries at a similar income level (Figure 1) (World Bank 2018a).<sup>3</sup> Equally impressive are the reductions in mortality. Between 1990 and 2017, the under-five child mortality rate fell from 52 to 21 per 1,000 live births (World Bank 2018a); and between 1990 and 2015, the maternal mortality ratio fell from 139 to 54 per 100,000 live births

<sup>2</sup> In Vietnam, the policy on cost recovery broadly refers to the reduction in direct subsidies for hospitals’ recurrent costs, and for an increasing share of these costs to be reimbursed by the social health insurance scheme and paid for by out-of-pocket spending. This is not consistent with the standard international use of the term, which would take into account full economic costs. In addition, as the health insurance fund managed by Vietnam Social Security (VSS) remains reliant on budget transfers, part of the costs are still indirectly borne by government subsidies.

<sup>3</sup> Vietnam fares well on life expectancy, even based on the Vietnam General Statistics Office estimate of 73.5 years.

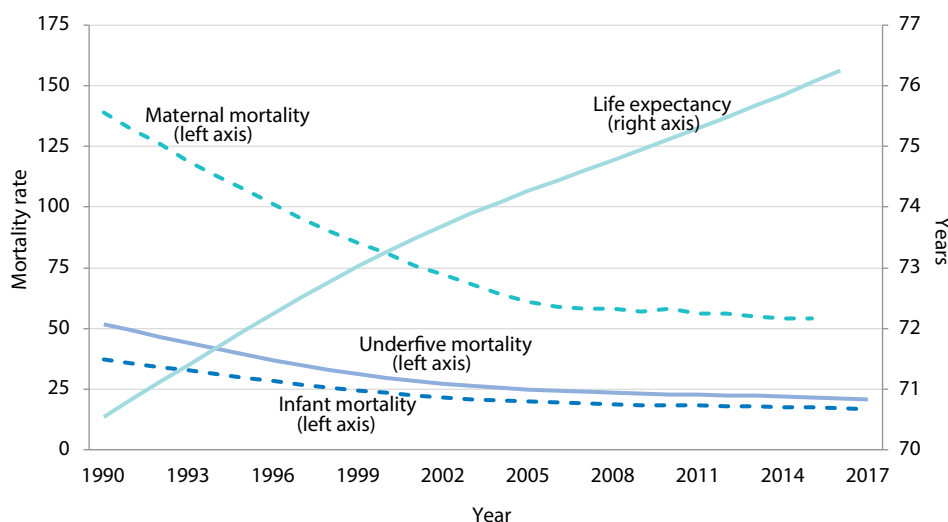
(Figure 2) (WHO et al. 2015). In fact, Vietnam has already met or surpassed the targets of the 2030 Sustainable Development Goals (SDGs) for mortality reduction; these are 12 and 25 per 1,000 live births for neonatal and under-five mortality, and 70 per 100,000 live births for maternal mortality.

**Figure 1: Life Expectancy versus Income, Vietnam and Comparator Countries, 2016**



Source: World Bank (2018a).

**Figure 2: Key Health Outcomes, 1990–2017**



Source: World Bank (2018a).

Note: Maternal mortality ratio is measured as number of deaths per 100,000 live births, while infant and under-five mortality rates are measured as number of deaths per 1,000 live births.

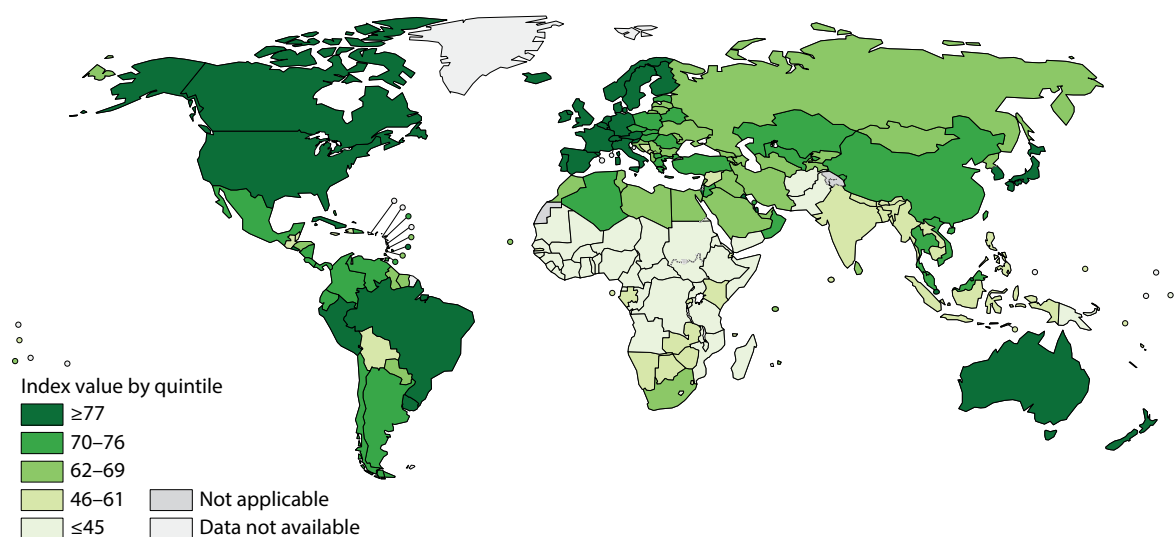
**Access to health services has also expanded rapidly, and coverage of essential services is high.** In 2014, the proportion of births assisted by a skilled birth attendant was 93.8 percent, and the proportion of pregnant women receiving four or more antenatal care visits was 73.7 percent (GSO Vietnam and UNICEF 2015). In 2017, the nationwide full immunization rate was 96.4 percent and reached at least 95.0 percent in 53 out of 63 provinces (GSO Vietnam 2018b). In 2016, 7.9 percent of people (8.4 percent in rural and 7.0 percent in urban areas) had at least one inpatient visit, while 36.0 percent (34.4 percent in rural and 39.4 percent in urban areas) had had an outpatient visit in the previous 12 months (GSO Vietnam 2018a).



**Vietnam's scores on global indexes of human capital (including health outcomes) and UHC confirm that, overall, Vietnam performs well for its level of income.** The World Bank's Human Capital Project gives Vietnam a Human Capital Index (HCI)<sup>4</sup> score of 0.67, exceeding the global average of 0.57, the East Asia Pacific region average of 0.61, and the LMIC average of 0.48 (World Bank 2018c). In fact, Vietnam's average score even exceeds the upper-middle-income average of 0.58. On the health-related components of the HCI, Vietnam's performance also far surpasses that of other LMICs: 98 out of 100 children born survive to age five (compared to the LMIC average of 96 out of 100); 88 percent of 15-year-olds live to age 60 (compared to the LMIC average of 80 percent); and 75 percent of children are not stunted (compared to the LMIC average of 73 percent).

**Another important benchmarking instrument is the UHC service coverage index.** Developed jointly by the World Bank and the World Health Organization (WHO), this index is used to monitor progress on the health service coverage dimension of SDG 3.8.1 (UHC). Vietnam's score on this index is 73 (out of 100), comparing favorably to the average of 59 for South-eastern Asia and to the global average of 64; it is also not far behind the average for East Asia at 77 (WHO and World Bank 2017).<sup>5</sup> Performance on the UHC service coverage index ranges from 22 to 86 across 183 countries of all levels of income (Figure 3).

**Figure 3: Vietnam's Achievement on the UHC Service Coverage Index, compared to Other Countries**



Source: WHO and World Bank 2017.

Note: This map has been produced by WHO. The boundaries, colours or other designations or denominations used in this map and the publication do not imply, on the part of the World Bank or WHO, any opinion or judgement on the legal status of any country, territory, city or area or of its authorities, or any endorsement or acceptance of such boundaries or frontiers.

**Disadvantaged groups in Vietnam—especially ethnic minorities and those living in poor, remote, and mountainous provinces—have substantially worse health outcomes than the national average.** In 2017, child mortality rates in rural areas (26.0 per 1,000 live births) were more than double those in urban areas (12.7).

4 The HCI measures the amount of human capital that a child born today can expect to attain by age 18. It conveys the productivity of the next generation of workers compared to a benchmark of complete education and full health (which would be a score of 1). It is made up of five indicators: the probability of survival to age five, expected years of schooling, harmonized test scores as a measure of quality of learning, adult survival rate (fraction of 15-year-olds who will survive to age 60), and the proportion of children who are not stunted. The HCI is constructed for 157 countries across the income spectrum.

5 The UHC service coverage index is a single indicator constructed from subindexes representing the four categories of reproductive, maternal, neonatal, and child health services; infectious diseases; NCDs; and service capacity and access. The South-eastern Asia region includes Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Timor-Leste, and Vietnam. The East Asia region includes China, Democratic People's Republic of Korea, Japan, Mongolia, and Republic of Korea. More information can be found at <http://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf?sequence=1>.

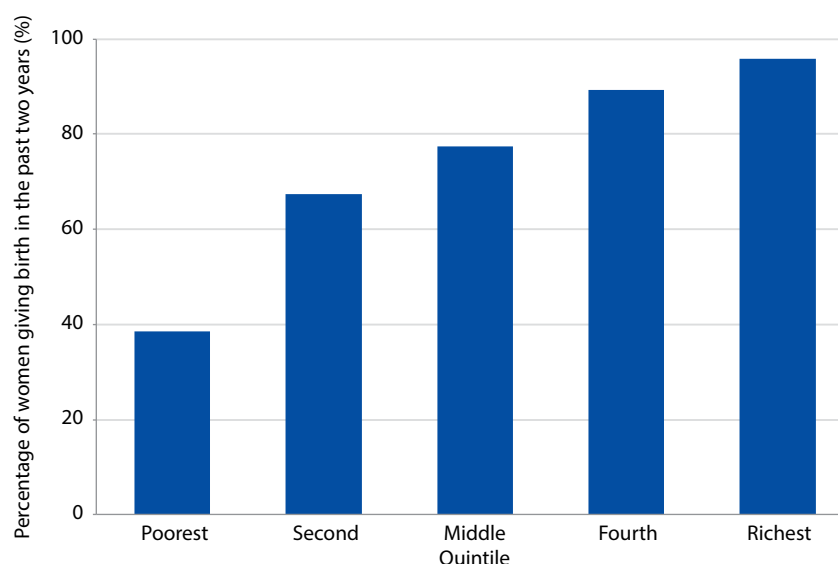


Child mortality rates in some remote mountainous provinces exceeded 50 but were less than 20 in most delta provinces (GSO Vietnam 2018b). Similarly, while the national under-five stunting prevalence was 24.2 percent in 2017, in recent years it reached over 35.0 percent in some remote mountainous provinces (GSO Vietnam 2018b; National Institute of Nutrition 2016).

**Access to essential health services among disadvantaged groups is also far less than the national average.**

The proportion of births assisted by a trained staff was 68.3 percent among ethnic minority women and 73.4 percent among the poorest quintile, compared to over 95.0 percent among women in the remaining quintiles (GSO Vietnam and UNICEF 2015). The proportion of pregnant women having four or more prenatal care visits was only 38.6 percent among the poorest quintile but rose to 67.0 percent in the second-poorest quintile and to 96.0 percent in the richest quintile (GSO Vietnam and UNICEF 2015) (see Figure 4). Full immunization rates fall as low as 70.0 percent among disadvantaged groups, such as ethnic minorities (69.4 percent), the poorest quintile (72.2 percent), and those in mountainous provinces (such as the Central Highlands, 70.5 percent, and Northern Midlands and Mountains, 71.0 percent) (GSO Vietnam and UNICEF 2015).

**Figure 4: Antenatal Care Coverage by Income Quintile (at least Four Visits), 2014**

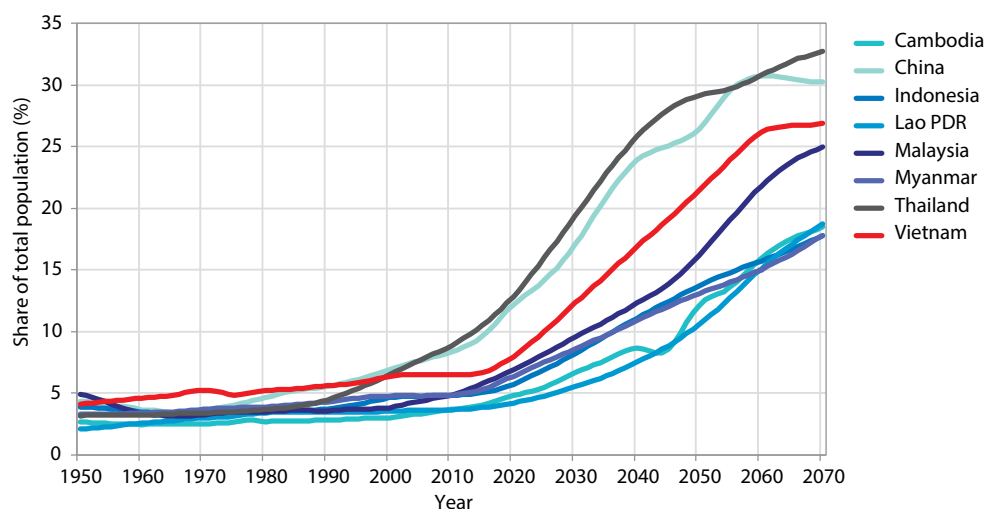


Source: GSO and UNICEF (2015).

Note: This indicator is measured as the percentage of women aged 15-49 with a live birth in the last two years, who were attended to during their last pregnancy at least four times by any provider.

**The fact that Vietnam is one of the most rapidly ageing countries in Asia will have important implications for future health care demand, health spending, and health outcomes.** The percentage of the population age 65+ is expected to increase by two-and-a-half times by 2050, growing from an estimated 7.1 percent of the population in 2015 to 18.0 percent by 2049 (GSO Vietnam and UNFPA 2016) before leveling off around the year 2060. This rate of ageing is high compared to other East Asian countries (MOH Vietnam and HPG 2017) and slower only in comparison to China and Thailand (Figure 5). In 2016, a person in Vietnam living to age 60 is, on average, expected to live another 22.7 years, but to remain healthy only for 17.2 of those years (WHO 2018b), implying high needs for personal care of older persons in those years of poor health. As the size of the elderly population climbs, the population support ratio—the number of people ages 20 to 64 per individual age 65 and older—is forecast to decline from 9.3 in 2015 to just 2.6 in 2050 (UN DESA 2017). Unless action is taken now to ensure healthy ageing, the burden of caregiving will be unsustainable. In addition, the working-age population will begin to decline in absolute terms (World Bank and Ministry of Planning and Investment of Vietnam 2016). Importantly, the ageing of Vietnam's population is occurring at a much lower level of income than it did (or will) in other Asian countries such as Japan, the Republic of Korea, Thailand, and China. This raises questions about how the associated increase in health care demand will be financed.

**Figure 5: Share of Population Age 65 or Older, Vietnam versus Comparator Countries, 1950–2070**



Source: UUN DESA (2017).

**In part due to ageing as well as to lifestyle factors and success in combatting other diseases, Vietnam's disease profile is now dominated by noncommunicable diseases (NCDs).** The NCD share of the disease burden (measured in disability-adjusted life years [DALYs]) grew rapidly from 51 percent in 1990 to 74 percent in 2017 (IHME 2017). NCDs occupy seven spots in the top ten causes of Vietnam's disease burden (see Table 2). In 2017, cervical cancer resulted in 3.8 times as many deaths as did maternal causes.<sup>6</sup> The single leading contributor to the disease burden is stroke (within the category of cardiovascular disease), accounting for 10 percent of all DALYs and 18 percent of all deaths in 2017 (IHME 2017). Leading risk factors associated with stroke (as well as with other major contributors to the disease burden) are uncontrolled hypertension, high cholesterol, diabetes, smoking, and an unhealthy diet. As Vietnam grapples with the shifting disease burden, it will also face the challenge of the rising expectations of a growing middle class that will demand better quality and more technologically sophisticated health care, typically with a preference for hospital and specialist care.

**Table 2: Top Ten Causes of Disease Burden, 1990–2017**

| Rank in 2017 |  | Category | Percentage |        |        |        |
|--------------|--|----------|------------|--------|--------|--------|
|              |  |          | 1990       | 2000   | 2010   | 2017   |
| 1            | Cardiovascular diseases                      | NCD      | 11.7       | 14.5   | 15.9   | 17.0   |
| 2            | Neoplasms                                    | NCD      | 6.9        | 9.4    | 11.2   | 13.1   |
| 3            | Musculoskeletal disorders                    | NCD      | 3.6        | 5.1    | 6.3    | 6.9    |
| 4            | Diabetes and kidney diseases                 | NCD      | 3.3        | 4.3    | 5.1    | 6.2    |
| 5            | Neurological disorders                       | NCD      | 3.5        | 4.7    | 5.3    | 5.4    |
| 6            | Other NCDs                                   | NCD      | 7.8        | 6.7    | 5.9    | 5.0    |
| 7            | Unintentional injuries                       | INJ      | 6.7        | 6.3    | 5.6    | 5.0    |
| 8            | Mental disorders                             | NCD      | 3.4        | 4.5    | 4.9    | 4.9    |
| 9            | Transport injuries                           | INJ      | 4.2        | 4.8    | 5.6    | 4.9    |
| 10           | Respiratory infections and tuberculosis (TB) | CD       | 11.1       | 7.1    | 5.5    | 4.4    |
|              | DALYs per 100,000 population                 |          | 33,766     | 26,510 | 25,785 | 25,809 |

Source: IHME (2017).

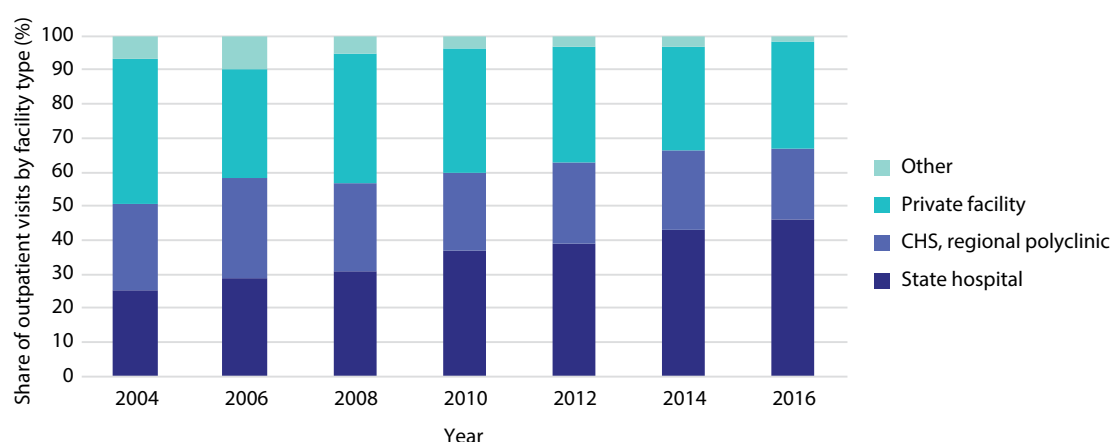
Note: NCD = Noncommunicable disease; CD = Communicable disease; INJ = Injuries; DALYs = Disability-adjusted life years.

<sup>6</sup> According to the Institute of Health Metrics and Evaluation's Global Burden of Disease study, among women of reproductive age (15 to 49), 210 maternal deaths occur per year, while there are 790 cervical cancer deaths per year.

**The health system in Vietnam is not yet ready to manage the changing health needs that have come about due to these epidemiological and demographic shifts.** While Vietnam's health system has delivered good population health outcomes so far, the scope of services, competencies, and quality of care will need to adapt to meet the needs of an ageing population and a rising burden of chronic and noncommunicable diseases. For instance, the 2015 Stepwise Approach to Surveillance (STEPS) survey found that in the “cascade of care”<sup>7</sup> for hypertension and diabetes, many patients are “lost” at both the diagnosis and treatment stages. Among survey respondents who were hypertensive, only 43 percent had been previously diagnosed by doctors, and just 14 percent reported that their condition was currently being managed at a health facility. Among those assessed as being diabetics, 31 percent had previously been diagnosed, and only 29 percent were receiving treatment or being managed for their raised blood glucose (MOH Vietnam 2016).

**The health service delivery model in Vietnam is also characterized by an overreliance on hospital-based care and overservicing relative to need, both of which are expensive and not sustainable.** Vietnam's rate of hospital admissions and average length of stay are higher than regional averages (OECD and WHO 2016). In 2016, almost half of all outpatient visits took place in a hospital, and this share has been rising steadily over time (Figure 6), even as overuse of hospital care has long been recognized as a health system problem (GSO Vietnam 2018a).

**Figure 6: High and Increasing Share in the Use of Hospital Care for Outpatient Visits, 2004–2016**



Source: GSO Vietnam (2018a).

Note: CHS = Commune Health Station

**Regulatory and health financing policies fail to incentivize care delivery at lower levels.** People tend not to have a primary care provider who acts as a care coordinator to guide them through the system to get effective and appropriate care. Despite higher copayment rates at higher-level hospitals to discourage bypassing, the deterrent effect has not been strong because service prices have been substantially subsidized. That said, with user fees now increasingly aimed at full cost recovery, disincentives to bypassing are likely to be stronger than in the past.<sup>8</sup> Public hospitals are also encouraged to raise capital from the private sector (including from their own staff) to invest in new medical technologies and can charge higher fees for the use of private equipment. In addition, the financial autonomy policy allows hospitals to top up staff incomes from operating surplus, encouraging overservicing. These factors create powerful incentives for hospitals to offer expensive, high-tech services, some

<sup>7</sup> The cascade of care, sometimes called the “treatment cascade”, is a term that has typically been used for infectious disease detection and treatment (especially for HIV and tuberculosis), but has also recently been applied to NCDs and chronic conditions.

<sup>8</sup> In the case of bypassing from the district to higher-level facilities for outpatient care, health insurance will reimburse nothing. In the case of bypassing to the central level for inpatient care, health insurance reimbursement will cover 40 percent of the normal reimbursement share (for example, for contributing members who receive 80 percent payment from insurance,  $80 \text{ percent} \times 40 \text{ percent} = 32 \text{ percent}$  paid by insurance and 68 percent paid by patient). In the case of bypassing to the provincial level for inpatient care, insurance will reimburse only 60 percent of the normal amount (for example,  $80 \text{ percent} \times 60 \text{ percent} = 48 \text{ percent}$ ).

of which may be medically unnecessary or interpreted by patients as a sign of quality, further exacerbating bypassing and overcrowding.

**At the same time, the lower levels of care are not yet sufficiently equipped or enabled through policy and financing to tackle the shift in the disease burden.** On average, only 21 percent of outpatient contacts are at commune health stations or regional polyclinics (GSO Vietnam 2018a). That said, commune health stations are better utilized in more remote areas; for example, in the mountainous provinces, where their share in outpatient contacts is well over 50 percent. However, basic infrastructure, equipment, and competencies are often lacking: in 2016, only 69.8 percent of rural communes met the 2014 national commune health benchmarks (Central Steering Committee for the Census of Rural Areas, Agriculture and Aquaculture 2016).

**Moreover, health workers at commune health stations have difficulties in dealing appropriately with specific medical conditions in line with diagnostic and treatment guidelines.** Medical knowledge among health workers at the commune level is far lower than of health workers at the district level: survey findings show that 90 percent of health workers who performed poorly in a test of medical knowledge<sup>9</sup> were in the communes, whereas 90 percent of those above average were in district hospitals. Low knowledge of treatment guidelines impedes doctors' ability to ask the right questions about patient history or to conduct appropriate physical examinations, leading in turn to inaccurate diagnoses and improper treatment. For example, at least 55 percent of the most knowledgeable doctors (mostly in districts) asked the right questions in a case presentation of type II diabetes, while only 10 percent of the least knowledgeable doctors (mostly in communes) did so. In district hospitals, 69 percent of doctors prescribed some correct treatment for type II diabetes, compared to 54 percent of doctors at the commune level (World Bank 2016).

**Another challenge is that current provider payment arrangements do not offer appropriate incentives to commune health station workers.** Staff are paid salaries, drugs are provided in-kind from the district hospital, and health insurance reimbursement at the commune level is only for a small set of curative care services, paid on a fee-for-service (FFS) basis.

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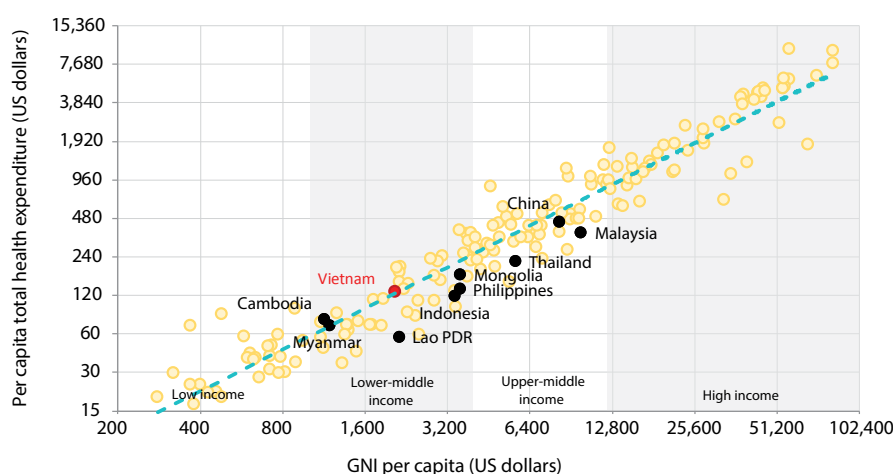
<sup>9</sup> Defined as two standard deviations below average in medical knowledge, based on an assessment using clinical vignettes.



## B: OVERVIEW OF HEALTH FINANCING PATTERNS AND TRENDS

**Vietnam's total health expenditure is comparable to countries of similar income levels, both in per capita terms and as a share of GDP.** Based on the latest available data (2016), total health expenditure per capita was VND 2.8 million or US\$129 (WHO 2018a). In absolute terms, this level of spending was about average, compared to other countries at a similar level of income (Figure 7). As a share of national income, Vietnam's level of health spending was slightly higher than average: in 2016, total health spending was 5.9 percent of GDP—just a touch higher than the 5.7 percent average for LMICs (Table 3).

**Figure 7: Total Health Spending, Vietnam versus Comparator Countries, 2016**

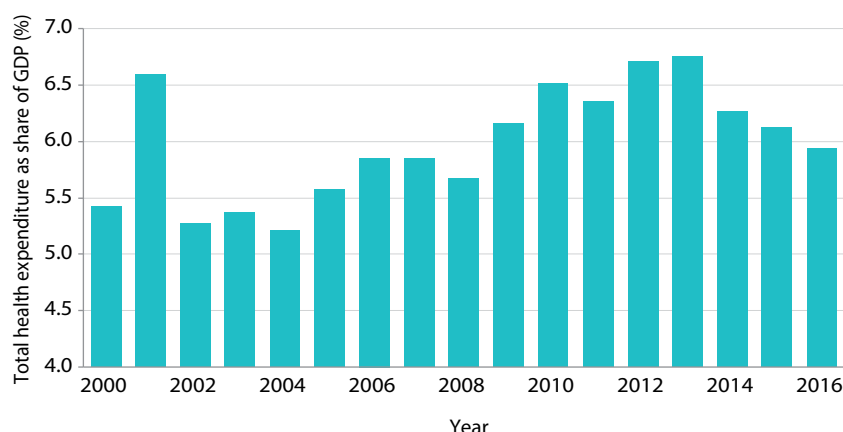


Source: World Bank (2018a); WHO (2018a).

Note: Both X-and Y-axes are expressed in log scale.



**Figure 8: Total Health Spending as a Share of GDP, 2000-2016**



Source: WHO (2018a).

**Table 3: Health Financing Indicators, Vietnam and Comparator Countries, 2016**

| Country/<br>region                              | GDP per<br>capita<br>(current US\$) | Total health<br>expenditure<br>per capita<br>(current US\$) | Total health<br>expenditure as a<br>share of GDP<br>(%) | Public share<br>of total health<br>expenditure (%) | Public spending<br>on health as a<br>share of<br>government<br>spending (%) | Public spending<br>on health as a<br>share of GDP<br>(%) |
|---|-------------------------------------|---|---|--|---|--|
| <b>Vietnam</b>                                  | <b>2,171</b>                        | <b>128.9</b>  | <b>5.9</b>  | <b>47.0</b>  | <b>9.3</b>  | <b>2.8</b>   |
| Myanmar   | 1,221                               | 70.2  | 5.7   | 18.7   | 5.0   | 1.1  |
| Cambodia  | 1,277                               | 78.4  | 6.1   | 24.4   | 7.0   | 1.5  |
| Lao PDR   | 2,339                               | 56.9  | 2.4   | 37.0   | 4.4   | 0.9  |
| Thailand  | 5,979                               | 221.9   | 3.7   | 78.3   | 15.3  | 2.9  |
| LMICs (average)                                 | 2,312                               | 136.1   | 5.7   | 46.2   | 8.8   | 2.7  |
| East Asia and Pacific<br>(average) <sup>a</sup> | 2,438                               | 135.0   | 5.8   | 54.2   | 8.0   | 3.4  |

Sources: World Bank (2018a); WHO (2018a)

Note: LMICs = Lower-middle-income country.

a. LMICs only.

**Health spending in Vietnam has increased significantly since 2000.** In nominal terms, total health spending has increased more than tenfold between 2000 and 2016. Even after accounting for inflation and population growth, total health spending has more than doubled over this period. Health spending has increased gradually as a share of GDP, albeit with some fluctuations: from just above 5 percent in the early 2000s to 6 percent or more in recent years, reaching almost 7 percent in 2013 (WHO 2018a) (Figure 8).

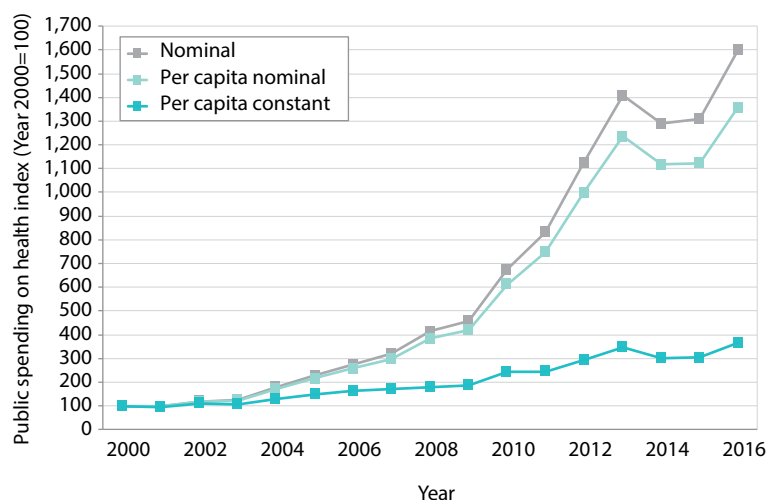
**Public spending on health<sup>10</sup> has also increased significantly since 2000, though with a noticeable decline in 2014.** From 2000 to 2016, public spending on health increased from VND 7.8 trillion to VND 125.6 trillion (WHO 2018a). In per capita inflation-adjusted terms, the increase has been threefold (Figure 9). This upward

<sup>10</sup> In general, a country's public spending on health can come from four sources of financing:

- Transfers from government domestic revenue allocated to health purposes. In Vietnam, this is best approximated as the "state budget for health." In the context of fiscal decentralization in Vietnam, the state budget for health includes only central-level spending on health and transfers to subnational governments that are dedicated to the health sector. Local governments at the province, district, and commune levels may allocate additional funds to health from their local budgets. These amounts are not captured in the state budget spending on health.
- Social health insurance contributions. In Vietnam, this includes contributions to the health insurance fund managed by VSS from employees, employers, and households.
- Compulsory prepayment other than social health insurance, such as when private insurers participate in the market to fulfill mandatory coverage requirements. The use of this financing modality is limited in Vietnam.
- Transfers distributed by the government from foreign origin, allocated to health purposes, such as through external financing for health that flows through the government system and budget.

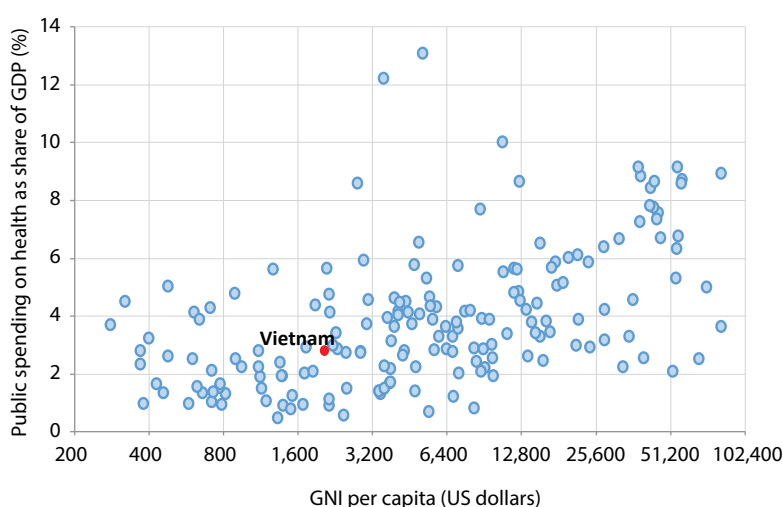
trajectory reversed in 2014, when public spending on health declined in real terms, but increased again in 2016. Public spending on health in Vietnam in 2016 was 2.8 percent of GDP—about average compared to other countries at a similar level of income (Figure 10).

**Figure 9: Public Spending on Health, 2000–2016**



Source: WHO (2018a).

**Figure 10: Public Spending on Health as a Share of GDP, 2016**

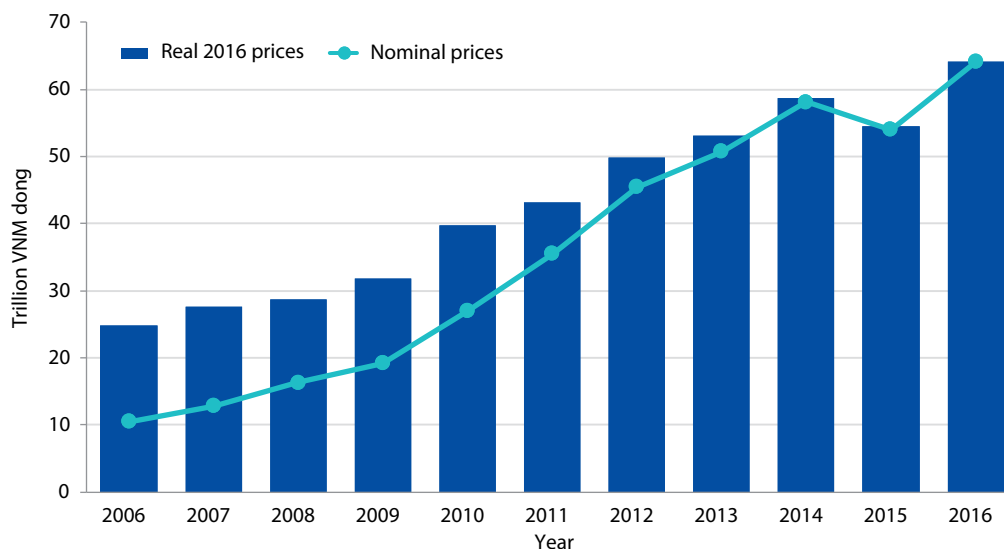


Source: World Bank (2018a); WHO (2018a).

Note: X-axis is expressed in log scale.

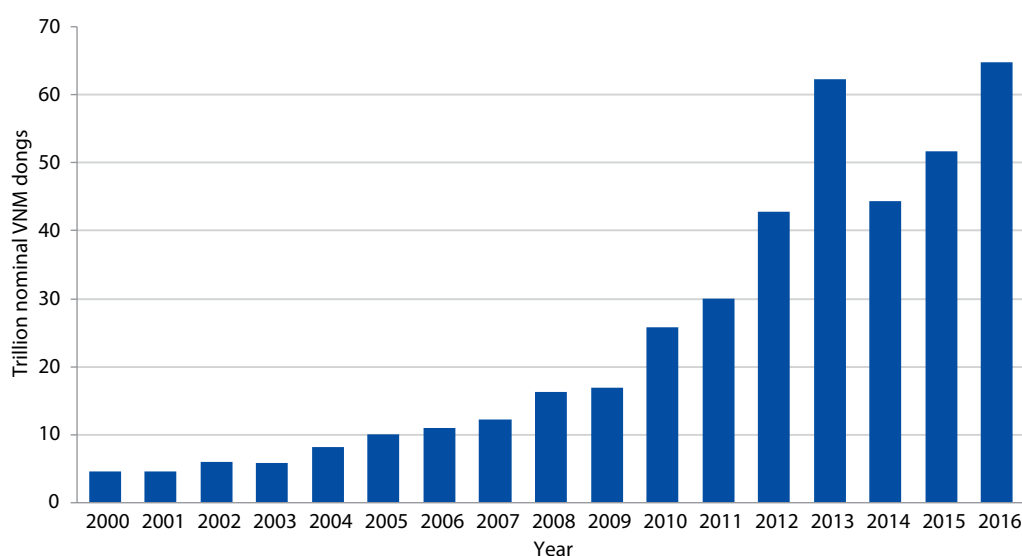
**The increase in public spending on health has come from two main sources: domestic government spending on health and SHI expenditure.** Between 2000 and 2016, per capita public spending on health in Vietnam grew at an average rate of 9.0 percent per year. Domestic government spending on health (known in Vietnam as “state budget spending on health”) accounted for the majority share of this increase, growing at an average of 10.4 percent per year. In real terms, total state budget spending on health increased from VND 25 trillion in 2006 to over VND 60 trillion in 2016 (Figure 11). The increase in per capita public spending on health was also bolstered by a notable increase in SHI expenditure, which increased annually between 2000 and 2016 at an average of 9.0 percent (Figure 12). External financing also contributed to the growth in public spending on health per capita, but only by a small amount.

**Figure 11: Government Budgetary Spending on Health, 2006–2016**



Source: WHO (2018a).

**Figure 12: Social Health Insurance Spending, 2000–2016**



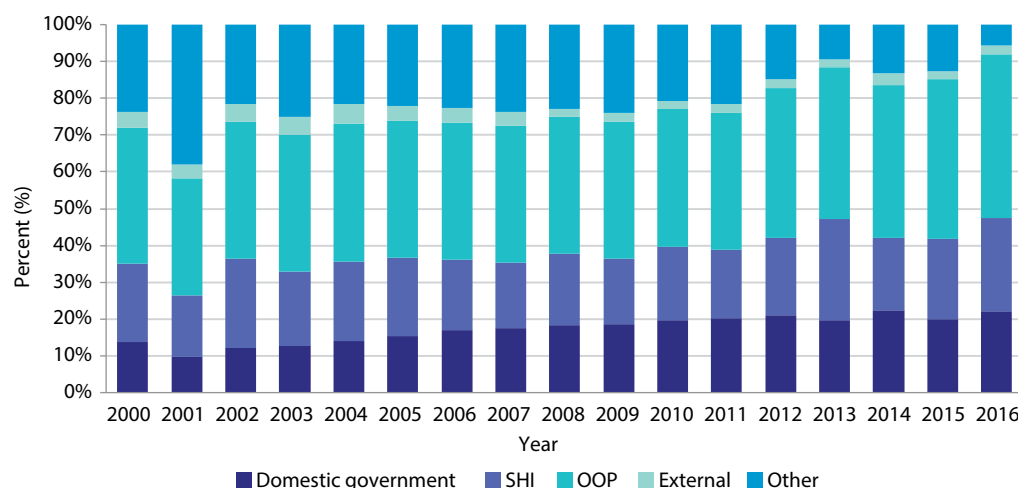
Source: WHO (2018a).

**Public spending on health has increased slightly as a share of total health spending.** Between 2000 and 2016, public spending on health as a share of total health expenditure increased gradually from around 35 percent in 2000 to just over 40 percent after 2011 (the share reached 47 percent in 2013 and again in 2016) (Figure 13).<sup>11</sup> Domestic government spending on health increased from 14 to 22 percent of total health spending during this period. This excludes transfers to SHI revenues on behalf of entitlement groups—an important source of SHI revenues. Expenditure from SHI has stayed roughly the same, averaging around 21 percent of total health spending over the past 17 years.

<sup>11</sup> “Other” includes (a) compulsory prepayment other than SHI, such as mandatory purchase of private health insurance—this accounted for 8 percent of total health expenditure in 2000 and fell to 3 percent in 2012; there are no data from 2013 to 2015; (b) voluntary insurance, approximately 1 to 2 percent of total health expenditure; (c) other domestic revenue from corporations and nonprofit institutions serving households (NPISH), accounting for 4 percent or less; and (d) other revenue that cannot be specified, typically accounting for 8 to 15 percent of total health expenditure but peaking at 25 percent in 2001.



**Figure 13: Composition of Health Spending by Source, 2000–2016**



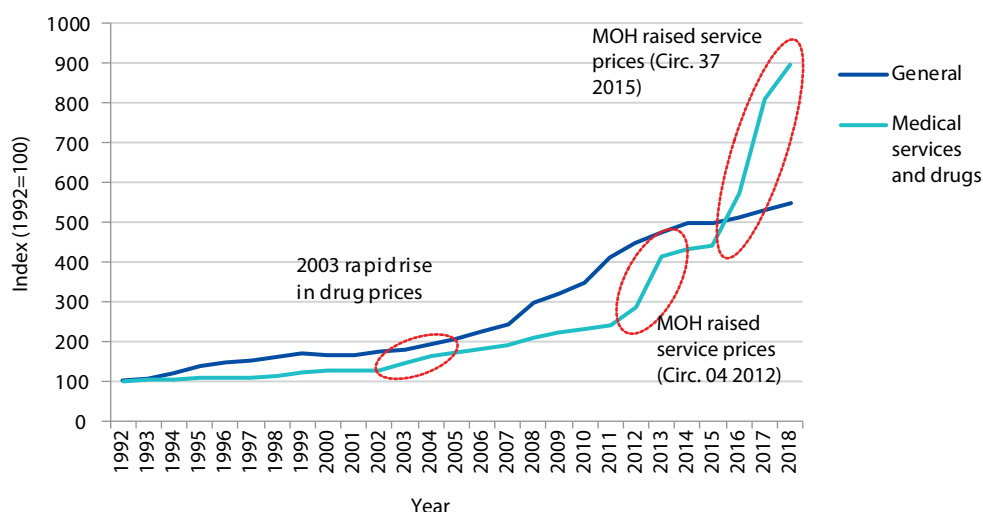
Source: WHO (2018a).

**Increases in public spending on health over the past few years have, in part, been due to an increase in population coverage, and thereby higher utilization and SHI claims.** This is good, as it means that more people are now accessing the care they need and are possibly doing so because of health insurance coverage they did not previously have. Several countries where UHC schemes have been launched (whether insurance based or not) have seen a large uptick in utilization at the same time as the programs are being expanded.

**Aside from increased coverage and utilization, however, there are other reasons for the increase in health insurance expenditure and in average costs.** First, the present system of provider payment creates a perverse incentive to increase the volume of procedures performed, particularly expensive and high-tech procedures. In the absence of consensus and policy guidance on a closed-ended provider payment system that would help to control SHI expenditure, Vietnam Social Security (VSS), which manages the SHI fund, uses the FFS payment method to reimburse for curative care, with few controls on the conditions and rules for payment. From the perspective of providers operating in an open-ended FFS system, a higher volume of services provided translates directly into higher revenues and profit. The result is strong incentives for provider-induced demand, including overprescribing medicines and performing nonessential or unnecessary tests. Patients accept such prescriptions and tests due to asymmetries of information, or they themselves request tests or procedures using innovative medical technology, which they perceive to be of better quality.

**Second, the policy on hospital autonomy and the associated shift toward full cost recovery for curative services has led the Ministry of Health to sharply increase administrative prices of health services.** The overarching policy objective is for public hospitals to become financially autonomous. The implementation of this policy has entailed a reduction of direct subsidies for recurrent costs of curative health services, and a requirement that hospitals cover their operating costs from service revenues—whether by user fees or through SHI reimbursement. From 2014 to 2017, various service cost components—including salaries—were included in the service prices to be reimbursed by SHI. At the same time, user fees for curative care were increased to ensure that public hospitals would be able to recover costs that were previously funded through government subsidies. Administrative prices of health services were increased sharply, with a concomitant spike in the consumer price index (CPI) for medical services and drugs (Figure 14).

**Figure 14: Consumer Price Index for Medical Services and Drugs, 1992–2018**

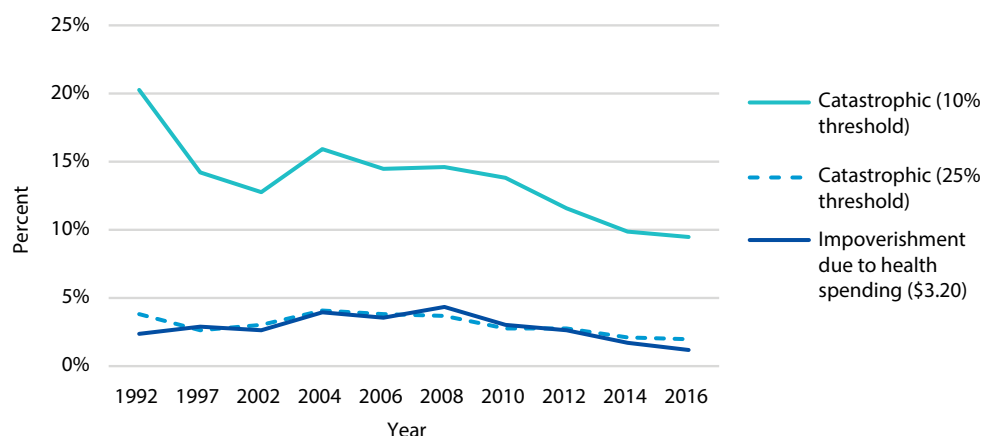


Source: GSO Vietnam (2018c).  
Note: MOH = Ministry of Health.

**Despite policy intentions to reduce OOP spending by households, this source of financing continues to comprise the largest share of spending in the health system.** As shown in Figure 13, the OOP share has remained persistently high at just under 40 percent since 2000; between 2011 and 2016, it increased further from 38 percent to 45 percent (WHO 2018a). Shifting the composition of health financing from payment at the point of care (through OOP) to pooled prepayment (for example, through health insurance or state budget) is important because it spreads the risk of unpredictable and potentially costly health care expenditure across the population. Despite the expansion of health insurance coverage (from 13 percent to 87 percent between 2000 and 2017) and the increase in public spending on health, Vietnam's health financing system still relies predominantly on OOP payments.

**Yet, Vietnam has seen substantial improvement in financial protection of households against large OOP health spending.** Despite the persistence of OOP spending as the predominant source of financing at the system level and the rising share of health spending being borne by households at the point of care, the health financing system in Vietnam has provided significant protection to households against the financial risks associated with health care costs. Catastrophic health expenditure has been declining. In 2016, incidence of catastrophic health spending was 9.5 percent (at the 10 percent threshold) or 1.8 percent (at the 25 percent threshold) (Figure 15). This outcome is comparable to the global average of 9.2 percent and 1.8 percent at the respective thresholds and is better than the average for Asia of 12.8 percent and 3.1 percent at the respective thresholds (WHO and World Bank 2017). Impoverishment due to health spending is very low, at 1.3 percent. Vietnam was in fact among the top five countries for the largest decline in incidence of impoverishment due to OOP spending, measured based on available cross-country data (WHO and World Bank 2017).

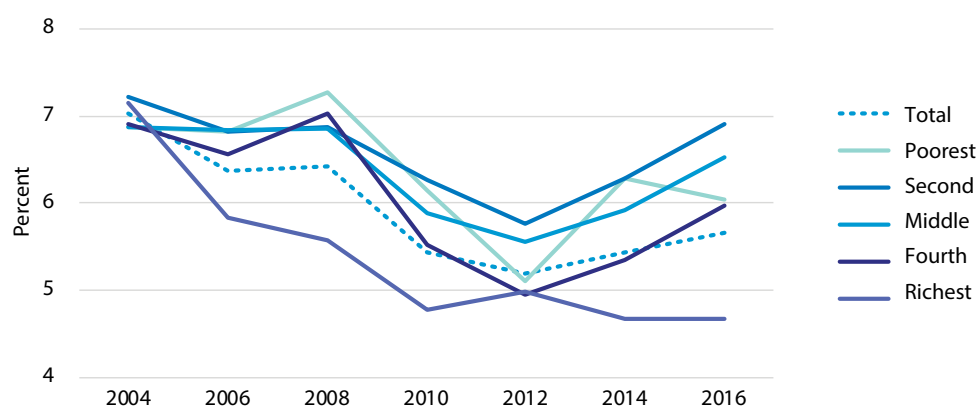
**Figure 15: Catastrophic and Impoverishing Health Spending, 1992–2016**



Sources: VHLSS 1992–2016, estimates from HEFPI database, and authors' calculations.

**After declining for almost a decade, the share of household income that is spent on health care has been increasing recently for all income groups—except the rich.** After a long-lasting downward trend (between 2004 and 2012) among all income groups in the share of household income that is spent on health care, from 7 percent to approximately 5 percent on average, between 2012 and 2016, the share of income spent on health began to increase again. The exception was among the wealthiest quintile, where the downward trend continued (Figure 16).

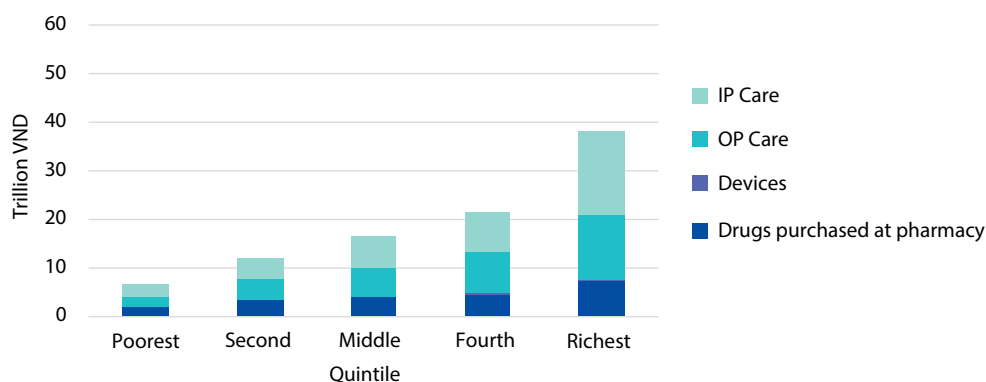
**Figure 16: Out-of-Pocket Spending on Health as a Share of Total Household Spending, by Income Quintile, 2004–2016**



Source: GSO (2018a), with authors' calculations

**In absolute terms, health spending is concentrated among the better-off, but there is not much difference across income groups in the composition of health spending.** The richest quintile spends more than five times what the poorest quintile spends on health care, and almost double of what the second-richest quintile spends (Figure 17). Also, while the absolute amount of average household OOP expenditure on health care has been increasing (including in real terms) over time, this increase has been concentrated among higher-income households. Inpatient care comprises a substantial proportion of OOP spending across all income groups, with the richest quintile spending a relatively greater share on inpatient care. Middle-income groups spent relatively more on outpatient care. Drugs purchased from pharmacies account for around 20 percent of OOP spending.

**Figure 17: Level of Out-of-Pocket Spending on Health by Income Quintile, 2016**



Source: GSO (2018a) with authors' calculations.

Note: IP = Inpatient; OP = Outpatient.

**In conclusion, while OOP remains a large share of overall health system financing in Vietnam, the impact on household well-being remains limited.** Typically, an OOP share of total health expenditure of 15 to 20 percent is associated with lower incidence of financial catastrophe (Xu et al. 2010). However, the ultimate objective is the impact of that spending on household well-being. In Vietnam, it appears that OOP spending on health is not concentrated among the poor, who spend about the same share of total household expenditure on health as other quintiles. Moreover, the improvements in financial protection indicators suggest that households, including the poor, bear a limited amount of financial risk associated with their health expenses.

**These improvements in financial protection also point toward the good outcomes that have resulted from higher government spending on health and higher SHI coverage.** State budget spending on health that is channeled toward primary care and preventive services benefits poor and rural populations, who use these services more at the commune and district levels. Effective targeting of health insurance premium subsidies has also contributed significantly to improving financial coverage for poor and vulnerable groups. Health insurance coverage rates are highest in the poorest quintile and have been increasing in all income groups. Poor and near-poor groups are subject to zero or low co-insurance payments when seeking care in district and lower levels or through referrals. All in all, financial protection has improved across the board and especially for poor and vulnerable groups.

#### **A note on the data:**

**By and large, this report uses data from WHO's Global Health Expenditure Database (GHED). This is mainly to ensure consistency in methodology for trend analysis.** With a change in methodology for National Health Accounts (NHA) to the System of Health Accounts (SHA) 2011, a consistent and reliable time series (2000–2016) on health spending is only available in the GHED. At the time of writing, the latest available data were for 2016. Vietnam's NHA country reports, based on the former methodology, are available for 1998–2012. The NHA report for 2013–2015, published in 2018, uses the SHA 2011 methodology. In reviewing these data sources, the authors found large discrepancies in reported numbers. Ministry of Health (MOH) Vietnam has confirmed that some key discrepancies can be attributed to the change in methodology.

**However, there are limitations to the GHED data, which can be improved with better data collection on health spending in Vietnam.** Some examples include the following:

- **General government health expenditure currently does not include a full picture of spending on health at the local level (province and below).** The exact amount that local governments allocate to health is not captured in a comprehensive or consolidated manner. This is because local governments have flexibility in allocating their budget across sectors. The amount they allocate to health could vary from one year to the next, and this may not be fully captured in central-level accounts.
- **Capital expenditure only captures public, central-level data. Capital expenditure in the GHED only includes public investments.** Further, it also only includes capital expenditure by the MOH. Capital expenditure at the provincial level will include projects that are authorized and funded by central transfers but may not include smaller capital expenditures that are financed through local budgets. The Ministry of Planning and Investment (MPI) tracks total investments by sector. In the most recent years for which data are available (2014, 2015), GHED figures are approximately two-thirds of the MPI numbers for total investments in health care in Vietnam.





## C: ASSESSING FISCAL SPACE FOR HEALTH

### 1. Approach

**In the changing economic and policy environment and through this period of transition, how can Vietnam maintain a sufficient level of public spending on health to sustain and further good health outcomes and respond to new health challenges?** What are the prospects for increasing public spending on health—in other words, what are the key sources of fiscal space for health in Vietnam?

**Fiscal space can be defined as “the availability of budgetary room that allows a government to provide resources for a given desired purpose without any prejudice to the sustainability of a government’s financial position”** (Heller 2006). Specifically, for the health sector, fiscal space refers to the ability of governments to increase spending on health without jeopardizing the government’s long-term solvency or crowding out expenditure in other sectors needed to achieve other development objectives (Cashin and Tandon 2010).

**Fiscal space for health can be generated from a variety of sources, broadly grouped into five categories** (Cashin and Tandon 2010; Heller 2006):

1. Conducive macroeconomic conditions, such as economic growth and increases in overall government revenue that, in turn, might lead to increases in government spending for health
2. Increase in the prioritization of health, leading to an increase in health’s share of public expenditure

3. Increase in health sector–specific resources, such as consumption or income taxes that are earmarked for health
4. Increase in grants and foreign aid specific to the health sector
5. Increase in the efficiency of public spending on health

Mathematically, public spending on health can be represented as follows:

$$\begin{aligned} \text{Public expenditure on health per capita} = \\ \text{Real GDP per capita} \times \text{Public expenditure share of GDP} \\ \times \text{Health's share of public expenditure} \end{aligned}$$

Focusing on each of these constituent parts gives us a modified fiscal space framework. This modified framework categorizes increases in public spending for health into three primary sources (Tandon et al., 2018):

- (a) **Macroeconomic growth**, which would lead to increases in real GDP per capita.
- (b) **Higher fiscal resources**, which would affect public expenditure as a share of GDP. Increases in aggregate public expenditures can come from higher aggregate government revenues; deficit financing, including external financing through public channels; and health sector–specific resources, such as consumption or income taxes that are earmarked for health.
- (c) **Reprioritization of health**, which would affect health's share of public expenditure.

**The rest of this paper will focus on these three categories of the modified framework.** Additional pillars include (a) complementary financing and (b) efficiency gains. Complementary financing refers to funds that are channeled outside the public system, such as external financing that flows through nongovernmental and civil society organizations. We choose to exclude complementary financing from this analysis, as the bulk of external financing in Vietnam flows through the government budget system and is delivered through centrally managed government programs. Efficiency gains in the health sector are immensely important in Vietnam. Key aspects of inefficiency will be highlighted.

## 2. Macroeconomic conditions

### *Vietnam's economy is on the rebound, but significant risks remain*

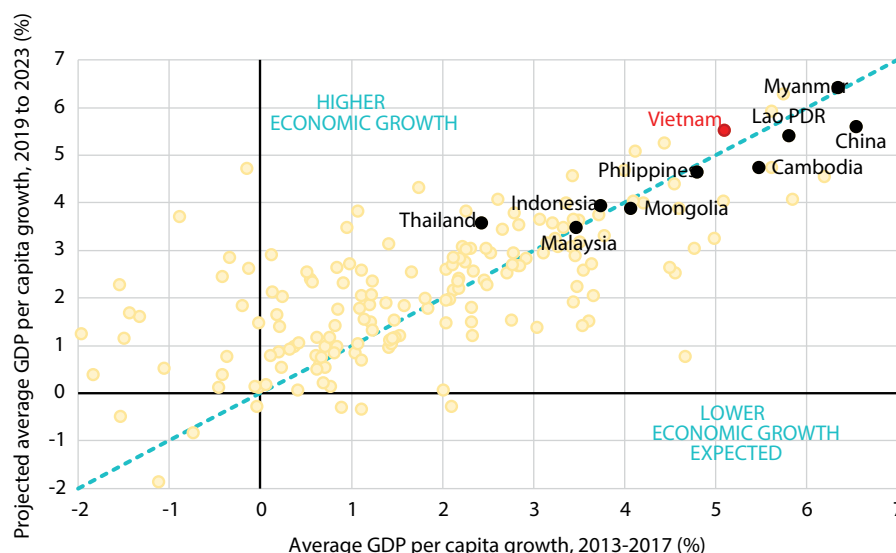
**Economic growth is a key determinant of overall fiscal space as well as of fiscal space for health.** Even if public spending on health as a share of GDP remains unchanged, if GDP in a country grows at a certain rate per year in real terms, it follows that public spending on health would also increase at that same rate. In India, for example, government health expenditure per capita more than doubled in real terms from 1995 to 2010, even though there was almost no change in government spending on health as a share of GDP (approximately 1 percent throughout this period).

**Vietnam's economy has grown at a fast pace over the last decade, and the medium-term economic outlook remains good.** The average growth in GDP per capita over the past five years has been just above 5 percent. With an open economy, Vietnam is susceptible to external shocks, but recovery since the 2009 financial crisis has nonetheless been strong. The economic outlook continues to be good. Favorable domestic and external conditions have facilitated strong growth in 2018, and this is expected to be sustained in the medium term. Growth in real GDP per capita is projected to be approximately 5.3 percent in 2019 and will



hold steady at an average of 5.4 percent up to 2023. Vietnam's growth outlook is better than that of most other comparator countries (Figure 18).

**Figure 18: Past and Projected GDP Growth, Vietnam versus Comparator Countries, 2013-2023**

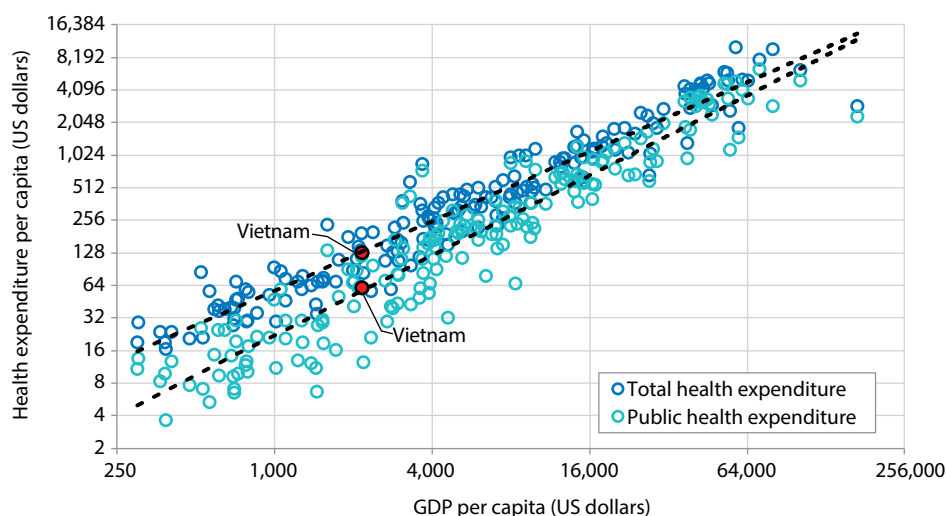


Source: IMF (2018b).

**Despite these good growth prospects in the short term, significant risks remain.** Domestically, slower progress in restructuring state-owned enterprises and the banking sectors could adversely affect the macrofinancial situation, undermine growth prospects, and create large public sector liabilities. External risks include escalating trade protectionism, heightened geopolitical uncertainty at the global and regional levels, and faster-than-expected tightening of global financing conditions (World Bank 2018b). A key question, then, is how health spending might change in the context of a more conservative outlook on economic growth.

**Cross-country data show that both total health spending and public spending on health tend to rise with GDP.** Based on the latest available data, the degree of “responsiveness”—or elasticity—of health spending (total and public) relative to income is 1.07 and 1.23, respectively (Figure 19). This indicates that a 1 percent rise in income was associated with an increase in total health spending by 1.07 percent, while the associated increase in public spending on health was slightly higher at a rate of 1.23 percent. Thus, if a country’s economy is growing, it is likely that health spending will similarly increase, often with the public share of health spending increasing at a slightly higher rate.

**Figure 19: Total and Public Spending on Health versus GDP, 2016**

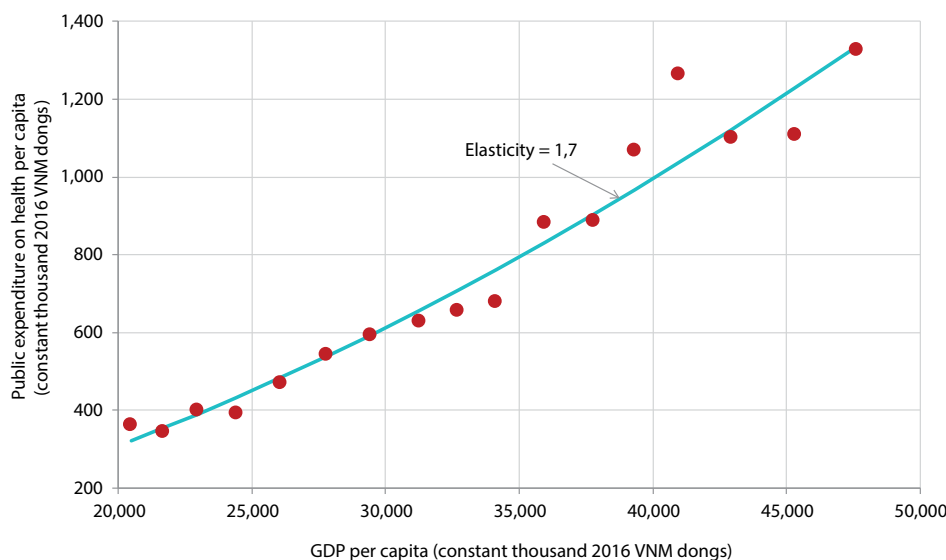


Source: WHO (2018a).

Note: Both X- and Y-axes are expressed in log scale.

**Over a 17-year trend, public spending on health in Vietnam has increased at a faster rate than GDP growth.** Figure 20 shows this trend, with an elasticity of public spending on health relative to GDP growth of 1.7. In other words, on average over the last 17 years, for every 1 percent increase in GDP per capita, public spending on health in Vietnam increased by 1.7 percent. This trend reversed in 2014 with a decline in public spending on health in real terms while GDP per capita continued to rise, but increased again in 2016.

**Figure 20: Elasticity of Public Spending on Health, 2000–2016**



Source: WHO (2018a).

**At current growth projections, and if income elasticity of public spending on health remains positive, Vietnam could expect additional fiscal resources for health of up to 0.4 percent of GDP by 2023.** Given Vietnam's good growth prospects and taking into consideration the potential economic headwinds highlighted earlier, we use a more conservative estimate for income elasticity of public spending on health: 1.3, which is closer to the average across countries, and lower than the historical trend in Vietnam of 1.7. From

the present<sup>12</sup> up to 2023, if public spending on health increases by 1.3 percent for every 1.0 percent increase in GDP, Vietnam could expect public spending on health to increase to 3.2 percent of GDP, up from its 2016 level of 2.8 percent. Even if public spending on health as a share of GDP remains unchanged at 2.8 percent, by 2023 it would increase to VND 196 trillion in real terms (Table 4). This calculation assumes the government does not deprioritize the health sector, relative to other sectors. Scenario 3 in the table below shows an instance in which income elasticity of public spending on health is less than 1, where public spending on health declines as a share of GDP but continues to increase—albeit at a slower pace—in real terms.

**Table 4: Projections of Fiscal Space for Health based on Economic Growth, 2016–2023**

| Year   | 2016  | 2017<br>(est.) | 2018<br>(est.) | 2019<br>(est.) | 2020<br>(est.) | 2021<br>(est.) | 2022<br>(est.) | 2023<br>(est.) |
|--|-------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Real GDP growth (%)  | 6.2   | 6.8            | 6.5            | 6.5            | 6.5            | 6.5            | 6.5            | 6.5            |
| Real GDP (VND, trillion)   | 4,503 | 4,809          | 5,121          | 5,452          | 5,806          | 6,186          | 6,588          | 7,016          |
| <b>Scenario 1: Elasticity of public spending on health to GDP is 1.3</b>                           |       |                |                |                |                |                |                |                |
| Real public spending on health (VND, trillion)   | 126   | 137            | 149            | 161            | 175            | 190            | 206            | 223            |
| Public spending on health (percentage of GDP)  | 2.8   | 2.9            | 2.9            | 3.0            | 3.0            | 3.1            | 3.1            | 3.2            |
| <b>Scenario 2: Public spending on health as a share of GDP remains the same as in 2016 (2.8 %)</b> |       |                |                |                |                |                |                |                |
| Real public spending on health (VND, trillion)   | 126   | 135            | 143            | 153            | 162            | 173            | 184            | 196            |
| Public spending on health (percentage of GDP)  | 2.8   | 2.8            | 2.8            | 2.8            | 2.8            | 2.8            | 2.8            | 2.8            |
| <b>Scenario 3: Elasticity of public spending on health to GDP is 0.8</b>                           |       |                |                |                |                |                |                |                |
| Real public spending on health (VND, trillion)   | 126   | 133            | 140            | 147            | 155            | 163            | 171            | 180            |
| Public spending on health (percentage of GDP)  | 2.8   | 2.8            | 2.7            | 2.7            | 2.7            | 2.6            | 2.6            | 2.6            |

Source: World Bank (2018a), Authors' calculations.

**Fiscal space generated through economic growth is not unqualified. Additional monies generated through economic growth will be accompanied by upward pressure on wages, but this could be offset by higher workforce productivity.** As national income rises, so do wages and salaries. Economic growth would thus be expected to come hand in hand with upward wage pressures, including for health professionals, so that they can maintain their relative position in a growing economy. A better-skilled health workforce could be more productive, especially with greater assistance from health technology. This could lead to greater efficiency and thereby generate effective fiscal space, though to a limited extent, given the labor-intensive nature of health service delivery. Thus, additional fiscal space for health that is generated through economic growth would automatically be absorbed by the existing health workforce and would not be available for new inputs and services, though some of this could be offset by increases in productivity.

**To summarize, there are moderate prospects for additional fiscal space for health through economic growth.** Despite potential macroeconomic risks, Vietnam's growth outlook is good. That said, the high elasticity of public spending on health relative to income may not be easily sustained—indeed, there was a decline in 2014—especially in a climate of economic risks and uncertainties. A more likely trend would be of Scenarios 1 or 2 above, where a moderate increase in fiscal space for health of up to 0.4 percent of GDP becomes available through economic growth. Much of this would automatically be absorbed in the form of higher wages and salaries rather than generate fiscal space for higher demand and new services.

<sup>12</sup> We have used 2016 figures as the basis for these projections. This is because 2016 is the most recent year for which reconciled public spending data are available.

### 3. Options for increasing aggregate public spending

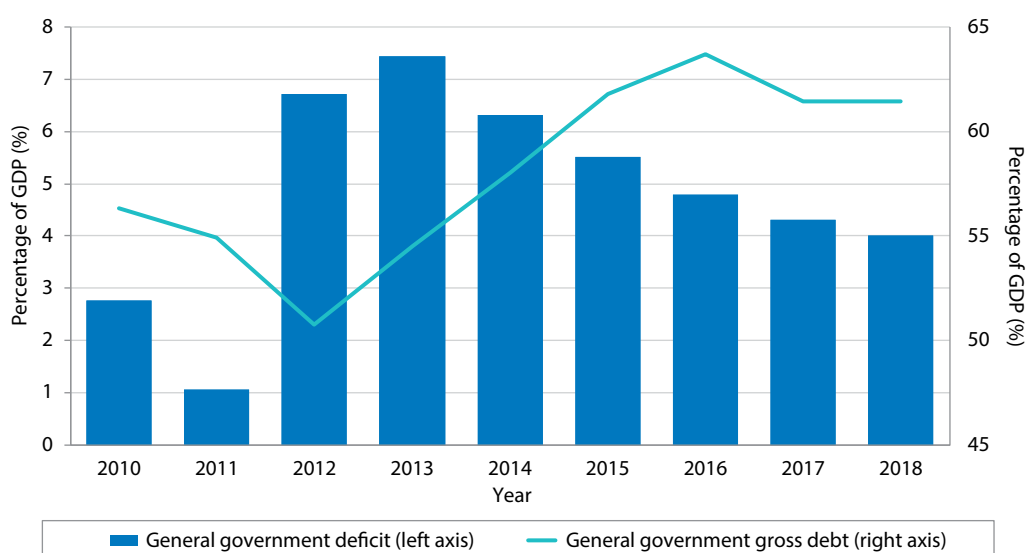
**A second source of fiscal space is from additional fiscal resources, which would allow the government to increase its aggregate public expenditures.** This source of fiscal space is considered separately from economic growth to follow the mathematical decomposition of public spending on health presented earlier. However, it is important to note that the various sources of fiscal space are not necessarily independent of one another. Part of the increase in aggregate public expenditures—which we will examine below—could be a result of government revenue buoyancy from economic growth, as outlined earlier. The reason for distinguishing between the two in this analysis is to try to pick up the direct contribution of each constituent part of public spending on health rather than the indirect contribution through related factors (Tandon et al. 2018).

Higher public spending is facilitated by additional fiscal resources, which, in turn, come from (a) higher aggregate government revenues; (b) deficit financing, including external financing (through public channels) and specific to the health sector; (c) consumption and income revenue streams that are earmarked for health sector spending. The following section looks at each of these potential sources of additional fiscal resources.

*Vietnam is undergoing a period of fiscal consolidation, with government revenue and expenditure shares on the decline*

**Vietnam is currently undergoing a period of fiscal consolidation.** This policy decision comes at the end of almost a decade of a countercyclical fiscal position, with large increases in public expenditure designed to mitigate the impact of the global financial crisis. Between 2012 and 2015, the average fiscal deficit was 6.5 percent of GDP—higher than in previous periods and high by international standards (World Bank and Government of Vietnam 2017). Due to persistent budget deficits, the debt-to-GDP ratio increased rapidly, reaching 63.7 percent in 2016 (World Bank 2018b) (Figure 21). Vietnam was at risk of entering the territory of increased risk of distress and exceeding the statutory debt ceiling of 65 percent of GDP.

**Figure 21: General Government Deficit and Debt as Shares of GDP, 2010–2018**



Source: Vietnam General Statistics Office; State Bank of Vietnam; IMF (2018b).

**The Government of Vietnam, to ensure fiscal sustainability, set itself a target of gradually reducing the level of fiscal deficit.** The Medium-Term Financing Plan of the Government for 2016–2020 set a deficit target of

3.5 percent of GDP. There has already been some progress toward this target. An expenditure-led adjustment reduced the overall fiscal deficit to 4.5 percent of GDP in 2017. This, together with a reduction in government guarantees and significant privatization proceeds, resulted in a decline in the debt-to-GDP ratio to 61.4 percent in 2017 (World Bank 2018a). Further fiscal consolidation measures are under way, with a focus on containing expenditure growth.

**Revenue collection, too, has undergone a cycle of growth and decline.** Between 2006 and 2015, Vietnam's high economic growth—at an annual average growth rate of above 6 percent—helped raise state budget revenue. From 2011 to 2015, however, revenue collection moderated significantly, continuing to increase in real terms but at a slower pace than GDP growth. State budget revenue as a percentage of GDP declined from an average of 26 percent during 2006 to 2010 to approximately 23 percent from 2011 to 2015 (World Bank and Government of Vietnam 2017). Revenue performance in 2017 and 2018 has been buoyant. Total (tax and nontax) revenue collection in 2017 held steady at the same level as in the two previous fiscal years, at 23.6 percent of GDP (World Bank 2018a).

**There have also been structural changes to Vietnam's tax system and shifts in the composition of tax revenues.** Over time, the tax-to-GDP ratio has declined. Revenues from natural resources have declined—oil revenue has declined from 3.4 percent to less than 1.0 percent of GDP in the last five years (Table 5). Vietnam has also significantly reduced import tariffs under various free trade agreements and lowered its corporate income tax rate to 20 percent. These latter changes may have created a more growth-friendly tax environment and stimulated investment, growth, and job creation, but may also have contributed to a lower overall tax take. Overall, the tax revenue-to-GDP ratio has fallen from about 23 percent of GDP in 2010 to about 18 to 19 percent, where it has held steady over the last five years.

**Table 5: Government Revenue as a Share of GDP, 2013–2018**

|                                 | 2013 | 2014 | 2015 | 2016 | 2017 (est.) | 2018 (Baseline est.) |
|---------------------------------|------|------|------|------|-------------|----------------------|
| <b>Total revenue and grants</b> | 23.1 | 22.2 | 23.8 | 23.7 | 23.6        | 23.3                 |
| <b>Tax revenue</b>              | 19.1 | 18.2 | 18.0 | 17.9 | 18.7        | 18.8                 |
| <i>Oil revenue</i>              | 3.4  | 2.5  | 1.6  | 0.9  | 0.9         | 0.7                  |
| CIT                             | 2.5  | 1.8  | 1.2  | 0.9  | 0.6         | 0.4                  |
| Natural resource tax            | 0.8  | 0.7  | 0.4  | 0.4  | 0.3         | 0.2                  |
| <i>Non-oil tax revenue</i>      | 15.8 | 15.7 | 16.4 | 17.1 | 17.9        | 18.2                 |
| PIT                             | 1.3  | 1.2  | 1.4  | 1.4  | 1.6         | 1.8                  |
| CIT                             | 3.9  | 3.4  | 3.6  | 3.6  | 3.8         | 4.0                  |
| VAT                             | 5.8  | 6.1  | 6.0  | 6.0  | 6.3         | 6.5                  |
| Trade                           | 2.2  | 2.4  | 2.4  | 2.1  | 1.9         | 1.7                  |
| Others                          | 2.5  | 2.5  | 3.1  | 3.9  | 4.2         | 4.3                  |
| <b>Grants</b>                   | 0.3  | 0.3  | 0.3  | 0.2  | 0.1         | 0.1                  |
| <b>Other revenue</b>            | 3.7  | 3.7  | 5.4  | 5.6  | 4.7         | 4.4                  |

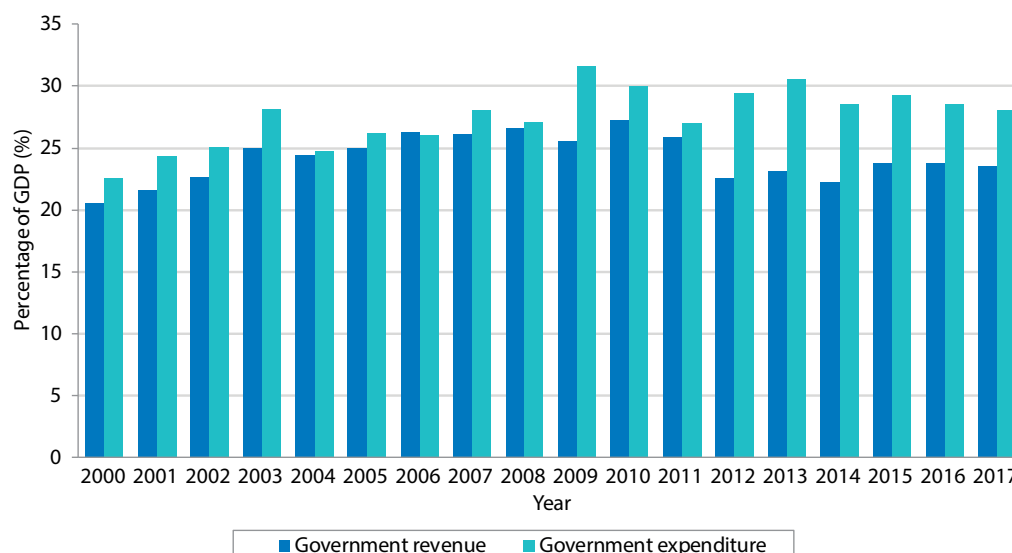
Source: IMF (2018a).

Note: CIT = Corporate income tax; PIT = Personal income tax; VAT = Value-added tax.

**The trend in government expenditures mirrors that of government revenue.** From 2000 to 2010, government expenditures climbed steadily from 23 percent to 30 percent of GDP (Figure 22). Total expenditures gradually (but erratically) declined afterwards, reaching 28 percent of GDP in 2017, largely due to lower capital expenditure and rationalization of other discretionary spending items. Further consolidation on the expenditure side will be needed to reduce the budget deficit. The Government of Vietnam is working on

reforms to improve efficiency of spending, including rightsizing the public administration and getting better value for money in public investment and procurement of goods and services (World Bank 2018a).

**Figure 22: General Government Revenue and Expenditure as Shares of GDP, 2000-2017**



Source: IMF (2018b).

**In sum, revenue and expenditure shares are expected to see moderate declines.** Projections by the International Monetary Fund (IMF) for 2019 to 2023 show that revenue and spending are expected to hold steady at approximately 23 percent and 28 percent of GDP, respectively (Table 6). The moderated outlook reflects the need for fiscal consolidation, which is coming after a period of high economic growth and high spending.

**Table 6: Key Fiscal Indicators and Projections, 2015–2023**

|  | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|--|------|------|------|------|------|------|------|------|------|
| General government revenue as share of GDP | 23.8 | 23.7 | 23.5 | 23.3 | 23.0 | 23.0 | 22.9 | 22.9 | 22.9 |
| Government spending as share of GDP        | 29.2 | 28.5 | 28.1 | 27.9 | 27.8 | 27.7 | 27.6 | 27.6 | 27.6 |

Source: IMF (2018b).

**Given the context of fiscal consolidation, the prospects of higher revenue and expenditure—including higher spending in the health sector—are slim in the foreseeable future.** With a drive toward fiscal consolidation focused on expenditure controls and a concerted effort to reduce the budget deficit, revenue and expenditure as a share of GDP are expected to decline. Vietnam is unlikely to see an increase in aggregate public spending in the short to medium term. This source of fiscal space is thus not a good candidate for potential increases in public spending on health.

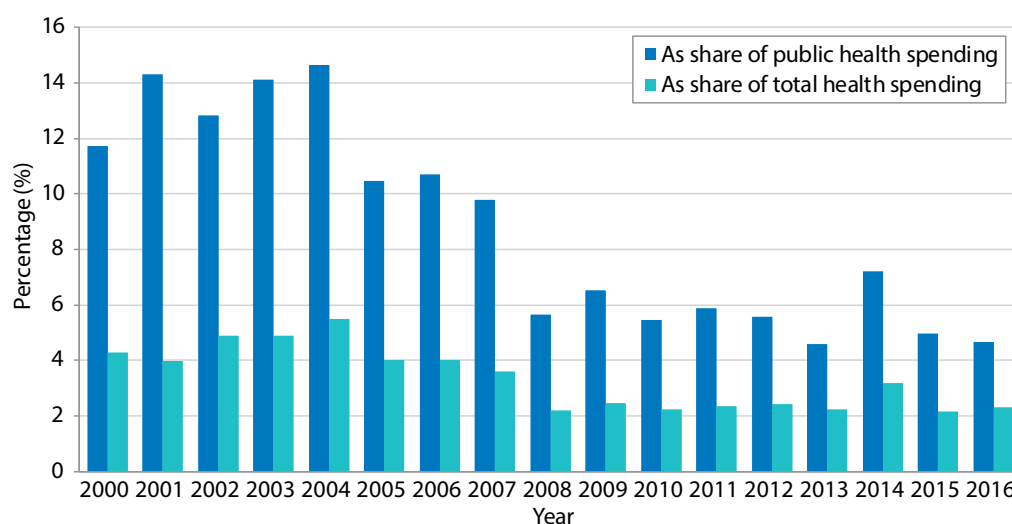
### *External assistance for health is a declining source of fiscal space*

**As Vietnam's economy has grown and the country has transitioned to lower-middle-income status, development assistance—including development assistance for health—has declined.** With increasing borrowing needs but constraints in access to concessional external financing, the Government of Vietnam has relied mainly on domestic debt to meet its growing financing needs. The share of domestic debt in total public debt increased from 45.0 percent in 2010 to 55.4 percent in 2015 (World Bank 2017a).

**External financing through development assistance for health can be an important source of fiscal space for low- to middle-income countries.** The share of development assistance for health declines steadily as a country's income rises and it phases out from eligibility for assistance. Typically, governments progressively replace external financing with domestic sources of funds. However, there may be a lag in this transition, leaving unfunded mandates and uncertainty as to whether activities that were previously funded by external sources will be picked up through public financing. This is one of the salient and emerging trends in the health financing transition that many countries, including Vietnam, are currently experiencing.

**In the health sector, external financing comprised a small share of total health spending for many years.** As early as 1995, just 3.5 percent of total health expenditure came from external assistance. This share has hovered around the 3.0 percent range for the past 10 years (Figure 23). Vietnam's improved income status has been a trigger for reductions in grant and concessionary financing from key development partners.

**Figure 23: Trend in External Financing for Health, 2000–2016**

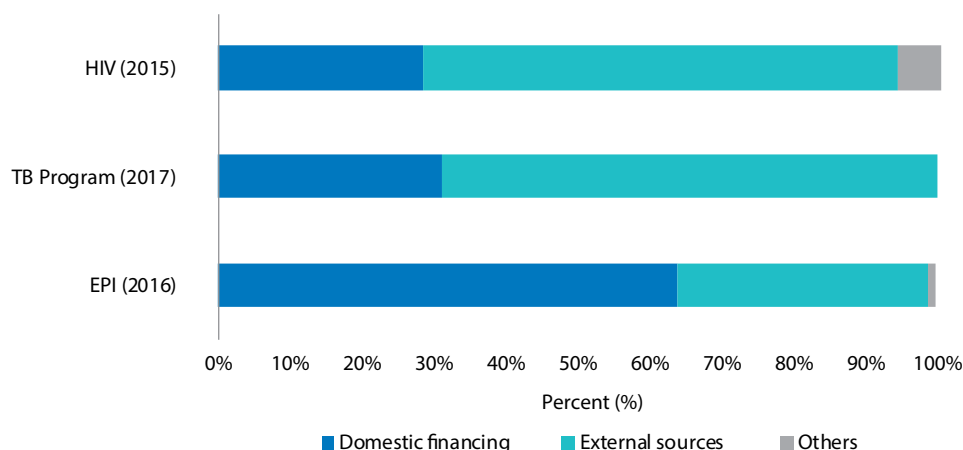


Source: WHO (2018a).

Note: External financing includes those channeled outside the government.

**While development assistance has comprised a small share of total and public spending on health for many years, it continues to be a key source of funds for certain disease programs.** Chief among these are the Expanded Program on Immunization (EPI), TB, and Human Immunodeficiency Virus (HIV). Data from the most recent year available show that external sources of financing comprised 66 percent of HIV program funding (2015), 69 percent of National TB program funding (2017), and 35 percent of EPI program funding (2016) (Figure 24).

**Figure 24: External Financing Comprises a Significant Share of Financing for Priority Programs 2015-2017**



Source: Authors' correspondence with program managers for HIV, TB, and EPI in 2018.

Note: EPI = Expanded Program for Immunization.

**External financing for some programs will be phased out soon.** The funding outlook for other programs is uncertain, though there is no strict “graduation” criteria for Vietnam. Currently, Global Alliance for Vaccines and Immunization (Gavi) is the major external contributor to the EPI program in Vietnam. Vietnam is now in its last round of Targeted Country Assistance by Gavi; there will be no further grants beyond the current transition grant. The current support focuses on advocacy work, strengthening the capacity of the national regulatory authority, procurement systems, costing, and reaching remote localities. The National EPI program anticipates that beyond 2020, the EPI program’s budget will be insufficient, especially if Vietnam aims to introduce new vaccines such as Rotavirus and Pneumococcal Conjugate Vaccine (PCV).<sup>13</sup> Financing from the Global Fund for HIV, TB, and Malaria, which comprises the majority of financing for the HIV and TB programs, is granted on a three-year basis. There is scope for further rounds of funding, but the amount is neither guaranteed nor secured until the grant proposal is approved, shortly before the funding cycle begins.

The decline in external financing for health is happening in parallel with other transitions in Vietnam—all of which will have an impact on these priority programs.

**First, the cost of treatment under these priority programs will no longer be financed by vertical program funding; instead, it will be subsumed under SHI reimbursement.** Antiretrovirals and first-line TB medicines are slated to fall under the ambit of SHI reimbursement starting in 2019. In addition, these medicines will be procured by a relatively new Central Procurement Unit under the Ministry of Health (MOH).

**Second, subnational governments are being required to take on greater responsibility for financing health programs, including these priority programs.** The revenue and expenditure responsibilities for many of these programs have been spelled out in a series of government documents over the past few years. For immunization, for example, the National Assembly Law on Prevention and Control of Infectious Diseases of November 21, 2007 (Article 30) stipulates that the State shall ensure funding for vaccines. Decree 104/ND-CP 2016 and Prime Minister’s Decision 1125/QĐ-TTg passed in July 2017 delineate responsibility between central and local governments for ensuring sustainable financing for immunization activities. Broadly, the division of responsibility is that the central government will assume responsibility for financing vaccines, logistics, management costs, and operating expenses for remote areas. Local governments are expected to finance

<sup>13</sup> Based on communication with national EPI representatives in Vietnam.



operating costs, cold chain, and other recurrent expenses to maintain EPI activities in their localities. Decision 1205 further reinforces the policy direction of local governments to assume a greater share of operating costs for immunizations, including the “injection fee”: a small incentive of VND 20,000 for the health worker, for each fully immunized child.

**Third, as part of a government-wide rationalization of National Targeted Programs (NTPs), these priority health programs have now been folded under a single Targeted Program.** This new program will have a lower share of state budget financing than the previous NTPs did. The new Population and Health Target Program for 2016–2020 encompasses a range of health care and preventive and health improvement services, including the abovementioned priority programs. The total anticipated quantum of funding for the new Target Program is higher than that for the previous health NTPs. However, the share which is to come from the state budget is lower, and many of the other sources are uncertain. The estimated budget for this program was outlined in Prime Minister’s Decision No. 1125/QĐ-TTg. The total budget for the program was set to be VND 19.4 trillion, with scope for adjustment up to VND 20.4 trillion, pending fiscal availability, as determined by the Ministry of Finance (MOF). The decision envisions the amount to be fulfilled through state (central) budget contributions of VND 9.5 trillion. Local budgets and income from lotteries are asked to contribute VND 5 trillion, while Overseas Development Assistance (ODA) will comprise VND 4.4 trillion. Other “eligibly/legally mobilized funds” including contributions from individuals and organizations are thought to be able to provide VND 0.5 trillion, suggesting a role for social mobilization. This means that the state budget share would be 49 percent—even lower than the share under the former NTPs of 53 percent. Local funds and ODA are each expected to make up about 25 percent of the program budget.

**The upshot of these policies is that the degree of certainty of domestic funding for priority programs has declined, as external sources of financing are being phased out.** In the context of fiscal space for health, external financing is no longer a sustainable and reliable source of funds for health spending in Vietnam. Domestic financing, too, appears to be an uncertain source of financing for priority health programs and for the health sector more broadly, given the potential variability of local budget allocations to health.

#### 4. Raising revenues specific to the health sector

**New sources of revenue that are specific to the health sector can be another source of fiscal space.** In general, sector budgets are allocated from a general pool of consolidated funds of government revenues. For the health sector, however, many countries have had experience in collecting taxes and generating revenues that are intended specifically for health expenditure. There are several policy options for this, such as committing a fixed portion of general tax revenue to a government health program, dedicating an entire tax to fund a specific health program, or channeling a tax into the health budget. Here, we will examine two sources of health sector-specific revenues: (a) SHI contributions and (b) taxes on products that are bad for health (tobacco and sugar-sweetened beverages).

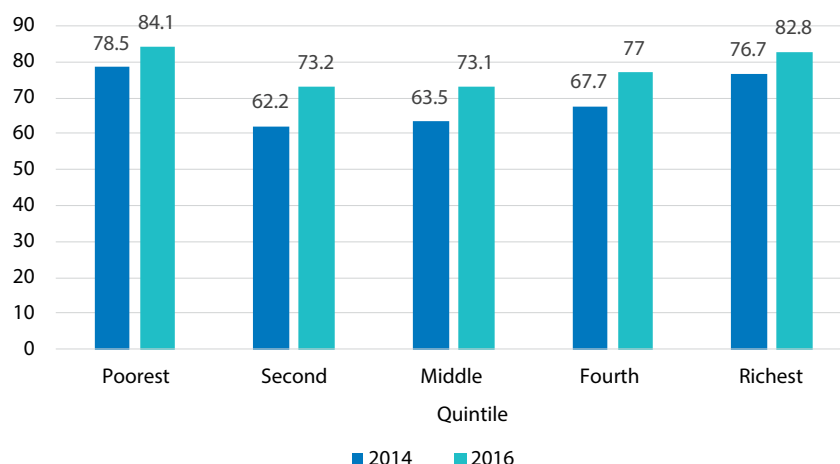
##### *SHI premiums*

**The increase in SHI spending over the past decade has been a significant contributor to the overall increase in public spending on health.** In 2016, the health insurance fund was estimated to have spent VND 65 trillion, up from VND 50 trillion in 2015 and VND 45 trillion in 2014 (WHO 2018a).

**On the revenue side, the health insurance fund is still highly dependent on general government budget transfers to cover the contributions for eligible entitlement groups.** The rapid increase in population coverage under the SHI scheme was made possible through large increases in government budgetary transfers

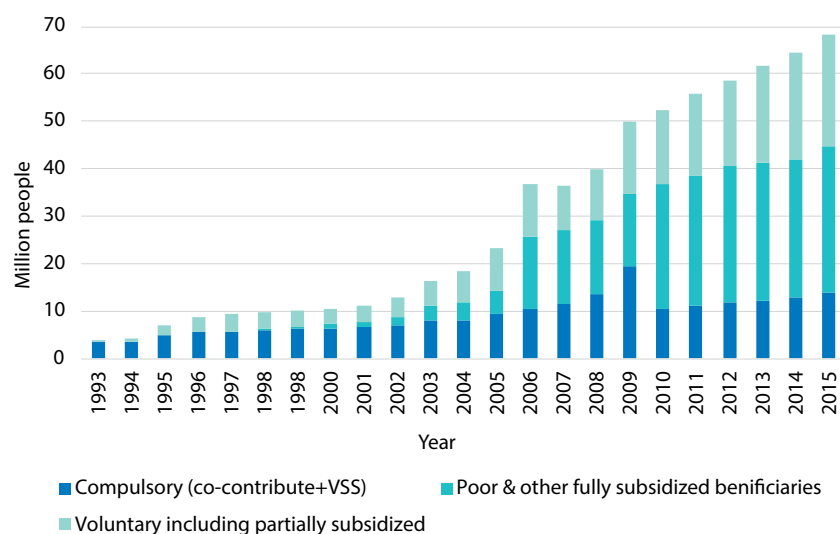
to fully subsidize insurance payments for the poor, children, and the elderly and partially subsidize the near poor and other vulnerable groups. Coverage has expanded from 5 percent in its year of inception (1993) to 60 percent in 2010, and is reported to have reached nearly 87 percent by mid-2018 (MOH Vietnam 2011). Health insurance coverage rates are highest in the poorest quintile and have been increasing in all income groups (Figure 25). Of almost 75 million people covered under the SHI scheme today, about 27 to 30 million vulnerable and poor have their premium payments covered by the government (MOH Vietnam and HFG 2018), while roughly another 23 million are partially subsidized (Figure 26). State budget transfers to the health insurance fund have risen sharply and now account for about 25 percent of the revenue of the health insurance fund, up from only 5 percent in 2005.

**Figure 25: Health Insurance Coverage Rates by Income Quintile, 2014 and 2016**



Source: GSO (2016 and 2018a).

**Figure 26: Social Health Insurance Coverage by Financing Source, 1993–2015**



Source: Authors' calculation from MOH supplied data.

**There is some scope for increasing fiscal space for health by increasing the number of contributing members in the SHI scheme and the average contribution rate therein.** The health insurance fund could mobilize additional funds by providing coverage to the remaining 13 percent of the population that is not yet covered. Another option under discussion is to increase the base salary on which the premium rate is charged. Currently, for individuals whose insurance is subsidized by the state budget (for example, the poor) and family-

based health insurance policyholders (those without an employer), the insurance premium of 4.5 percent is applied to the minimum wage. The minimum wage as of July 2018 was relatively low, at VND 1.4 million a month (approximately US\$66). In turn, this translates into a low contribution rate from these groups. For government employees, the average wage on which 4.5 percent is applied is five times higher (VND 6.4 million in 2017). Increasing the base on which insurance premium rates are applied could substantially increase SHI revenues.

**Another option is to increase the maximum allowable premium rate.** While the current SHI law allows for contribution rates up to 6.0 percent of salary (for formal sector workers), the current collection rate is 4.5 percent. There is little political appetite to increase it to 6.0 percent ahead of 2020. One reason cited by government officials is that higher premiums would affect business sentiment and create a disincentive for investment, thereby adversely affecting economic growth. Another reason is that a higher premium rate would substantially increase the amount of state budget that would have to be transferred to the Vietnam Social Security (VSS) for government employee health insurance contributions. As part of discussions to revise the SHI law, there have been proposals to increase the maximum allowable contribution rate to 8 percent. In practice, a higher collection rate may only be implemented many years later. Thus, it is not a viable source of additional fiscal space in the short term, though it remains a possibility in the long term.

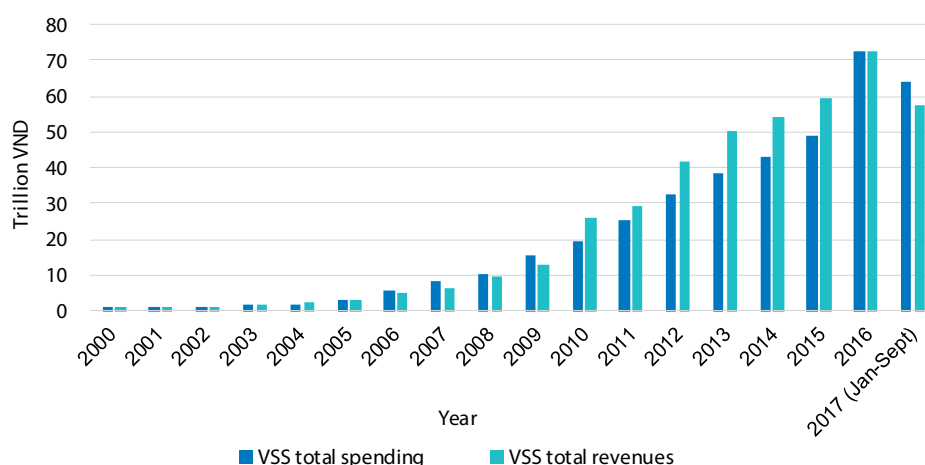
**Even if health insurance contributions are raised, the increases in revenues will need to be channeled toward existing liabilities and to cover a rapidly growing deficit.** While in earlier years health insurance revenues more than covered expenditures, the fund has recently begun to draw on its reserves to cover liabilities. Already running an annual deficit, the health insurance scheme may run down its reserve fund by 2020. Figure 27 shows revenue exceeding expenditure by a healthy margin from 2010 to 2015. While official data are not yet available for more recent years, local reports suggest that expenditure exceeded revenue by VND 10 trillion in 2017. There are significant risks that at this level of overspending, the reserve fund will only last till 2020.<sup>14</sup> Uncontrolled reimbursement through a fee-for-service payment method and administrative price hikes, as outlined in Section B of this paper, have contributed to and will only further exacerbate the deficit. The SHI fund is also expected to take on the costs of treatment for selected priority programs, such as HIV and TB, though the impact on liabilities is not expected to be large.<sup>15</sup> In this context, it is likely that any additional fiscal space for health coming from SHI revenues will largely be used to ensure that the health insurance fund remains solvent in the short term, rather than be channeled toward the new and increasing health demands of the population.

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<sup>14</sup> <http://english.vietnamnet.vn/fms/society/185789/health-insurance-fund-in-deficit.html>.

<sup>15</sup> Projections of liabilities to the insurance fund from this transition indicate that in 2015, the SHI fund would pay VND 266.5 billion for antiretroviral (ARV) treatment services. Compared to the current overall spending of the VSS fund, this amounts to about 0.5 percent of total VSS reimbursements in 2015, but is expected to increase to VND 812.8 billion by 2020 (VAAC and HFG 2014). Similar projections are needed for the impact of transferring financing responsibility for TB treatment services to VSS.

**Figure 27: Health Insurance Fund Revenue and Expenditure, 2000–2017**



Sources: MOH Health Statistics Yearbook; GSO Statistical Yearbook 2016 and 2017. 2017 estimates reported in <http://laodongxahoi.net/9-thang-dau-nam-2017-ca-nuoc-co-1323-trieu-nguoi-tham-gia-bao-hiem-xa-hoi-bat-buoc-1307969.html>.

Note: VSS = Vietnam Social Security. 2017 data is only for January to September.

**Faced with increasing liabilities and an impending deficit, VSS has been actively seeking ways to control expenditures.** This is a necessary and positive step toward improving efficiency of health spending and should continue into the long term. Some identified options include endeavoring to at least sustain its current level of revenue through active monitoring of evasion of health insurance contributions; stepping up efforts to ensure continued enrollment of individuals who are only partially subsidized by the government as well as of those in the informal sector; exploring reforms in provider payment methods to reduce incentives for unnecessary care and to increase value for money in spending; reviewing and revising the list of medicines and devices for health insurance reimbursement, with a view to paying for only essential cost-effective medicines and devices and at a more standardized rate; and establishing treatment guidelines and evidence-based conditions to determine clinical eligibility for reimbursement of high-tech and expensive services such as MRI, PET, and CT scans.

### *Earmarked taxes*

**Many countries have imposed taxes on products deemed to be bad for health and have earmarked these tax revenues to the health sector.** Targeting products that are bad for health allows the policy to be introduced and the tax to be raised primarily as a public health initiative to curb consumption, and secondarily as a revenue collection measure. Earmarking taxes on cigarettes, alcohol, and more recently, sugar, has been used by many countries as a way of raising revenues for the health sector. In the Philippines, for example, the revision of the Sin Tax Law in 2012 and the increase in tobacco and alcohol taxes therein led to a doubling of sin tax revenues. In 2015, sin taxes comprised more than 1 percent of GDP (Kaiser, Bredenkamp, and Iglesias 2016). Much of this revenue was used to provide health insurance coverage to the poor, facilitating the increase in coverage from 5.2 million poor primary members in 2012 to 15.4 million in 2015.

**It is important to note, however, that even revenue earmarking does not guarantee that product-specific taxes would truly be additional to existing public spending on health.** In many countries, earmarking has not brought about a significant and sustained increase in the priority placed on health in overall government spending. Budgets are fungible; earmarking one revenue source may result in offsets through cuts in other sources (Cashin, Sparkes, and Bloom 2017).

**Currently, Vietnam collects and earmarks taxes as part of its tobacco control effort, but the amount and scope of use of the fund are limited.** In 2013, a Tobacco Control Fund was established under the Vietnam Tobacco Control Law, for financing tobacco control activities. The fund is collected through a surcharge on tobacco manufacturers and importers. Today, the compulsory contribution is 1.5 percent of the factory prices of all cigarette packs produced locally or imported into Vietnam. This is set to increase to 2.0 percent in 2019. While there are no published government data on the amount of tax revenue collected, one estimate put the figure at VND 300 billion per year in 2014 (Perucic 2016)—less than 0.001 percent of GDP.

**There are proposals under consideration in Vietnam to introduce and increase excise taxes on products that are deemed bad for health.** However, earmarking these tax revenues to the health sector has not been discussed as a fiscal policy option. In 2018, MOF Vietnam put forward a proposal to introduce a specific tax of VND 2,000<sup>16</sup> or possibly even VND 5,000<sup>17</sup> per pack of cigarettes. Preliminary estimates suggest that this would yield tax revenues of approximately 0.4 percent of GDP. There was also a proposal to impose a special consumption tax of 10 percent on a range of sugar-sweetened beverages, though this is no longer being considered. However, in the absence of discussions and a consensus on earmarking these funds to the health sector, these taxes would be channeled into a consolidated fund managed centrally along with other tax revenues. Indeed, from the perspective of fiscal policy, earmarking reduces the ability to reallocate funds as priorities change and could itself be inefficient. In sum, while there is potential to raise product-specific taxes in Vietnam, the revenue that would be collected is not being considered as a sector-specific tax and is thus not a viable source of fiscal space for health.

## 5. Prioritization of health within government spending

**The third key source of fiscal space for health is an increase in the share of government spending that goes to health.** Reprioritization implies that the government would decide to increase a sector's share of total government spending, preferably at the expense of spending on relatively less meritorious activities.

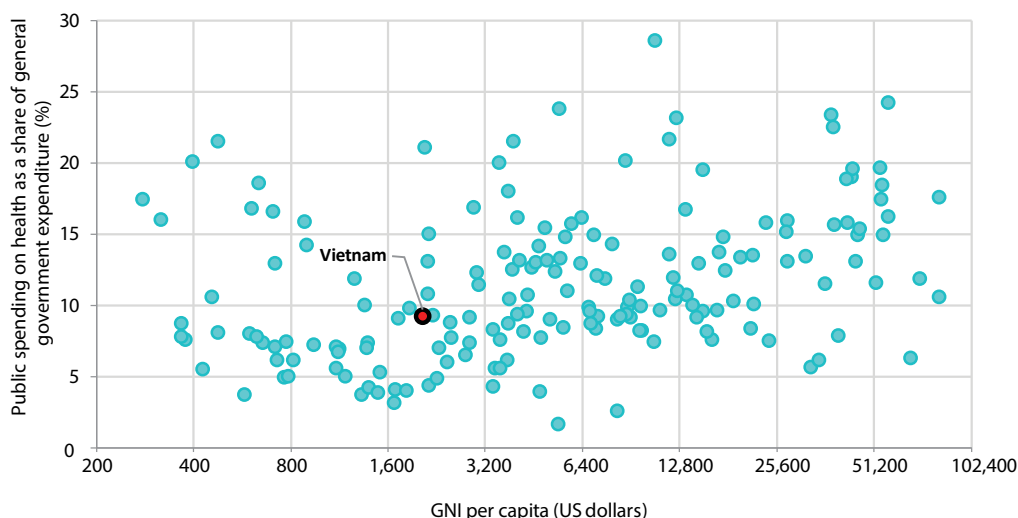
### *Limited scope for increases in the health share of government spending*

**Across countries, there is wide variation in the extent to which health is prioritized by governments.** Figure 28 shows a weak correlation between gross national income (GNI) and health share of government spending, with Vietnam about average relative to other countries at a similar level of income. In 2016, Vietnam spent 9.3 percent of its budget on health, slightly higher than the average share of 8.8 percent among LMICs (Table 2 in earlier section). Even after controlling for income, there are large variations across countries in prioritization of health expenditure. Prioritizing the health sector is thus a key intermediate factor in translating the impact of changes in the overall macrofiscal environment on public financing for health.

16 As reported by local media outlet: <https://customsnews.vn/ministry-proposes-tobacco-tax-increase-to-vnd2000-6718.html>.

17 Based on the World Bank's ongoing dialogue with the MOF, as of December 2018.

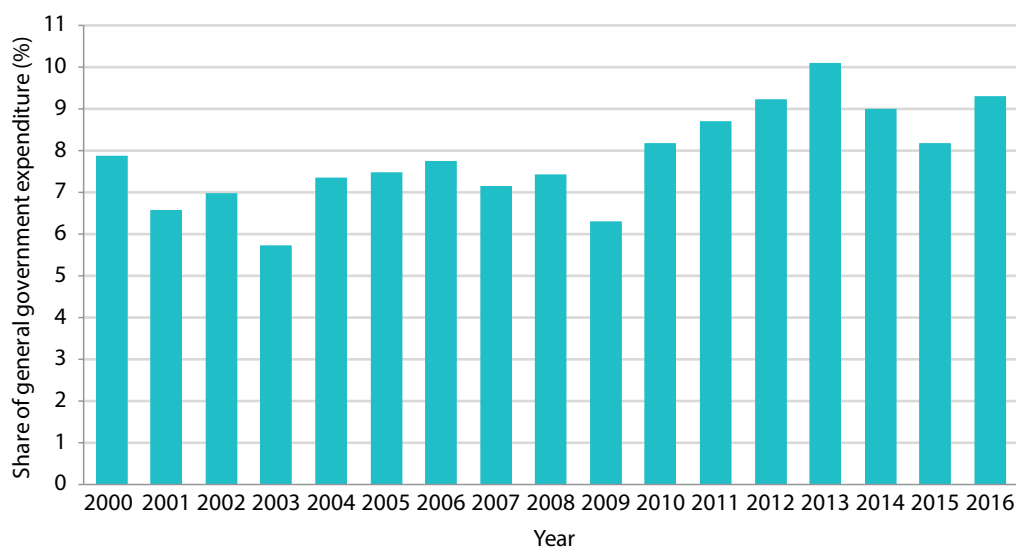
**Figure 28: Public Spending on Health as a Share of General Government Expenditure, 2016**



Source: World Bank (2018a); WHO (2018a).  
Note: X-axis is expressed in log scale.

**As a share of total government spending, public spending on health in Vietnam has been on a slight upward trend.** Public spending on health as a share of total government spending was approximately 7 percent in the early 2000s, increasing to 9 percent in more recent years (Figure 29). This trend has been quite weak, however, and in fact declined in some years (2014 and 2015).

**Figure 29: Public Spending on Health as Share of Total Government Spending, 2000–2016**

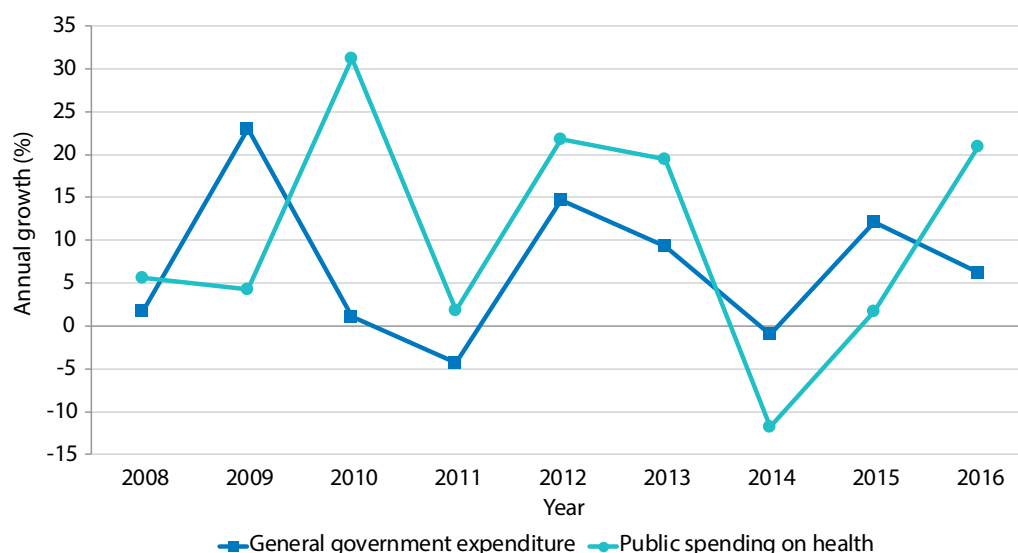


Source: WHO (2018a).

**Soft earmarking of expenditure to the health sector has likely contributed to the slight upward trend in health as a share of government spending—but not by much.** Resolution No. 18/2008/NQ-QH12, passed by the National Assembly, stated the objective that the health budget should increase faster than the rate of increase of general government spending. In practice, between 2008 and 2016, the average annual growth in real public spending on health was higher than the average annual growth in real general government

expenditure: 10.6 percent versus 7.0 percent (Figure 30). There were also more years in which the annual growth in public spending on health was higher than the annual growth in general government spending, yet this was not consistently the case. This suggests that the policy pronouncement is more of an aspirational target than a hard expenditure earmark.

**Figure 30: Annual Growth in General Government Spending and Public Spending on Health, 2008–2016**



Source: WHO (2018a).

**Going forward, government pronouncements suggest that health will continue to be prioritized in government spending.** Based on past trends, however, the magnitude of increase will not be significant. Resolution 20-NQ/TW (2017) set out the government’s direction for the health sector, including the stated objective that “to continue the level of investment in and prioritization of the health sector, the rate of increase in expenditure on health should be faster than that of the State budget”—a pronouncement similar to the one the government made in 2008. Based on past trends, then, it is possible that the health share of government spending will continue a slight upward trajectory, but there is no reason to expect that the annual increase in the health budget will exceed the aspirational target laid out in the resolution.

#### *A larger role for spending on health from local budgets, which are variable and uncertain*

**While government health spending (at the central level) appears to receive continued prioritization, there have also been indications that local budgets are expected to play a greater role in health spending.** While the state budget will continue to cover large capital expenditures, preventive care, and SHI contributions for the poor and other subsidized groups, its role in financing priority programs and curative care has already begun to decline.

**In line with the long-standing trend of fiscal decentralization, subnational governments have played an increasing role in financing health programs.** Local governments at the province, district, and commune levels are permitted to allocate additional funds to health from their local budgets. Decisions on how to allocate local budgets are variously made by Departments of Finance and Health and local committees, depending on the specific arrangements for decentralization in each province.

**There is no central report or database that records how much local governments spend on health, making it difficult to fully assess the prioritization of health in the government budget.** Fiscal decentralization has led to a system in which provinces are mandated to report on spending from funds allocated to them from the central budget but are not required to report to a central authority on local budget allocations and spending. Reporting lines follow local governance arrangements, leading to gaps in records of local spending on each sector. This makes it difficult to understand whether health is prioritized in a local budget and thus to assess whether reprioritization would open up additional fiscal space for health for each locality. There could be a significant variation in prioritization of health across provinces, depending on other spending needs in a given fiscal year.

## 6. The need for efficiency gains—doing more with less when fiscal space is limited

**This fiscal space assessment has shown that while there is likely to be increased demand for health services in Vietnam, there is also limited scope to increase government spending to meet the demand.** Rapid ageing and a shift in the disease burden toward noncommunicable and chronic conditions will increase demand and create cost pressures. As Vietnam's middle class grows, there will also be higher demand for access to new medical technology, as well as rising expectations that government deliver quality services and provide citizens with greater voice and choice. At the same time, medium-term fiscal risks, ongoing fiscal consolidation, and levels of health spending that are already on par with or above that of comparator countries mean that further increases of government spending on health are unlikely.

**With limited options to further increase fiscal space for health, achieving efficiency gains in the health sector is more important than ever.** Meeting the growing health needs and wants of the population will have to be achieved by getting more value for money from existing health spending rather than by increasing the overall fiscal envelope of resources for health.

**Broadly defined, efficiency implies allocating and utilizing resources in a way that maximizes outputs for a given level of inputs or attaining a given level of output with the least possible amount or cost of inputs.** Both allocative and technical efficiency are relevant. Allocative efficiency means that the right share of resources is being devoted to health care versus other goods in the economy, and within health care that the right share of resources is going to each health outcome or activity among all possible health sector outcomes and activities. Technical efficiency entails using the least amount of resources or the right combination of inputs to produce a given mix of goods and services. One can think of allocative efficiency as “doing the right thing,” while technical efficiency is about “doing things the right way” (Yip and Hafez 2015). An additional dimension of efficiency is to do things “in the right place” (World Bank 2017a), which highlights the importance of the appropriate level of care (for example, primary health facility versus hospital) in achieving efficient resource use.

**While there are many important areas of the health system where efficiency could be improved, in Vietnam the largest efficiency gains will be made through implementation of policies related to public hospitals.** A large share of total health spending in Vietnam (73 percent) occurs at hospitals. This is high compared to other countries in the region: 40 percent in the Philippines, 53 percent in Malaysia, and approximately 60 percent in Indonesia.<sup>18</sup> Increasing resources to the health sector in the current financing and service delivery arrangements, where the bulk of spending is at hospitals, will not be efficient. If Vietnam is to “avoid the trap of a high-cost health system” (World Bank 2017b), it must address certain problems, including provider payment mechanisms that do not incentivize efficient use of resources, an overreliance on hospital-centered service delivery at the central and provincial levels, inefficiencies in hospital investment decisions,

<sup>18</sup> In Indonesia, two-thirds of total health spending is for curative care, while more than 65 percent of SHI expenditures were for hospital-based inpatient and outpatient care.



policies and practices that result in excessive spending on pharmaceuticals, and weaknesses in monitoring and accountability mechanisms.

### *Reforming provider payment mechanisms*

**First, and arguably most importantly, to address inefficiencies in health spending, there must be reform of the fee-for-service payment mechanism used by Vietnam Social Security to reimburse for curative care.** Of all public spending on health, 40 percent is spent by VSS to reimburse health facilities, mainly hospitals, to cover recurrent spending on curative care. VSS uses the FFS payment method to reimburse for curative care. Unlike “mature” FFS systems, such as in the Republic of Korea and Japan, which give authority to the claims review agency to place strong controls on the conditions and rules for payment, Vietnam’s FFS mechanism sets few conditions for payment. Current treatment guidelines do not provide adequate detail to determine medical necessity. VSS is essentially obligated to pay for almost all services, diagnostic tests, and medicines prescribed or ordered by doctors. This unregulated FFS payment system has resulted in overservicing and cost escalation. These inefficiencies have been aggravated by the increase in administrative prices for curative care services to allow hospitals to increase service revenues in compensation for the decline in state subsidies.

**To address these inefficiencies, the MOH and VSS envisage transitioning to a diagnostic-related group (DRG) payment method of reimbursement for inpatient care.** Under a DRG payment method, providers are paid a fixed amount per episode of care in a particular diagnostic group (for example, uncomplicated appendicitis). Because providers can benefit financially by providing only the medically necessary items of care and by keeping the average cost per patient in a diagnostic group below the fixed reimbursement amount, the DRG system creates incentives for more efficient delivery of care. This reform, however, would not be a panacea. There may be specific diagnostic categories for which care cannot be standardized, and alternative payment methods would be required. Further, a reform toward DRGs for inpatient care would not resolve the inefficiencies in outpatient hospital care. Additional policies will need to be put in place to curb potential side effects of the DRG payment method, such as encouraging unnecessary admissions, cutting corners on quality of care, and upcoding (where health care providers classify patients as more complicated to receive a higher reimbursement rate). In general, however, a well-designed DRG payment mechanism that covers the majority of health conditions and diagnoses will incentivize providers to deliver more efficient inpatient care. A DRG road map and timeline should be an MOH priority.

### *Shifting care out of hospitals and keeping people healthy*

**A second important reason for inefficiency is the overreliance on hospital-based care.** The persistence of a hospital-centric model of service delivery in Vietnam, along with hospital overcrowding, weak primary care, and a lack of care coordination between hospitals and other providers, has been discussed in Section A of this report. In 2016, 52 percent of preventive care visits (mostly health checkups) and 50 percent of outpatient visits took place in hospitals (GSO Vietnam 2018a). Various policies create both demand- and supply-side incentives that perpetuate this. From the providers’ perspective, policies on autonomy for public service delivery units and income retention encourage hospitals to attract and retain patients to increase revenues, rather than refer them to other more appropriate levels of care. From the patients’ perspective, copayment policies impose little or no financial penalty for bypassing primary care services. There is also no requirement for empanelment—the practice of assigning and enrolling individuals with a primary care provider who would be the first point of contact and provide referrals to appropriate types and levels of care—thus leading to a lack in continuity of care for the individual across his or her lifetime.

**Keeping people healthy and out of hospitals would be a much more effective way of providing care and would be more efficient for the health system.** Insights from behavioral economics indicate that individuals tend to avoid or defer spending when the immediate benefits of their actions are not apparent or when an activity requires them to give up short-term benefit for a longer-term gain. This is also true for many health care decisions, such as eating more healthily, exercising regularly, spending on preventive care, and managing a chronic disease. There is thus an important role for public financing in health promotion and preventive care. Shifting the focus from spending in hospitals to larger investments in health promotion and preventive care can help keep people healthy and out of the health care system for as long as possible. Increasing the amount and share of state budget that is spent on health promotion and preventive care will require improvements in oversight and accountability of how these funds are allocated at both central and subnational levels.

**A new and more efficient orientation would entail shifting the delivery of low-complexity care out of hospitals to primary care and other intermediate units, while improving the integration of care across care settings.** Such a shift would typically lead to improved convenience for the patient and increased efficiencies in service delivery because primary and ambulatory care facilities tend to be lower cost even if the actual medical procedure remains the same. Bringing about these changes will require creating an enabling institutional, financial, and information environment to foster vertical care integration on the front lines of service delivery. Patients would also need to be assured that the shifting of care would improve the effectiveness, appropriateness, and convenience of their care and that they would be referred to higher-level care when needed. It would also likely require investment in the infrastructure, equipment, and competencies of staff at lower levels of care to ensure their ability to manage downshifted services without compromising quality and patient safety. MOH's prioritization of strengthening commune health station services (infrastructure, equipment, and competencies) in recent years, including through the development of an action plan to implement the Prime Minister's 2016 Grassroots Masterplan, is thus an important prerequisite for the implementation of policies associated with vertical integration and downshifting of services (especially for those services related to NCDs and chronic conditions).

### *Rationalizing capital planning*

**Third, greater efficiency is needed in investment decisions related to hospital infrastructure and equipment.** Beyond the cost of the initial investment, how hospitals are built predestines a large stream of operating and medical costs for decades to come. Similarly, decisions about which medical specializations, and thus which types of equipment should be purchased for which hospitals, will have important financial implications for the health system in terms of future maintenance costs, operating budget, and service fees (to be paid by health insurance or patients). Making the right decisions about capital investments, therefore, is important for health system efficiency and sustainability.

**Vietnam's current system of planning for capital investments in health is largely based on centrally planned norms and ratios, with limited consideration of their interaction with service planning and the changing health needs of the population.** This approach (for example, norms of hospital beds required per population) may fail to equilibrate supply and demand. Shifts in population structure and disease burden, as well as policies that increase patient demand for services at the hospital level and incentivize facilities to seek more public and private investment (for example, policies of fiscal decentralization, autonomy, socialization, and the FFS payment mechanism—all discussed above), necessitate a rethink of how hospital capital planning is done. Investment decisions related to hospital infrastructure and equipment need to take efficiency criteria into consideration, especially when they are financed mainly by public funds.

### *Improving pharmaceutical procurement and reducing irrational use of medicines*

**Fourth, while important reforms are under way, current policies and practices associated with pharmaceutical pricing and prescribing mean that the government and patients spend more on medicines than what is needed.** Pharmaceuticals accounted for about 33 percent of total health spending in 2014 (OECD and WHO 2016) and about 40 percent of SHI spending.<sup>19</sup> The drug formulary used by VSS places few restrictions on when a drug can be used and on its reimbursement by health insurance. Mirroring the decentralization of service delivery in Vietnam, pharmaceutical procurement was also decentralized to the provincial level, leading to large variations in prices for the same product.

**In response to the high level of spending on pharmaceuticals, the Government of Vietnam has undertaken several reforms in recent years to better manage the pharmaceutical sector.** In 2017, the National Centralized Drug Procurement Center was established under the MOH. Its mandate is to organize bids for procuring pharmaceutical products, conduct price negotiations for single-source innovator products, and establish a framework and set of guidelines under which subnational entities will conduct their own tendering processes, in accordance with the center's rules and regulations. The first national centralized round of bidding in December 2017 was said to have saved US\$21 million in state budget spending on health. This early outcome represents a step in the right direction to improve the efficiency of expenditure on pharmaceuticals in the public sector. In addition, VSS has piloted consolidated procurement of high-volume drugs.

**Nonetheless, more can be done to improve the efficiency of spending on pharmaceuticals, especially in the private retail sector.** A total of 83 percent of all pharmaceutical spending in Vietnam is in the private sector (OECD and WHO 2016). It is likely that much of this expenditure—and consumption—happens through the retail pharmacy sector but could also be the result of patients' OOP payments for medicines that are not available at public facilities or as part of treatment costs not covered by public funds, or for off-formulary medicines prescribed by doctors. Among the factors that contribute to high OOP expenditure on medicines are high levels of consumption of supplements and generic medicines (both over-the-counter drugs—for example, paracetamol and antibiotics—that can be obtained without a prescription), as well as irrational and overprescribing by doctors. Poor regulation of prescription and consumption of medicines can lead to problems such as inappropriate use and antimicrobial resistance. Improving patient education and awareness and regulating prescriptions can help curb excessive use of medicines.

### *Strengthening monitoring and accountability mechanisms*

**Finally, improving efficiency requires stronger monitoring and accountability mechanisms.** However, a high degree of decentralization has made it difficult to trace lines of accountability and monitor the performance of public sector agencies. The ability to hold public sector health facilities and health sector agencies accountable for meeting people's health needs can encourage improvements in service delivery and, in turn, client satisfaction. Achieving these objectives in an efficient and equitable way and being accountable for resources used is also an important part of public accountability and transparency. Decentralization of governance and financing mechanisms in Vietnam have, over time, contributed to high degrees of autonomy for both subnational governments and public service delivery units (for example, public hospitals). This mirrors the trend of fiscal decentralization, which has contributed to the fact that there are no centralized, consolidated accounts of local spending on health. Overall, decentralization has made it difficult to hold subnational health departments accountable for achieving national health goals.

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<sup>19</sup> Estimate is based on verbal communication with government representatives. No official data are available.





## D: KEY FINDINGS AND RECOMMENDATIONS

**Health spending in Vietnam has increased substantially over the past 16 years.** Today, Vietnam's spending on health is roughly what one would expect for a country at its level of development. Total health spending in Vietnam was 5.9 percent of GDP in 2016, comparable to countries at a similar level of income. This level of spending has, in fact, decreased in the past few years, from just under 7.0 percent of GDP in 2013.

**Broadly, the composition of health spending has not changed significantly.** Between 2000 and 2016, public spending on health and OOP spending have each been approximately 40 percent of total health spending. This is similar to the trend in other countries undergoing a health financing transition, where OOP spending increases at a faster rate than public spending on health. Unlike other countries, however, the high share of OOP spending has not gone hand in hand with high levels of impoverishing and catastrophic payments for health by households. Instead, financial protection against large health expenditures has improved over the years.

**While health financing in Vietnam has already undergone significant reform and there has been some good progress, changes in epidemiology, demographics, and increasing demand will continue to put upward pressure on health spending.** The role of public financing for health is ever more important to ensure sufficient coverage of essential services and to maintain adequate financial protection.

**Overall, however, additional fiscal space for health is limited in the medium term:**

- **There are moderate prospects for fiscal space for health from economic growth.** Vietnam's growth rate is projected to be high and steady in the medium term, at 6.5 percent per year. Trend data show that income elasticity of public spending on health was 1.7 (on average) from 2000 to 2016. That said, the high elasticity of public spending on health relative to income may not be easily sustained, given upcoming external risks and economic headwinds. A conservative estimate suggests that there could be a moderate increase in fiscal space for health—of approximately 0.4 percent of GDP—from economic growth alone.
- **Increases in aggregate spending are unlikely to occur, given the context of fiscal consolidation in Vietnam.** There are low prospects for increasing aggregate public spending. Public spending as a share of GDP has declined in the past few years and is expected to hold steady, at best. External financing for health has comprised a small share of total health spending for many years and will be phasing out for many priority health programs. There is also a high degree of uncertainty of domestic funding for priority programs at the same time as external sources of financing are being phased out, which may be a concern for these programs.
- **There are also low prospects for additional fiscal space from health sector-specific resources:**
  - **SHI membership** has increased substantially, and the government aims to achieve full population coverage by 2020. The average contribution rate may increase in the medium term, though there is little political will to raise it in the short term. However, given the lack of instruments for SHI to control excessive spending, any increases in revenue will quickly be absorbed by higher (and wasteful) expenditure. Reforms on the expenditure side will be necessary to improve efficiency of health sector spending.
  - **Taxes on tobacco and sugar-sweetened beverages** have been proposed, but it is unlikely that these revenues will be earmarked for health.
- **Prioritization of health in government spending is also not a good candidate for additional fiscal space for health.** With total health spending at 5.9 percent of GDP, increasing prioritization of health is unlikely, due to the perception that this level of spending is already sufficient. While there are aspirational targets for health as a higher share of government spending, trend data show that in practice government spending on health as a share of total government spending has not increased substantially over the past 16 years, inching up from an average of 7 percent in the early 2000s to 9 percent in more recent years. Local budgets are expected to play a greater role in public spending on health, but allocations therein can be variable and difficult to track.

**In this context, the largest source of (effective) fiscal space for health in Vietnam will be through improvements in health sector efficiency.** Additional resources will be better spent if Vietnam can first improve efficiency of existing spending on health. A more productive health sector—one that produces health rather than just consuming health care services—is also more likely to attract additional resources. The reform agenda should start in hospitals, where most of health spending currently occurs. A top priority is to reform the provider payment mechanism for inpatient care away from the current FFS model. However, the reform agenda quickly extends to a range of other care settings and health functions with which hospitals are closely intertwined. Indeed, improving efficiency will involve substantial reforms in service delivery arrangements, critical ancillary functions (for example, procurement), and governance and accountability.

**To achieve efficiency gains in the health sector, several reforms must be undertaken in the health service delivery system.** One of the biggest challenges in Vietnam's health service delivery system is the overuse of hospital-based care. This is a symptom of underlying problems, such as the fact that lower levels of care are

not yet sufficiently equipped to tackle people's health needs, and a lack of coordination among providers that gives individuals little confidence that they will receive appropriate and seamless care across facilities. Ensuring sustainability of financing for health thus depends largely on significant changes to the service delivery system. Raising more resources for health and reforming financing arrangements, alone, will not substantially change the trajectory and nature of health spending.

**Finally, improvements in recording, reporting, and analysis of data would aid our understanding of what is happening on the ground in the health sector.** While attempting to assess fiscal space for health in Vietnam, the authors encountered a nontrivial problem of differing accounts of health spending and wide gaps in data. Better availability of information would improve future monitoring of the health financing situation. The most significant gaps and associated recommendations include the following:

- **Absence of recording and reporting of public spending on health at the subnational level.** In the context of fiscal decentralization, this could account for a substantial amount of health spending that currently goes unrecorded and represents a gap in our knowledge of what is happening at the provincial, district, and commune levels. In turn, there is a gap in our knowledge of whether there are “unfunded mandates” in the health sector—that is, instances in which shifts in spending assignments and accountability have inadvertently resulted in no one being responsible for ensuring that a health objective or program receives sufficient funding. In the absence of proper recording, reporting, and analysis of local-level spending on health, it is also difficult to assess the adequacy of fiscal space for health at the subnational level. To this end, consolidating subnational budgets and reconciled actual spending at the central level (by the MOF or the MOH) would improve budget transparency and completeness and would inform us of local budget allocations and spending on health.
- **Lack of timely updates on the status of the SHI fund.** In line with policy intentions for SHI to play an increasingly important role in health financing, it will be important to have oversight on the fund balance to ensure adequacy and solvency and ensure that funds are being used effectively. Timely annual publications of statistics on coverage, revenues, expenditures, and uses of the SHI fund would enable more effective monitoring of this important source of financing for health.
- **Dearth of data on health spending in the private sector.** Given the large increases in OOP spending, it is important to improve our understanding of the magnitude and nature of private spending on health—including private investments, recurrent spending, and private health insurance activities.
- **Finally, in line with efforts to improve monitoring and accountability of public sector entities, the government could mandate reporting on high-level national targets on health financing.** These include the share of government health spending on preventive services and primary care, growth in the health share of government spending, and the SHI fund balance.



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