



DIRECTIONS IN DEVELOPMENT
Human Development

Moving toward Universal Coverage of Social Health Insurance in Vietnam

Assessment and Options

Aparnaa Somanathan, Ajay Tandon, Huong Lan Dao,
Kari L. Hurt, and Hernan L. Fuenzalida-Puelma



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Foreword

Globally, there is growing momentum in support of the objectives of Universal Health Coverage (UHC). Vietnam is one of the countries highlighted by the World Bank and others as having fully adopted UHC as a national strategy and as having made strong progress toward its goal of affordable access to needed and quality health services. Before December 2012, when the United Nations General Assembly called on governments to “urgently and significantly scale-up efforts to accelerate the transition toward universal access to affordable and quality healthcare services” and even before 2005, when the World Health Assembly called on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them,” Vietnam had already demonstrated its commitments to these goals even when it was a low-income country. The path that Vietnam has taken has many good practice examples in making equitable progress toward UHC, which this book and other World Bank research hopes to share with the world. In particular, I would highlight the focus at an early stage on including the poor and other vulnerable groups in the country’s financial mechanism for providing access to health services while at the same time ensuring that there is an expanding network of health service providers in the country. Another good practice example was merging different government programs under a unified national health insurance system when it passed a framework law in 2008. Still, Vietnam has set ambitious targets for itself to make further progress and the National Assembly plans to review the performance of the current health insurance system in order to make some adjustments in 2014 and consider other adjustments down the line. This has served as the main motivation of this book.

As set out by the Prime Minister in the Universal Health Coverage Masterplan (2012), Vietnam wants to go from nearly 60 percent (2010) participation in the social health insurance (SHI) system to at least 70 percent by 2015 and 80 percent by 2020 and to reduce out-of-pocket expenditure from about 57 percent (2010) to less than 40 percent of total expenditures by 2015. When the Minister of Health, Dr. Nguyen Thi Kim Tien, saw the challenges that the health system faced toward achieving its goals of Universal Health Coverage and she anticipated the legislation review by the National Assembly, she approached the World Bank and a few other key development partners active in health financing and health insurance policy discussions in Vietnam. This led to a process, coordinated

by the World Bank, to analyze the performance of the current system, identify the key challenges to achieve the nationally agreed targets, and address some of the specific questions by the health policy makers and legislators as to how to address some of these challenges in the short term as well as set the direction for reforms needed in the longer term. I would like to emphasize that this book is a culmination of this process, which had many different contributors and many steps along the way for consultation and discussion. While this book is ultimately the product of the World Bank and the responsibility for the recommendations rests with the World Bank, it would not have been possible without the contributions and active commitment of the World Health Organization (WHO), UNICEF, and the Rockefeller Foundation as development partners, the Ministry of Health (particularly the Health Insurance Department and the Department of Planning and Finance) and the Vietnam Social Security agency as counterparts, and the local policy research institutes of Health Strategy and Policy Institutes and the Center for Health System Research of the Hanoi Medical University. In many ways this process exemplifies what the World Bank strives to deliver to countries in bringing global knowledge, but also facilitating an in-country process of analysis and debate.

The book goes into detail on the many challenges that Vietnam faces to deliver on its commitment to achieve affordable access to needed and quality health services for its citizens. Globally, there is not a single path that Vietnam can follow. However, there are many lessons, including on expanding access to the “missing middle” population, which currently is not included in the national health insurance system, increasing the efficiency and equity of current health expenditures in order to provide more effective health services to those who are currently covered, and addressing the institutional constraints to effective management of the health insurance system. Many low- and middle-income countries continue to look up to Vietnam and will be watching Vietnam’s example of how these problems are addressed. The challenges are not easy, but Vietnam’s commitment to achieve Universal Health Coverage and its track record to date bode well for the future.

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Abbreviations

ADB	Asian Development Bank
ALOS	average length of stay
(B)BP	(basic) benefits package
CHS	commune health stations
CPI	consumer price index
CSMBS	Civil Servants' Medical Benefit Scheme (Thailand)
DoH	Department of Health
DRG	diagnostic related group
EAP	East Asia and Pacific
EML	Essential Medicines Lists
EU	European Union
FFS	fee-for-service
FONASA	Fondo Nacional de Salud (National Health Fund, Chile)
GDP	gross domestic product
GHE	Government Health Expenditure
GNI	gross national income
GoV	Government of Vietnam
HCMC	Ho Chi Minh City
HIC	health insurance card
HIL	health insurance list; Health Insurance Law
HIRA	Health Insurance Review and Assessment Service (Republic of Korea)
HIRL	Health Insurance Reimbursement List
HIV	human immunodeficiency virus
HMU	Hanoi Medical University
HRH	human resources for health
HSPI	Health Strategy and Policy Institute
HTA	health technology assessment
IB	innovator brand

IEC	information, education, and communication
IMF	International Monetary Fund
INN	International Nonproprietary Names
IPP	Individually Paying Program (Philippines)
IRP	international reference prices
IT	information technology
KAP	Knowledge, Attitudes and Practices
MoF	Ministry of Finance
MoH	Ministry of Health
NCD	noncommunicable disease
NCMS	National Cooperative Medical Scheme (China)
NHA	National Health Accounts
NHIS	National Health Insurance Service (Korea, Rep.)
NHSO	National Health Security Office (Thailand)
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket (payment)
PPP	public-private partnership
SHI(A)	social health insurance (agency)
SSS	Social Security Scheme (Thailand)
STI	sexually transmitted infection
TB	tuberculosis
UC	universal coverage
UCS	Universal Coverage Scheme (Thailand)
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VHLSS	Vietnam Household Living Standards Survey
VLSS	Vietnam Living Standards Survey
VND	Vietnam dong
VSS	Vietnam Social Security agency
WB	World Bank
WHO	World Health Organization

Overview

Over the past two decades Vietnam has made enormous progress toward achieving universal coverage (UC) for its population. In the early 1990s, out-of-pocket (OOP) payments accounted for over 70 percent of total health financing, with detrimental impacts on equity and financial protection. Over the next two decades, a series of incremental reforms saw coverage expand to different groups of the population. In 2009, the Government of Vietnam (GoV) passed the Law on Social Health Insurance to create a national Social Health Insurance (SHI) program, making SHI the primary mechanism for achieving UC. GoV commitment to the goal of UC is clearly very strong with rapid progress having been made in a single payer design and in increasing enrollment rates and budgetary resources. Recognizing that UC and associated increases in the demand for health care would put pressure on the delivery system, GoV has also invested substantially in the supply-side infrastructure and human resources for health in recent years.

Significant challenges remain, however, in terms of improving equity with continuing low rates of enrollment. Enrollment rates remain low even among those for whom enrollment is compulsory—such as formal sector workers—and despite large increases in the partial subsidy extended to the near-poor. Vietnam's SHI program is still characterized by a high degree of fragmentation in the pooling of funds. As a result, risk pooling is limited. The poor subsidize the rich, and poorer provinces subsidize richer provinces.

Ensuring financial protection also remains an elusive goal. In 2010, when nearly 60 percent of the population was already enrolled, the OOP share of total health spending was 57.6 percent. High OOP payments leave households exposed to financial risk, including that of impoverishment, deter utilization, and result in inequitable health-seeking behavior that is correlated with ability to pay rather than to need.

The Master Plan for Universal Coverage prepared in 2012 by the Ministry of Health (MoH) directly addresses both these deficiencies in coverage. It sets clear targets for expanding coverage from 2013 to 2020 as follows: attain at least 70 percent and 80 percent enrollment rates by 2015 and 2020

respectively, and reduce the OOP share of total expenditures to less than 40 percent by 2015.

The objective of this report is to assess the implementation of Vietnam SHI and provide options for moving toward UC, with a view to contributing to the law revision process. It begins by analyzing progress to date on the two major goals of the Master Plan. The report next assesses Vietnam's readiness to meet these goals, the challenges it will face in achieving UC, and key reforms needed to overcome those challenges. It does so through a health financing lens, focusing on how resources are mobilized, pooled, and allocated, and how services are purchased. The report also examines the stewardship of financing—that is, the organization, management, and governance of SHI as it has direct implications for achieving UC. The report ends by pulling together the recommendations in the form of an implementation road map.

Expanding breadth of coverage, particularly for those hard to reach groups such as the near-poor and informal sector would require substantially increasing general revenue subsidies and fully subsidizing the premiums for the near-poor. This strategy is administratively more efficient and an effective means to address adverse selection. Providing financial incentives to encourage family enrollment and introducing measures to enforce enrollment compliance among the mandated enrollment groups would further increase enrollment rates. Strengthening the demand side is also key.

High enrollment rates would, however, have little impact on financial protection and equity if OOP costs remain high. OOPs are persistently high due to a combination of: (a) increases in coverage-related utilization and/or spending; (b) cost-recovery by providers to make up shortfalls in Vietnam Social Security (VSS) reimbursement rates; (c) higher prices and/or provision of unnecessary services; and (d) supply-side constraints. Tackling this problem and significantly reducing the OOP burden on households requires system reforms related to the design of the benefits package (BP), the mix of provider payment mechanisms, and supply-side investments. In the short to medium term, strengthening the implementation of the copayment policy, further reducing copayments for the poor, introducing catastrophic cost coverage and shifting patients' preference toward lower-cost generic drugs would contribute to stemming the growth of OOPs.

Achieving UC will require sustained efforts to improve efficiency in the system, and gain better value for money from available budgetary resources; without these efforts, any further progress toward UC would be financially unsustainable. Under key assumptions about GDP growth, utilization rates, and unit costs, *at least* an additional 0.8–1.7 percent of GDP will be needed for health to meet the goals set out in the Master Plan. Vietnam can expect additional fiscal resources for health of about 0.4 percent of GDP by 2015, given projections of macroeconomic growth rates and despite the high-income elasticity of government expenditures on health. Clearly, only a portion of the total projected costs of expanding coverage can be met through

additional fiscal outlays. Cost containment and mobilizing resources through efficiency savings will be critical for making further sustained progress toward achieving UC.

There is considerable scope for improving efficiency by reforming current arrangements for pooling funds, and resource allocation and purchasing. Fragmentation in the pooling of funds gives rise to unnecessary administrative and transactions costs. Inefficiencies in resource allocation and purchasing arrangements include: (a) an overly generous benefits package; (b) provider payment mechanisms and the mix of incentives facing providers which result in an oversupply of services; (c) high prices, overconsumption, and inappropriate use of pharmaceuticals; and (d) the structure and incentives embedded within the delivery system. Underlying all of these inefficiencies is a set of distorted incentives facing providers—a consequence of the resource allocation and provider payment mechanisms as well as the market liberalization policies in the health sector in recent years. This report proposes several short- to medium-term health financing reforms that can help generate efficiency savings.

The organization, management, and governance of SHI are fragmented and often dysfunctional. This scenario makes SHI implementation slow, complex, and inefficient. To meet GoV's policy goals as set out in the Master Plan and move rapidly toward UC, the present institutional setting for SHI needs to be assessed and changed. The report proposes several short- to medium-term reforms for strengthening the organization, management, and governance of SHI.

The following is a summary of the key recommendations contained in this report, as well as the specific reforms and measures needed to implement the recommendations. The recommendations focus on the main UC-related goals of: (a) expanding the breadth of coverage; (b) increasing equity and financial protection; and (c) financing UC in a sustainable manner. A fourth cross-cutting goal is to strengthen the organization, management, and governance of SHI.

The reforms and measures needed are organized into three groups as shown in tables O.1, O.2, and O.3, and separate out the short-term and medium-term proposals in each case:

- *legislative and regulatory measures;*
- *health systems strengthening measures; and*
- *data and information gaps that need to be addressed.*

Table O.1 Legislative and Regulatory Measures

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
(1) To expand breadth of coverage, specifically to achieve the enrollment goals set in the Master Plan:		
a. Incrementally raise the general revenue subsidy for near-poor enrollment;	<ul style="list-style-type: none"> • Establish the state’s obligations to subsidize SHI contributions for individuals or households, specifying increases in the subsidies to 100 percent (by 2020) for groups such as the near-poor as a State budget commitment. • Delegate to Ministry of Finance (MoF)/MoH/VSS regulations the determination of the level of the subsidy: <ul style="list-style-type: none"> – Issue regulations to gradually increase the subsidy, taking into account macroeconomic conditions. 	
b. Strengthen the demand side: enhance information, education, and communication (IEC) about health insurance;	<ul style="list-style-type: none"> • State that SHI is an entitlement and the SHI Card a right in the Law: <ul style="list-style-type: none"> – Issue regulations to issue SHI cards with minimal bureaucracy. 	
c. Provide financial incentives to encourage family-based enrollment; and	<ul style="list-style-type: none"> • Define households/families, specify the subsidies, and mandate the enrollment of families in SHI in the revised health insurance list (HIL): <ul style="list-style-type: none"> – Issue joint MoF/MoH/VSS regulation on the subsidy for family enrollment where the household contribution rate for the near-poor would be subsidized in full or partially. 	<ul style="list-style-type: none"> • Define tax incentives for employers to encourage enrollment for families, which may also need amendment to tax laws: <ul style="list-style-type: none"> – Issue joint MoF/MoH/VSS regulation on employer subsidy for family rates for employees below an income threshold (to be defined)—a subsidy that could be tax deductible.
d. Enforce enrollment compliance in the mandatory enrollment group, particularly formal sector workers.	<ul style="list-style-type: none"> • Establish and strengthen VSS’s responsibilities for enrollment and enforcement of mandatory enrollment and provide VSS with powers to issue and enforce penalties. 	

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Table O.1 Legislative and Regulatory Measures (continued)

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
(2) To improve equity and financial protection, specifically to achieve the OOP reduction goals set in the Master Plan:		
a. Strengthen implementation of the copayment policy, including grievance mechanisms; make the policy more transparent and easy to understand; improve enforcement of the policy; ensure patients are well informed and able to access appropriate grievance mechanisms;	<ul style="list-style-type: none"> • Delegate authority for regulating procedures, rates, collection, and use of copayments to MoH/VSS: <ul style="list-style-type: none"> – Issue joint MoH/VSS regulation on copayments including: (a) copayment policy; (b) required posting of copayment policy in all health care establishments; and (c) sanctions for providers that do not comply. 	<ul style="list-style-type: none"> • Establish in the Law a conflict resolution system at VSS with regulations on grievance procedures.
b. Further reduce or waive copayments for the poor and vulnerable groups such as ethnic minorities;	<ul style="list-style-type: none"> • Strengthen current provisions in the Law to reduce or waive the copayments policy. 	
c. Introduce catastrophic cost coverage; and	<ul style="list-style-type: none"> • Introduce catastrophic coverage and give mandate to MoH/VSS to develop it by 2016, and delegate to MoH/VSS the development of implementing regulations once catastrophic coverage is approved: <ul style="list-style-type: none"> – MoH/VSS should develop regulations specifying how the caps would be varied by income. 	
d. Rationalize and cost out the benefits package, and ensure that it is fully financed by VSS reimbursements and subsidies so as to avoid the need for balance billing; introduce provider payment and purchasing reforms which will be instrumental in monitoring provider behavior, controlling balance billing, and curbing the practice of overprescribing drugs and overproviding services.	See Recommendations 3c-3f below.	See Recommendations 3c-3f below.

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Table O.1 Legislative and Regulatory Measures *(continued)*

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
(3) To finance UC in a sustainable manner by mobilizing resources in a fiscally sustainable manner, reducing fragmentation in pooling, and strengthening resource allocation and purchasing:		
a. Mobilize new revenues through:		
i. Introduction of sin taxes, especially on cigarettes;	<ul style="list-style-type: none"> Reference excise taxes on tobacco and alcohol that would be introduced or raised following changes to relevant tax laws, with clear indication that the income generated by these taxes will be used to finance SHI. This would also have to be included in tax legislation and regulations. 	<ul style="list-style-type: none"> Further strengthen legislation on sin taxes.
ii. Gradually increasing the premium rate; and	<ul style="list-style-type: none"> The Law already provides for this. <ul style="list-style-type: none"> Issue regulations to gradually increase the contribution rate taking into account efficiency gains in the health sector, economic outlook, and stakeholder views. 	
iii. Increasing the number of contributory SHI members by enforcing enrollment compliance.	See Recommendation 1d above.	See Recommendation 1d above.
b. Reduce fragmentation in the pooling of funds by:		
i. Consolidating risk groups further by reducing the number of insurance categories;	<ul style="list-style-type: none"> Reduce the number of insurance categories listed in the SHI Law, ideally reducing to two categories: members in the contributory regime or subsidized regime. 	
ii. Transferring the pooling function from the 63 provincial VSS to the national VSS/SHI agency (SHIA);		<ul style="list-style-type: none"> Revise the Law to transfer the pooling function from the 63 provincial VSS to the SHIA.
c. Rationalize and cost out the benefits package;	<ul style="list-style-type: none"> Clearly establish the responsibilities for benefits package design and implementation: MoH for clinical content, and relevant technical agency, as well as VSS and MoH for determining the cost effectiveness and implementation costs. Establish the concept that health care goods and services to be financed by SHI are those included in a basic package of goods and services. 	<ul style="list-style-type: none"> Establish or strengthen VSS's implementing powers to include: (a) effective regulatory functions; (b) participating in defining the benefit package and pricing of services; (c) billing control with billing regulations and monitoring compliance of billing; and (d) carrying out inspections and imposing penalties.

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Table O.1 Legislative and Regulatory Measures (continued)

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
<p>d. Strengthen the provider payment system by:</p> <p>i. harmonizing the appropriate mix of payment systems; and</p> <p>ii. ensuring that the payment systems are more strategically aligned to key health system goals;</p> <p>e. Defragment the procurement of, and payment for, pharmaceuticals; centralize the selection of drugs for the reimbursement list; introduce framework contracting for high-volume drugs; and introduce price-volume contracts for paying providers; and</p> <p>f. Improve control of pharmaceutical prices.</p>	<ul style="list-style-type: none"> • Institute a transparent process for determination/revision of the benefits package: • Issue a revised joint MoH/VSS regulation on the benefits package specifying the processes, and criteria for selection into benefits package (see more details in chapter 9). • Revise the regulation on payment systems based on the findings of the Provider Payment Diagnostic Assessment. Delegate to MoH/VSS regulations details on provider payment mechanisms: <ul style="list-style-type: none"> – Issue joint MoH/VSS comprehensive regulation on provider payment mechanisms including revision of: (a) capitation payments with new base rate and adjustment coefficients; and (b) fee-for-service (FFS) by streamlining the fee schedules, and bundling services. • Review current policies and regulations on pharmaceuticals and the current state of importing/ manufacturing, storage, distribution, and pricing. • See Recommendation 3d above on bundling services. • Same as above. 	<ul style="list-style-type: none"> • Incorporate clinical protocols, clinical governance, and the evaluation of benefits packages, including clear institutional responsibilities for each. • Continue to revise regulations on payment systems based on the findings of the Provider Payment Diagnostic Assessment. • Establish or strengthen VSS’s implementing powers to include: (a) establishing the purchasing policy and contracting mechanisms; (b) purchasing health care goods and services; (c) drafting and issuing contracts; (d) negotiating with suppliers; (e) processing claims and managing payment systems; and (f) carrying out inspections and imposing penalties. • Revise the regulations relating to procurement and pricing mechanisms. • Same as above.

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Table O.1 Legislative and Regulatory Measures *(continued)*

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
(4) To strengthen organization, governance, and management of SHI:		
a. Define the objectives of UC more clearly, and revise and define the roles and mandates of key agencies;	<ul style="list-style-type: none"> • Introduce a new article in the revised SHI Law specifying: (a) SHI as the financial instrument to achieve UC; and (b) the objectives of the SHIA. • Delegate effective regulatory and monitoring powers to VSS within the overall SHI supervision by the MoH. • Revise and define the roles and mandates, responsibilities, and authorities of key agencies (MoH, VSS) in SHI to reduce institutional fragmentation and dual mandates. VSS needs clearly defined functions that are in line with the SHI functions (beneficiaries enrollment and registration; collection; pooling; purchasing, payment of providers and suppliers); and implementing powers. MoH would retain its overall policy and regulatory role, regulation of providers and suppliers, as well as provision of public health services, to minimize conflict of objectives. 	
b. Strengthen the organization of SHI by putting in place a specialized SHI Division and eventually SHIA;	<ul style="list-style-type: none"> • Provide for VSS to manage SHI with a specialized SHI Division until an SHIA is established. • Provide for an SHI Director to be appointed by the government to manage the VSS/SHI unit or department. Alternatively, legislate for the VSS Management Council to appoint the SHI Director. 	<ul style="list-style-type: none"> • Establish a stand-alone SHIA as specified in the Law.

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Table O.1 Legislative and Regulatory Measures *(continued)*

<i>Key recommendations</i>	<i>Short term (2014–15)</i>	<i>Medium term (2016 and beyond)</i>
c. Strengthen SHI management arrangements; and		<ul style="list-style-type: none"> • Provide for the VSS/SHI Division to have an SHI Board as the SHI decision-making and supervisory body, with proper representation. Alternatively, have the VSS Management Council establish an SHI Management Committee as the managing council for SHI. • Provide for the Director of SHI to report to the SHI Managing Committee and perform as its Ex Officio Secretary (or by reason of the position) and participate in the Board with voice and no vote.
d. Strengthen SHI governance and accountability by clearly specifying financial accounting arrangements, conflict resolution arrangements, and penalties.		<ul style="list-style-type: none"> • Require VSS to have separate accounts for SHI to avoid cross-subsidizing from pensions and social assistance. • Establish within VSS an SHI conflict resolution system to address complaints by providers, suppliers, and beneficiaries: <ul style="list-style-type: none"> – Issue joint MoH/VSS/Ministry of Justice regulations on grievance procedures. • Require VSS to include information on complaints and conflict resolution in Annual Reports. • Clearly define the situations that merit penalties, the level of penalties, and the authority to impose and enforce penalties (should be VSS): <ul style="list-style-type: none"> – Issue revised joint MoH/VSS regulation on strict penalties for noncompliance with health insurance laws and regulations. • Require that State and external auditors audit VSS SHI accounts annually, and prepare and publicize annual reports on SHI funding, coverage including enrollment and services financed and provided, and other matters.

Table O.2 Health Systems Strengthening Measures*Medium- to long-term reforms*

- Strengthen availability and quality of primary care services to deliver the primary care benefit package under the new payment mechanisms.
- Create/strengthen a cadre of primary health care professionals: modernize the training curriculum, retrain existing staff, create new cadre, and provide the right incentives to work in poor, rural areas.
- Strengthen quality of care at all levels of the system through licensing and accreditation, issuing of clinical practice guidelines (including for drugs), and continuous quality assurance. This includes addressing the problem of irrational drug use through clinical practice guidelines.
- Good management information systems (MIS) are needed to: (a) effectively monitor compliance by enrollees; (b) avoid duplicate enrollment by those who fall into multiple categories; and (c) provide for the portability of insurance.

Table O.3 Data and Information Gaps to Be Addressed*Short term (2014–15)*

- Simulations and analyses to set the premiums and subsidies for family enrollment at appropriate levels: how much the premium should increase by, what increase in the premium would be affordable for both GoV and employers, and its impacts on wages and employment.
- Actuarial costing and projections for SHI, including more precise estimates of the behavioral responses of both consumers and suppliers to changes in insurance coverage.
- Expand the evidence base on costs and cost effectiveness to support the above process. UNICEF is already supporting efforts to develop and cost a package of interventions for women and children.
- Initiate pilots of portable insurance policies in large cities like Hanoi and Ho Chi Minh City.
- Analyze successful primary care models from other countries that are relevant to Vietnam.

Medium term (2016 and beyond)

- Survey providers and patients to get a better understanding of the extent of balance billing practices.
- Conduct a needs assessment and cost impact of the drugs on the Health Insurance Reimbursement List (HIRL), using data from other countries with advanced health technology assessment (HTA) systems.
- Analyze the distribution of hospital revenues to staff through pay-for-performance, social mobilization, public-private partnerships, and other mechanisms.
- Source data on quality of service provision.
- Source data on the provision of unnecessary care at facilities.

Moving toward Universal Coverage? Assessing the Way Forward

This introductory chapter describes the context in which this assessment was initiated and sets out the objectives of the assessment. It also defines universal coverage, the analytical basis for this report, and provides a road map for the report.

In the late 1980s, Doi Moi (renovation policy) led to a series of policy shifts in the health system. Central among these were the liberalization and privatization of the health care and pharmaceuticals markets, and the introduction of official user fees at public health facilities. These policy shifts meant that, by the early 1990s, out-of-pocket (OOP) payments accounted for over 70 percent of total health financing.

To address the growth in resultant OOP payments and associated problems of financial barriers to access, the government issued several policies aimed at expanding coverage throughout the 1990s and 2000s, particularly for the poor and other vulnerable groups. A series of voluntary noncommercial health insurance schemes were piloted between 1989 and 1992. The most critical policy change came in 2002, when the Government of Vietnam (GoV) decided to introduce the Health Care Fund for the Poor (including ethnic minorities).¹ Under this policy, the poor could either be enrolled in health insurance, or providers could be reimbursed for providing free health services to the poor. The latter option led to administrative difficulties, and in some cases adverse selection as providers registered the very sick in order to increase reimbursement levels. In 2005, Decree No. 63 was issued—it mandated full subsidizing of premiums for the poor, making enrollment mandatory for this group.

The Health Insurance Law (HIL) that was passed in 2009 created a national Social Health Insurance (SHI) program. The HIL stipulates that all children under six years of age, the elderly, the poor, and the near-poor would be compulsorily enrolled. Under the HIL, the government is responsible for fully subsidizing the health insurance premiums for children under six, the elderly, the poor, and ethnic minorities, and for partially subsidizing premiums for the

near-poor and students. The HIL also provides a road map for enrolling all other groups of the population.

Universal coverage (UC) can be an elusive concept and has been defined in many different, albeit related ways in recent years. In its simplest terms, UC is about three objectives: (a) equity (linking care to need, and not to ability to pay); (b) financial protection (ensuring that health care use does not lead to impoverishment); and (c) effective access to a comprehensive set of quality services (ensuring that providers make the right diagnosis and prescribe a treatment that is appropriate and affordable; Wagstaff 2013). In the context of assessing options for moving toward UC in Vietnam, this needs to be overlaid with a fourth objective: to ensure that the financing needed to achieve UC is mobilized in a fiscally sustainable manner, and is used efficiently and equitably.

SHI is the principal mechanism for achieving UC in Vietnam, although by no means the only one. Through key decisions taken during the 1990s and the passing of the HIL in 2009, Vietnam has made a policy choice to finance health care primarily through SHI. Thus, any assessment of Vietnam's path to UC must inevitably assess the implementation of SHI in Vietnam, and provide recommendations for strengthening this mechanism. There are several other programs—vaccination campaigns, certain maternal and child health interventions, and nutrition, public health, water and sanitation programs—that are funded by direct budget subsidies outside of SHI. Expanding and maintaining coverage of these programs are just as important for achieving UC. The focus of this report will, however, be on the expansion of coverage through SHI, given the request from the GoV that provides the motivation for this report (as explained below). Appendix A provides a brief overview of the Vietnam health system.

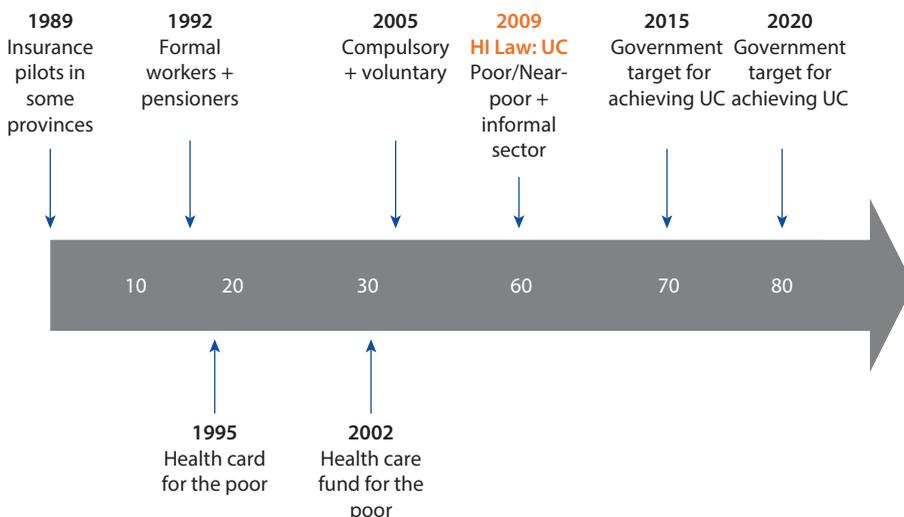
Major Achievements and Shortcomings on the Path to Universal Coverage

Progress toward UC in Vietnam is remarkable for its rapid increase in enrollment rates and single-payer design of the SHI system. Over the past two decades, coverage (as measured by enrollment rates) has increased significantly, reaching more than 64.8 percent of the population by 2011. Figure 1.1 shows the development of SHI in Vietnam over the past 20 years and the UC targets for 2014 and 2020. In principle, SHI in Vietnam involves a single payer and a single pool with a unified benefits package. The HIL of 2009 was an important step on the path to UC because it integrated the existing health insurance program with the program for the poor, thus bringing together all groups into one program. This put Vietnam ahead of several other countries in the region such as China and Indonesia, whose SHI schemes involve multiple payers.

The GoV has committed significant budgetary resources to expanding coverage—with recent expansion financed largely through tax subsidies to cover insurance premiums for the poor, near-poor, and other vulnerable groups. Figures 1.2 and 1.3 show trends in health expenditure and financing from 2001 to 2011. As SHI expanded rapidly during 2006–10, the government share of SHI

Figure 1.1 Evolution of Social Health Insurance in Vietnam (1989–2020)

Percent



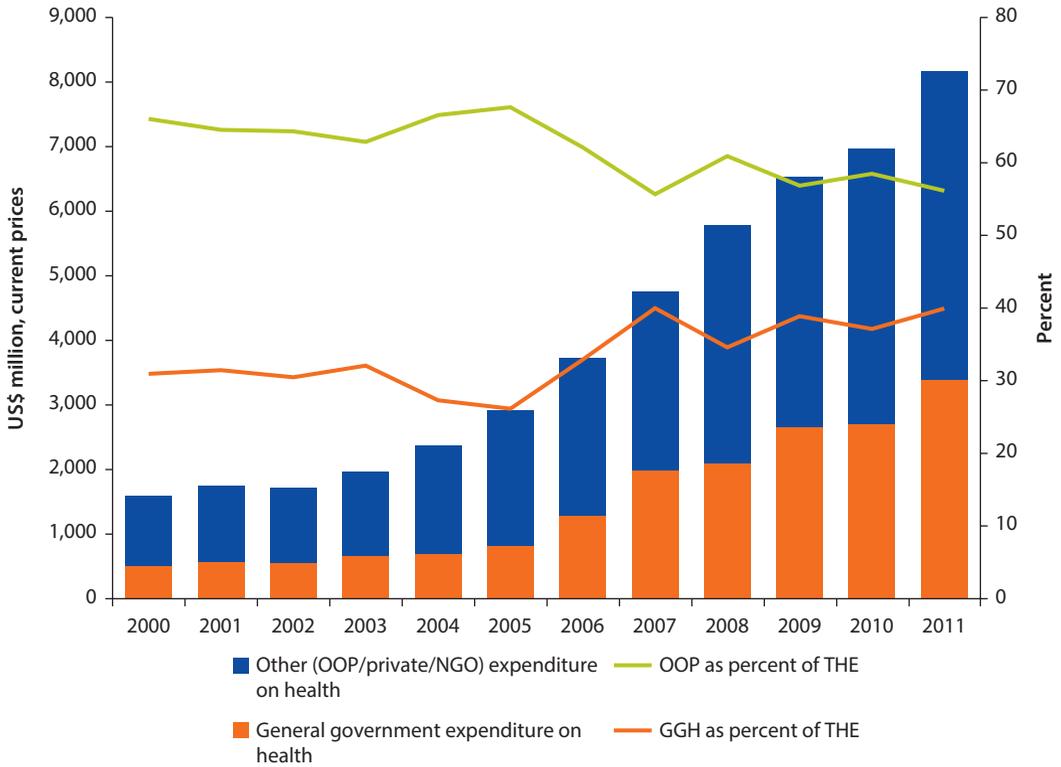
Note: This figure shows the proportion (%) of the population that was/is covered—defined as enrollment in health insurance schemes. The GoV targets for 2014 and 2020 are from the GoV’s road map. Prior to the Doi Moi reforms, health care was free of charge at the point of service delivery and fully subsidized by the state, but with limited depth of service coverage and of poor quality.

financing rose from 29 percent to almost 50 percent (figure 1.3). Government health spending increased at a faster rate than economic growth from 2006 to 2010. On the other hand, contributions from employers, employees, and individuals have declined as a share of total revenues. Vietnam, like other countries in the region, has recognized that expanding coverage based on contributory mechanisms alone is not feasible in a context where a large share of the population is still poor, in the informal sector, or both.

Progress toward meeting key UC goals such as equity and financial protection has been slow. Enrollment rates are still quite low among the near-poor and other groups whose premiums are substantially, if not fully subsidized. Enrollment compliance is weak among other groups for whom enrollment is mandatory. In addition, enrollment in SHI does not always translate into effective coverage through SHI. Utilization rates among the poor and other vulnerable groups continue to lag behind—hampered by poor knowledge, a lack of confidence in district hospital services, and other nonfinancial barriers to access. OOPs are high and expose households to financial catastrophe and impoverishment. They pose financial barriers to access and result in large inequalities in utilization between the poor and the rich, ethnic minority populations, and others.

SHI is characterized by a high degree of fragmentation in the pooling of funds, which is detrimental to both equity and efficiency. Although the HIL merged all of the insurance schemes in principle, in practice there are 63 provincial pools covering populations ranging in size from 300,000 to 4.8 million

Figure 1.2 Health Expenditure Trends and Composition (2000–11)



Source: Calculations using data from the WHO National Health Accounts—Vietnam (WHO 2013).

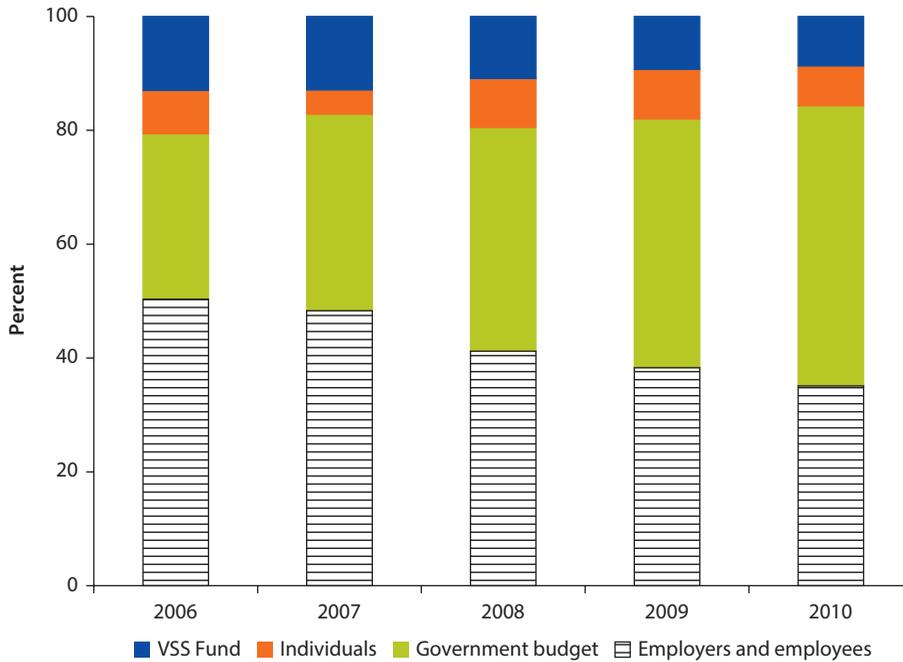
Note: GGH = Government General Health (Expenditures); OOP = out-of-pocket payments; and THE = Total Health Expenditures.

people. The large number of membership categories, each making differential contributions to the overall risk pool, worsens the fragmentation. As a result, risk pooling remains limited across insurance groups and provinces, while fragmentation is inefficient and increases administrative costs.

Inefficiencies in resource allocation and purchasing pose a threat to cost containment and the financial sustainability of SHI. The inefficiencies are related to what services are covered (benefits package), who delivers the services (delivery structure), and what incentive structure underlies the payment for services provided (provider payment mechanisms). Underlying all of these inefficiencies is a set of distorted incentives facing providers, a consequence of the purchasing and payment mechanisms as well as the market liberalization policies in the health sector in recent years in Vietnam. In the absence of efforts to control rising costs, making substantial progress toward UC is likely to become unaffordable.

In recent years the GoV has invested substantially on the supply side, particularly in the grassroots health network. After all, UC efforts can deliver effective coverage only when the delivery system has the capacity to absorb the increase in utilization. The implementation of Directive 06-CT-TW dated January 22, 2002,² resulted in the number of district hospitals and district hospital beds

Figure 1.3 Sources of Financing for SHI Revenues



Source: Calculations based on data from VSS 2012.
Note: VSS Fund pays the premiums for pensioners.

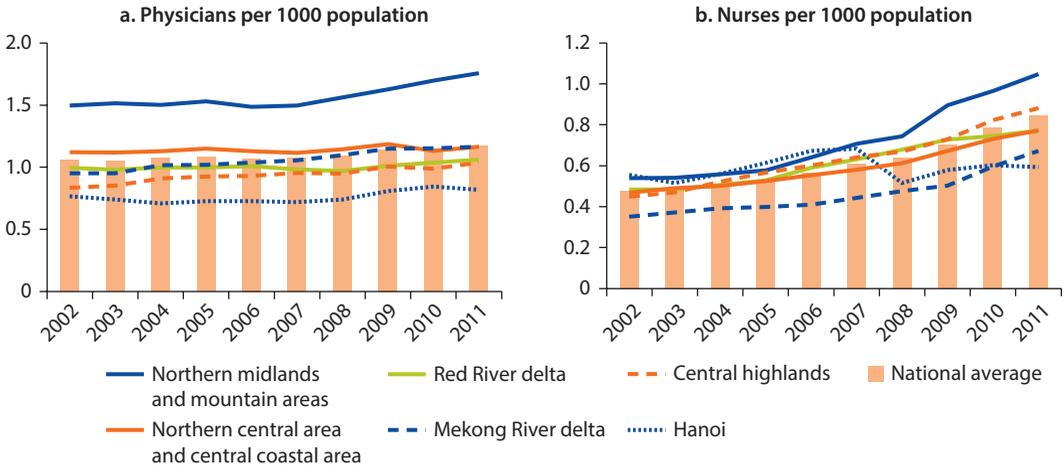
increasing by 17 percent and 64 percent respectively over a ten-year period, with the investment often financed through government bonds (Ministry of Health and Health Partnership Group 2013)(see appendix A).

Recognizing that the density of human resources for health (HRH) was low with severe shortages in remote and mountainous areas, the GoV developed a draft master plan for Human Resources Development (2011–20). This was designed, in particular, to strengthen the retention of personnel in Vietnam’s rural areas and to improve medical education.³ GoV’s initiatives have effectively increased the overall production of health professionals in the last ten years. Crucially, the increase in the density of HRH has tended to favor poorer regions. As figure 1.4 shows, the density for physicians and nurses has increased more rapidly in rural and remote areas, in particular the Northern Midlands and mountainous regions compared to Hanoi (World Bank 2013).

Despite these efforts, the quality and distribution of health services pose significant challenges for the achievement of UC. One major challenge is that primary care services—commune health stations (CHS) and district hospitals—are underfinanced, lacking in key inputs, and of poor quality as a result. In particular, the distribution of HRH disadvantages the lowest levels of care: in most regions, only two-thirds of CHSs have medical doctors (figure 1.5).

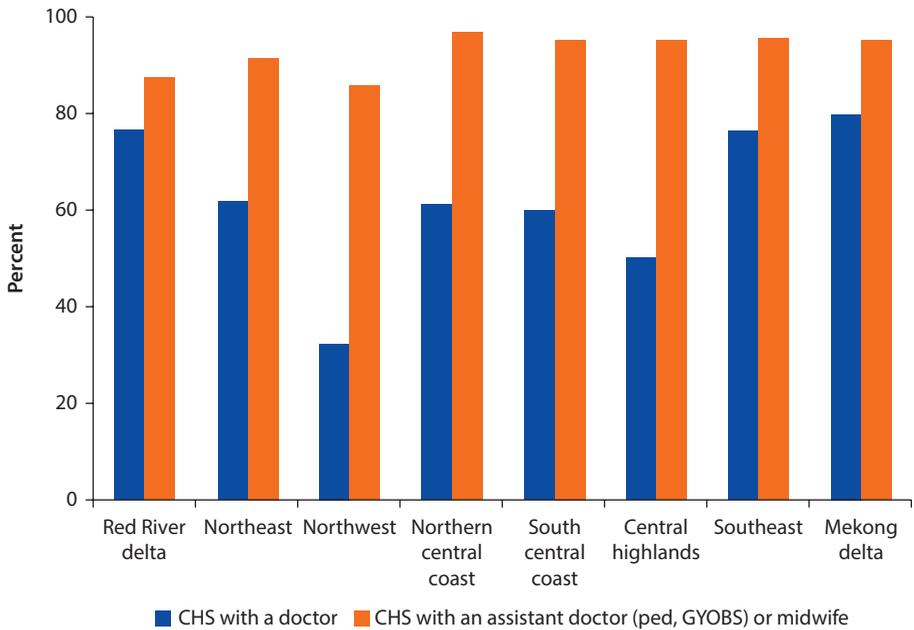
The distribution of HRH continues to be unequal: for instance, while only 27 percent of the general population is urban, 59 percent of medical doctors

Figure 1.4 Physicians and Nurses to Population Ratios by Geographical Region (2002–11)



Source: World Bank 2013.

Figure 1.5 Distribution of Health Professionals at the Commune Level



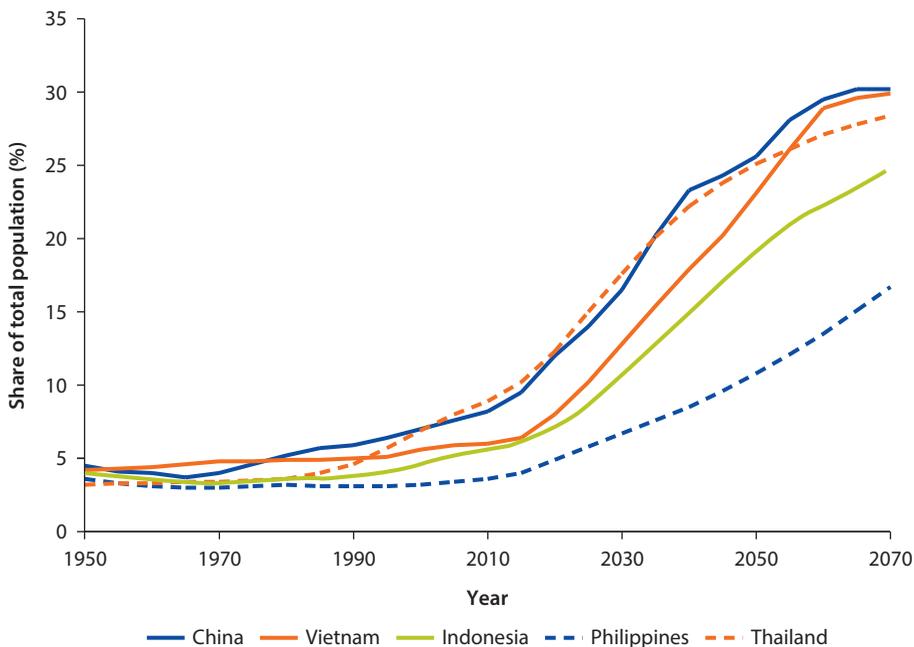
Source: World Bank 2013.

Note: CHS = commune health stations; ped = pediatric; GYOB: gynecology and obstetrics.

are in towns (World Bank 2013). A second major challenge is related to the quality and competencies of HRH. Medical training is hospital-based, leaving medical graduates with little preparation and incentive to work at the commune level. Even when CHSs are adequately staffed, the staff often lack the competencies to perform designated services and deal with emerging health problems (World Bank 2013). GoV investments to enhance quality have been substantial, but much more is needed to ensure that UC translates into effective coverage for all.

The deficiencies on the supply side are all the more critical in view of the demographic and epidemiological transition taking place in Vietnam. Vietnam will soon begin to age rapidly, with a sharp increase in the proportion of the population aged 65+ expected to occur following 2015, after many decades of relatively little change (figure 1.6). The share of the overall disease burden resulting from noncommunicable diseases (NCDs)—which was only 46 percent in 1990—is now 66 percent and expected to continue to increase.⁴ Both aging and rising NCDs will lead to further increases in utilization rates in the coming years. To address these challenges, Vietnam will need a multidimensional approach to strengthening the service delivery system, which focuses on how providers are linked and coordinated, how they are paid, and how they are held accountable for performance.

Figure 1.6 Share of Population Aged 65+ in Selected Countries (1950–2070)



Source: Based on data produced by the United Nations Department of Economic and Social Affairs, Population Division (<http://esa.un.org/unpd/wpp/Excel-Data/population.htm>).

Table 1.1 Road Map for Health Insurance Law Revision

<i>Key steps</i>	<i>Target date</i>
Supervision of Health Insurance implementation by MoH and National Assembly	April 2013
Submit draft revisions to the HIL to the Standing Committee of the National Assembly	September 2013
Discuss the HIL revisions at the National Assembly term meetings	November 2013
National Assembly approves draft Law at the next term meetings	June 2014

Note: All key milestones for 2013 have been met.

Government of Vietnam’s Agenda for Moving toward Universal Coverage

In 2012, the Ministry of Health (MoH) produced the “Master Plan for Universal Health Coverage from 2012–2015 and 2020” (referred to hereafter as the Master Plan). This was approved by the Prime Minister in 2012. The Master Plan is committed to a goal of expanding health insurance coverage along all dimensions of population coverage: (a) breadth of coverage as defined by enrollment rates; (b) equity and financial protection as defined by the OOP burden on individuals; and (c) the scope of the benefits package. The specific targets set out in the Master Plan are to reach at least 70 percent SHI coverage by 2015 and 80 percent SHI coverage by 2020; and to reduce OOPs to less than 40 percent of total expenditures by 2015. The Master Plan also includes financial projections based on premium rates and basic salary scales.

In 2014, the National Assembly is set to discuss and potentially revise the Law on Health Insurance. Four years into the implementation of the law, this is a good opportunity for carrying out mid-course corrections. The MoH is preparing its own review of the implementation of SHI and proposed revisions to the law to submit to the National Assembly. The key steps in this process are summarized in table 1.1.

The assessment in this report was carried out in response to a request from GoV, specifically MoH and Vietnam Social Security (VSS), to the development partners.⁵ The GoV requested this assessment to inform and supplement its own review and submission on the law revisions.

A Guide to This Report

The objective of this report is to assess the implementation of Vietnam SHI and provide options for moving toward UC, with a view of contributing to the law revision process. The primary audience is GoV, especially MoH, VSS, and the Committee for Social Affairs at the National Assembly, as well as the broader policy research community and development partners in Vietnam.

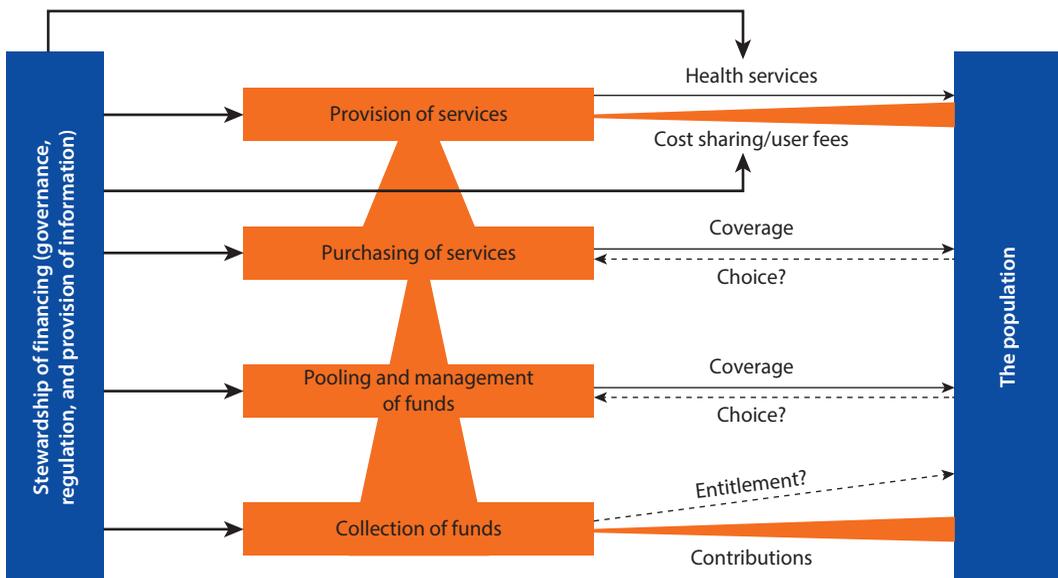
The report is structured as follows.

- Chapters 2 and 3 directly address the two major goals of the Master Plan: increasing the share of the population enrolled in SHI and reducing the OOP burden on households. Chapter 2 analyzes the main challenges to

attaining enrollment-related goals, and provides recommendations for not only increasing enrollment rates but also ensuring that enrollment translates to effective coverage. Chapter 3 of the report examines the implications of high OOP payments for equity and financial protection, analyzes the reasons why OOP payments remain high despite increases in SHI enrollment rates, and provides recommendations for containing OOPs.

- Having addressed the two primary goals of the Master Plan, the remainder of the report is devoted to assessing Vietnam’s readiness to meet these goals, and the challenges it faces in achieving UC from a primarily health financing perspective. The key functions of health financing are the mobilization of funds, pooling of resources, the allocation of resources, and purchasing of services. A cross-cutting issue that has implications for all of these three health financing functions is the stewardship of financing. Figure 1.7 summarizes this framework, which provides the conceptual basis for chapters 4–8.
- Chapter 4 provides an analysis of the cost implications of expanding coverage to meet the Master Plan’s targets, in terms of additional VSS outlays and supply-side subsidies needed, and under different scenarios of increases in utilization and unit costs. This sets the stage for analyzing how to mobilize resources for UC in chapter 5.
- Chapter 5 examines the macro-fiscal context and options for mobilizing resources for UC. Specifically, it examines the level of increase in government resources that would be both feasible and fiscally sustainable, and makes

Figure 1.7 Functions of Health Financing



Source: Kutzin 2001.

the point that achieving efficiency gains in the health sector will be critical for the financial sustainability of SHI. This is the focus of the next three chapters.

- Chapter 6 deals with the fragmentation in the pooling of funds and its implications for equity and efficiency. It examines key global experiences with consolidating fund pooling that are relevant for Vietnam, and provides recommendations for addressing this problem.
- Chapter 7 deals with the key sources of inefficiency in SHI related to resource allocation and purchasing. It examines key global experiences with strengthening resource allocation and purchasing that are relevant for Vietnam, and provides recommendations.
- Chapter 8 examines weaknesses in the stewardship of financing, specifically the organization, management, and governance of SHI, and provides recommendations for strengthening this area.
- Chapter 9 concludes the report by providing a road map for the recommendations contained in this report.

The UC definition provided in the opening of this chapter provides the analytical basis for this report with two key exceptions:

- First, this report neither includes an analysis of the implications of health service quality on UC nor provides any recommendations for strengthening quality. It is acknowledged that quality must not be ignored in assessing progress toward UC, however, given time constraints and in the absence of good data on quality, it was not possible to include this in the assessment. Chapters 3 and 6 do, however, point out the implications of poor quality service delivery for inequalities in access to services, regardless of how high coverage is, measured in terms of enrollment rates and financial protection.
- Second, this assessment does not undertake a thorough analysis of the benefits package, or provide recommendations on how the benefits package should be reformed. Benefits package reform is undoubtedly an important element of SHI reform and affects all elements of UC—equity, financial protection, quality, costs, and efficiency. However, benefits package reform requires comprehensive analysis that is well beyond the scope of this report. The report provides directions for reform of the benefits package, such as the steps needed to establish a pharmaceutical benefits package or to cost out the benefits package.

Methodology and Consultation Process

The development partners and research institutions that undertook this assessment engaged key GoV stakeholders (MoH, VSS, Ministry of Finance[MoF], People's Committee, and providers) in the assessment throughout by means of

Table 1.2 Components of the Review

No.	Component	Lead agency	Contributors and research partners	Data sources
1.	Assessment of coverage rates			
	(1) Scale, breadth, and depth of coverage	World Bank UNICEF		VSS Administrative Data, 2000–11 KAP survey, 2012
	(2) Equity and financial protection	WHO World Bank	HMU HSPI	VLSS 2004, 2006, 2008, 2010 National Health Accounts, 2008–10
2.	Costs and efficiency			
	(1) Stocktake and analysis of payment reforms	World Bank	HSPI	Data collected as part of an ongoing assessment of provider payment mechanisms
	(2) Cost projections	World Bank	Oxford University	National Health Accounts Expenditure data from VSS VLSS 2006, 2008, 2010
	(3) Study on essential medicines and technologies: irrational and inappropriate use	WHO		MoH and WHO surveys
3.	Fiscal space analysis	World Bank	HSPI	MoF, IMF, and World Bank data Expenditure data from VSS National Health Accounts
4.	Organization and management analysis	WHO		Interview and focus group discussions with key stakeholders

Note: KAP = Knowledge, Attitudes and Practices; HMU = Hanoi Medical University; VLSS = Vietnam Living Standards Survey; and HSPI = Health Strategy and Policy Institute.

informal technical meetings, consultations, and workshops. Several technical meetings with GoV stakeholders were held throughout the year to share key findings and discuss the potential costs and implications of revisions to the HIL (see summary in appendix B). In addition, the main findings and recommendations contained in this report were presented at two national-level workshops in Hanoi and Ho Chi Minh City in November and December 2012. Feedback provided during the workshops has been included in this report. Table 1.2 summarizes the background analyses undertaken for this assessment and the main data sources.

Notes

1. Decision 139/2002/QĐ-TTĐ dated October 15, 2002, issued by the Prime Minister, on the establishment of the Health Care Fund for the Poor at provincial level to support exemption of health care costs for the poor, through either direct support or subsidizing health insurance.
2. Directive 06-CT-TW dated January 22, 2002, issued by General Secretary of the Central Party on strengthening health care at grassroots level.

3. The first strategy provided financial incentives to workers, up to 70 percent of basic salary, for both recruitment and retention in rural areas (D 64/2009). Another instrument used to improve staff retention in rural areas was the “rural pipeline” strategy, which provided training for assistant doctors from rural areas who wished to become medical doctors for rural areas (C 06/2008). A similar policy was also used for pharmacists and nurses from disadvantaged and minority groups. Provinces are mandated to cover education fees. The program is expected to enroll over 2,500 medical doctors, 840 pharmacists, and more than 8,000 nurses between 2007 and 2018. A short-term rotation system from higher to lower facility levels was also proposed to boost quality at the commune level and foster interaction between urban and rural health workers (D 1816/2008) (World Bank 2013).
4. From a health financing and service delivery perspective, what sets NCDs apart is their chronic nature: they are generally typified by long durations and slow progression rates, but they can also result in rapid premature death (for example, with stroke and cardiovascular conditions). NCDs are generally more expensive to treat and require sustained case management, often requiring multiple contacts with the health system over one’s lifetime. Management of NCDs also requires primary care services to play an important and effective role in screening and delivering preventive and promotive interventions which, for most NCDs, are far more cost-effective than treatment at advanced stages of progression. There is also evidence to suggest that NCDs are more likely to result in catastrophic health spending, placing households at risk of impoverishment.
5. Rockefeller Foundation, World Bank, World Health Organization, and UNICEF.

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Master Plan Goal 1: Increasing Enrollment Rates

This chapter examines how to increase the share of the population enrolled in social health insurance (SHI) and ensure that enrollment translates into effective coverage. Vietnam faces the “missing middle” problem in that enrollment rates are highest among low- and high-income groups, but persistently low among groups in the middle such as non-/near-poor and informal sector workers, with associated problems of adverse selection and a fragmentation of risk pools. Increasing general revenue subsidies for SHI and fully subsidizing the premiums for the near-poor would be critical for expanding coverage for these groups. This strategy is administratively more efficient than attempting to expand contributory SHI for these groups and an effective means to address adverse selection. Providing financial incentives to encourage family enrollment and introducing measures to enforce enrollment compliance among the mandated enrolled groups would further increase enrollment rates. Strengthening the demand side, particularly by enhancing information, education, and communication about health insurance would be vital for ensuring that those enrolled do make effective use of SHI when seeking care.

Understanding Where the Gaps in Coverage Are

Increasing the proportion of the population enrolled in SHI is a key policy goal for the Government of Vietnam (GoV). GoV has set a target of achieving at least 70 percent and 80 percent coverage by 2015 and 2020. The Master Plan (MoH 2012) includes explicit enrollment rate targets for the different groups. This chapter examines how to increase enrollment rates efficiently and equitably, maintain enrollment rates among those who are already enrolled, and ensure that those who are enrolled actually use the health insurance.

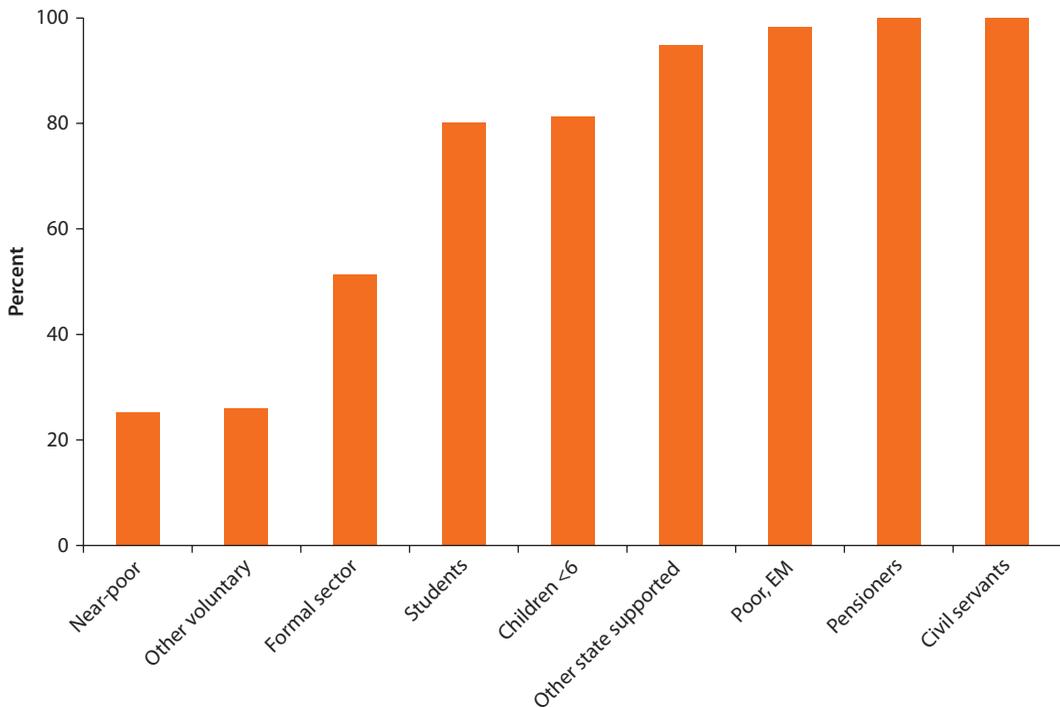
About 31.9 million Vietnamese were not enrolled in SHI in 2011.¹ Of these, 15.7 million were the largely non-poor informal sector workers and their families, who belong to the voluntary enrollment group; 7.4 million were the near-poor and students, whose enrollment is partially subsidized by the state;

6.2 million were formal sector workers, whose enrollment ought to be paid for by the employers; and 1.9 million were children under six whose enrollment is fully subsidized by the state. Of the 14.3 million population that is classified as poor or belonging to ethnic minorities, whose enrollment is fully subsidized by the state, less than 0.3 million were not enrolled (figure 2.1).

Vietnam faces the “missing middle” problem typical of most countries in the region in that insurance enrollment rates are highest among the lower- and higher-income groups, and lowest among the middle-income groups (figure 2.2). This middle consists largely of the nonpoor informal sector. Families of formal sector workers belong in this group since SHI for formal sector workers is limited to individuals only. Individuals engaged in the agriculture, forestry, and fisheries sectors also belong in the missing middle. Under the SHI Law, all of these groups are classified under the voluntary, contributory subcategory. Enrollment remains low among this group—26 percent in 2011—because the cost is too high and/or the value of health insurance is not perceived as being commensurate with the cost of enrollment.

Enrollment rates among the near-poor have risen only slowly despite a 50 percent (increased to 70 percent in 2012) government subsidy toward the

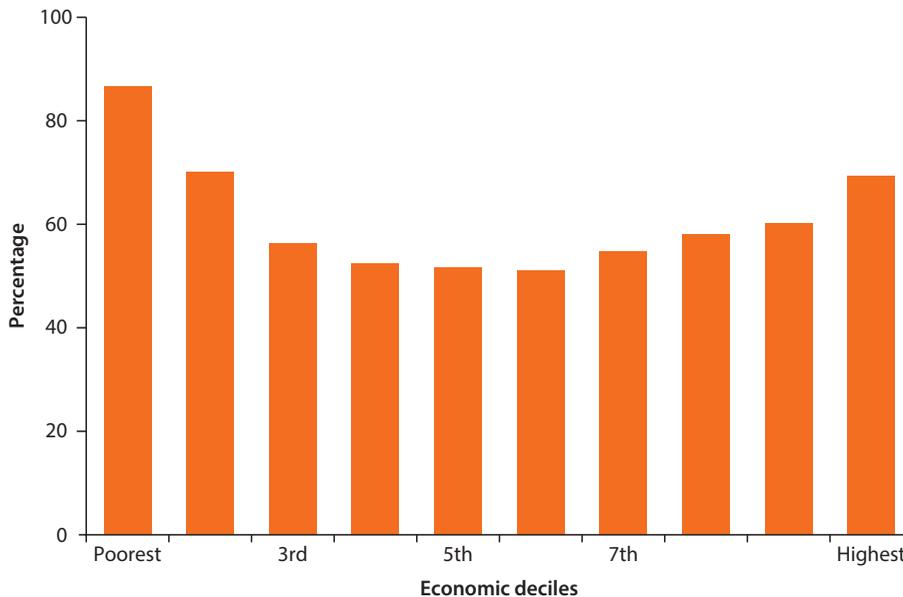
Figure 2.1 Enrollment Rates as a Share of the Population



Source: Calculations based on data from VSS 2012.

Note: “Other voluntary” includes farmers and other similar groups who are voluntarily enrolled. “Other state supported” includes commune officers entitled to state allowance, meritorious people, war veterans, members of the National Assembly and People’s Council, social beneficiaries, dependents of the military and public security officers, and intelligence agents.

EM = ethnic minorities.

Figure 2.2 Health Insurance Coverage by Economic Decile (2010)

Source: Estimates based on data from the Vietnam Living Standards Measurement Survey, 2010.

Note: Economic deciles are based on household consumption per capita. The poor and near-poor are defined as the bottom three economic deciles of the population.

health insurance premium. Although enrollment is mandatory for these groups, in practice enrollment is largely voluntary. Anecdotal evidence suggests that affordability is the main reason why enrollment rates are low among this group. Under the World Bank's Central North Region Health Support Project, the subsidy for the near-poor was increased to 80–90 percent and coverage has risen to 74 percent. Under the World Bank's Mekong Region Health Project, the subsidy for the near-poor was increased to 70 percent. In project areas, coverage rose to 50 percent. By contrast, the government subsidy for the near-poor was 50 percent (until 2012), and the national average coverage rate is 17 percent. The reality is that, with a low poverty line, the near-poor are not all that different from the poor. To these groups, affordability is probably the most important constraint for enrolling into contributory insurance schemes, no matter how large the subsidy is.

Enrollment among formal sector workers, a mandated enrollment group, is also low—59 percent in 2011—primarily due to weak enrollment compliance. While the Vietnam Social Security agency (VSS) has jurisdiction over many critical elements of health insurance in Vietnam, it is not legally empowered to conduct inspections of SHI compliance (that is, to ensure that companies register all employees). This is a function left to other government agencies, which lack adequate financial and human resources to fulfill this role. As a result, private enterprises are not monitored or inspected thoroughly for compliance.

Adverse selection is a major threat to the financial sustainability of SHI because many groups in the population belong in the voluntary enrollment

category and enrollment compliance is weak even in the mandatory enrollment category. There is evidence of adverse selection among the voluntary, contributory subgroups. Vietnam Household Living Standards Survey (VHLSS) data show that among people who do not fall into any of the mandatory groups, illness during the previous four weeks and previous year significantly increases their motivation to enroll. Families of formal sector workers have a higher probability of enrolling in SHI when they have been ill during the past 12 months (Lieberman and Wagstaff 2009). Indeed, average SHI expenditures per capita far exceed the premium for the voluntary insurance groups. Reducing the size of the voluntary enrollment group is therefore critical not only for improving coverage, but also addressing the problem of adverse selection.

Enrollment rates are high among the fully subsidized and mandated enrollment groups—92 percent in 2011—but this does not translate to effective coverage. Nearly 27 percent of all children under six do not have their health insurance cards (HICs), with the rate even higher for ethnic minority children and children without birth certificates. The enrollees do not always receive the HIC, and are not aware of their entitlements or able to use services. The Knowledge, Attitudes and Practices (KAP) survey carried out by MOH and UNICEF (2012) identified several reasons for this in relation to children under six (box 2.1).

The lack of portability of health insurance is another factor that undermines effective coverage. Internal migration has increased in recent years. The National Census in 2009 showed that the number of registered migrants aged five and above rose from 4.5 million in 1994–1999 to 6.6 million in 2004–2009. Current SHI Law does not allow the insured to seek care outside the locality where they are registered except in the case of emergencies. A 2011 study of migrants showed that less than 15 percent of migrants owned a HIC. When ill, 78 percent of migrants paid out of pocket for health care. For SHI beneficiaries among the

Box 2.1 Survey of the Knowledge, Attitudes, and Behavior of Parents Related to the Use of SHI for Children Under Six Years of Age in Vietnam

In 2012, Ministry of Health (MoH) and UNICEF conducted a study to better understand the constraints and bottlenecks in the implementation of SHI and identify ways of increasing coverage and uptake of services covered for children under six. A representative sample of urban, rural, and ethnic minority households was selected from four provinces (Ho Chi Minh City [HCMC], Ninh Thuan, Kon Tum, and Dien Bien). The sample consisted of 450 households or 1,800 families. In addition to administering questionnaires, 80 in-depth interviews and a dozen focus group discussions with policy makers, service providers, and parents were conducted.

Survey findings

1. Not all eligible families own health insurance cards.

About one-quarter of families surveyed did not own the card even though they were eligible, with the proportion of households without a card highest among ethnic minority

box continues next page

Box 2.1 Survey of the Knowledge, Attitudes, and Behavior of Parents Related to the Use of SHI for Children Under Six Years of Age in Vietnam (continued)

groups and migrant populations in HCMC. Reasons include: (a) poor knowledge about services covered for children under six; (b) being able to use the birth certificate instead of the insurance card; and (c) a perception that services at government health centers at the district level are of poor quality.

2. *Not all families who own cards actually use them.*

Only one out of five survey participants actually used the card. The rate of nonuse of the card was especially high among migrant populations and ethnic groups residing in remote mountainous areas in Dien Bien. Families lack knowledge on how the health referral systems work and parents preferred to take their sick children directly to a district facility rather than a commune or village health center. Hidden costs related to transport, seeking alternative childcare, and accessing services also deterred families from using government facilities. Some families preferred to use private facilities, as they could be accessed in the evening when government centers were closed.

3. *Communication about health insurance cards remains weak.*

Families learn about the services covered by health insurance for children under six from health workers, population collaborators, local authorities, TV, and social workers, respectively. Yet, families who had a permanent residence had more knowledge and access to additional information than migrant families. Parents and families are not fully knowledgeable about all services that are covered under the health insurance scheme for children under six, as only one-half of surveyed families were ever counseled.

Recommendations from the survey include:

- a. Improve cooperation between health sector and social affairs to improve the procedure of issuance and payment.
- b. Provide greater flexibility for migrant families to access health facilities in different provinces or districts.
- c. Improve counseling to parents in relevant ethnic minority languages as part of routine outreach and campaigns around child health.
- d. Communication needs to go beyond awareness raising to address confidence and self-esteem to obtain, use, and demand services.
- e. A communication plan should be linked to the overall system of improving access and use of health insurance for children under six.

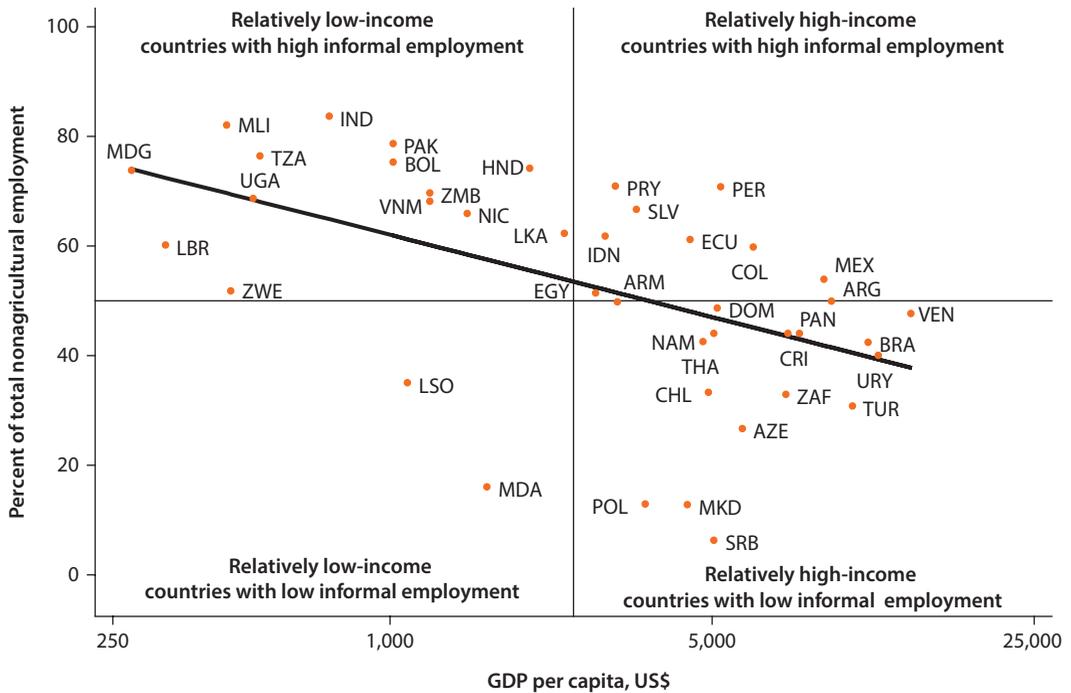
Source: MoH and UNICEF 2013.

migrants, SHI only covered 10 percent of total costs, while nearly 60 percent of migrants did not seek care at all.

Global Experiences with Increasing Enrollment Rates and Coverage

Enrolling the informal sector is not simply a short-term problem. Globally and historically, richer countries have tended to have lower levels of informality (the proportion of labor force in informal employment) than poorer countries

Figure 2.3 Informal Employment and GDP Per Capita in 41 Countries



Source: Based on data from the ILO Department of Statistics (2012) and the World Bank’s World Development Indicators.
Note: x-axis in log scale. Countries represented on the chart: ARG: Argentina, ARM: Armenia, AZE: Azerbaijan, BOL: Bolivia, BRA: Brazil, CHL: Chile, COL: Colombia, CRI: Costa Rica, DOM: Dominican Republic, ECU: Ecuador, EGY: Egypt, Arab Rep., HND: Honduras, IDN: India, IND: Indonesia, LBR: Liberia, LKA: Sri Lanka, LSO: Lesotho, MDA: Moldova, MDG: Madagascar, MEX: Mexico, MKD: Macedonia, FYR, MLI: Mali, NAM: Namibia, NIC: Nicaragua, PAK: Pakistan, PAN: Panama, PER: Peru, POL: Poland, PRY: Paraguay, SLV: El Salvador, SRB: Serbia, THA: Thailand, TUR: Turkey, TZA: Tanzania, UGA: Uganda, URY: Uruguay, VEN: Venezuela, RB, VNM: Vietnam, ZAF: South Africa, ZMB: Zambia, ZWE: Zimbabwe.

(Bonfert, Martin, and Langenbrunner 2013) (figure 2.3). Economies such as Japan, the Republic of Korea, and Taiwan, China, saw dramatic reductions in informality alongside rapid economic growth. This trend has been questioned of late, particularly in the East Asia Pacific region, where informality has proved to be more persistent.

Like many other developing countries in this region, Vietnam is expected to have a large informal sector over the next few decades and face associated problems of limited ability to raise public revenues from income and labor-related taxes. Problems usually encountered with providing health insurance for the informal sector, such as low enrollment rates, difficulties in assessing income and collecting payments, and adverse selection are likely to persist. Thus, strategies are needed to enroll the informal sector, as well as other hard-to-reach groups such as the near-poor more quickly and cost-effectively.

General Revenue Financing to Subsidize Enrollment

Expanding coverage, particularly for the near-poor and informal sector, will require significant additional general revenue financing. At present, the strategy

for expanding coverage to the informal sector and the near-poor relies largely on voluntary enrollment. To date, no country has ever achieved universal coverage (UC) by relying mainly on voluntary contributions (Kutzin 2012). Instead, most countries that have successfully expanded coverage to the hard-to-reach near-poor and/or informal sectors have done so by mandating enrollment and financing it through general revenues, either in whole or in part (box 2.2). Compulsion, with subsidization for the poor, is a necessary condition for universality (Fuchs 1996).

Subsidizing coverage through general revenues may imply moving away from the idea of a purely or even a predominantly contributory basis for entitlement and coverage. In the case of Japan, rapid economic growth and dramatic reductions in the size of the informal sector made it possible to achieve UC on a largely contributory basis. In the case of Korea and Taiwan, China, the combination of rapid economic growth and authoritarian political regimes made it possible to enforce mandatory enrollment and ensure employers complied with the law to meet one-half of their employees' contribution (Kwon 2011). In present-day low- and middle-income Asian countries, economic growth has been curtailed by the global economic crisis, and informality is quite persistent, as already noted. In this context, countries would need to expand coverage on a noncontributory basis to achieve UC.

Relying on general revenues to enroll the informal sector has several benefits including administrative efficiency, avoidance of the risk of adverse selection, and

Box 2.2 The Role of General Revenues in Subsidizing Enrollment: The Global Experience

China: The National Cooperative Medical Scheme (NCMS) for the rural population in China provides an 85 percent subsidy toward premiums, and has achieved over 90 percent coverage.

Germany: Allocates general government revenues to subsidize coverage for those who cannot afford to enroll.

Hungary: Increasingly relying on general revenues to cover the informal sector.

Japan: Introduced the Citizen Health Insurance Scheme in 1958, and made enrollment mandatory for those not employed in the formal sector. Although this was initially a community-based insurance scheme, increasingly local governments subsidize enrollment.

Republic of Korea: Partial general revenue subsidy for informal sector workers.

Mali: Subsidizes premiums at 50 percent.

Moldova: Increasingly relying on general revenues to cover the informal sector.

Taiwan, China: Partial general revenue subsidy for informal sector workers.

Thailand: Extended SHI coverage to 90–100 percent of the population despite its lower-middle-income status. Sixty percent or more of the insurance fund was from general revenues.

United States: Administers subsidies on a sliding scale for the nonformal sector.

Source: Bonfert, Martin, and Langenbrunner 2013.

the fact that it is more progressive financing. Given the mobility and high degree of fluctuation of their incomes, the administrative costs of enrolling, monitoring, and collecting contributions are high for informal sector workers. Second, mandatory enrollment of the population through transfers from general revenues effectively reduces the risk of adverse selection, which occurs under voluntary enrollment. Box 2.3 provides two examples from this region where the costs of voluntary contributory enrollment proved high. Third, general revenue taxation is a more progressive source of financing than SHI, as the contribution for SHI is either proportional to current income and subject to a cap, or levied at a flat rate (Kwon 2009).

There are also two drawbacks to consider: the budgetary impact and the risk of the sector expanding. In the absence of any new tax revenues, the general revenue-financed coverage expansion will have an immediate budgetary impact, thus reducing fiscal space across sectors. This increases SHI's dependence on allocations from MoF, potentially jeopardizing financial sustainability (Bonfert, Martin, and Langenbrunner 2013). Korea and the Philippines are addressing these issues through the introduction of a so-called sin tax (see chapter 5). Secondly, tax financing for the informal sector may increase informality: as health insurance for informal sector workers is provided at no cost or reduced cost, there is an incentive for employers and/or workers to stay or even switch to informal arrangements to avoid paying the mandatory contributions associated with formal employment (see box 2.4).

Box 2.3 Challenges of Voluntary, Contributory-Based Enrollment in the Philippines and Thailand

Philippines: In 1999, PhilHealth launched the Individually Paying Program (IPP) in order to extend SHI coverage to all nonpoor informal sector workers. Enrollment was mandatory for individuals not covered by any other program. From 1999 to 2012, despite various attempts to enforce enrollment of the near-poor and nonpoor informal sector (for example by (a) requiring proof of PhilHealth membership to obtain a new driving and other professional licenses, and (b) the SHI fund providing religious and cooperative organizations with group discounts to encourage them to enroll their entire membership), two-thirds of the voluntary enrollees did not pay their premiums on a regular basis. Moreover, IPP enrollees were more likely to be chronically ill and have higher utilization rates than the average beneficiary of PhilHealth. Under the 2013 amendment to the health insurance law, the near-poor are now eligible for coverage under the subsidized Sponsored Program.

Thailand: Starting in 1991, the Voluntary Health Card Scheme attempted to expand coverage to informal sector workers. The scheme failed largely due to adverse selection and abuse (for example, through enrollment following diagnosis of a condition). The scheme was abandoned in 2007 and replaced by the fully subsidized Universal Coverage Scheme (UCS; Hsiao and Shaw 2007).²

Source: Bonfert, Martin, and Langenbrunner 2013.

Box 2.4 Evidence That Tax Financing for the Informal Sector Increases Informality

Colombia: An increase in informal sector employment of 2–4 percent was attributable to the design of the health sector reform, which included subsidized premiums for the poor and nonworking populations (Bitran 2013).

Thailand: The introduction of UCS increased informal sector employment by 2 percent after the reform, growing to 10 percent over the first three years (Wagstaff and Manachotphong 2012).

Box 2.5 Experience with Family-Based Enrollment from the EAP Region

China: The NCMS in rural areas provides family enrollment, but the other two schemes do not.

Japan: Insurance was extended to dependents of formal sector workers as early as 1939.

Republic of Korea: The SHI scheme adopted family-based membership early on, with dependents becoming members of the scheme that the head of household was enrolled in. To ease the financial burden on small business, employers of firms with fewer than five employees were exempted from paying their contribution for their employees until 2000 (Kwon 2009).

Philippines: Each membership category of PhilHealth entitles the legal dependent³ of the principal member to standard benefits (Obermann et al. 2006).

Thailand: The Civil Servants' Medical Benefit Scheme (CSMBS) covers civil servants as well as their dependents.⁴ Enrollment into CSMBS is free and is seen as a fringe benefit for government employees who receive lower wages than private sector employees. While the health insurance scheme for all other formal sector workers—the Social Security Scheme (SSS)—does not cover family members, the latter are entitled to join the UCS, enrollment of which is entirely free of charge. With nearly two-thirds of the Thai workforce in the informal sector, enrolling the informal sector as well as the family members of formal sector workers in UCS proved to be the most efficient way to expand coverage.

Family Enrollment

Family-based enrollment increases risk pooling and addresses the problem of adverse selection. It typically involves enrollment of the employee's immediate family consisting of spouse and children, however, it can also include other members of the family. It reduces the size of the informal sector by extending coverage to spouses and family members of formal sector workers. It also expands the risk pool and assists in spreading health risks more widely across the population. By reducing the share of the population that would otherwise have been voluntarily enrolled, it also reduces the risk of adverse selection. East Asia and Pacific (EAP) countries that have successfully expanded SHI to achieve UC have tended to encourage family-based enrollment (box 2.5).

Family enrollment does, however, imply greater spending, with contributions typically having to double to cover workers' dependents (Hsiao and Shaw 2007). In Thailand, coverage was extended to dependents only after SHI accumulated a large surplus. The majority of family members are now covered through UCS. China's NCMS membership for family members is subsidized, but family members still need to pay the same premium as the main enrollees to enroll.

Enforcing Mandatory Enrollment in the Formal Sector

Weak enrollment compliance is a characteristic of many SHI systems and is widely recognized as a barrier to increasing coverage rates among the near-poor and formal sector workers, and achieving UC generally. In Colombia, evasion in the contributory scheme was estimated to cost US\$836 million in forgone revenues (2.75 percent of GDP) mostly due to underreporting of income and nonpayment (Escobar and Panopoulou 2003). Evasion is also a problem in the Philippines among small businesses, with only 30 percent of those who should be contributing actually paying (Jowett and Hsiao 2007). Good information systems and strong governance and organization of all payment collection, including payroll taxes and SHI payments, are vital for ensuring enrollment compliance.

Information, Education, and Communication

The decision to enroll in, and use, health insurance is strongly influenced by perceptions, education, and cultural factors. In Kenya, for instance, the most important factor preventing enrollment is informal sector workers' lack of awareness about the National Hospital Insurance Fund (Mathauer, Schmidt, and Wenyaa 2008). In Indonesia, the main barrier to accessing health insurance was simply a lack of information about available options (Bappenas 2012). Thus, information dissemination and sensitization about health insurance entitlements are critical for ensuring effective coverage. Such information and social marketing have indeed played a critical role in expanding coverage in several countries (box 2.6).

Box 2.6 The Role of Information, Education, and Communication in Expanding Coverage

China: For rural residents, media advertising is used to encourage voluntary enrollment. Reimbursement of claims for individual patients is posted on village bulletin boards to publicize the tangible monetary benefits of health insurance (Liang and Langenbrunner 2013).

Thailand: Mass media coverage played a crucial role in expanding coverage rapidly (Van Lente, Pujjianto, and Thiede 2012).

Recommendations

Short Term

Recommendation 1: Substantially increase general revenue financing to subsidize enrollment for the near-poor and/or informal sector. This includes raising the subsidy for the near-poor to 100 percent.

Vietnam has already acknowledged the important role of general revenues by fully subsidizing the cost of insurance premiums for the poor and other vulnerable groups, and raising the subsidy for the near-poor to 70 percent in 2012. To achieve UC, these subsidies will have to be expanded further. The subsidy for the near-poor will have to be increased to 100 percent in the short term. The government should also incrementally increase the subsidy for the premium for those in the agriculture, fisheries, and forestry sectors who, although not poor, may face significant barriers to purchasing health insurance and accessing health services. The fiscal implications of this recommendation are estimated and discussed in chapters 4 and 5.

Recommendation 2: Strengthen the demand side by enhancing information, education, and communication (IEC) about health insurance.

When households/individuals still fail to register or use the HIC despite facing zero costs of enrollment, more clearly needs to be done to strengthen information and education about SHI, and invest in behavior change communication. Understanding what beneficiaries are entitled to, and how health providers actually use and process SHI, is important.

The KAP survey report (UNICEF 2012) points out that making sure that the population comprises informed users of SHI who know what they should expect would also make providers more accountable to their beneficiaries. The recommendations from the KAP survey, particularly in relation to children under six, are:

1. There needs to be a more effective communication strategy which focuses on parents and caregivers; includes a mix of approaches and channels; is sensitive to the needs of specific groups like ethnic minorities, and includes monitoring and evaluation indicators to measure changes in knowledge, attitudes, and practice. The evaluations should be used to modify and improve the communication strategy.
2. Better communication is needed to make sure users understand the use of referral services.
3. Better communication is needed on the scope of the package that is covered by SHI, so as to dispel any misperceptions about hidden costs.
4. Issues such as delays in obtaining cards for enrollees need to be addressed by VSS.

Medium Term

Recommendation 3: Provide financial incentives to encourage family-based enrollment.

Vietnam SHI can extend family enrollment in two ways. Firstly, it can provide additional incentives to the near-poor to enroll their families in health insurance. The subsidy for family enrollees (initially defined as the spouse and children under the age of 21) could be increased to 80–90 percent, instead of the 70 percent for individual enrollees. The World Bank’s Central North Project provided a 10 percent additional subsidy for family enrollment and resulted in a higher take-up than under the individual policy. This indicates there is demand for family enrollment. Secondly, family membership could be offered to formal sector workers, and employers could be encouraged to provide for family enrollment through tax breaks. Payroll taxes will have to increase to cover the costs of family enrollment; however, the increase in enrollment rates and, consequently, in premium revenues could have a beneficial impact on SHI more broadly. Preliminary estimates indicate that the costs to GoV of increasing family enrollment would range from VND 4,838 billion to VND 7,221 billion under different assumptions of how much of the premium of the different groups is subsidized by the government (table 2.1).

Recommendation 4: Enforce enrollment compliance in the mandatory enrollment group, particularly formal sector workers. This would include implementing the decree stipulating penalties for violation of health insurance regulations, and increasing the penalties for noncompliance.

In Vietnam, increasing compliance with SHI enrollment could mitigate adverse selection in the mandatory SHI scheme, maximize premium contributions, and reduce fraud and abuse. A government decree stipulating penalties for violation of health insurance regulations has been issued now but penalties are too low to enforce compliance with SHI regulations. Good information management systems are needed to significantly increase compliance. This would ideally include unique identifiers, the ability to carry out real-time coverage checks between provider and VSS, and a revenue collection database which would link

Table 2.1 Simulations of the Incremental Costs of Covering All Eligible Families

<i>Assumption number</i>	<i>Chapter 2 health insurance premium</i>	<i>Features</i>	<i>Incremental cost (VND)</i>
1	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor and 30% of the premium for nonpoor farmers. Civil servants pay for dependents.	4,838 billion
2	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor, 100% for the poor, and 30% of the premium for nonpoor farmers.	4,902 billion
3	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor, 100% for the poor, and 50% for nonpoor farmers.	5,493 billion
4	4.5% of the basic salary	GoV subsidizes 100% of the premium for near-poor, 100% for the poor, and 50% for nonpoor farmers.	7,221 billion

Source: Hanoi Medical University and World Health Organization 2013.

individual identifiers to the employer identifier. The organization, management, and governance of SHI more broadly are also critical, as discussed further in chapter 7.

Notes

1. In 2013, during the regular supervision of health insurance (HI) implementation in 42 provinces, it was found that about 800,000 HI cards (about 2 percent of the total number of cards issued) were duplicated. Some enrollees were found to have up to five cards each. This was almost always for groups whose insurance enrollment is fully subsidized by the government, including the poor, war veterans, meritorious people, and children under 6. Since the total number of enrollees and the enrollment rate are both calculated on the basis of the number of cards issued rather than the number of people actually registered, the existence of multiple cards per enrollee implies that the enrollment numbers/rates may be overestimated. This issue is currently under review by GoV.
2. UCS is a tax-funded health insurance scheme, targeting 47 million people who were not covered by the existing Civil Servants' Medical Benefit Scheme (CSMBS) or Social Security Scheme (SSS).
3. Legal dependents are spouse and children below 21 years of age, as well as children and parents over 21 years of age with physical or mental disabilities.
4. Dependents are spouses, parents, and children under 21.

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Master Plan Goal 2: Improving Financial Protection and Equity

This chapter examines how best to reduce the out-of-pocket (OOP) costs of health care. The previous chapter provided recommendations for raising enrollment rates. High enrollment rates would, however, have little impact on financial protection and equity if OOP costs remain high. OOPs are persistently high in Vietnam due to a combination of: (a) increases in coverage-related utilization and/or spending; (b) cost recovery by providers to make up shortfalls in Vietnam Social Security (VSS) reimbursement rates; and (c) higher prices and/or provision of unnecessary services that are a result of the distorted incentives structure that providers face. Ensuring strict controls on balance billing and providing a right-sized basic benefits package that can be fully financed through VSS reimbursements and subsidies would be the most effective way to control growth of OOP costs. Both will require systemic reforms over the medium to longer term, including reforms to provider payment mechanisms and the delivery system. In the short to medium term, strengthening the implementation of the copayment policy, making the policy more transparent with easily accessible grievance mechanisms, further reducing copayments for the poor, introducing catastrophic cost coverage, and shifting patients' preference toward lower-cost generic drugs would contribute to stemming the growth of OOPs.

The Government of Vietnam's (GoV) Master Plan has set the goal of progressively taking steps to reform health financing mechanisms so as to reduce OOP payments made by patients to under 40 percent by 2015. This chapter discusses why OOPs are a concern for policy makers, examines the reasons why OOPs are still high despite increasing levels of coverage, and provides recommendations on how to improve financial protection, focusing on measures to increase depth and scope of coverage.

Implications of High Out-of-Pocket Payments for Financial Protection and Equity

High OOP payments can expose households to financial risk including that of impoverishment, deter utilization, and often result in inequitable health-seeking behavior that is correlated with ability to pay rather than to need (WHO 2010). In short, high OOPs are inimical to the goal of achieving universal coverage (UC). Expanding the breadth of coverage and enrolling as much of the population as possible is not guaranteed to reduce the OOP burden on the population and thus improve financial protection and equity. If social health insurance (SHI) beneficiaries are liable for high copayments or direct payments (inadequate depth of coverage), or if the scope of the SHI benefits package is limited (inadequate scope of coverage), SHI beneficiaries may still incur high OOP payments.

It is notable that rising SHI coverage and SHI spending in recent years in Vietnam has not translated into a decline in OOP payments incurred by households. Even in 2010, with a coverage rate of almost 60 percent of the population, the OOP share of total health spending remained relatively high at 57.6 percent (figure 3.1). Vietnam's OOP share of total health spending is the second highest in the East Asia and Pacific (EAP) region—below that of Myanmar but higher than that of the Philippines, Indonesia, and China. Moreover, the OOP share of total spending is much higher than would be expected given Vietnam's income level (figure 3.2). Cross-country evidence shows quite clearly that a greater reliance on OOPs results in more catastrophic payments for households and greater

Figure 3.1 OOP Share of Total Health Spending and SHI Coverage in Vietnam (1995–2011)

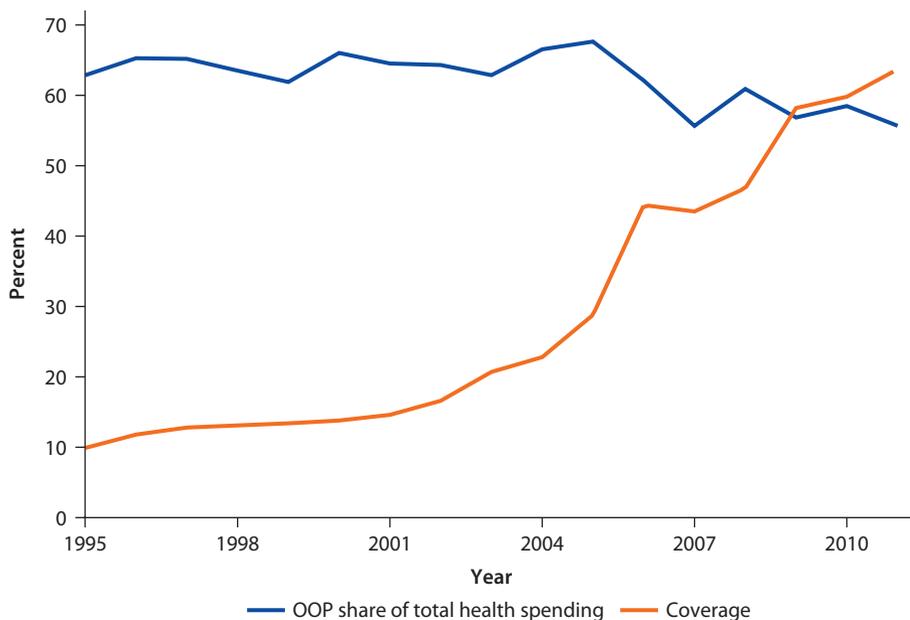
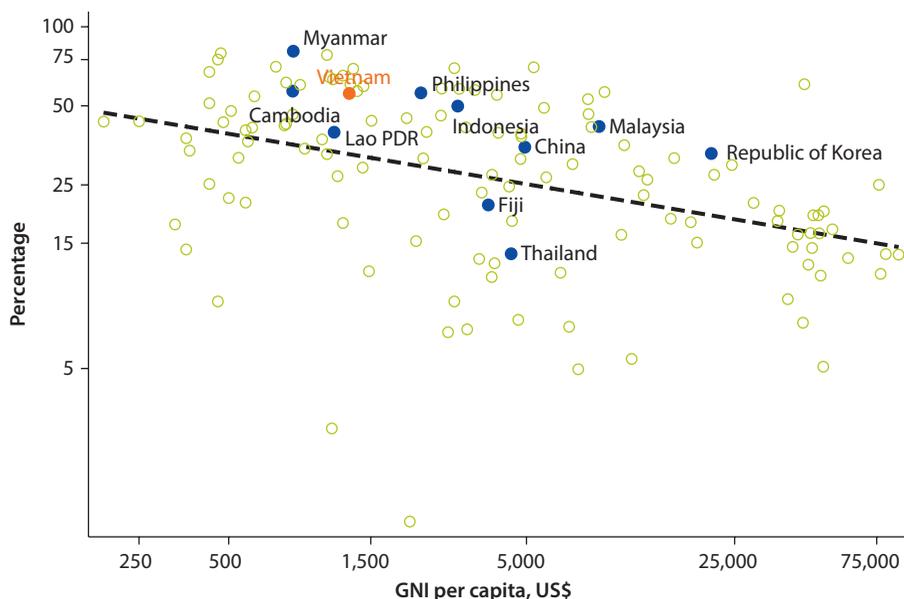


Figure 3.2 OOP Share of Spending in Vietnam and Other EAP Countries (2011)

Source: Estimates based on WHO (2014), and the reference for the back of the chapter is: World Health Organization, 2014. National Health Accounts—Global Health Expenditure Database. http://www.who.int/nha/expenditure_database/en
Note: x and y axis in log scale. GNI = gross national income.

inequality of service use (Van Doorslaer et al. 2006; World Bank 2013). This is clearly the case in Vietnam, as is elaborated on below.

Rich households account for the bulk of all OOP spending. About 25 percent of total OOP health spending comes from the top economic decile of the population. Only about 4 percent of total OOP spending comes from the bottom two economic deciles. On average, about 4–5 percent of total household consumption expenditure across all deciles is devoted to OOP spending (figure 3.3).

For the poor, who have limited disposal income and savings or assets, high OOP spending can be catastrophic and/or impoverishing. Figure 3.4 shows that the share of households experiencing catastrophic OOP spending¹ in the poorest two quintiles has changed little over time. The same is true of the probability of OOP-related impoverishment² for the poorest quintile, although not for the second-poorest quintile (Hanoi Medical University and WHO 2012). This implies that, despite increases in SHI coverage, OOP payments continue to have a catastrophic and potentially impoverishing effect on poor households. In short, Vietnam SHI provides limited financial protection, particularly for poor households.

When the poor have limited financial protection for health, this leads to large inequalities in utilization, and potentially large inequalities in health outcomes. Measures of financial protection, such as those presented in figure 3.4, are not adjusted for need. Since the poor are usually in worse health than the better-off, these measures of financial protection understate the true degree of inequality. The data in table 3.1 show the poorest and richest quintile's shares of hospital

Figure 3.3 Total OOP Spending by Economic Decile (2010)

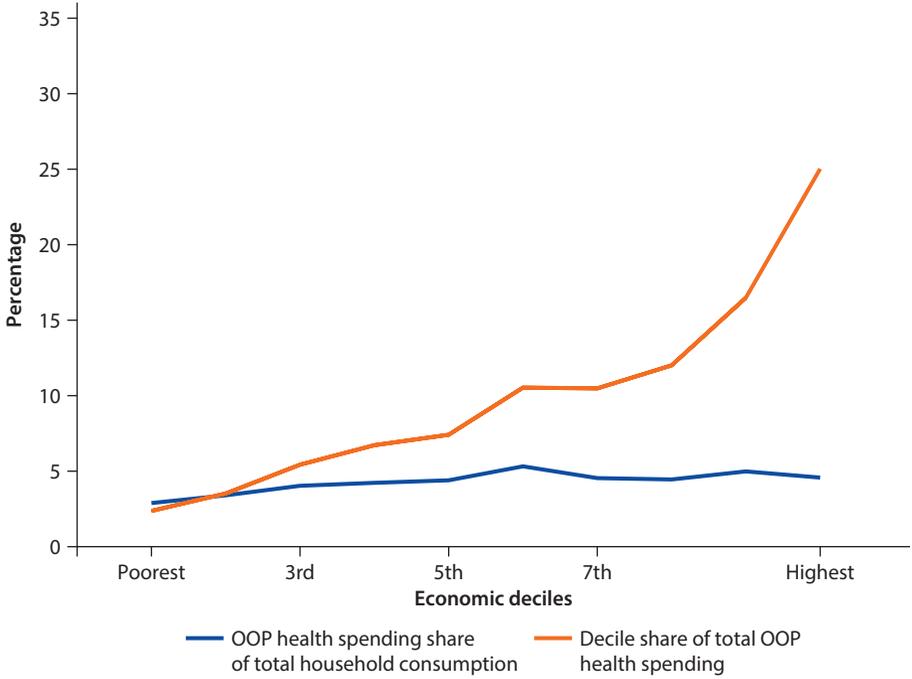
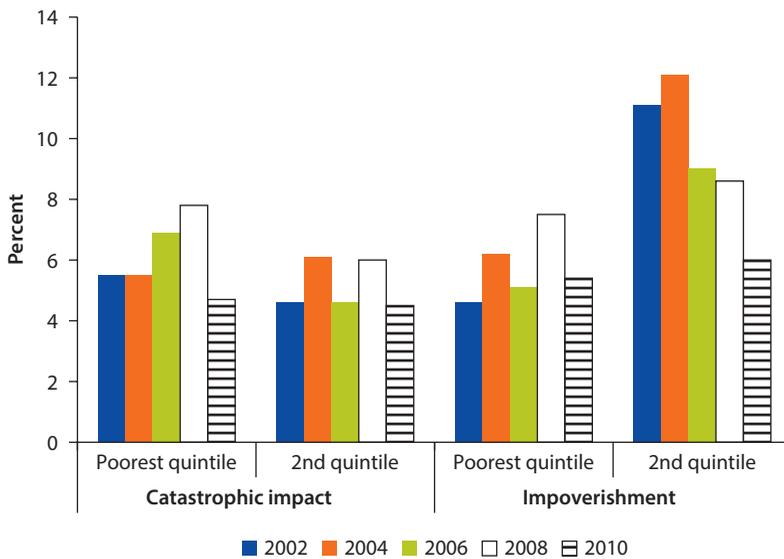


Figure 3.4 Share of Poor Households Experiencing Catastrophic and Impoverishing OOPs



Source: Hanoi Medical University and WHO 2012.

Table 3.1 Poorest and Richest Quintile Shares (Percent) of Total Utilization (2006–10)

Year	Quintile	Hospitals		Nonhospital (CHS)	
		Inpatient (episodes)	Outpatient (visits)	Inpatient (episodes)	Outpatient (visits)
2006	Poorest quintile	15	10	45	28
	Richest quintile	24	35	6	10
2008	Poorest quintile	17	11	32	32
	Richest quintile	24	29	3	9
2010	Poorest quintile	19	11	35	31
	Richest quintile	19	32	6	7

Source: HSPI 2010.

Table 3.2 Distribution (Percent) of Last Health Facility Used by Poverty Status, Ethnicity, and Health Insurance Coverage (2009)

	Kinh ^a nonpoor		Ethnic minority nonpoor		Kinh poor		Ethnic minority poor	
	Without HI	With HI	Without HI	With HI	Without HI	With HI	Without HI	With HI
	Private sector	71	22	51	11	42	15	43
CHS	13	46	18	55	30	54	37	67
District hospital	5	18	21	24	16	25	14	22
Provincial hospital	11	14	10	10	12	6	6	2
Number of health facilities in the sample	392	245	353	242	198	381	284	615

Source: Yen et al. 2013.

Note: The differences among the different groups were statistically significant. HI = health insurance; CHS = commune health stations.

a. The Kinh ethnic group constitutes approximately 82 percent of the country's population.

and nonhospital utilization during 2006–10. The poorest quintile accounts for a disproportionately large share of nonhospital visits, mainly to commune health stations (CHSs). Meanwhile, the richest quintile accounts for a significantly greater share of the hospital visits. It is notable, however, that the distribution of hospital inpatient visits has improved from 2006 to 2010: in 2010, the poorest and richest quintiles accounted for the same share of public hospital inpatient visits. Data in table 3.2 from a different survey carried out in selected districts show that poor ethnic minority households are far more likely to use CHSs than district or provincial hospitals. The nonpoor make greater use of the hospitals.

Underlying these utilization patterns are large inequalities in the quality of care received by the poor and ethnic minorities. As mentioned above, the poor, particularly poor ethnic minorities, are more likely to visit CHSs, which are less well-resourced and staffed by providers who exert less effort. The rich visit hospitals, which are staffed by doctors and better supplied with medicines and other inputs than CHSs. This inequality in quality of care is as important as inequality in the quantity of care. Castel (2009) showed that in the Kom Tum province ethnic minorities and informal sector workers received less expensive services than nonpoor patients with the same disease. The study also showed that financial barriers imposed by hospitals were cited as the most prominent barriers to

access by the poor and ethnic minorities, rather than culture or distance. Moreover, inequalities in health care use are a concern because they are potentially related to inequalities in actual health outcomes. There is evidence that this is indeed the case in countries in Europe and Central Asia, for instance (World Bank 2012).

Understanding Why Out-of-Pocket Payments Are Persistently High

Insurance coverage should, by definition, reduce the OOP burden on households; so why has the OOP share of total spending remained persistently high in Vietnam?

1. Increases in coverage-related utilization and/or utilization-related spending.
Estimates from 2010 Vietnam Living Standard Survey (VLSS) data indicate that the distribution of OOP health spending is roughly aligned with that of the share of the population covered (that is, over 60 percent of total OOP spending reflects direct payments for health from those covered) (Tandon, Harimurti, and Pambudi 2013). SHI enrollees had higher outpatient utilization rates (38.9 percent among enrollees, 29.5 percent among others) and admission rates (9.2 percent among enrollees, 5.7 percent among others).³ This is consistent with the global evidence that an expansion of government-funded health care, regardless of whether it is from insurance or general revenues, will tend to increase the quantity of care received, which will put upward pressure on OOPs when the generosity of coverage is less than 100 percent. Copayments, deductibles, and excluded items such as drugs will result in more OOPs as service use increases (World Bank 2013).
2. VSS reimbursements/subsidies do not completely cover the SHI benefits package and providers end up recovering their costs via OOPs from patients. SHI reimbursement rates have not kept pace with increases in the price of medical services and drugs for nearly two decades. The first national fee schedule was established in 1995, and was updated only once (in 2006, to add 992 mostly complex medical services) before the most recent revision, which went into effect in May 2012. Prior to this recent update, the prices of services had not been adjusted, even in line with inflation (Tandon, Harimurti, and Pambudi 2013). As a result, VSS picked up only a portion of the total cost of care, leaving providers to claim the remainder through user fees from patients. In this context, providers also faced strong incentives to provide the most profitable services covered under SHI or provide services not covered under the benefits package (Lieberman and Wagstaff 2009).
The recent increase in the fee schedule will not necessarily reduce the OOP burden on households. The fee schedule determines the prices that hospitals charge for their services. Both VSS and households pay according to the fee schedule. Increasing the fee schedule would only reduce the OOP burden on households if most of the population is already insured.

With a significant share of the population (37 percent) still uninsured, increasing the fee schedule may worsen the lack of financial protection because the uninsured will incur these higher fees as OOPs. In addition, with weak and poor quality primary care, patients will continue to bypass commune and district level services and incur even higher fees for bypassing.

3. Higher prices and/or oversupply of services are a consequence of the distorted incentive structure that providers face.

As will be discussed in chapter 7, providers face strong incentives to oversupply services. The scope of the benefits package is expansive, but not evidence-based or rationed in any way. Expensive, high-tech procedures are included in the benefits package and subject to high copayments (Van Tien et al. 2011). Balance billing is widespread with hospitals charging patients for “better quality” technical services, pharmaceuticals, and supplies that are not part of the official price list and package.⁴ Drug prices are exceptionally high. The higher prices paid by hospitals are passed on to patients, which contributes further to cost escalation and high OOP payments (Van Tien et al. 2011).

4. There is no cap on copayment expenditures.

SHI includes caps on benefits, but no cap on copayment-related charges. This is one of the main determinants of the high rates of catastrophic spending and impoverishment.

5. Beneficiaries have a poor understanding of insurance entitlements, particularly copayment policies.

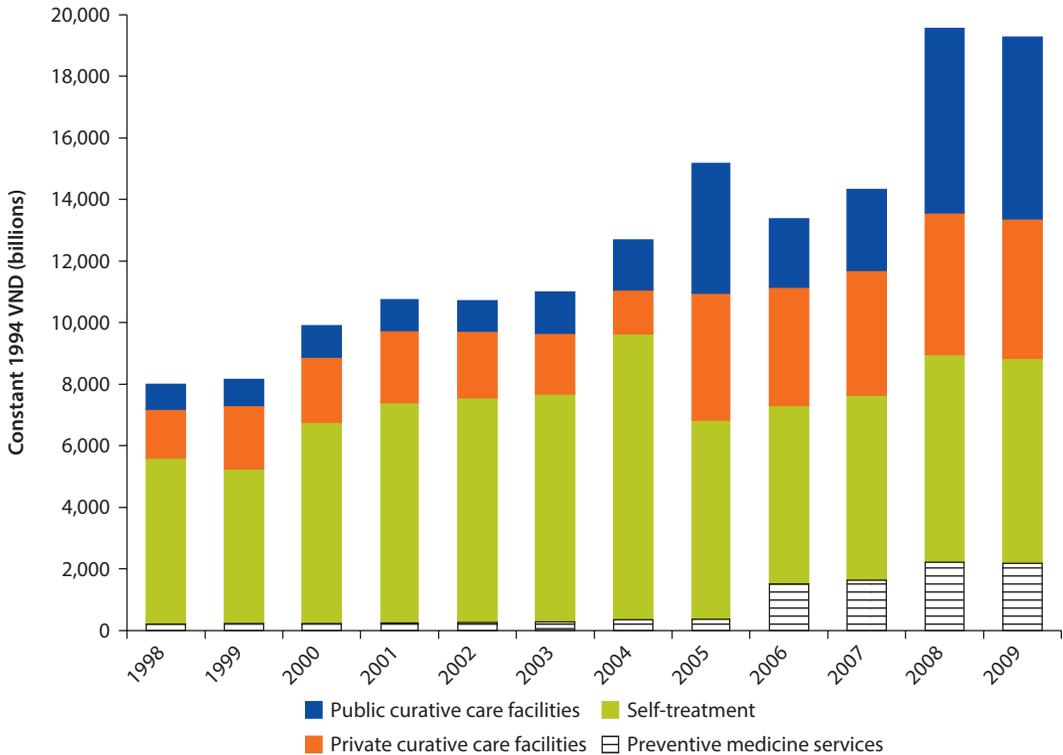
As discussed in chapter 2, many of those who are eligible for insurance do not have a good understanding about the entitlements, limits of coverage, and copayment policies. This results in patients not enrolling in SHI, not using the card even when they are enrolled, or paying more in copayments than they should.

6. Deficiencies on the supply side lead patients to seek care outside the range of covered services.

Primary care facilities, specifically CHSs, are of poor quality, understaffed, and lacking in key inputs, as shown in chapter 1. As a result, patients are forced to bypass them to access higher levels of care, where they incur higher copayment rates, or seek care at private health facilities, which are not covered by SHI. The majority of OOPs are incurred on self-treatment and private sector services, which are not covered by SHI (figure 3.5).

Regional Patterns in Out-of-Pocket Spending and Coverage

Despite increasing rates of insurance coverage, a high level of OOP health spending is a common phenomenon in the EAP region. As is the case in Vietnam (figure 3.1), the share of OOPs in total health spending in Indonesia and the Philippines has remained high despite rising insurance coverage rates (figure 3.6). Only in China and Thailand has the increased rate of insurance coverage been accompanied by a decline in OOP spending.

Figure 3.5 Trends in Real OOP Spending by Health Service Activity (1998–2009)

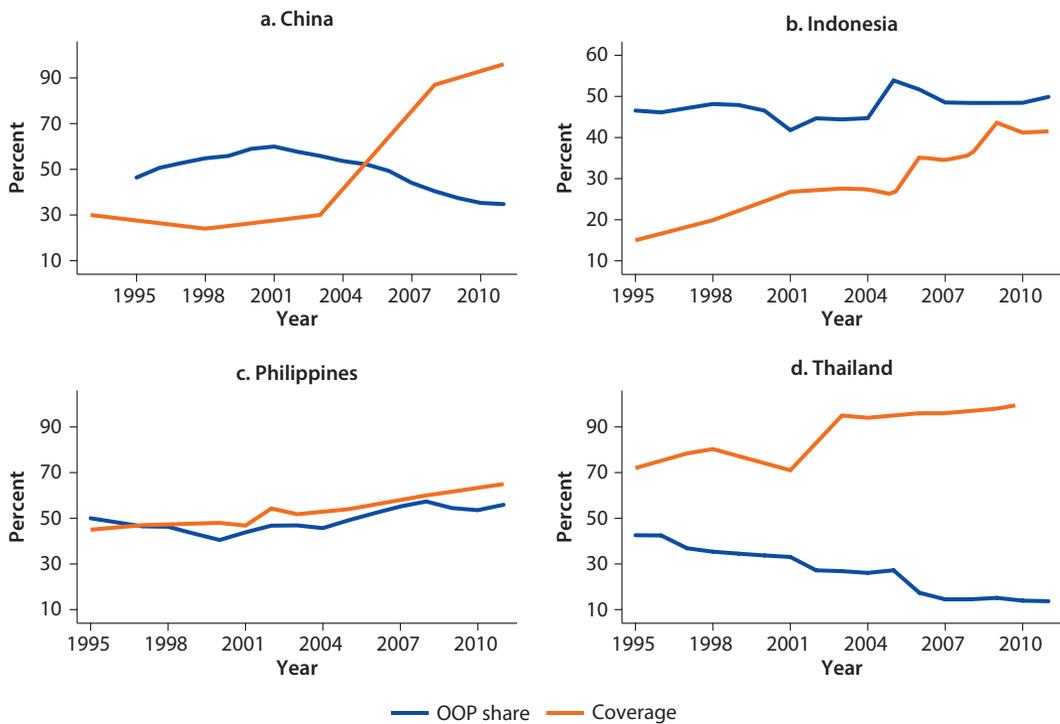
Source: World Bank 2013.

In Indonesia and the Philippines, the explanation for high OOP spending is similar to that in Vietnam:

1. Since the benefits package is comprehensive on paper, but not fully financed by SHI/subsidies in practice, providers resort to balance billing from patients.
2. Providers and beneficiaries have a relatively poor understanding of their benefits and entitlements and fail to make use of them.
3. Supply-side deficiencies, particularly at the primary care level, mean that the insured end up self-referring to higher levels (incurring higher copayments) or seeking care in the private sector (not covered by insurance).

In Thailand, by contrast, the implementation of Universal Coverage Scheme (UCS) was preceded by significant public sector investments to strengthen the supply side. This meant that the health service delivery system had the capacity to absorb the increases in health care utilization following the implementation of UCS. The strong supply side, combined with significant payment and purchasing reforms to control costs, meant that the implementation of UCS was not accompanied by significant increases in OOPs as in other countries. In China, the decline in the share of OOPs in total spending is simply due to large injections of budgetary resources into the health sector.

Figure 3.6 Patterns in OOP Spending Shares and Insurance Coverage (1995–2010)



Source: Tandon, Harimurti, and Pambudi 2013.

Recommendations

Efforts to rationalize and cost out the benefits package, and ensure that it is fully financed by VSS reimbursements and subsidies, albeit with a limited role for copayments, will be critical for addressing the OOP problem in Vietnam. Equally important are provider payment and purchasing reforms, which will be instrumental in monitoring provider behavior, controlling balance billing, and curbing the practice of overprescribing drugs and overproviding services. All of these issues are discussed in chapter 7. The following are a set of recommendations that can be implemented prior to, or alongside, the broader benefits package and provider payment reforms so as to immediately address the OOP problem.

Short Term:

Recommendation 1: Strengthen implementation of the copayment policy, including grievance mechanisms: make the policy more transparent and easy to understand; improve enforcement of the policy; ensure patients are well informed and able to access appropriate grievance mechanisms.

A copayment policy exists that, at least in principle, protects the poor through exemptions and reductions in the copayment rate. In practice, copayments are a barrier to accessing health care for the poor because patients end up being

charged considerably more than what is dictated by the copayment policy. The following recommendations should help address this problem:

1. The copayment policy should be simple and transparent—easy to determine for the patient and easy to communicate for the provider.
2. Copayments should only be paid at the cashier and a receipt provided at the end of the transaction.
3. Information, education, and communication efforts (chapter 2) should incorporate clear information about the copayment policy.
4. Patients should be well informed—not only about the policy, but also about grievance mechanisms that are relatively easy to access for all.
5. Correct implementation of the copayment policy should be monitored and enforced. When a provider is found not to be complying with the policy, there should be mechanisms to sanction them.

Medium Term:

Recommendation 2: Further reduce or waive copayments for the poor and vulnerable groups such as ethnic minorities.

Additional measures might be needed to protect the poor and other vulnerable groups such as ethnic minorities from OOPs. One option is to further reduce or waive copayments entirely. Providers would then need to be compensated for this, possibly through increased supply-side subsidies. Another alternative is to implement Decision 14, thus subsidizing the cost of auxiliary utilization-related expenditures such as travel and meal costs for the vulnerable groups.

Recommendation 3: Introduce catastrophic cost coverage.

Some countries have specific coverage to provide protection against catastrophic costs. For instance, in Japan, no more copayments are charged once monthly copayments reach a certain level. Since catastrophic payments are more likely to affect the poor (who do not have savings to fall back on), an equitable way to do this is to vary it by income. In Japan, the threshold for the monthly copayment amount is tiered into three levels according to the enrollee's income, and a 1 percent copayment is levied for the amount above the threshold.

Challenges associated with introducing catastrophic cost coverage include having accurate information on an enrollee's OOPs during the month or year to assess whether the catastrophic limit has been reached. This is difficult in a setting where the health insurance management information system is weak, and where individuals may seek care from several different hospitals. Unique patient identifiers are a key for making this work. Many copayments—such as informal payments—may be undocumented. Still, the benefits of such coverage in terms of protecting Vietnamese households from financial catastrophe and impoverishment are enormous. Thus, making the necessary investments to implement the catastrophic cost coverage would be worthwhile.

Notes

1. Catastrophic OOP spending is defined as OOP spending exceeding 40 percent of the household's capacity to pay. A household's capacity to pay is defined as effective income remaining after basic subsistence needs have been met. Effective income is taken to be the total consumption expenditure of the household.
2. A household is defined as being impoverished by OOPs if a nonpoor household's consumption falls below the poverty line once OOPs are taken into account. The poverty line is defined as the food expenditure of the household whose food expenditure share of total household expenditure is at the 50th percentile.
3. Empirical evaluations carried out during the course of SHI's evolution show mixed results with regard to the impact of insurance on utilization and OOPs. Some studies (Wagstaff 2007) found that free health care for the poor had a positive impact on utilization but no significant impact on OOPs, while others (Bales et al. 2007; Wagstaff 2009) found that the same program reduced OOPs significantly but had no impact on utilization. There are no evaluations yet of the post-2008 expansion of SHI coverage.
4. For instance, under a recent World Bank project that financed a health insurance package of services, the difference between the cost of the package and what health insurance actually financed was attributed to balance billing for extras such as more up-to-date surgical thread and pharmaceuticals that are not included in the VSS lists (information provided by Kari L. Hurt, project task team leader).

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Estimating the Cost of Moving toward Universal Coverage

The previous two chapters examined the Master Plan's two major targets for moving toward universal coverage (UC)—increasing enrollment rates and reducing the out-of-pocket (OOP) burden on households—and provided recommendations for meeting the targets. This chapter provides indicative, albeit crude, estimates of the costs of meeting those targets, in terms of additional Vietnam Social Security (VSS) outlays and supply-side subsidies needed, and under different scenarios of increases in utilization and unit costs. Based on the revenue projections outlined in the Master Plan, an additional 0.6–0.8 percent of gross domestic product (GDP) will be needed to attain 70 percent coverage. This will raise health's share of aggregate government expenditure by an additional 3.8–4.3 percentage points (up from 6.3 percent in 2010). Significantly higher spending will be needed if utilization rates increase with a rise in coverage, VSS outlays are increased to absorb OOP spending, and additional supply-side government financing is taken into consideration. Under these scenarios, an additional 0.8–1.7 percent of GDP will be needed. To meet these projected expenditures, health's share of aggregate government expenditure would need to increase by 4.7–8.0 percentage points.

Costing Universal Coverage: Revenue Projections Based on the Master Plan

Although there is currently no formal actuarial costing for UC in Vietnam, the Master Plan includes some projections of direct costs of coverage under the assumption of rising coverage rates for different population subgroups over time. Significant increases are projected to come from those in the compulsory contributory, partially-subsidized (government), and voluntary contributory subgroups (MoH 2012). Under the scenario of attaining a population coverage rate of around 70 percent by 2015, the Master Plan projects a slow decline in the proportion of those fully subsidized by the government from 49 percent of all covered in 2011 to 43 percent of all covered in 2015, offset by increases in coverage of contributory and partially-subsidized groups (table 4.1). The government's Master Plan also

Table 4.1 Actual and Predicted Insurance Coverage Rates in the Master Plan (2010–15)

Population subgroup	Coverage rate (%)					
	2010	2011	2012	2013	2014	2015
Compulsory						
Contributory: civil servants; private formal sector workers	62	59	69	71	73	75
Fully subsidized (VSS): pensioners	94	100	100	100	100	100
Fully subsidized (government): meritorious persons; children under six; the poor	81	92	95	96	97	100
Partially subsidized (government): near-poor; students	53	62	57	62	66	69
Voluntary^a						
Contributory: self-paid	21	26	27	30	32	35
Total coverage rate (%)	59	64	66	68	70	71
Proportion of those covered fully subsidized (government)	49	49	48	47	45	43
Proportion of those covered partially subsidized (government)	21	21	22	22	23	23
Total population (millions)	86.9	87.8	88.6	89.5	90.5	91.4

Source: MoH 2012.

a. Voluntary enrollment is to be discontinued after December 2013.

includes the objective of reducing OOP payments to less than 40 percent of total health spending by 2015 (MoH 2012).

Based on the Master Plan, the fiscal implications of expanding coverage to 70 percent will likely require additional government health expenditures in the range of 0.6–0.8 percent of GDP by 2015. Under two different scenarios based primarily on the extent of contributions and government premium subsidization, VSS revenues are projected to be Vietnam dong (VND) 99–110 trillion in 2015. The Master Plan assumes that the government would finance about 40 percent of the contributions of social health insurance (SHI) coverage.¹ This would mean SHI-related fiscal costs in the range of VND 39–45 trillion, up from about VND 8 trillion in 2010. If non-SHI government health spending stays at the same levels as in 2010 (at 1.7 percent of GDP), this implies additional combined SHI and non-SHI-related fiscal outlays in the range of 0.6–0.8 percent of GDP (these Master Plan scenarios are summarized as scenarios I and II in table 4.2).

Costing Universal Coverage: Expenditure Projections Using the Lieberman-Wagstaff Model

The Master Plan model focuses on revenue projections and does not take into account potential increases in utilization rates, changes in the unit costs of utilization, or complementary increases in supply-side financing that may be needed to improve and deepen coverage. A World Bank UC costing exercise by Lieberman and Wagstaff (2009) used 2006 baseline data to estimate the costs of expanding coverage under different scenarios as a result of such factors and how these might be shared by different actors in the system.

Table 4.2 Costing UC in Vietnam: Master Plan Model

	<i>Government's Master Plan (2015)</i>		
	<i>Current (2010)</i>	<i>Scenario I</i>	<i>Scenario II</i>
Key assumptions		<ul style="list-style-type: none"> • Contributions 4.5%; • Minimum wage VND 1,500,000 (increasing by 30% per year thereafter); • Premium subsidy for near-poor: 70%, students: 50%, farmers: 30%. 	<ul style="list-style-type: none"> • Contributions 5%; • Minimum wage VND 1,500,000 (increasing by 30% per year thereafter); • Premium subsidy for near-poor: 70%, students: 50%, farmers: 30% in 2012.
Government expenditures subsidizing VSS (SHI demand-side)	~VND 8 trillion	~VND 39 trillion	~VND 45 trillion
Non-SHI government expenditures on health (supply-side)	~VND 33 trillion	~VND 80 trillion	~VND 80 trillion
Total government expenditures on health (GHE)	~VND 41 trillion	~VND 119 trillion	~VND 125 trillion
GHE as share of total government expenditure (%)	6.3	10.1	10.6
GHE as share of GDP (%)	1.9	2.5	2.7

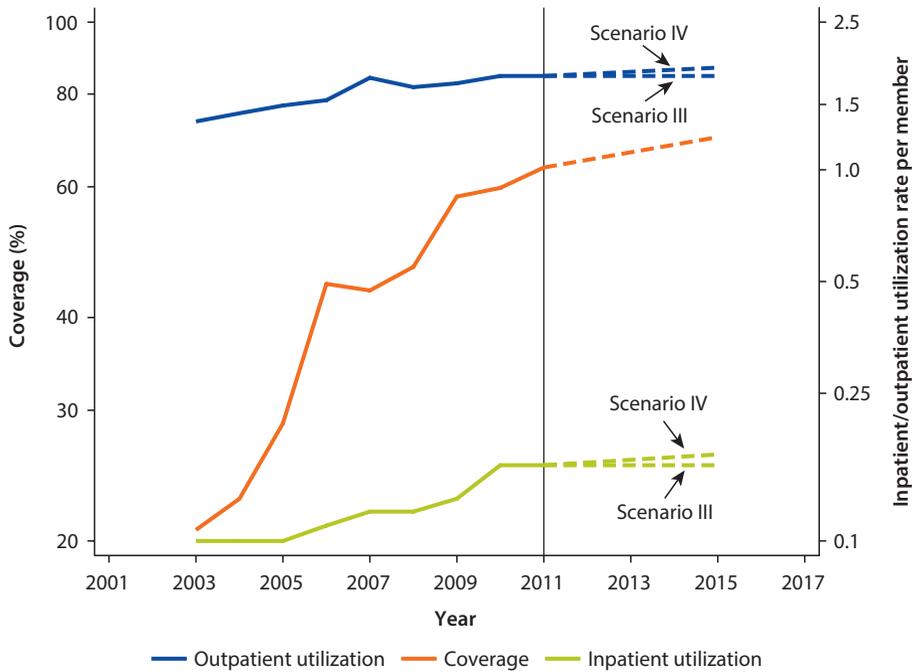
Source: Estimates based on cost projections carried out for this report; Yip and Hafez 2013.

Note: These are revenue (not expenditure) projections.

This subsection describes cost and fiscal simulations using a simplified update of the Lieberman-Wagstaff UC model. This uses baseline data from 2010 for predicting total and government health expenditures, assuming different scenarios incorporating potential increases in utilization, in unit costs of utilization, and also possible increases in supply-side financing to improve and deepen coverage. As described in more detail below, two additional scenarios are presented to complement the government's revenue-based projections (summarized in the previous subsection).

Vietnam's expansion of SHI coverage is occurring in a dynamic context with rising utilization rates. Both inpatient and outpatient utilization rates among members (and, more generally, in the population) have been increasing and are likely to continue to increase in the near future in response to greater awareness and socialization of coverage benefits as well as due to other sociodemographic factors (including rising living standards and education levels in the country). Population aging is another factor, as highlighted in chapter 1. Analysis of VSS data indicates that outpatient utilization rates among VSS members increased from about 1.35 visits per member in 2003 to 1.79 in 2011, an increase of about 3.7 percent per year. Inpatient utilization rates saw an even greater proportional increase over the same period: from 0.10 in 2003 to 0.16 in 2011, an increase of about 6.3 percent per year (figure 4.1).

Figure 4.1 Outpatient/Inpatient Utilization Rates among VSS Members (Actual: 2003–11, Projected: 2012–15)



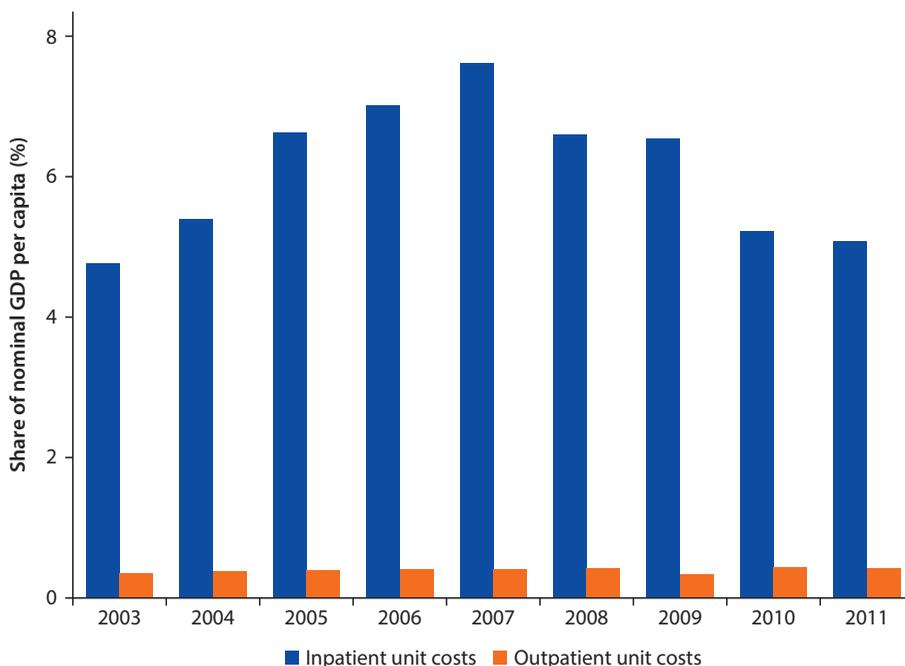
Source: Estimates based on data from VSS.

Note: Both y axes in log scales.

Complementing the government's revenue-based projections, scenarios III and IV summarize expenditure-based cost projections. Scenario III assumes a maximum increase in inpatient and outpatient utilization rates in 2015 of 6.9 percent and 5.3 percent respectively, based on predictions from an estimated regression model using Vietnam Living Standards Survey (VLSS) 2010 data (figure 4.1; Yip and Hafez 2013). Scenario III also assumes a 50 percent increase in inpatient and outpatient unit costs, proposed to capture the recent increase in the fee schedule in the country. Figure 4.2 shows the trend in VSS inpatient and outpatient unit costs over the time period 2003–11 as a share of GDP. The recent increase in the fee schedule is likely to increase both inpatient and outpatient unit costs significantly.²

Scenario III also assumes higher VSS outlays to absorb OOP spending so that the latter represents 40 percent of total health spending (as envisioned in the government's Master Plan). In addition to the expenditure drivers under scenario III, scenario IV considers an increase in supply-side government spending of 50 percent (to 2.6 percent of GDP, up from 1.7 percent of GDP). An increase of this scale is likely to be required to cope with higher demand and to improve coverage. Scenarios III and IV imply additional SHI-related fiscal costs of attaining 70 percent coverage by 2015 in the range of VND 49 trillion (table 4.3).³ If nonSHI government health spending is factored in, then this

Figure 4.2 Outpatient/Inpatient Utilization Unit Costs (2003–11)



Source: Estimates based on data from VSS.

Table 4.3 Costing UC in Vietnam: Lieberman-Wagstaff Model

	Current (2010)	Lieberman-Wagstaff Model II (2015)	
		Scenario III	Scenario IV
Key assumptions		<ul style="list-style-type: none"> • Increase in inpatient and outpatient utilization rates and costs • Increases in VSS outlays to absorb OOP spending 	<ul style="list-style-type: none"> • Increase in inpatient and outpatient utilization rates and costs; • Increases in VSS outlays to absorb OOP spending and increases in supply-side spending
Government expenditures subsidizing VSS (SHI demand-side)	~VND 8 trillion	~VND 49 trillion	~VND 49 trillion
Non-SHI government expenditures on health (supply-side)	~VND 33 trillion	~VND 80 trillion	~VND 119 trillion
Total government expenditure on health (GHE)	~VND 41 trillion	~VND 129 trillion	~VND 168 trillion
GHE as share of total government expenditure (%)	6.3	11.0	14.3
GHE as share of GDP (%)	1.9	2.7	3.6

Source: Estimates based on cost projections carried out for this report; Yip and Hafez 2013.

implies combined SHI and non-SHI-related fiscal outlays in the range of VND 129–168 trillion, or additional outlays in the 0.8–1.7 percent of GDP range (table 4.3).

These estimates for UC in Vietnam are very similar in magnitude to those estimated using more sophisticated and complex actuarial projection models in other countries in the region. In Indonesia, for instance, actuarial estimates predict additional government health outlays in the range of 1–2 percent of GDP are likely to be needed to attain UC in the country by 2015 (with health's share of overall government expenditure needing to increase from about 6 percent to between 8 and 13 percent depending on the scenario considered). Similar increases in government health spending have been estimated to attain UC in India as well as in the Philippines.

Summary: Estimates of the Costs of Achieving Universal Coverage

The analysis in this chapter provides indicative, albeit crude, estimates of the increases in fiscal outlays and government health spending that are likely to be required to attain 70 percent coverage toward UC in Vietnam. The revenue and expenditure implications of attaining 70 percent coverage will depend on: (a) the ability of the government to enroll additional members as planned; (b) the impact on utilization rates and unit costs of utilization; and (c) trends in supply-side financing.

Based on the revenue projections outlined in the Government of Vietnam's Master Plan, an additional 0.6–0.8 percent of GDP will be needed to attain 70 percent coverage. This will raise health's share of aggregate government expenditure by an additional 3.8–4.3 percentage points (up from 6.3 percent in 2010). However, complementary expenditure-based scenarios outlined above indicate that higher levels of spending will be needed if utilization rates increase with a rise in coverage, VSS outlays are increased to absorb OOP spending, and additional supply-side government financing is taken into consideration. Under the latter scenarios, an additional 0.8–1.7 percent of GDP will be needed. This will imply that health's share of aggregate government expenditure would need to increase by 4.7–8.0 percentage points.

Notes

1. If the government were to also fully subsidize those who it partially subsidizes (that is, the near-poor and pupils/students), then that would require the government's share of contributions for SHI coverage to increase to 50 percent, an additional VND 10 trillion by 2015 under both Master Plan scenarios; this may be something the government should consider implementing over the next three to five years to increase coverage rates among those who are currently partially subsidized.
2. Inpatient unit costs are defined here as VSS inpatient spending per admission; similarly, outpatient unit costs are defined as VSS outpatient expenditure per outpatient visit.
3. Over a longer time horizon, increases in utilization and costs due to aging and the rise in noncommunicable diseases will also put additional pressure on SHI expenditures.

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- MoH (Ministry of Health). 2012. Decision 538/QĐ-TTg dated March 29, 2013, by the Prime Minister to approve the Master Plan on Universal Health Insurance Coverage for the period from 2012–2015 and vision to 2020.
- Yip, W. C.-M., and R. Hafez. 2013. “Demand and Cost Projections for Vietnam.” Background paper produced for the report, *Moving towards Universal Coverage of Social Health Insurance in Vietnam: Assessment and Options*.

Mobilizing Resources for Universal Coverage: The Macro-Fiscal Context

This chapter examines how the achievement of universal coverage (UC) goals can be financed, based on the indicative cost projections provided in chapter 4. The recommendations provided in earlier chapters all require an increase in budgetary spending to meet the two major goals of the Master Plan. This chapter therefore focuses on public expenditures for health from a fiscal space perspective, and the extent to which additional resources can be mobilized to finance the expansion in coverage. The prospects of expanding fiscal space for health are assessed with respect to the five major pillars: (a) conducive macroeconomic conditions; (b) reprioritization of health in the budget; (c) health sector-specific resources; (d) grants and foreign aid; and (e) efficiency gains. Vietnam can expect additional fiscal resources for health of about 0.4 percent of GDP by 2015, given projections of macroeconomic growth rates and assuming that the relatively high income elasticity of government expenditures on health is sustained and the health share of budget is protected and sustained. Clearly, only a portion of the total projected costs of expanding coverage can be met through additional fiscal outlays. Reducing inefficiency will be critical for making further sustained progress toward achieving UC.

Assessing fiscal space for health basically entails an evaluation of the different sources of financing that might potentially be available to increase government health spending. This assumes a clear case has been made that such an increase is merited and that the net societal benefits of increasing government health spending are positive. Clearly, from a financial sustainability perspective, controlling costs and improving efficiency is an important aspect of the overall framework within which such an assessment for the health sector needs to be made. However, macro-fiscal constraints and cross-sectoral considerations can severely limit the amount of flexibility countries have in terms of their ability to increase government health spending, regardless of how meritorious the purpose might be.

Fiscal space for health entails examining five broad sources of public financing in detail:

1. a conducive macro-fiscal environment such as high levels of economic growth and increases in government revenues that, in turn, could facilitate increases in public spending for health;
2. a reprioritization of health within the government budget;
3. an increase in health sector-specific resources, for example through earmarked taxation;
4. health sector-specific grants and foreign aid; and
5. an increase in the efficiency of existing government health outlays, either via cost-containment policies and/or through improvements in technical and allocative efficiency of health outlays.

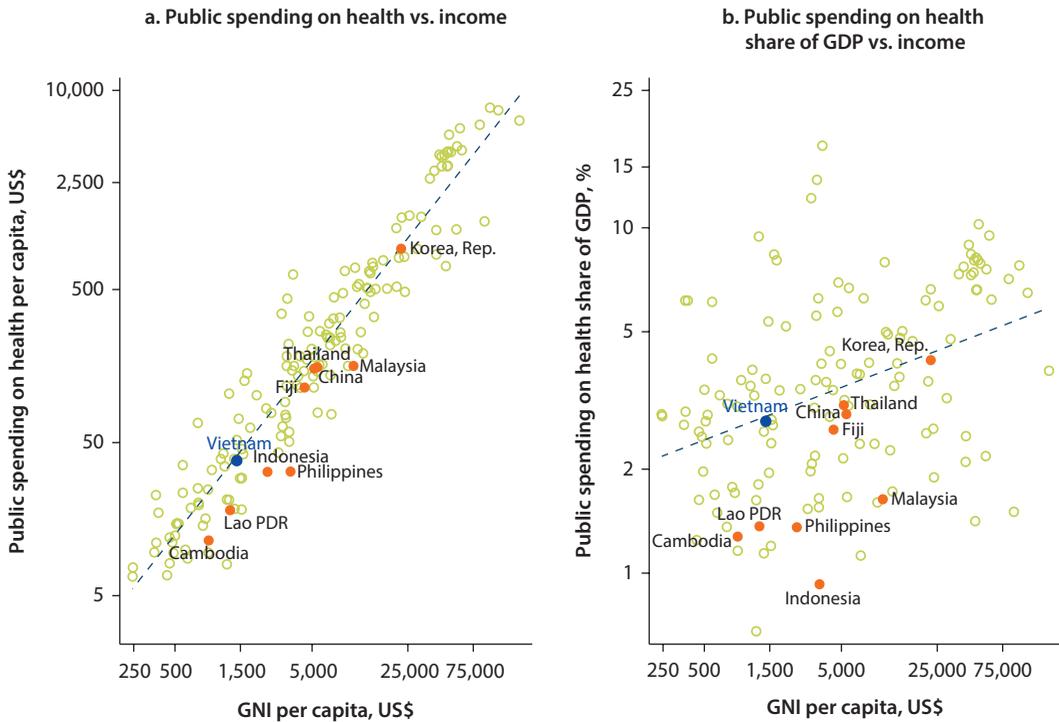
This chapter of the report examines the first four of these possible sources for public financing. The importance of efficiency savings and cost control in achieving UC in a financially sustainable manner are discussed in the next chapter, and recommendations provided on how to achieve this.

Macro-Fiscal Environment

Conducive macro-fiscal conditions are important for fiscal space considerations for any sector. These conditions include sustained economic growth, improvements in revenue generation, and sustainable levels of deficits and debt. There are several reasons why economic growth is an important factor driving fiscal space more generally, and specifically for health. First, even if public spending on health as a proportion of gross domestic product (GDP) remains unchanged, an increase in GDP by a certain percentage per year in real terms implies that public spending on health would also increase by the same percentage per year in real terms (assuming changes in prices of health are not significantly different from changes in overall prices over time). Second, as noted in a seminal article by Newhouse (1977), national income tends to be the biggest determinant of public (and private) health spending across countries. Hence, it is critical to assess public spending on health within a broader macroeconomic context.

Sustained periods of economic growth and macro-fiscal stability usually result in increases in public spending on health. Periods of robust economic growth and macro-fiscal stability often result in increases not only in the level but also in the share of the public sector in the economy, including for health (ADB 2006). In health, this is evident in cross-sectional data (figure 5.1). Across a range of countries, public expenditure on health increases both in levels and as a share of GDP as national income rises.

The reasons for this are grounded, in part, on the macro-fiscal environment within which a government operates, as well as the relaxation of budgetary constraints with rising income. As economies grow and the population becomes richer, the nature of the disease burden, demographics, and the preference

Figure 5.1 Public Spending on Health versus Income (2011)

Source: WHO 2013b; World Bank 2013.

Note: x and y axes on each figure in log scale.

structure for the demand for public financing for health also tend to evolve (Shelton 2007). The provision of health services—a relatively labor-intensive process—tends to also be more expensive in richer countries, driving up public (and private) spending on health. Health care costs tend to be higher in richer countries, driven by relative price differences as well as availability of higher-technology care, among other factors. Richer countries also tend to have more educated and older, aging populations with a preference structure that generally emphasizes greater levels of social protection. Higher costs and more demand for publicly financed health care, as well as private health insurance market failures—combined with a greater fiscal and institutional ability to address these issues—help explain why governments spend more as a share of their budget on health, on average, as countries become richer (Shelton 2007).¹

With a gross national income (GNI) per capita in 2011 of US\$1,270, Vietnam is classified as a lower-middle-income country. About 17 percent of the country's population continues to live on less than US\$1 per day, and about one-half lives on less than US\$2 per day.² Vietnam has been an economic powerhouse in recent years, with economic growth rates averaging 7 percent per year since the onset of liberalization under Doi Moi in 1986 (7.2 percent per year in the past decade). Taxes comprise the main source of revenue for Vietnam's government.

Table 5.1 Revenue Sources in Vietnam (2008–11)

Revenue item	2008		2009		2010		2011	
	Trillions of VND	%						
Tax revenue	363	85	373	82	477	86	615	87
Oil revenue	90	25	61	16	69	14	111	18
Nonoil revenue	274	75	312	84	408	86	504	82
Grants	9	2	8	2	5	1	7	1
Other revenue	57	13	72	16	69	13	82	12
Total revenue	429	100	453	100	551	100	704	100

Source: IMF 2012.

Note: Numbers for 2010 and 2011 are estimates.

In 2011, taxes accounted for about 87 percent of total revenues in the country, with other sources comprising about 12 percent and grants filling in the remaining 1 percent (table 5.1).

The first five-year plan following national reunification, passed in 1978, established the basis for fiscal decentralization in Vietnam by assigning expenditure responsibilities to subnational governments (Vo 2005). In the 30 years of reforms since then, fiscal decentralization has increased. By 2010, local governments executed 51 percent of investment from the state budget (World Bank 2011). The Budget Law, passed in 2002, currently governs revenue assignment between the central and local levels. This law stipulates that all taxes are defined as national.

Subnational governments (at the provincial, district, and commune levels) have limited ability to establish their own funding resources: revenue sharing and intergovernmental transfers are important for financing local budgets. About 60 percent of all revenues are assigned to the central government (for example, export and oil taxes and revenues). The remaining 40 percent are shared between the central and provincial levels (for example, corporate income tax, excise tax on domestic goods and services) or are assigned only to the provincial level (for example, land taxes, including land use tax and taxes on land use transfers, and natural resource taxes, excluding oil) (Hanai and Huyen Thi Bach 2006). However, approximately one-half of the revenues assigned to the central government are transferred to the province level. After transfers, the share of total revenues held by the central government is about 30 percent, with 70 percent held at the province level (World Bank 2011).

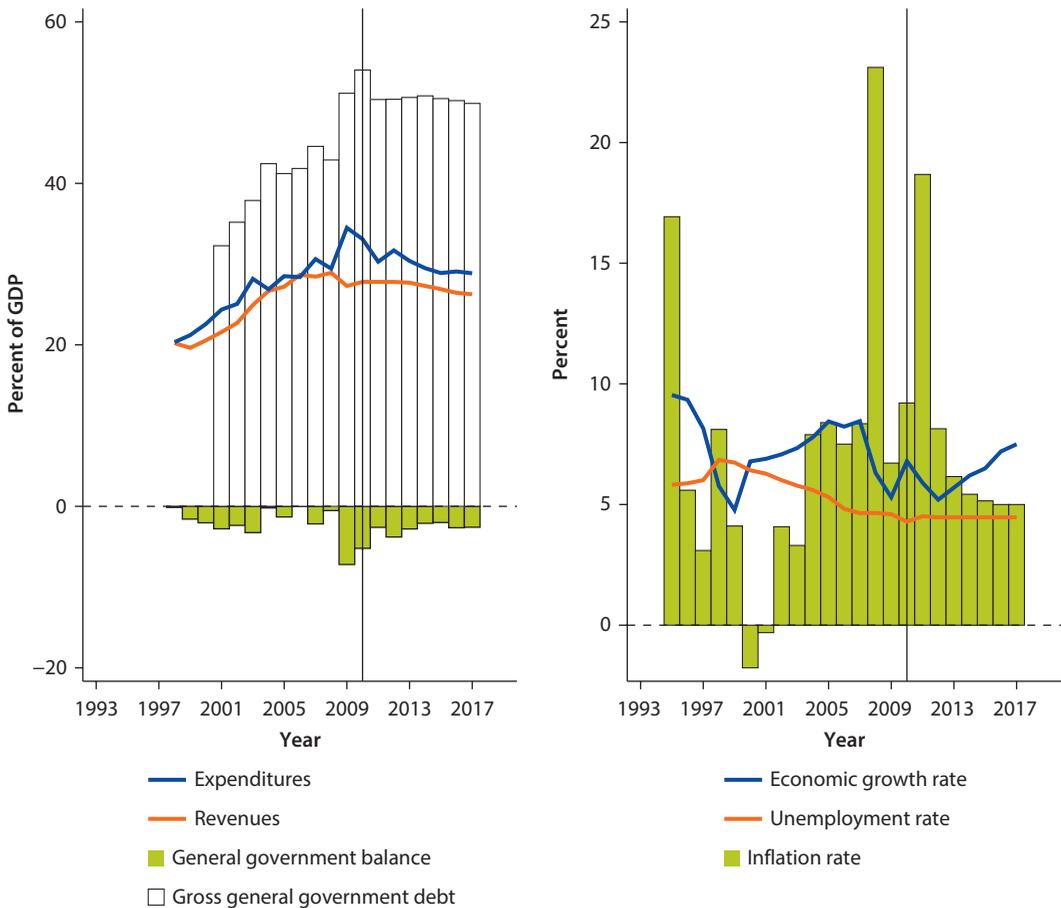
Growth in Vietnam has slowed in the past couple of years as a result of the global economic slowdown, but projections indicate that Vietnam will rebound in the medium term. Vietnam's GDP growth was about 8.5 percent in 2007. Following the onset of the global economic crisis, growth declined to 6.3 percent in 2008, and to only about 5.3 percent in 2009. Growth rates recovered to 6.8 percent in 2010 before declining to 6.2 percent in 2011 and then falling sharply to 5.2 percent in 2012. Growth is expected to remain relatively flat in the 5.3–5.5 percent range through 2017.³ This second-round macroeconomic slowdown has been the result of a slow reversal of fiscal and monetary stimulus

measures put in place to deal with the original 2008 global crisis. Inflation, which has been a problem in recent years, is projected to stabilize at around 5 percent per annum (figure 5.2). Debt levels have been relatively low in Vietnam, and are projected to decline over the coming three to five years. The government revenue share of GDP is expected to remain in the range of 21–22 percent of GDP.⁴

Vietnam is not an outlier relative to comparator countries when it comes to government spending on health. At roughly US\$38 per capita in 2011, general government spending on health in Vietnam was exactly as expected for its income level and higher than that of regional neighbors such as Cambodia, Lao PDR, and the Philippines.⁵ Public spending on health as a share of GDP in Vietnam was also about as expected for its income level (figure 5.1).

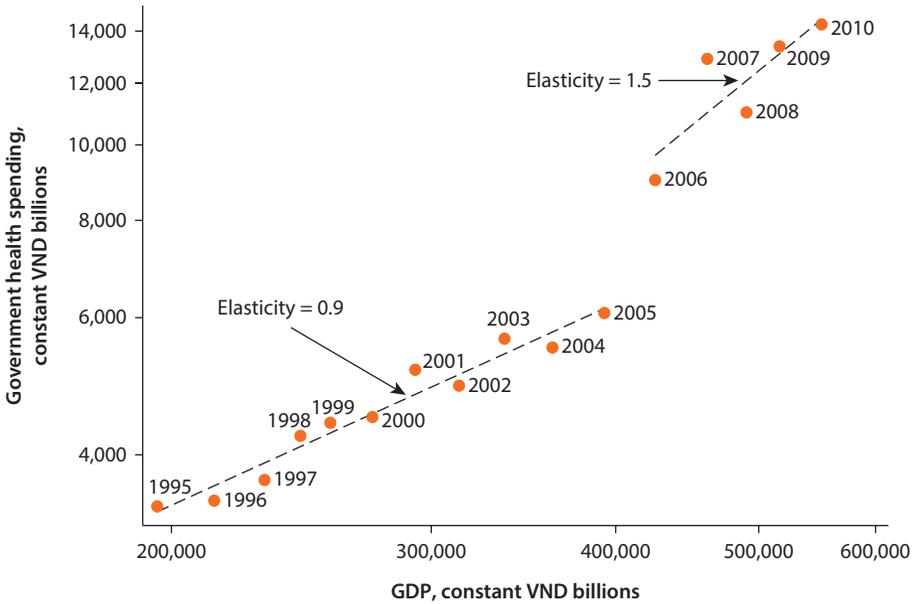
The income elasticity of government health spending in Vietnam has varied significantly over the past decade or so.⁶ Two regimes are apparent, with a break occurring around 2006. Prior to 2006, government health spending grew at a rate

Figure 5.2 Key Fiscal/Economic Indicators for Vietnam (1995–2017)



Source: World Bank 2013; IMF 2013.

Figure 5.3 Income Elasticity of Government Health Spending in Vietnam (1995–2010)



Source: Estimates based on data from WHO 2013a.
 Note: x and y axis are in log scale.

Table 5.2 Projections of Government Health Spending Based on Economic Growth (2010–17)

Year	2010	2011	2012	2013	2014	2015	2016	2017
Real GDP growth (%)	6.8	6.2	5.2	5.3	5.4	5.4	5.5	5.5
Government health spending share of GDP (%)	1.9	1.9	2.0	2.0	2.1	2.2	2.2	2.3

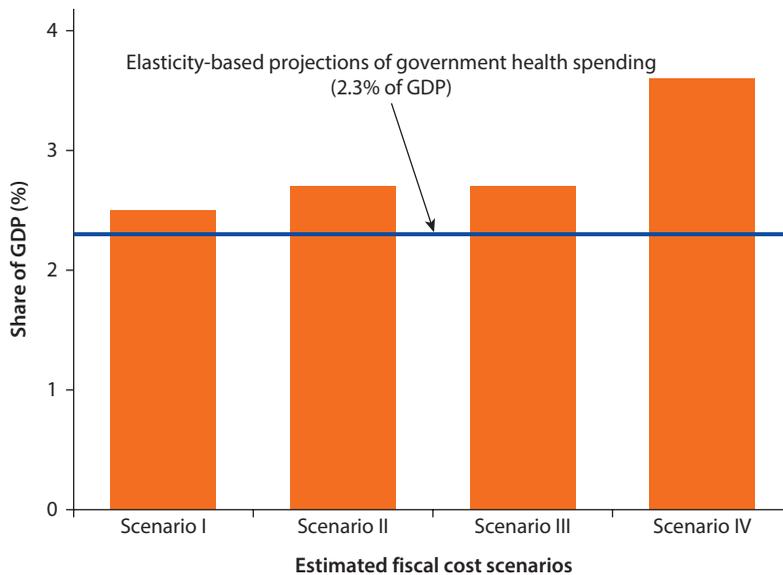
Note: Elasticity-based projections 2011–17.

lower than that of economic growth: the income elasticity was only about 0.9 (figure 5.3). Following 2006, the income elasticity increased significantly to 1.5.

At current growth projections—and if income elasticity stays at post-2006 levels—Vietnam could expect additional fiscal resources for health of about 0.3 percent of GDP from 2010 to 2015. At current growth projections, and assuming that government health expenditures on health follow the same rising trend as they have in the period post-2006, Vietnam could expect government spending on health to be about 2.2 percent of GDP by 2015, an increase of about 0.3 percent of GDP from 2010 numbers (table 5.2). This would not be within the range required under all of the scenarios for financing 70 percent of UC discussed in chapter 4. Additional fiscal resources—over and above what may be expected to be realized based on macro-fiscal trends alone—will be needed (figure 5.4).

To summarize, from a macro-fiscal perspective, the prospect of additional public resources for health becoming available is likely to be limited, even if the

Figure 5.4 Projected Government Health Spending Scenarios: Needs vs. Predicted (2015)



income elasticity of government health spending remains as high as it has been in the post-2006 period. Until recently, Vietnam's rapid economic growth over an extended period and healthy revenue flows were instrumental in providing substantial additional revenues for all sectors, including health. The economy has now slowed. However, if trends continue, then, at least in the short to medium term, the availability of additional fiscal resources for health is likely to increase government health spending as a share of GDP to about 2.3 percent by 2015. Additional reprioritization efforts will be required for health's spending share to increase beyond this as required under the scenarios described in chapter 4, and this is the focus of the next subsection.

Reprioritizing Health

A second source of fiscal space can arise from reprioritizing health to increase its share in the government's budget. There may be scope for raising health's share of overall government spending in some countries, particularly if the share of health in the government budget is lower than comparator countries in the same region or those with similar income levels and if certain expenditure categories can be identified that are deemed unproductive or unnecessary and can be reduced to allow room for additional health spending.

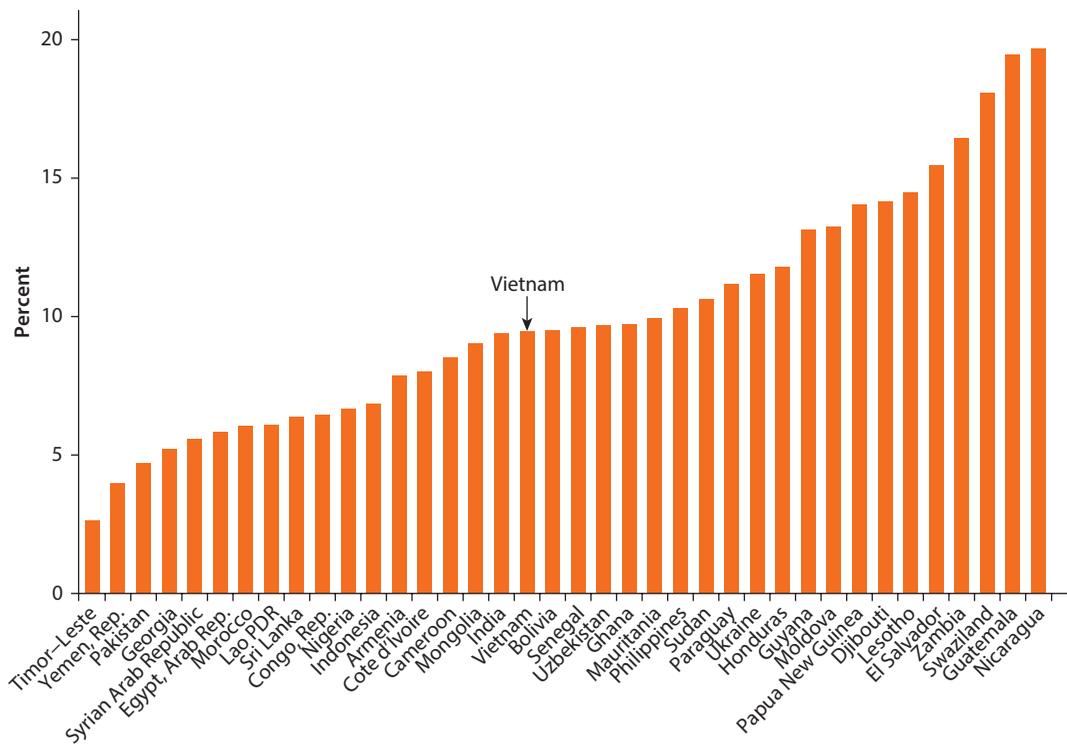
Even though a country's macroeconomic fundamentals may suggest that an increase in overall spending may be feasible if warranted, there is no guarantee that a conducive macro-fiscal environment will lead to an increase in government

spending specifically for health, even if overall government expenditures rise. On average, as countries become richer, the share of health in the government's budget (and as a share of GDP) does tend to increase. However, there are huge variations around this trend, reflecting in large part the intervening influence of other factors such as the extent to which health is prioritized over other sectors as well as the ways in which the health system is organized and financed.

Among lower-middle-income countries, health's budget share ranged from less than 5 percent for countries such as Pakistan to more than 15 percent for countries such as Zambia (figure 5.5).⁷ Averaging in the 6–7 percent range over the past couple of years, Vietnam share of health in aggregate government expenditures is somewhat below average relative to its income and regional comparators (the average among East Asia and Pacific [EAP] and lower-middle-income countries tends to be in the 10–11 percent range).⁸

Health appears to be increasingly accorded a higher priority in Vietnam. In fact, health spending is protected by law in Vietnam: the National Assembly passed Resolution No. 18/2008/NQ-QH12 in 2008 to protect and promote government spending on health. According to Article 2 of the resolution, the government would commit "...to increase the share of annual state budget allocations for health, and to ensure that the growth rate of spending on health is

Figure 5.5 Health Share of the Government Budget in Lower-Middle-Income Countries (2012)



Source: WHO 2013b.

greater than the growth rate of overall spending through the state budget” (Grover 2011). Due to the resolution the government is obligated to reserve at least 30 percent of the health budget of the state for preventive medicine. Following implementation of the resolution, the annual growth in government health budgetary allocations since 2009 has generally exceeded the average growth of the total government budget (see also discussion in previous subsection)(Van Tien et al. 2011).

Given the costs of UC and projections of government expenditures and revenues to 2015, non-SHI (social health insurance) spending on health as a share of the overall budget will need to increase under the different scenarios summarized in chapter 4. This is going to require health’s share of aggregate government expenditure to increase by several percentage points. Some reprioritization within the budget could be considered if potentially unproductive spending in other sectors can be identified (or to identify cost efficiencies within existing health sector allocations, as discussed in the next chapter).

Health Sector-Specific Resources

New health-specific resources can be an additional source of fiscal space for the sector. These policy options might entail the introduction of earmarked taxes and/or expansion of the SHI pool to include larger numbers of contributing members or increasing their premium rates. Earmarking can involve dedicating an entire tax to fund a particular program (for example, a dedicated payroll tax earmarked for SHI) or setting aside a fixed portion of a particular tax to fund a program (for example, a fixed proportion of general tax revenues allocated to the health budget).

If health spending is low or unstable, an earmarked tax may be seen as a way to insulate health spending from other competing publicly funded activities. From an economic perspective, earmarking is often viewed as an imposition of an unnecessary constraint on fiscal policy making, one that reduces flexibility and allocative efficiency (Savedoff 2004). In addition, there are numerous examples of situations where earmarked funds have been diverted to other activities, especially in poor governance settings (Prakongsai, Patcharanarumol, and Tangcharoensathien 2008). In addition, earmarking may not necessarily guarantee that additional resources will be available to the health sector.

Taxes on the consumption of goods that adversely affect health are often earmarked for the health sector. Taxes on the consumption of tobacco and alcohol, for instance, are often considered to be beneficial not only from a public health perspective but also from an economic perspective.⁹ Even if not earmarked for health, higher taxes can discourage consumption, reduce illness and accidents (in the case of alcohol), and reduce future demand for health services, which can reduce the pressure for more resources. Tobacco use, of any kind, is the leading cause of preventable death in the world and killed nearly 6 million people in 2011. Almost 80 percent of these deaths occurred in low- and middle-income countries. On current trends, the number will rise to 8 million deaths annually by 2030.

These deaths and health problems associated with smoking, including chronic diseases such as cancer, lung diseases, and cardiovascular diseases, cause hundreds of billions of dollars of economic damage worldwide each year (WHO 2011). Many deaths occur during prime working years (30–69), which both reduces overall productivity and deprives families of wage earners (Anh et al. 2011).

It has been shown in a number of countries that the most effective method for reducing tobacco consumption and improving health is to increase the price of tobacco products through tax increases (WHO 2011). Higher tobacco prices are effective because they encourage existing tobacco users to quit, prevent young people from starting, and reduce the amount of tobacco consumed among continuing users. Despite reducing demand, tobacco tax revenues also increase. Although all consumption taxes are regressive—since poorer households spend a larger proportion of their income on consumption—there are other issues with tobacco taxation that should be considered.

Thailand is an example of a country that has successfully implemented an earmarked tax that directly funds health promotion activities. In 2001, Thailand instituted the Thai Health Promotion Foundation (ThaiHealth), funding for which comes directly from a 2 percent earmarked tax on tobacco and alcohol consumption that provides an estimated annual revenue stream of US\$100 million. Thailand has also steadily increased cigarette taxation over the years, leading to declining consumption rates but increased government revenue from tobacco taxes. Other countries that have earmarked sin taxes include Australia, the Republic of Korea, and the United States (WHO 2010).

Almost one-half of Vietnamese men (but less than 2 percent of women) are smokers, and two-thirds of all households in Vietnam have at least one smoker. Water pipes and cigarettes are the primary forms of tobacco consumption in the country, with water pipes more common among lower-income groups and cigarettes more common among higher-income groups (Guindon et al. 2010). Cigarettes are taxed at a rate of 42 percent in the country (excise taxes are about 33 percent of the retail sales price, and value-added tax is about 9 percent), whereas water pipe tobacco is not taxed.

The cigarette tax rate is well below the 65–80 percent of the retail sales price recommended by the World Bank. World Health Organization (WHO) has recommended that excise taxes alone should account for 70 percent of the sales price based on studies of countries that have seen health improvements from decreased smoking). Tobacco use is higher among the poor worldwide and this holds true in Vietnam as well (Anh et al. 2011). On average, poorer households spend more on cigarettes than on education or health care (Lam, Simon, and Taylor 2006). Poorer households also carry a higher health burden from smoking. The government pays more than half of these costs in Vietnam (Ross, Trung, and Phu 2007). The latter study (2007) estimated that VND 4.5 trillion could be raised as additional revenues should tobacco taxes be increased by one-third on cigarettes in the country (this would also reduce the number of smokers by about 1 million).

There is some potential for mobilizing additional resources for UC through increasing the number of contributing SHI members in Vietnam. In fact, the

Master Plan assumes that SHI coverage of contributory members (civil servants and private formal sector workers) would increase from roughly 60 percent currently to 75 percent by 2015, and that some of the additional resources needed to cover the fully- and partially-subsidized groups would come from the contributory group. Although a large proportion of those who are not currently covered are nonpoor, informality remains a barrier to collecting contributions, as was discussed in chapter 2.

Increasing the premium provides an alternative way to mobilize additional resources for UC. Lieberman and Wagstaff (2009) argue that there is room to increase the premium for contributory members, given the relatively large incidence of out-of-pocket (OOP) payments in the country. In their model, a doubling of premium contributions from the formal sector could also make additional resources available to increase the depth of the SHI program for all members. The law in Vietnam does allow for premium rates to be increased, however, given the current slowdown in economic growth, this may be a difficult option to implement.

Rising premiums could adversely impact employment, as employers may react negatively to higher insurance costs. Raising the premium may also encourage informality, given that premium rates for informal workers are subsidized. One option might be for the government to introduce increases in contributions in a phased manner—rather than a “big bang” increase—over the next three to five years, taking account of efficiency gains in the health sector and the potential burden on households and employers as well as managing perceptions that certain groups are not “overpaying” in terms of their contributions to SHI (even if such an increase in contributions may be merited from the perspective of progressivity and social solidarity). In managing the latter, if additional complementary increases in the subsidized premium are also implemented over the same time period, then this might end up increasing, rather than reducing, fiscal costs.

External Resources

Another way to generate fiscal space for health—especially in low-income countries—is for governments to seek additional health-specific foreign aid and grants from international donors. Official development assistance (ODA) commitments for health in Vietnam over the period 2008–10 totaled US\$479 million from bilateral sources and US\$507 million from multilateral sources. The United States and Korea were the largest bilateral donors and the World Bank and the Asian Development Bank (ADB; special funds) were the largest multilateral donors (table 5.3). Over the period 2008–10, about 9 percent of all donor commitments were for sexually transmitted infection (STI) control including human immunodeficiency virus (HIV), 5 percent were for basic health care, and 1 percent was for tuberculosis (TB) control. Between 2006 and 2008, 1.3 percent and 0.05 percent of all donor commitments were for malaria and family planning, respectively.¹⁰

WHO estimates that about 3.4 percent of total health expenditure in Vietnam in 2010 was financed by external sources. This proportion has generally been constant since 1998 (figure 5.6). The current proportion of external resources as a share of health spending for Vietnam is substantially lower than the average for lower-middle-income countries (12.4 percent) and for the EAP region as a whole (18.1 percent), although the latter average, in particular, is biased upwards because of the inclusion of small Pacific countries.

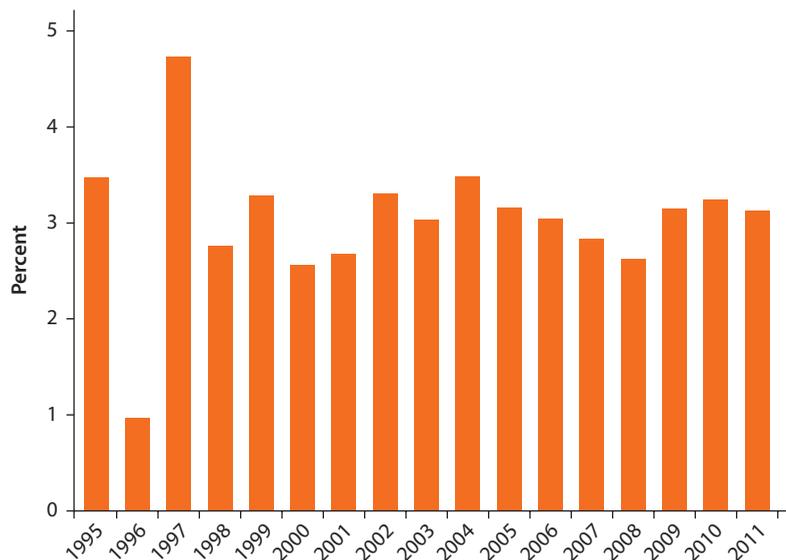
Given recent declining trends and Vietnam's lower-middle-income status, it does not appear as though foreign aid is a viable option for generating fiscal space for health in Vietnam, particularly since the current crisis is having an impact on

Table 5.3 Annual ODA for Health in Vietnam (2008–10) (Average)

<i>Source</i>	<i>Commitment amount (US\$ millions)</i>
Total bilateral	160
United States	70
Republic of Korea	22
Germany	15
Total multilateral	169
International Development Association	52
ADB Special Funds	44
European Union (EU) institutions	24

Source: OECD 2013.

Figure 5.6 External Resources Share of Total Health Spending in Vietnam (1995–2011)



Source: WHO 2013a.

Table 5.4 Fiscal Space for Health at a Glance for Vietnam

<i>Fiscal space source</i>	<i>Key information</i>	<i>Prospects for fiscal space</i>
Macroeconomic conditions	Growth rates expected to rebound to precrisis levels; high income elasticity of government expenditures on health.	Medium
Reprioritization of health in the government budget	Health spending as share of budget is protected by law but unclear how this will be enforced and whether this will be sustained.	Medium
Health sector-specific resources	“Sin” taxes, especially on cigarettes, and increasing the number of contributing SHI members may be utilized to generate fiscal space earmarked for health, but this may not be enough.	Medium
Health sector-specific grants and foreign aid	Dependence on external assistance is low, but declining aid trends limit potential to receive increases in aid for health.	Poor
Efficiency gains	Next chapter	Very good

most of the donor countries. Until 2011, aid had risen steadily for more than 10 years, however, aid for core bilateral projects, which fund many health programs in Vietnam, fell by 4.5 percent in real terms in 2011 (OECD 2012).

Recommendation

The costs of attaining the UC targets in the Master Plan cannot be met through additional fiscal outlays alone. Cost containment and mobilizing resources through efficiency savings will therefore be critical for achieving UC.

The future challenge for Vietnam will be to find ways to expand the fiscal space for health to accommodate emerging pressures for increases in expenditures, particularly given the policy goals of reaching 70 percent coverage by 2015 and 80 percent by 2020. This chapter assessed public expenditures on health in Vietnam from a fiscal space perspective. Table 5.4 summarizes the prospects of fiscal space for health from the five major pillars described in this chapter. The best options for fiscal space for health for Vietnam are likely to be from an improvement in the efficiency of existing resources in the health sector. This is the subject of the next chapter.

Notes

1. Empirical evidence suggests the importance of other factors such as the prevalence of corruption, ethno-linguistic fractionalization, and average education levels in the population as determinants of the extent to which health is, or is not, prioritized by governments.
2. These are based on the World Bank’s analysis of 2008 data from Vietnam.
3. World Bank staff estimates.

4. Vietnam's revenue share of GDP is about average for lower-middle-income countries; it is notably higher than that of neighboring countries such as Indonesia and the Philippines, which have revenue-to-GDP shares that are closer to 20 percent.
5. Public (or general) government spending on health includes all SHI expenditures.
6. Income elasticity is defined as the percent change in government health spending for a percent change in GDP.
7. This refers to health's share of aggregate government spending and is a proxy for prioritization; higher shares may not necessarily translate into higher per capita government health spending rates if, for instance, aggregate government spending is low in a given country.
8. National Health Accounts (NHA) estimates from WHO differ somewhat from country-specific estimates of government health spending and aggregate government expenditures reported in earlier sections of the policy note; for cross-country comparisons, the note reports WHO NHA data and for Vietnam-specific analyses the note reports country-specific data, the latter obtained from Vietnam Social Security (VSS), International Monetary Fund (IMF), and World Bank estimates.
9. Australia, the Republic of Korea, Thailand, and the United States are examples of countries that have successfully implemented earmarked taxes on tobacco and used the revenues for public health purposes. The Philippines has recently passed legislation that earmarks sin taxes for financing premiums of poor and vulnerable groups under their social insurance program.
10. Although there were no commitments for malaria or family planning in 2009 or 2010, there were disbursements for malaria in both years and for family planning in 2009. Between 2008 and 2010, about 13 percent of all disbursements were for STI control including HIV, 3.2 percent were for basic health care, 0.9 percent were for TB control, 1.1 percent for malaria, and 0.3 percent for family planning.

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Reducing Fragmentation in the Pooling of Funds

The previous two chapters showed that only a portion of the total projected costs of expanding coverage could be met through additional budgetary resources. This chapter and the next one examine how the available resources can be used most efficiently and equitably.

Fragmentation of social health insurance (SHI) funds is both inefficient and inequitable. In principle, Vietnam has a single-payer insurance system, with a single pool and unified benefits package. In practice, SHI funds and risk pools are highly fragmented across the multiple insurance groups and provinces. This has led to large inequalities, while unnecessarily increasing administrative costs in a context where fiscal space and financing options are limited.

Fragmentation in the Pooling of Funds and Its Implications

In principle, Vietnam's SHI program involves a single payer and a single pool with a unified benefits package. In the early stages of SHI development, multiple health insurance schemes were created (as described in chapter 1), each with its own fund. Moreover, between 1992 and 1998, each province had its own health insurance fund. The Health Insurance Law (HIL) of 2008 was an important step on the path to universal coverage (UC) because it consolidated insurance schemes and funds into a single insurance program and created a single payer in Vietnam Social Security (VSS). This put Vietnam ahead of several other countries in the region such as China and Indonesia, whose SHI schemes involve multiple payers.

In practice, Vietnam's SHI program is still characterized by a high degree of fragmentation in the pooling of funds. Under the HIL, SHI funds do operate within a single pool. In practice, there are 63 provincial pools covering populations ranging in size from 300,000 to 4.8 million people. The large number of membership categories, each of which makes differential contributions to the overall risk pool, worsens the fragmentation.

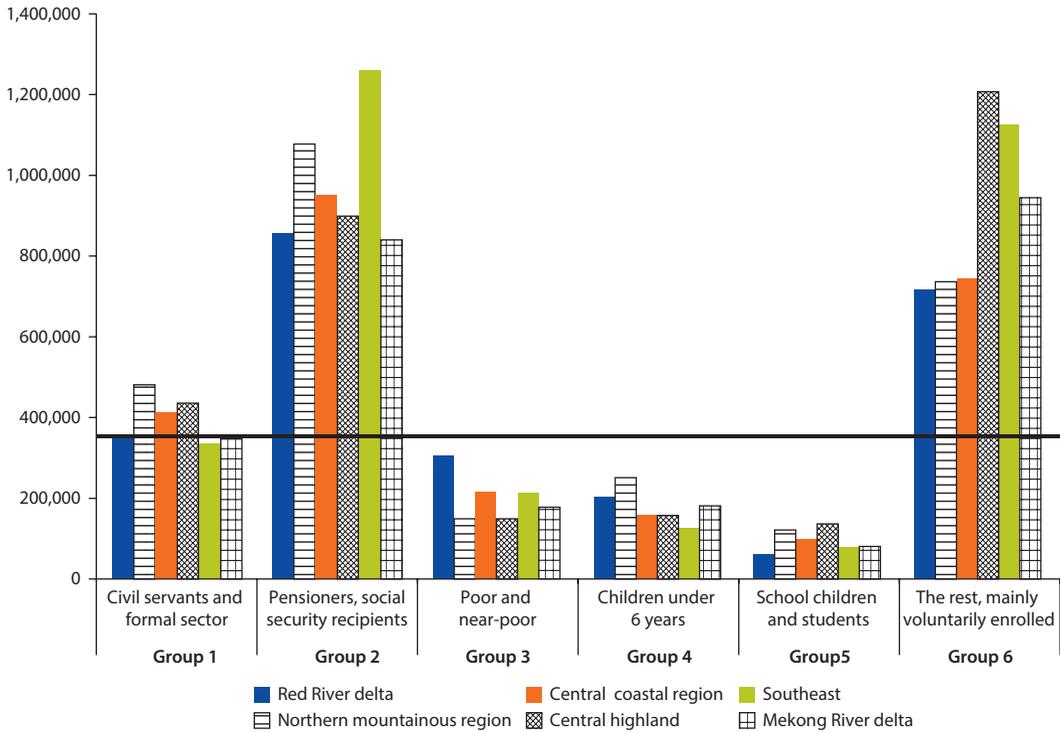
Risk pooling remains limited across insurance groups¹ and provinces. To begin with, insurance revenues are not pooled across insurance groups. The insurance groups are not based on the principle of risk of adjustment to ensure fair payments to facilities according to the case-mix risk of patients they manage within each group. There is considerable heterogeneity of risk across the insurance groups (Van Tien et al. 2011). Second, there is limited pooling of insurance revenues across provinces. Health insurance funds continue to be managed by provincial-level VSS. The value of the fund in any given province is capped at 90 percent of the contributions of members in that province. If a province ends up with a fund surplus at the end of the year, 60 percent is retained for investment, while 40 percent is absorbed into a central reserve fund. Third, the capitation system that is in place further contributes to the fragmentation in the pooling of funds. The capitation rates are calculated separately for each of the six different beneficiary groups based on historical expenditures and utilization of those specific groups (see appendix A for more details of the capitation method). The genesis of this fragmented system can be traced back to the early stages of SHI development when multiple insurance schemes were in existence.

The separate calculation of capitation rates for each beneficiary group worsens inequalities between the rich and the poor. The capitation rates largely reflect existing physical and geographic barriers to access to care for different groups. For instance, the capitation rate for civil servants and formal sector workers is almost twice that of the poor, despite having age- and sex-adjusted risks of incurring similar levels of health expenditures. Figure 6.1 shows average capitation rates by region for the six groups. In 2010–11, the annual premium for subsidized members was about Vietnam dong (VND) 380,000, or 4.5 percent of the minimum salary, denoted by the red line in figure 6.1. It is clear that school children and students as well as the poor are levied a capitation rate that is significantly below the contribution rate. In effect, the poor are subsidizing better-off groups such as formal sector workers and pensioners.

This method for calculating the capitation rate also worsens existing inequalities across provinces, as provinces with a larger share of poor or minority groups tend to have lower per capita expenditures than better-off provinces because these groups have lower utilization of services. This reflects, in part, the weaker infrastructure and quality of health services in those provinces. For instance, for the poor, capitation rates are highest in the Red River Delta, Southeast, and South Central Coast, probably reflecting greater ease of accessing services and greater availability of high-tech services in those provinces. The size of the capitation fund in each province, therefore, varies by the composition of the enrollees, geographic barriers to accessing services, and the technical capacity of hospitals to deliver services. Since the surplus of one province can be used to pay for the deficits of another, poorer provinces end up subsidizing richer provinces.

The so-called capitation system thus results in underprovision of services to the poor and other vulnerable groups. Given large differences in the capitation rates, provinces actually maintain subpools for each of the six groups and

Figure 6.1 Average Capitation Rates (VND) by Region (2011)



Source: HSPI 2013.

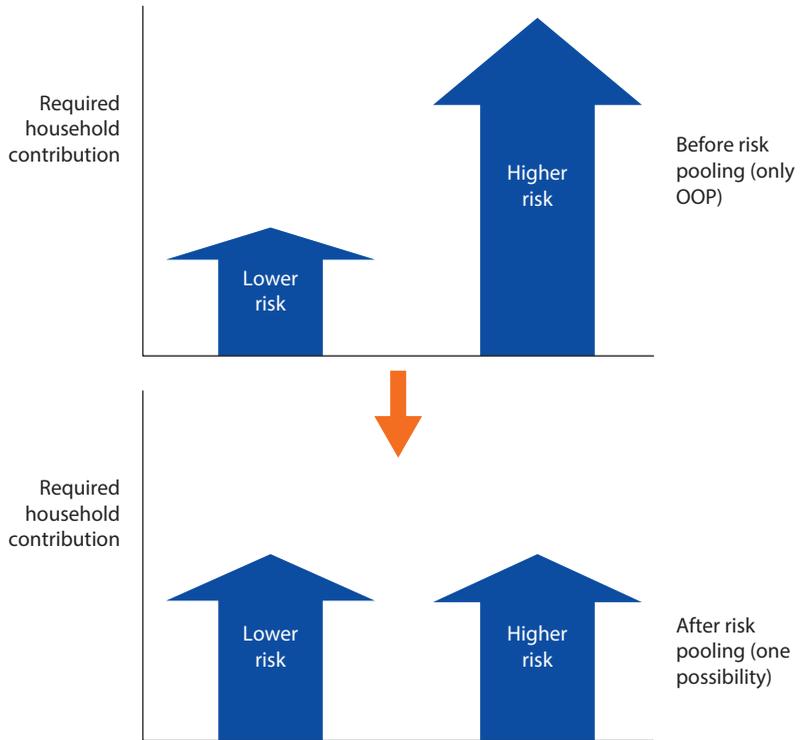
Note: Black line shows the annual premium for subsidized members of VND 380,000 (4.5 percent of the minimum salary).

transfer the subpool ceilings to district hospitals (Van Tien et al. 2011). District hospitals then limit services to within the available budget for each group. For instance, health facilities with a relatively large share of people receiving subsidies for the poor are more likely to underprovide services due to the relatively lower value of the capitation rate for that group. Combined with existing inequalities in utilization and expenditures (discussed in chapter 3), this pattern of underproviding for the poor worsens the fragmentation of pooling.

Finally, fragmentation is inefficient and increases administrative costs. Duplication of coverage is not uncommon, as in the case of children under six and students who are eligible for coverage under other categories as well. In addition, the relative lack of pooling decreases VSS’ ability to leverage benefits from strategic purchasing as multiple purchasers dilute incentives to increase provider performance (as will be discussed in chapter 8).

Global Experiences with Reducing the Fragmentation of Funds

A primary objective of UC is to pool risks from the rich to the poor, from the healthy to the sick, and from the young to the old. This helps improve equity in access to services and mitigates the impact of out-of-pocket payments on

Figure 6.2 Effects of Risk Pooling

Source: Baeza and Packard 2006. As cited in Langenbrunner and Somanathan 2011.

Note: OOP = out-of-pocket payments.

the poor, the sick, and the elderly (figure 6.2). Vietnam is not unusual in the region in not yet having fully achieved this objective. China, Indonesia, and the Philippines all have multiple insurance schemes, with each scheme varying in its dimensions of management and benefits, little risk adjustment across schemes, and consequently significant fragmentation in the pooling of funds. Indonesia has legislated a process for moving to a single scheme beginning in 2014, but it is not clear how long this will take in practice.

The risk pooling objective is generally better met as countries move from low- and middle-income to high-income status (Langenbrunner and Somanathan 2011). The strategies taken by Japan, the Republic of Korea, and Taiwan, China, to consolidate pooling are relevant because, historically, all three countries started out with multiple insurer schemes based on occupation and residence, as in Vietnam (box 6.1). The experience of Chile (box 6.2) is also worth noting because it highlights the beneficial impacts of consolidating pooling from an efficiency perspective. There are two key issues to note. One is that the consolidation of pools is a process that involves gradual integration as shown in figure 6.3. The other is that in all four countries discussed below, it was a complex technical and political process that took place over many years.

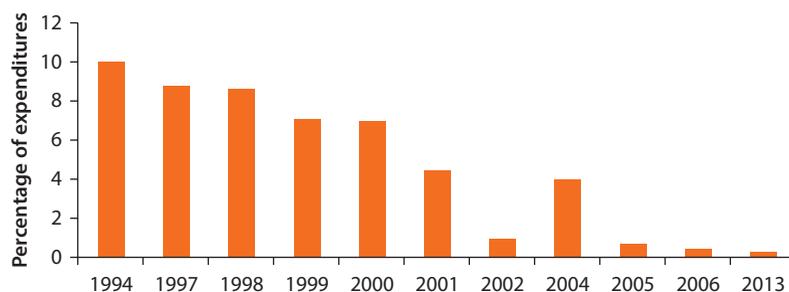
Box 6.1 The Evolution of Fund Pooling in Japan, the Republic of Korea, and Taiwan, China

Republic of Korea: The National Health Insurance System started with more than 350 not-for-profit health insurance societies for three different groups of insured persons: industrial workers, government employees and teachers, and self-employed workers. It was phased in over 12 years, beginning in 1977, according to the size of the employer. In July 2000, under strong political leadership, the societies were merged into a single scheme. The integration included 139 employee societies, 227 self-employed groups, and the government and private school programs. Inequity across income and occupation groups was a major concern leading to the reform. The financial merger was not fully implemented until July 2003. Administrative costs are much lower because of the integration of schemes—falling from an estimated 10.0 percent of all expenditures in 1994 to 0.4 percent in 2006 (figure B6.1.1).

Taiwan, China: UC was achieved by merging three existing SHI schemes into a single fund. Before 1995, only 57 percent of residents had coverage through Labor Insurance (instituted in 1950), Government Employee Insurance (1958), and Farmers' Insurance (1989). The single-payer model was developed to better ensure access and to better control costs at a national (and global) level (Lu and Hsiao 2003). Claims processing was standardized. As in Korea, administrative costs in Taiwan, China, are low, at an estimated 1.76 percent (Hu 2007).

Japan: Multiple pools exist but with equalization mechanisms to ensure risk adjustment. There are three separate tiers of SHI plans, with many variations within each. The first two tiers are employer based, and the third is community based,^a comprising about 3,000 plans in total. The contribution base and relative risks vary across Japanese plans and tiers. There are three equalization mechanisms across plans: (a) government subsidies for plans with low-income enrollees; (b) cross-subsidization across plans and a mandatory reinsurance

Figure B6.1.1 Administrative Costs as a Percentage of Expenditures in the National Health Insurance System of the Republic of Korea (1994–2006)



Source: Chun 2007. As cited in Langenbrunner and Somanathan 2011. Data for 2013 provided by the Korea Health Insurance and Review Agency 2014.

box continues next page

Box 6.1 The Evolution of Fund Pooling in Japan, the Republic of Korea, and Taiwan, China *(continued)*

fund for all plans (each plan contributes 80 percent of the total budget to a reinsurance fund, and medical claims exceeding a target level are then paid out of the reinsurance fund); and (c) a uniform fee schedule for providers (Ikegami 2008).

Source: Langenbrunner and Somanathan 2011.

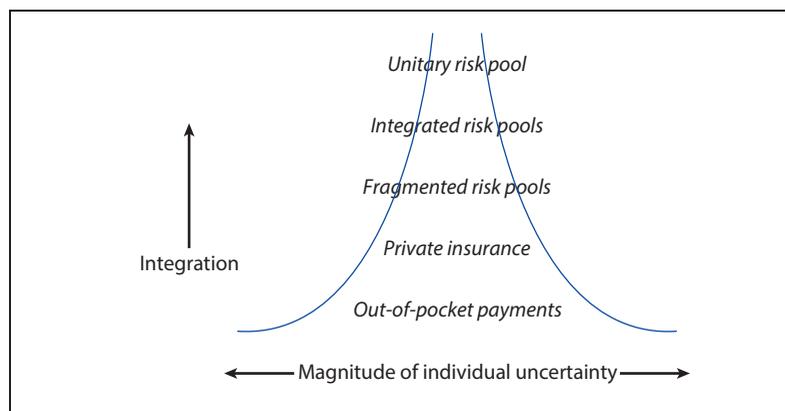
a. The first tier features the public sector plan, plans for employees of large companies, and plans managed by the mutual aid associations for civil servants. There are currently 78 plans for civil servants and 1,600 plans for employees of large corporations. The second tier consists of one government (MoH) subsidy plan for small- and medium-size enterprises. The third tier—so-called citizen health insurance for the self-employed and pensioners—consists of community-based plans, including 1,820 municipality-based plans and 166 occupation-based plans (for example, plans for carpenters, physicians, and dentists).

Box 6.2 Consolidation of Funding through Public Financing Reforms in Chile

In 1985, Chile implemented a radical reform of the health system (with structural reforms in the old-age pension system). The country separated the insurance and financial administration from public provision of health care services and created the Fondo Nacional de Salud (FONASA, or the National Health Fund). FONASA was financed by a combination of general taxation (to subsidize the contributions for the poor, who are included in the pool from general taxation) and a 7 percent payroll tax contribution from formal sector workers (public and private). The reform aimed to consolidate all public financing for health in a single fund, reducing duplication and establishing the basis for implementing strategic purchasing in the public sector. FONASA consolidated the Ministry of Health's (MoH) financing (from general taxation) and the public Social Insurance Scheme for formal workers (abolished in 1985). As a result of subsequent reforms in the mid-1990s and a final set of legal reforms in 2004, FONASA has become the most important insurer in the country, covering almost 80 percent of the population. FONASA is mandated to collect and pool all public revenue for health and to use the revenue to purchase services from public and private providers. Implementation of FONASA reforms has taken more than 10 years. Consolidating all resources was a complex technical and political process. FONASA's consolidation as the health service purchasing agency in the public sector has been particularly complex and required substantial political and technical efforts in the 1990s.

Source: Baeza and Packard 2006. As cited in Langenbrunner and Somanathan (2011).

Decentralization poses particular challenges for pooling. Extension of social protection may be more difficult without the strong involvement of provincial and district governments. As is the case in Vietnam, subnational schemes can contribute to the fragmentation of risk and inefficiencies, requiring strong central government regulation and leadership to ensure harmonization. China's National Cooperative Medical Scheme (NCMS) experience (box 6.3) is a good example

Figure 6.3 Risk Pooling

Source: Smith and Witter 2004.

Box 6.3 Harmonizing National and Subnational Efforts under the NCMS in China

China's NCMS required strong guidance from the central government to fulfill the objectives of financial protection and inclusion of the low-income population as mandated in the NCMS design. China staggered premium contributions to incentivize local governments to act. A greater proportion of premiums were paid by the central government, with provincial and district governments only providing a minimal match of funds. Insurance funds are pooled locally, giving local leaders the ability to take ownership, and align funds with local needs and participation. The management of pools of funds at local levels further strengthens local interest in the performance and outreach of the health system. Specific enrollment targets are set, and local authorities are assessed on how successful they are in meeting these targets.

Source: Bonfert, Martin, and Langenbrunner 2013.

of strong guidance from the central government being critical for achieving the financial protection and coverage goals of NCMS. There are several benefits of improved efficiency and equity in a single (national) pooling mechanism compared with multiple (subnational) pooling mechanisms (Kwon 2011).

Recommendations

Recommendation 1: Risk pools should be consolidated further by reducing the number of insurance categories.

All beneficiaries should belong to either the contributory regime or the subsidized regime. Further consolidation of categories is already under discussion for proposed revision of the SHI Law in 2014.

Recommendation 2: In the long term, the pooling function should be transferred from the 63 provincial VSS to the national VSS/Social Health Insurance Agency (SHIA).

As discussed in more detail in Chapter 8, this requires that VSS acquire the expertise and competence to properly conduct this critical task of risk pooling and not merely distribute resources without any form of risk adjustment or equalization.

Note

1. At present, there are six different insurance groups: (a) civil servants and formal sector workers; (b) pensioners, meritorious people, beneficiaries of social security/protection allowances, and veterans; (c) the poor and near-poor; (d) children under six years of age; (e) school children and students; and (f) all remaining members including voluntarily insured members.

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Strengthening Resource Allocation and Purchasing

The previous chapter examined inefficiencies in current arrangements for pooling resources. This chapter examines inefficiencies in current arrangements for resource allocation and purchasing, which include the following:

- 1. an overly generous benefits package that continues to be expanded without due consideration of cost-effectiveness and other criteria;*
- 2. provider payment mechanisms and the mix of incentives facing providers, which result in the overuse or supply of services;*
- 3. high prices, overconsumption, and inappropriate use of pharmaceuticals; and*
- 4. the structure and incentives embedded within the delivery system, which result in excessive use of hospital services and inefficient practices within hospitals.*

Underlying all of these inefficiencies is a set of distorted incentives facing providers, a consequence of the resource allocation and provider payment mechanisms as well as the market liberalization policies in the health sector in recent years in Vietnam.

Without reforms to address the above inefficiencies and underlying causes, any further progress toward universal coverage (UC) would be unsustainable. Needed reforms include (a) a clear process for refining and standardizing the benefits package; (b) substantial revisions to the capitation-type payment mechanism and fee-for-service (FFS); (c) measures to reduce inefficiencies in the procurement of, and payment for, pharmaceuticals and to control pharmaceutical prices; and (d) in the long term, the establishment of a well-defined package of primary care services that would be paid through capitation, alongside the strengthening of primary care infrastructure.

Getting better value for the existing resources will be critical for achieving the Government of Vietnam's (GoV) UC goals and for ensuring these goals are met in a financially sustainable manner. This requires increasing the efficiency of both tax and social insurance spending in the health sector. Efficiency is defined as utilizing and allocating inputs so as to attain the maximum possible output(s)

Table 7.1 Major Sources of Inefficiency in Health Systems Worldwide

<i>Cause</i>
1 Underuse of generics and higher-than-necessary prices for medicines
2 Use of substandard and counterfeit medicines
3 Inappropriate and ineffective use of medicines
4 Overuse or oversupply of equipment, investigations, and procedures
5 Inappropriate or costly staff mix, unmotivated health workers
6 Inappropriate hospital admissions and length of stay
7 Inappropriate hospital size (low use of infrastructure)
8 Medical errors and suboptimal quality of care
9 Waste, corruption, and fraud
10 Inefficient mix of health interventions (for example, between prevention and treatment)

Source: WHO 2010.

for a given level of inputs or attaining a given level of output with the minimum inputs (or the least cost). Two components of efficiency are generally differentiated: (a) *technical efficiency*, which attains the most output from a given set of inputs; and (b) *allocative efficiency*, which chooses the optimal set of inputs, given their prices, to attain the maximum output at least cost (Hollingsworth and Peacock 2008).¹

The resource allocation and purchasing decisions a country makes have the greatest impact on both technical and allocative efficiency. They include decisions about what services are covered (benefits package), who delivers the services (delivery structure), and what incentive structure underlies the payment for services provided (provider payment mechanisms). For instance, of the “Top 10” list of major sources of inefficiency in the health sector identified by the World Health Organization (WHO) (table 7.1), almost all are amenable to change through the design of the benefits package, provider payment mechanisms, and the delivery structure. This chapter examines the key elements of resource allocation and purchasing that need to be strengthened to generate the efficiency savings Vietnam needs.

Sources of Inefficiency

Design of the Benefits Package

The current social health insurance (SHI) benefits package is generous and continues to be expanded without evidence-based assessments or a standardized process. The package covered by SHI is defined in the Health Insurance List (HIL) to include a wide range of curative and preventive care services. The Law also specifies the copayment rates and benefit ceilings. Recent reforms have increased depth of coverage and all members are entitled to the same package, although not everyone benefits equally, as the inequalities presented in chapter 3 showed. The key issue is that there is no regulated or transparent process for making decisions regarding additions to the benefits package: no defined criteria, specification of information to be considered, or rules about who should be on the committee to represent different stakeholders and provide an unbiased and

expert opinion on the matter. In addition, Vietnam Social Security (VSS) is the payer and has no direct role in this process and, therefore, is the recipient of decisions which impact their sustainability. Finally, there is no specialized team responsible for providing informed and consistent decision making in this process based on cost-effectiveness analysis, health technology assessments (HTA), or evidence-based protocols.

A direct consequence of this benefits package design is that costs have increased rapidly, both for the insurer and the insured. The user fee schedule that VSS uses to reimburse providers was not increased from 2005 to 2012. Faced with a binding budget constraint, providers sought to ration services by billing patients for the extra cost of services covered by the generous benefits package which, in turn, explains the high and persistent out-of-pocket (OOP) payments (see chapter 3). The user fee schedule was revised in 2012 and added 993 service items not included in the earlier schedule. This is expected to put additional pressure on VSS expenditures from 2013 onwards. A particular source of inefficiency in the design of the benefits package is related pharmaceuticals, which are discussed in the section on pharmaceuticals below.

Provider Payment Mechanisms and the Mix of Incentives Facing Providers

GoV has taken some important and decisive steps in the area of provider payment reform. It has introduced a closed-ended provider payment system in the form of capitation. It has also introduced caps on FFS payments, and is experimenting with diagnostic related group (DRG) payments with the objective of eventually introducing case-based payments. Few countries have achieved UC and sustained it without moving away from, or strictly controlling, FFS provider payment systems.

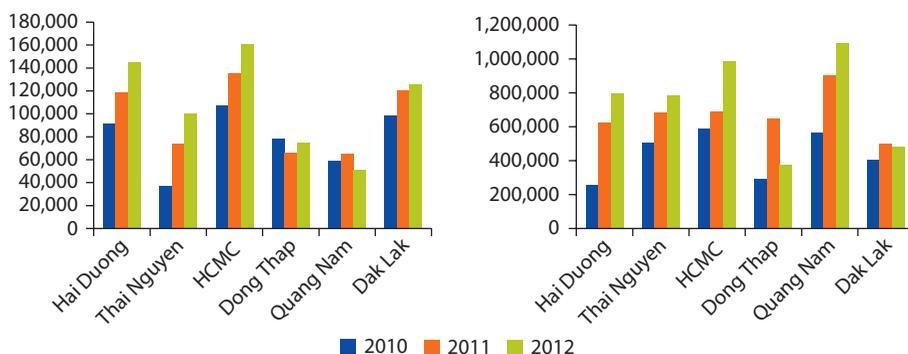
There is, however, a patchwork of payment mechanisms in place, giving rise to a highly fragmented system with conflicting incentives. Current payment mechanisms include FFS, capitation, and a DRG pilot, together with supply-side subsidies paid through both global and line-item budgets (table 7.2). In this context, the strategic purchasing function cannot be fully exploited to reduce inefficiencies in the pooling and purchasing of services.

The capitation system has not yet succeeded in controlling costs or contributed to the development of an effective district-level referral system. Although capitation was intended as a step toward more effective purchasing, there is very little difference in practice between FFS and capitation, and the capitation payment system does not include most of the features of capitation that are typically implemented internationally. The average payment per outpatient visit and inpatient admission at district hospitals has increased in nearly all of the study provinces since 2010 (World Bank 2013a) (figure 7.1). By placing district hospitals entirely at risk for the costs of referrals and self-referrals to the provincial level, the capitation system has provided little incentive for district hospitals to refer patients and carry out their gatekeeping functions effectively. Secondary and tertiary hospitals that are paid on an FFS basis have little incentive to control costs, since the risk is borne by the district hospital.

Table 7.2 Mapping of Provider Payment Methods by Different Health Purchasers in Vietnam

Type of provider	Purchaser			
	Provincial Health		Other Ministries	VSS
	MoH	Department		
Payment method				
Central hospitals	Global budget			FFS, Capitation
Provincial hospitals		Global budget		FFS, Capitation
Provincial preventive centers		Global budget, Line item budget		
District hospitals		Global budget		FFS, Capitation
District health centers		Global budget, Line item budget		
CHSs		Line item budget		
Other ministry hospitals			Global budget, Line item budget	FFS, Capitation
Private clinics				FFS, Capitation
Private hospitals				FFS, Capitation (rare)

Source: HSPI 2013.

Figure 7.1 Average Payment (in VND) by VSS to District Hospitals per Outpatient Visit (Left) and Inpatient Admission (Right) (2010–12)

Source: HSPI 2013.

Note: HCMC = Ho Chi Minh City.

The continued reliance on FFS payment methods combined with the introduction of market liberalization policies in the health sector has led to providers engaging in revenue-enhancing practices. Supply-side subsidies account for less than 30 percent of total hospital revenues. The majority of central and provincial hospitals derive 70 to 90 percent of their revenues from the provision of services reimbursed by VSS, from patients, or both. The market liberalization policy has made hospitals financially dependent on sales revenues. The combination of a limited supply-side subsidy, market liberalization policy, and FFS payments has distorted incentives. Providers face strong incentives to generate demand by creating new service lines, investing in new medical equipment, and providing more intensive procedures. The Hospital Autonomy policy (Decree No. 43) has

created an enabling environment to respond to these incentives by allowing hospitals to define service mix and mobilize resources. This created an explicit link between hospital revenues and staff incomes and reinforced incentives to engage in revenue-enhancing practices.

Revenue-enhancing practices by providers result in the oversupply of equipment, procedures, and drugs, and are a major source of inefficiency. Most hospitals operate profit-sharing schemes among staff, in accordance with Decree No. 43 regulations. These include the payment of performance-related bonuses well in excess of the government salaries paid to staff. Second, the practice of “social mobilization” is used in most central and provincial hospitals whereby staff pool money to make the investment. Since revenues from the use of the equipment contribute to the profit-sharing schemes, staff face strong incentives to perform as many procedures as possible using the equipment. Technology is also purchased for marketing purposes. For instance, one provincial hospital possesses seven ultrasounds, each producing an average of 107 tests per day. In short, hospital autonomy without accountability, combined with a lack of effective control of FFS mechanisms, encourages hospitals to increase high-cost services.

Pharmaceutical Procurement and Consumption

The rapid escalation of pharmaceutical costs in Vietnam poses a major threat to SHI’s financial sustainability and the goal of achieving UC. Drug and medical price inflation have generally exceeded general inflation in recent years. Pharmaceuticals account for a disproportionately large share of insurance and OOP spending. Chapter 3 showed that drugs account for a significant share of total OOPs. In 2009 and 2010, pharmaceuticals accounted for 69 percent and 60 percent respectively of total VSS spending on health. Pharmaceuticals also accounted for 64 percent of all government central hospital spending, and 70 percent of provincial hospital spending (VSS and user fees). VSS pays an average of 89.2 percent of total pharmaceutical expenditures in hospitals (Escalante 2012).

High Pharmaceutical Prices Associated with Inefficient Procurement

High pharmaceutical spending is driven in part by the high prices paid for pharmaceuticals. Drug prices in Vietnam are significantly higher than international reference prices (IRPs). Among publicly procured drugs, prices for innovator brand drugs in Vietnam were 10.4 times higher than IRPs for the same drugs, and prices for lowest-priced generic equivalents 1.1 times higher in 2010 (table 7.3).

Table 7.3 Ratio of Median Prices to IRPs (2010)

<i>Type</i>	<i>Public facilities</i>	<i>Hospital dispensaries</i>	<i>Private drug outlets</i>	<i>Overall</i>
Innovator brand (IB) drugs	10.4 (0.4–22.2)	13.0 (0.4–41.8)	13.4 (0.4–41.5)	12.1 (0.4–41.1)
Lowest-priced generic equivalent	1.1 (0.1–3.4)	1.4 (0.1–5.1)	1.7 (0.1–5.1)	1.4 (0.1–4.9)

Source: Escalante 2012.

Note: Range of values around the median is shown in parentheses.

Although the domestic-to-IRP differential has narrowed since 2005 (Nguyen et al. 2009) thanks to efforts to tighten drug policy (Decree 79 and Circular 11),² it is still quite large and a major source of inefficiency. Not only are prices high, they are also increasing rapidly. In 2012, medicines and health care posted the highest increase in the consumer price index (CPI) at 3.36 percent (GSO 2012).

Inefficiencies in the procurement of pharmaceuticals are a key factor underlying the high prices paid for pharmaceuticals in Vietnam. First, the current procurement system is highly decentralized and complex, involving more than 1,000 entities (figure D.1, appendix D). It results in wide differentials in the prices of medicines, often for the same type, dosage, and formulation across hospitals and supplies (figures D.2 and D.3, appendix D) (Escalante 2012). Second, the procurement system is characterized by irregularities that contravene procurement regulations, which mandates awarding the contract to the suppliers with the lowest prices. For instance, in the case of Hospital A shown in figure D.4 (appendix D), the tender for the same drug was awarded to five different suppliers at different prices. Members of hospital procurement committees report that winning bids are often based on doctors' requests and perceptions of quality and efficacy, or on hospital management decisions (Escalante 2012). Doctors' perceptions are influenced by payments of commission by pharmaceutical companies. A government internal audit in 2012 showed that losses associated with bidding amounted to Vietnam dong (VND) 22 billion (approx. US\$1 million). The audit found that tender prices were 47–357 percent higher than the actual winning bids, and that prices of the winning bids were often higher than prices offered by unsuccessful bids. In Hanoi, the prices of winning bids are 130–245 percent higher than the import prices including cost, insurance, and freight costs (Escalante 2012).

Overconsumption and Inappropriate Use of Pharmaceuticals

The combination of FFS payments with market liberalization policies in the health sector has contributed to the overconsumption of pharmaceuticals. As explained in the previous section, providers face strong incentives to increase volume, purchase consumables and drugs with high margins, and decrease use of those consumables and drugs with low margins. Since secondary and tertiary hospitals do not bear any of the risk associated with high drug spending under FFS payments, they are more likely to overprescribe drugs for insured patients. VSS and patients (via user fees) bear the cost. This is compounded by the practice of pharmaceutical companies paying commission to providers as incentives for prescribing their drugs.

The policies and regulations to control overconsumption of pharmaceuticals are ineffective. Regulations such as limits on the value per prescription or requirements to dispense low-priced generics are in place to restrict spending on pharmaceuticals. Providers evade such regulations by recording more than one visit per patient to elicit a higher reimbursement value for those pharmaceuticals, or by requiring that patients pay OOP for alternative, better-quality drugs on the market (Khanh 2007). Similarly, there are regulations prohibiting the payment of commissions to doctors by pharmaceutical companies, but these have little effect.

Both providers and patients have a strong preference for branded and imported drugs which tend to be more expensive. Generics are less likely to be available at health facilities and less likely to be prescribed (Escalante 2012). Lowest-price generics were available in only 26 percent of public health facilities, 21 percent of hospital dispensaries, and 29 percent of private drug outlets in 2010 (WHO, DAV, and HSPI 2010). These rates have declined since 2005. Generics accounted for a relatively low share of medicines prescribed at the different hospitals—37 percent in central hospitals, 22 percent in provincial hospitals, 29 percent in district hospitals, and 38 percent in commune health stations (CHSs).

Imported products comprised 57 percent of total pharmaceutical consumption in 2010 (WHO-UNIDO 2011) and accounted for 80 percent and 60 percent of total procurement at central and provincial hospitals respectively (see figure D.5, appendix D, for the value in VND). Only 25 percent of prescriptions for generic medicines in hospitals are for locally manufactured products (Economist Intelligence Unit 2011). These patterns of procurement and consumption of drugs persist despite policies and regulations which encourage the use of the low-cost locally manufactured and/or generic drugs.

There is also a great deal of irrational use of pharmaceuticals including the excessive use of antibiotics and corticosteroids. Two surveys on the rational use of drugs conducted by Ministry of Health (MoH) and WHO (MoH and WHO 2009; WHO, DAV, and HSPI 2010) provide evidence of this. The 2009 survey found that 71 percent of all inpatients and 47 percent of outpatients were given at least one form of antibiotics. Of the inpatient cases who were prescribed antibiotics, 22 percent were cases of acute pneumonia, for which antibiotics are indicated; 78 percent were cases of hypertension, diarrhea, and normal delivery, for which antibiotics are not normally indicated. The 2010 survey found that in the records of child pneumonia examined, antibiotics were prescribed to all, corticosteroids to 40 percent, and at least two antibiotic combinations to 49 percent of cases. A volume analysis of the top 30 medicines with the highest consumption value shows that a disproportionately large share is accounted for by products with little therapeutic value (such as glucosamine, ginkgo biloba, and sodium ophthalmic drops).³

Finally, as with the rest of the benefits package, there is no evidence-based process for selecting drugs for reimbursement. The Health Insurance Reimbursement List (HIRL) for reimbursement by VSS for modern medicines contains 900 types of medicines based on their International Proprietary Names, with 1,143 types, formulations, and combinations (table 7.4). Only 27 percent (128) of drugs in the National Essential Medicines Lists (EML) are contained in the HIRL. Circular 30 clearly states that medicines that are not contained in the EML and are not recommended in the WHO Model List should not be included in the HIRL and yet, the HIRL includes hundreds of such formulations and combinations.

Structure and Incentives of the Delivery System

Excessive use of hospitals and inefficient practices within hospitals are the two major inefficiencies related to the broader delivery system. To begin with,

Table 7.4 Comparison of the Structure of the HIRL for Medicines with WHO and National EML

<i>Comparative parameters</i>	<i>WHO Model List^a</i>	<i>National EML</i>	<i>HIRL</i>
Total number of medicines by International Nonproprietary Names (INN)	423	476	1,143
Number of therapeutic categories	29	28	30
Process for inclusion	Evidence-based; cost-effectiveness analysis; HTA	Primarily based on WHO Model List	Submissions from hospitals
Categorized based on level of care	Yes: core and complementary lists	Yes: Level I-IV of health facilities	Yes: Level I-IV of health facilities
Appropriate dosage forms provided	Yes	No	No
Price criteria	Yes	Unclear	No

Source: Escalante 2012.

Note: Level 1: Specialized, central, and tertiary hospitals; Level 2: Provincial hospitals; Level 3/4: District and intercommune hospitals.

a. The WHO Model List is classified into the core and complementary lists, where the core list presents a list of minimum medicine needs for a basic health-care system, and includes the most efficacious, safe, and cost-effective medicines for priority conditions. The complementary list presents essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, and/or specialized medical care and/or specialized training are needed.

Table 7.5 Distribution of Patients Treated at Hospital Outpatient Department by Hospital Level for Conditions Treatable at Lower-Level Facilities by Level Where They Should Be Treated
Percent

<i>Level where patients should be treated</i>	<i>Central general hospital (n = 1946)</i>	<i>Central obstetrics hospital (n = 557)</i>	<i>Central pediatrics (n = 448)</i>	<i>Provincial general hospital (n = 5316)</i>	<i>Provincial specialty (n = 1722)</i>	<i>District hospital (n = 4797)</i>
Central hospital	39.1	6.5	5.8	2.7	0.9	0.4
Provincial level	35.4	43.3	35.5	43.3	42.4	7.3
District level	20.2	49.3	58.3	41.4	47.4	71.4
CHS	–	–	–	10.9	5.8	19.1
Other specialty	5.3	0.9	0.4	1.7	3.5	1.8

Source: HSPI 2010.

Note: This table is based on a one-day sample of outpatients and appropriateness of care (for that level) assessed by attending physicians and based on “technical level” norms of MoH.

hospitals are widely used for conditions that can be delivered more cost-effectively at lower levels of the system. A recent study (World Bank, MoH, and HSPI 2011) found that, between 2004 and 2008, average outpatient utilization increased by 10 percent annually in central hospitals and provincial general hospitals, and 14 percent in district hospitals in the sample. The same study found that the number of hospital visits and admissions increased by 1.3–1.5 times in central hospitals and provincial general hospitals, and 1.2–1.4 times in district hospitals. While part of the increase in hospital utilization is almost certainly due to increases in income and insurance coverage, part of the increase was likely due to services that could have been provided at a lower level.

A recent Health Strategy and Policy Institute (HSPI) study found that most central-level tertiary care hospitals act as secondary care facilities, providing services that can best be handled at provincial and district hospitals, while provincial hospitals handle cases more appropriate for district hospitals (table 7.5). Secondly, these overused hospitals are characterized by a high level of internal inefficiency. The combination of rising occupancy and unchanged average length of stay (ALOS)

rates suggests that there has been little improvement in the efficiency of case management over time. In addition, patient flow management is deficient in hospitals. This is marked by the absence of an appointment system to rationalize patient flows and a poorly functioning referral mechanism.

The direct consequence of this is overcrowding at the secondary and tertiary levels of the system. For inpatient care, bed occupancy rates are very high even when “actual” beds are considered (HSPI 2010) (table 7.6).^{4,5} ALOS rates have also remained high and stable from 2004 to 2008 for the hospitals included in the HSPI study. For outpatient care, overcrowding is associated with very high workloads for staff, especially physicians; however, there is little actual evidence that the workload for staff is unmanageably high.

There are three key factors underlying inefficiencies related to the service delivery system. One is the revenue-enhancing practices by providers, which were discussed above. Under FFS payment, hospitals also face incentives to keep patients in hospital for longer and provide more services. A second factor is deficient and poor quality care at the lower levels of the system. VSS rules on volume and dosage of drugs discriminate against the lower levels. This worsens care at lower level facilities. As a result, patients lack confidence in lower-level facilities and bypass the district hospitals and CHSs to seek care at hospitals. A third factor is the lack of coordinated care and adequate gatekeeping functions in the system.

Last but not least, a common element in all of the above inefficiencies is the lack of strategic purchasing capacity in VSS. In chapter 6, it was argued that the fragmentation of fund pools limits the purchasing power of VSS. Chapter 8 will argue that a lack of clarity over key SHI responsibilities, specifically those of the purchaser, is a key underlying factor. As discussed in the next section, global experience also shows that strategic purchasing capacity is critical for achieving cost containment.

Table 7.6 Hospital Bed Occupancy Rates (2008)

Percent

Factor	Based on statistical ledgers (N)		
	Central hospitals (34)	Provincial hospitals (62)	District hospitals (614)
Occupancy rates:			
On planned beds	85–290	109–141	91–139
On actual beds	–	99–127	88–120
Number of hospitals with Occupancy rate >100%			
On planned beds	29	57	404
On actual beds	21	42	304
Factor	Based on sample survey (N)		
	Central hospitals (5)	Provincial hospitals (9)	District hospitals (6)
Occupancy rates:			
On planned beds	138–193	92–211	101–186
On actual beds	–	74–145	–

Source: HSPI 2010.

Global Experiences with Strengthening Resource Allocation and Purchasing

Rationalizing the Benefits Package

Most countries, in particular those with SHI financed systems, grapple with decisions about which services to include in the benefits package and at what level of patient cost sharing. Ideally, it should be based on objective criteria such as cost-effectiveness, medical necessity, potential financial burden on patients, and impact on the fiscal status of health insurance, and determined through a transparent process. In practice, however, it is inherently a priority-setting exercise involving value judgments and influenced by a mix of political, social, and economic factors.

Two specific challenges that countries often face are related to uncertainty about what a core package is, and the “delisting” of services from existing packages. There is no clear evidence or guidance at present on what a core package of services should include. Since insurance is primarily about protecting individuals from catastrophic financial expenses, it is often argued that the core package should focus on covering these; however, this creates incentives for people to postpone seeking care until acute services can be accessed. Besides, it is outpatient care along with high pharmaceutical expenditures that often results in catastrophic expenses for low-income households (Wagner et al. 2011). It is also argued that providing a good outpatient benefits package is strategically important because it increases the enrollees’ exposure to the health insurance system, and encourages them to stay enrolled (Kwon 2011). Meanwhile, highly cost-effective nutrition-related and maternal and child health interventions are often left out of the package because, at least historically, they have been covered through vertical programs.

Removing or “delisting” services can be politically difficult when the starting point is an overly generous benefits package as in Vietnam. In the Republic of Korea, for instance, the national health insurance scheme started with a low benefits package and benefit coverage was extended incrementally. The government placed a higher priority on the extension of population coverage because extending benefit coverage (with a high contribution) can be a barrier to the rapid extension of population coverage (Kwon 2009). However, this meant that insurance coverage was lacking in depth and left households vulnerable to large copayments.

In countries that have introduced evidence-based and informed decision making for the benefits package, instituting a transparent process has been the key to success. This typically involves a committee consisting, among others, of providers and researchers who are charged with making recommendations based on clear and agreed-upon criteria such as cost-effectiveness, medical necessity, and financial burden on patients. The committee and decision process can be used for the inclusion of new services, exclusion of existing services, and the copayment rate for different types of services, providers, and patients. HTA may be used as part of this process, but not on its own.

Benefits package design and revision cannot be reduced to a single methodology and relies instead on balancing evidence and value judgments through a consensus-building process. Thailand's Universal Coverage Scheme (UCS) (box 7.1) and Korea's National Health Insurance program (box 7.2) provide good examples of this process.

Refining Provider Payment Mechanisms

In many countries in the East Asia Pacific region the situation is similar to Vietnam. Line-item budgets, typically based on bed norms, have created incentives for hospitals to admit and keep patients for longer than necessary. The significant inflationary effects of FFS systems are well established in Canada; the Czech Republic; parts of the Russian Federation; Taiwan, China; and the United States (Langenbrunner and Somanathan 2011). FFS systems are, however, still relied upon and are associated with providers oversupplying services.

Optimal systems do not exist and provider payment systems and incentives need to be designed to address the specific policy issues and objectives inherent in a country's health sector (Langenbrunner and Somanathan 2011). There are, however, a few key trends from the global experience that are worth noting. First, for physician services, three provider payment models tend to dominate in Western Europe and the high-income countries of East Asia: salary, capitation,

Box 7.1 The Benefits Package Decision Process under the UCS in Thailand

With new health technologies and interventions, the National Health Security Office's (NHSO) Committee on Benefits Package is in charge of revising the benefits package and making recommendations to the NHSO on the adoption of new drugs and technologies based on guidelines established in 2010. The NHSO requests the Health Intervention and Technology Assessment Program and the International Health Policy Program, two technical agencies working on health technology assessment and health system evaluation under the Ministry of Public Health, to supply evidence such as the effectiveness and cost-effectiveness of various health interventions that will be considered for benefits package expansion. Financial feasibility, budgetary impact, and ethical considerations are among the important criteria involved in the decision-making process.

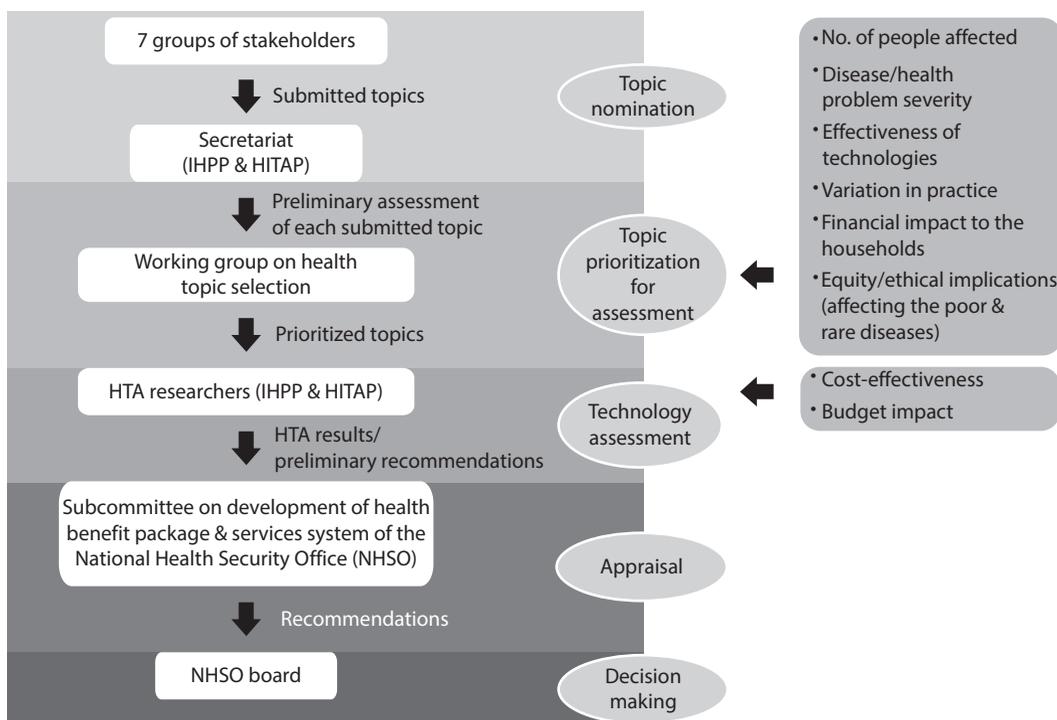
A recent example is the case of the Human Papilloma Vaccine, where the Committee on Benefits Package did not accept it for inclusion in the benefits package even though the vaccine-producing company offered the price more cheaply than was deemed to be cost-effective (Praditsitthikorn et al. 2011). There have, however, been treatments or interventions that have been included (such as renal replacement therapy) despite potential long-term affordability challenges.

The explicit protocol to include economic evaluation and budget impact evidence in the Committee's decision-making process on Benefit Package was adopted in 2012. The schematic diagram of the decision process is provided below (figure B7.1.1).

box continues next page

Box 7.1 The Benefits Package Decision Process under the UCS in Thailand (continued)

Figure B7.1.1 Schematic Diagram of the Decision Process



Source: Hanvoravongchai 2013.

Note: IHPP: International Health Policy Program, Thailand. HITAP: Health Intervention and Technology Assessment Program.

Box 7.2 The Benefits Package Decision-Making Process: Republic of Korea National Health Insurance

The following are the steps taken under the National Health Insurance program in the Republic of Korea to add new services to the benefits package:

1. Consumer or provider groups make a request to include a new health technology or intervention.
2. The request is reviewed by committees (consisting of experts) at the National Health Insurance Service (NHIS) and Health Insurance Review and Assessment Service (HIRA) based on various criteria (clinical effectiveness, cost-effectiveness, number of patients affected, financial OOP burden, and budget impact).
3. The final decision is taken by the Health Insurance Policy Committee (a tripartite committee consisting of consumers, providers, and the government/public sector).

Source: Kwon 2013.

and FFS, or some combination of the three. The FFS model in Western Europe and Japan is quite different from the one in Vietnam. Specifically, the FFS systems in the former are subject to an overall cap on total expenditures, and prices and volumes are determined within the target ceiling. This strategy avoids the cost inflation associated with FFS payment in many settings. Second, for inpatient care services, countries tend to move to some combination of global budgets and case-mix adjusted payment categories within the hospital sector. In Western Europe, most countries have moved to a performance-based approach using some combination of payment per admission based on case-mix-adjusted DRGs, while subject to a global budget. Third, the presence of a large purchaser with adequate strategic purchasing capacity has proved critical for cost containment. Being a large, preferably single purchaser, gives the purchaser greater bargaining power to negotiate prices with providers, and control utilization and quality (box 7.3).

Box 7.3 Cost Containment through Provider Payment and Purchasing Reforms in Thailand and Turkey

Thailand

The NHSO is the largest purchaser in Thailand, purchasing services on behalf of 75 percent of the total population (approximately 50 million UCS members). The NHSO has adequate strategic purchasing capacity and has used its bargaining power to reduce the price of medicines, medical products, and interventions over time. For instance, the price of hemodialysis decreased from US\$67 to US\$50 per cycle, leading to savings of US\$170 million per year.

The combination of mixed payment methods (capitation for outpatient care and DRGs for inpatient care) with a global budget for inpatient care has further contributed to cost containment. The closed-end payment system has provided strong signals to providers to contain costs by prescribing generic medicines, appropriate dispensing of medical technologies, and encouraging preventive treatments. At the same time, to counteract underprovision of services, a potential downside of closed end payment, NHSO has established mechanisms such as (a) a 24-hour complaint management mechanism by NHSO staff; (b) quality assurance through hospital accreditation mechanisms; (c) a routine auditing system by random medical audit teams with financial penalties in place; (d) utilization reviews to monitor utilization rates; and (e) an annual poll survey of consumers' and providers' satisfaction conducted by independent polling institutes.

It should be noted that, despite the above measures, overall UCS expenditures have continued to rise. The cost per member rose from Thai baht (B) 1,201.40 in 2002 to B 2,693.50 in 2011, or a total of less than B 60 billion in 2002 to over B 120 billion in 2011. This is equivalent to a 70 percent increase in real terms over the period. The increase is attributed to rising remuneration of health care staff, particularly a rapid increase in extra incentive payments to keep highly skilled professionals in the system.

box continues next page

Box 7.3 Cost Containment through Provider Payment and Purchasing Reforms in Thailand and Turkey (*continued*)

Turkey

During the 2000s, Turkey undertook comprehensive hospital reforms in the broader context of the Health Transformation Program, which was geared toward improving effectiveness, equity, and efficiency. A key reform in this area was the introduction of a performance-based supplementary payment system for employees of MoH hospitals beginning in 2004, based on prespecified individual and institutional criteria. These changes in hospital financing were facilitated by reforms that brought together all previous health insurance schemes under the umbrella of the Social Security Institution. Furthermore, expenditure caps for the MoH, private, and university hospitals have been introduced in recent years to ensure controlled growth in hospital spending that is in line with GDP. In 2007, a fixed global budget for all MoH hospitals was implemented and, to date, this has been successful in containing further spending growth in these hospitals. Since 2010, the government has also successfully maintained spending with agreed limits for university and private hospitals.

Source: Hanvoravongchai 2013; World Bank 2013b; World Bank 2013c.

Containing Pharmaceutical Costs

Successful control of pharmaceutical spending requires a combination of initiatives involving procurement reform and “smart purchasing” of drugs. In other countries, these reforms have included efforts to shift preferences toward generics, external reference pricing, the regulation of margins, clawbacks, price volume contracts, and a systematic review of reimbursement policies, especially for high-cost drugs (Seiter 2010). Meanwhile, addressing the problem of overconsumption and inappropriate use of pharmaceuticals will require greater transparency and sharing of information, better monitoring, and, most importantly, provider payment reforms. Box 7.4 describes strategies adopted by a number of countries to control pharmaceutical costs.

Recommendations

Recommendation 1: Rationalize and cost out the benefits package.

Short Term:

- Institute a transparent process for rationalizing the benefits package, particularly for adding new technologies and services. The process and the criteria used to assess technologies and services need to be agreed on. This step should be implemented alongside efforts to clarify the roles and responsibilities of the key players (MoH, VSS) in the determination of the benefits package (discussed in chapter 8).
- This rationalization process should avoid the false dichotomy that often exists between preventive and curative care services, which often results in critical

Box 7.4 Effective Containment of Pharmaceutical Costs in Selected Countries

Croatia: After several years of growing cost pressures, during 2009–10 Croatia reformed its regulations related to the pricing and reimbursement of medicines. Reforms included greater transparency in decision making; a stronger role for evidence-based medicine and health economic criteria; so-called rebates, payback, and cross-product agreements in contracting with pharmaceutical companies; and other measures. As a result of these steps, expenditure on prescription medicines fell by 13 percent between 2009 and 2010, while spending on expensive hospital medicines decreased by 29 percent (Voncina and Strizrep 2010).

Republic of Korea: The National Health Insurance Service (NHIS) has put in place a mix of strategies to help contain pharmaceutical costs. Since 2006, NHIS has had a positive list of drugs in the benefits package, with two distinct steps taken to include new drugs into the list. When a new drug is imported or produced, HIRA takes the decision to list the drug based on cost-effectiveness, clinical effectiveness, budget impact, and whether and at what price the drug is reimbursed in other countries. The NHIS then negotiates the prices of the drug directly with pharmaceutical manufacturers using a price-volume arrangement. The price is negotiated based on the expected sales of the new drug as well as the substitution effect. If actual sales exceed expected sales during a specific period, the price of the drug is reduced proportionately. The decision to include the drug in the positive list is taken at the end.

Thailand: The Universal Coverage Scheme (UCS) employs several mechanisms to help contain pharmaceutical costs. The pharmaceutical benefit package is based on the National Essential Drug List, which includes medicines that are selected based on their effectiveness, safety, as well as cost-effectiveness. It also has a specific policy for encouraging generic drug prescriptions. The UCS also has strong monopsony power to negotiate prices with service providers and suppliers. For high-price pharmaceuticals, a central price negotiation system is in place to collectively bargain for the best-priced items. UCS previously also used the threat of compulsory licensing of medicines to obtain cheaper prices for drugs that are still under patent (for example, antiretrovirals, cancer drugs, and erythropoietin). It is estimated that the NHSO saved B 12.5 billion through a combination of cost-control measures, including on pharmaceuticals.

Source: Croatia—World Bank 2013d; Republic of Korea—Lee 2013; Thailand—Hanvoravongchai 2013.

personal preventive services being excluded from the package. Personal preventive services that have proven to be highly cost-effective and equity enhancing in other settings include counseling, family planning, screening, and nutrition services.

- Expand the evidence base on costs and cost-effectiveness to support the above process. UNICEF is already supporting efforts to develop and cost a package of interventions for women and children.
- With respect to the pharmaceutical benefits package:
 - Carry out a systematic review of the current health insurance and other drug lists, taking into account the therapeutic value of drugs, cost-effectiveness,

and other important criteria. A first step would be to remove all drugs that are known to be ineffective or to have a negative risk-benefit ratio based on the literature. A set of rules for including new drugs in the list can then be developed. This could be based initially on a needs assessment and the cost impact of the drugs, and use relevant data from other countries with advanced HTA systems;⁶ and

- Adopt a formulary to restrict reimbursement to essential or cost-effective medicines.

Medium Term:

- Introduce differential cost-sharing arrangements based on service characteristics to modify financial incentives faced by patients;
- Strengthen clinical governance so that the provision of care under the benefits package is based on evidence-based clinical decision making; and
- With respect to the pharmaceutical benefits package,
 - Shift insured patients' preference toward lower-cost generic drugs. This can be achieved through lower copayments to encourage consumption of generic medicines (Kaplan, Wirtz, and Laing 2011) and information to help overcome potential biases against local and/or generic drugs.

Recommendations 2–4 below relate to reform of the provider payment system and were drawn up through the Provider Payment Diagnostic Assessment that GoV undertook during 2012–13.

Recommendation 2: Harmonize the appropriate mix of payment systems.

Short Term:

- For provincial hospital services, the capitation payment system should be immediately revised to remove provincial-level referrals and self-referrals. An alternative payment system should be used to pay for provincial-level referrals, such as capped FFS for outpatient specialty services and case-based payment for inpatient referrals.

Medium Term:

- For provincial hospital services, the above reforms should be accompanied by referral guidelines related to clinical practice guidelines or clinical pathways that are currently being developed. HSPI is currently developing a simulation model to predict the potential impacts on resource allocation across districts and levels of care, as well as total costs to VSS of alternative payment models for provincial-level referrals.
- For district hospitals, Vietnam should consider removing all inpatient services from the capitation payment system. International experience shows that capitation is rarely, if ever, used to pay for inpatient services. There are several reasons for this. First, unlike primary care, inpatient service utilization is

infrequent at the individual level and, therefore, more difficult to predict at the small population level. It is, therefore, unlikely that the capitated hospital payments will match actual need and utilization. Second, the incentives of capitation to reduce input use and shift services to prevention while reducing curative services could have more serious adverse consequences at the level of inpatient services. As in the case of provincial-level services, capped FFS for outpatient specialty services and case-based payment for inpatient services could be considered also for district hospitals, depending on the results of the simulation and impact analysis.

- A well-defined package of primary care services that would be paid through capitation should be identified, including diagnosis and treatment of common diseases at the district hospital, district health center, and CHS levels. Medicines that are related to these services and already covered in the benefits package should also be included. Preventive services are currently excluded because they are paid through the budget, but over time capitation should include prevention and health promotion to create the full incentives for providers to prevent and manage common conditions. Although the package should be clearly defined, flexibility will be needed in the short to medium term because capacity varies at the district level, and there are no clear guidelines for what should be managed at the district level and what should be referred.

Recommendation 3: The provider payment systems should be designed more strategically to contribute to key health system objectives: reducing the fragmentation of risk pools and expanding effective coverage, addressing the problem of hospital overcrowding, and overuse of high-cost services.

Medium Term:

Introduce reforms to the capitation payment system:

- Equalize the capitation base rate. While it has been difficult for Vietnam to pool revenues across the different insurance groups, some indirect pooling, at least at the level of primary care benefits, could be achieved by equalizing the capitation base rate.
- Adjustment coefficients should be introduced. A coefficient of 1.1 is currently applied uniformly, and the basis for this adjustment is unclear. A set of geographic and age/sex adjustment coefficients based on actual cost differences should be introduced to improve the equity of the payment system.

Introduce reforms to the FFS system:

- Streamline the fee schedule and bundle services. The current number of services in the fee schedule is very large and mostly unbundled. Streamlining the fee schedule and bundling some services may reduce the incentive to overprovide services and transfer at least a small amount of risk for input use to the

providers. Drugs could be included in bundled payments for procedures and treatments, which would help address growth in drug costs as well.

- Review the basis for calculating fees. Fees currently have no clear basis in costs and policy priorities, resulting in more expensive high-tech services with higher fees being favored. The fee schedule should be used as a policy lever to disproportionately reward high-priority services and discourage higher-cost, lower-impact services with relatively lower fees.

Recommendation 4: The provider payment systems should be accompanied by more effective implementation arrangements and appropriate complementary measures.

Long Term:

These complementary measures would provide more clarity about the agreement between purchasers and providers and the expectations on both sides. They would also counteract some of the adverse incentives of the various payment systems, and work to reduce the enormous incentives in the system to push patients toward more and more expensive services, for which they often end up paying mostly, or completely, OOP. The contract between VSS and providers could be better used to specify and enforce these complementary measures. Some priority areas identified by recent stakeholder meetings in Vietnam include

1. a well-functioning gatekeeping and referral system;
2. appropriate copayments;
3. limits on balance billing with a movement toward eliminating the practice;
4. better health information systems and quality monitoring; and
5. a rationalized and financially sustainable basic benefits package.

Recommendation 5: Defragment the procurement of, and payment for, pharmaceuticals: centralize the selection of drugs for the reimbursement list, introduce framework contracting for high-volume drugs, and introduce price-volume contracts for paying providers.

Under the current system, awards and price negotiations take place at the level of the procuring unit, resulting in a wide variation in prices. Defragmenting the procurement process would help reduce the variations in prices. Defragmenting the payment to providers would also help. Three key reforms are proposed.

Short Term:

- The selection of drugs for the reimbursement list (or a specific pharmaceutical benefits package—see below) should be centralized. It is recommended that facilities are still allowed to use 10–15 percent of their drug budget to buy drugs outside the list, to adjust for different preferences and to avoid having a lot of marginal requests for inclusion in the reimbursement list. This could be combined with Recommendation 1 above.

Medium Term:

- Framework contracting should be introduced for high-volume drugs. Facilities would buy framework contracts from a central price list at preagreed prices. They would have two or three choices for each molecule, but would be prohibited from buying these drugs outside the list. The framework contracts would be retendered every year so that enough manufacturers remain in the market. The range of these contracts can be expanded over time to include all drugs on the reimbursement list and not just high-volume drugs.
- Pharmaceutical prices ought to be bundled with the cost of treatment for each case, except for expensive pharmaceuticals. (See also Recommendation 3 above on reforming FFS payment mechanisms).

Recommendation 6: Improve control of pharmaceutical prices.

Several key mechanisms for price control already exist, but reference pricing by International Nonproprietary Names (INN) needs to be implemented effectively. Price margins need to be regulated more strictly. Lessons learned from pilots to control price margins need to be assessed and appropriate policies developed to replace Decree 120, which was abandoned due to challenges in implementing it. There are two key recommendations for increasing the use of generics.

Medium Term:

- The rules and incentives need to be geared toward prescribing and using generics. The VSS reimbursement list can either list generic names only and set maximum reimbursement rates (applicable for generics and originator brands), or define which brands can be prescribed after VSS negotiates framework contracts with suppliers. Even though this might lead to competition over volume and shelf space among brands that are priced at the same (maximum allowable) level, VSS would at least know how much is paid across all facilities.
- Significant investment is needed into visible quality assurance policies and an education effort to wean the population off their “brand addiction.” In a “brand-addicted” market, a generic drug policy is likely to lead to dissatisfaction among patients, and to providers persuading patients to pay over the limit for preferred brands. One way of preventing it is to ensure the reimbursement ceiling is high enough to allow multinationals to get under it. In the long term, education and quality assurance would be key. A good starting point would be to prioritize the registration of generics.

Addressing weaknesses related to the delivery structure is beyond the scope of this report. GoV issued a separate Master Plan to ease overcrowding in September 2010. The Master Plan acknowledges the need for software solutions such as developing financial mechanisms, revising regulations, modernizing hospital management, expanding and improving primary care, improving supervision and quality monitoring, and strengthening the information environment to address the accountability and governance shortcomings. These are all reforms

in the right direction. To be effective, however, they would need to be implemented with a strategy for strengthening organization and governance in the health sector. This is the subject of the next chapter.

Notes

1. Subsumed under technical and allocative efficiencies, there may be efficiencies related to scale and scope in the health system.
2. Decree 79 in 2006 and Circular 11 in 2007 to guide the implementation of the Decree were aimed at dropping ceilings on drug price margins and clarified which kinds of prices should be used for comparison.
3. Based on analysis of IMS data on the volume of the top 30 medicines with the highest consumption value carried out by WHO's Vietnam Country Office and reported in Escalante (2012).
4. This study, which is the most reliable evidence to date on hospital overcrowding, is based on MoH ledgers for certain hospital statistics but mainly draws on research conducted in 2008–09 in a sample of hospitals in six provinces. The sample included five central hospitals, 10 provincial hospitals (three obstetric and one pediatric hospital), and 12 district hospitals.
5. Actual beds are beds that have been added to “planned” beds on which government subsidies are based.
6. Many developed countries have set up special agencies for the assessment of new technologies—HTA agencies. While providing the basis for reimbursement decisions, these agencies are often separated from the decision-making process to assure their independence and avoid conflicts of interest.

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Strengthening the Organization, Management, and Governance of Social Health Insurance

The previous chapters have shown that the performance of the social health insurance (SHI) system would need to improve in many respects to meet the universal coverage (UC) goals set out in the Master Plan. SHI manages large amounts of financial resources that are mobilized through a myriad of contracts with public and private providers and suppliers that require sufficient and sophisticated management skills. To address the current set of challenges, the SHI system has to be clearly defined, regulated, and supervised. This chapter examines the organization, governance, and management of SHI in Vietnam with the aim of identifying the tools and processes that are already in place and/or are needed to keep the actors involved in SHI accountable.

The organization, management, and governance of SHI need to be analyzed critically in order to address the structural and operational issues facing SHI in the immediate future. For UC to be achieved within the timeframes that the government has set forth, bold decisions have to be taken and translated into providing SHI with a road map for success. This includes revising the SHI Law, which the government has set out to do in 2014 (WHO 2013). It also implies revising the roles of Vietnam Social Security (VSS) and of the Ministry of Health (MoH) regarding SHI. In particular, it is essential to have one specialized and dedicated entity for SHI with its own SHI Board to ensure rational decision making, transparency, and accountability.

To begin with, two basic questions need to be addressed:

1. Who, or which entity, will be responsible for making participation in SHI universal with properly financed quality health care goods and services? and
2. Which changes in SHI administration are necessary to expand enrollment and increase financial protection and access to universal health care (UHC) services?

UC for the population is an explicit policy goal of the Government of Vietnam (GoV) enshrined in the Constitution: “The State... ensures health care insurance and creates favorable conditions for all people to enjoy health care.” In this constitutional context, GoV has given high political and institutional priority to SHI as the main legal and financial instrument for financing access to available health care goods and services for the population and to achieve UC.

In the endeavor for financial protection and UC, it is important to have an approach that is innovative, integrative (that is, it effectively assembles and converges all available resources—legal, financial, institutional, and human), and timely (within the timetables of the Master Plan for UHC from 2012 to 2015 and 2020 submitted by the MoH to the prime minister in 2012).

Problem Diagnosis

Design Failure

Current SHI organization and management present problems that serve to explain the relatively low performance of SHI in terms of enrollment, financial protection coverage, and actual access to quality health care goods and services. The overall problem has to do with the current structure for SHI administration and management. The nature of this problem is simple. The SHI Law has a good design for SHI administration and management, but an independent social health insurance agency (SHIA) has not yet been implemented. Instead, some features of SHI administration and management have been entrusted to VSS, and others to the MoH. Failure in design is the cause of most inefficiencies and low performance in any organizational endeavor, be it public or private. In the case of SHI in Vietnam, which is a financial venture of major proportions, failure in the interim design is the prime cause of current implementation problems.

Institutional Fragmentation

The consequent institutional fragmentation prevents a coherent implementation of SHI functions, for example, on the critical function of purchasing of health care goods and services and contracting with providers and suppliers. In the Vietnam institutional public system, VSS is considered an implementer organization, but with no implementing powers. This means that VSS does not have the ability to control the implementation process with implementing regulations, inspections for regulatory compliance, follow up of contract compliance, and resolving conflicts with providers and among providers and beneficiaries. VSS is assigned responsibility for purchasing health services but cannot operate as a strategic purchaser to effectively manage some of the risks involved in the health insurance scheme, including the fundamental risk of overexpenditure.

Institutional fragmentation causes gaps in managerial and technical capacity related to monitoring and enforcement of enrollment and collection of contributions, financial and claims management, actuarial analysis, benefit package design, and setting of payment mechanisms and remuneration rates. Other important tasks such as accreditation, costing of health services and monitoring,

cost projection, actuarial analysis, monitoring of key system performance indicators, as well as guidance and assistance to employers and beneficiaries have been largely overlooked.

The MoH and the Ministry of Finance (MoF) are responsible for setting SHI rules and regulations including both “health insurance (HI) policies” and implementation regulations. Within MoH, SHI rule-setting responsibilities are divided across several departments, with each department dealing with a very specific task and issue (WHO 2013). Effective operation of the health insurance scheme is, therefore, compromised because policies and rules are not adequately integrated. MoH competes with VSS as SHI implementer rather than providing the overall SHI policy vision.

Different Management Structures

Differences in management structures and levels of authority between VSS and MoH make communication and collaboration difficult. VSS is vertically organized, with a central agency and provincial and district agencies that are highly dependent on central instructions and decisions (WHO 2013). The role of VSS includes all social insurance schemes—pension insurance, health insurance, and other short-term allowances such as sickness and maternity. Health insurance is one of many VSS responsibilities (WHO 2013).

The technical competence to administer a complex health insurance system is underestimated and made even more difficult to manage when health financing/insurance functions within VSS are internally fragmented and intermingled with those functions pertaining to other social insurance schemes. At the MoH, three central departments deal with, and are in charge of, health insurance matters. The critical task of local oversight of health insurance is devolved to the provincial level. Both the central MoH and provincial Departments of Health (DoH) have direct oversight and ultimate responsibility for the operations of all government health care service providers, with limited coordination and uniform oversight approaches. In all, the problem of SHI governance is imbedded in the present institutional configuration.

While there are no formal/legal “veto powers” of VSS, experience over the past five years indicates that the MoH always has to negotiate with VSS to get an agreement on legal and regulatory provisions before submitting them to government, be it the cabinet or the prime minister (WHO 2013). As a result of the current decision-making structures and rules, legal and regulatory provisions around health financing sometimes turn out to be incoherent or vague. The VSS Director-General is responsible to the government, the prime minister, the VSS Management Council, and relevant cabinet members. These multiple layers of responsibility weaken overall accountability. There are no legal specifications of the implications of this responsibility other than reporting requirements (WHO 2013).

Reporting and Transparency

The SHI Law does not adequately outline reporting requirements. Minimal reporting requirements, therefore, result in minimal reporting by VSS. Of critical

importance for SHI is the fact that VSS reporting is aggregated for all funds under VSS management, rather than a disaggregated one for each social insurance component (WHO 2013). Thus, the uniqueness of SHI financial management performance cannot be properly understood or assessed—resulting in an outcome that lacks transparency.

Weak Supervision

The only mechanism for oversight is the VSS Management Council, which is in charge of overseeing all social insurances under VSS. The roles and functions legally ascribed to this body are limited. For instance, the VSS Management Council has no decision-making powers other than decisions on investments. Hence, it does not perform in practice as a strong supervisory or oversight body. Most critically, the VSS Director-General himself is the Standing Vice Chairperson of the Management Council (WHO 2013). There is a conflict of interest, in that the key person in charge of oversight is supervising himself.

The VSS Management Council does not allow for wider stakeholder participation and key actors (providers, beneficiaries) are not represented. For instance,

- at the provincial level, there is no mechanism for stakeholder participation;
- accountability of VSS and of government with respect to implementing HI is rather weak; and
- there are few consequences for poor performance. It is also difficult to pinpoint the responsible actor.

Overall Diagnosis

The resulting diagnosis is that organization, management, and governance of SHI are fragmented and dysfunctional. This scenario makes SHI implementation slow, complex, and inefficient. To meet GoV's policy goals as set out in the Master Plan and move rapidly toward UHC, the present institutional setting for SHI needs to be assessed and changed. This chapter elaborates on these issues and proposes some corrective courses of action.

Brief Overview of the Social Health Insurance Law of 2008

The SHI Law sets up the general framework for health insurance in Vietnam and aims to ensure financial protection for the population in accessing available quality health care. Subsequent implementing regulations (Circular 09, Circular 10, Circular 11) seek to clarify and guide implementation of the SHI Law. The SHI Law defines the scope (Article 1) and principles of health insurance (Article 3), identifies the subjects and beneficiaries, both mandatory and voluntary, and their contribution, and state subsidies when applicable (Articles 12–15). It also deals with the health insurance card (Articles 16–20), health insurance benefits in general terms (Articles 21–23), and rights and obligations of the insured, providers, and the SHIA, although these are yet to be established (Articles 36–44) (WHO 2013).

The definition of SHI as “the non-profit type of insurance that is implemented in the health care sector by the State, and involves the participation of responsible parties under the provision of this law,” does not define the “type of insurance” nor make explicit the objective of SHI. SHI is a specialized type of insurance and is different to private indemnity health insurance (WHO 2013). Its specific purpose is to provide financial protection to the whole population for accessing health care goods and services. In the SHI Law, the objective of SHI has either not been stated or is stated inadequately.

The first health insurance decree in 1992 stated: “SHI is established to mobilize contribution from individuals, collectives, community and society, to improve quality of health care”. This was revised in two subsequent decrees as: “the purpose of SHI is to mobilize contribution of employers, workers, organizations, and individuals, to pay for the cost of health care, when an HI card holder is sick.” These “definitions” failed to emphasize specifically that the ultimate goal is financial protection to access needed quality health care for the population at large. Overemphasis on resource mobilization overlooked the importance of the optimal use of the resources. The Law created a single mandatory SHI scheme for pensioners, formal sector workers, socially privileged groups (such as revolution meritorious people, war widows, and orphans), the poor (previously covered by the Health Care Fund for the Poor), near-poor, children, and other social protection groups. The Law set a goal for compulsory enrollment of all population segments by 2014.

The existence of almost 30 categories of SHI beneficiaries in the SHI Law is unnecessary and an administrative burden. All beneficiaries belong to either the contributory regime (all those with ability to pay social insurance premiums/contributions based on the formal employment sector) or the subsidized regime (all those whose premiums/contributions are subsidized one way or another and in any proportion by the State or other entities). Multiple categories complicate enrollment and are a source of inefficiency, as discussed in chapter 2.

Moreover, having multiple beneficiary categories can result in the same person falling into two membership categories: a child from a poor family, for example, falls into both the children category as well as the poor. This overlap complicates the enrollment procedures, and lists end up being unreliable. There are no regulated priorities or criteria for classification. It is difficult to shift from one group to another—for instance, a person in the informal sector gaining employment in the formal sector. In addition, this process and its fragmentation also complicate the issuing of ID cards, and it is open to confusion, the issue of multiple ID cards to enrollees, and fraud and abuse (WHO 2013). Because enrollment does not mean actual access to health care coverage, these issues are of critical importance for achieving, UHC and universal financial protection. Chapter 2 elaborates further on the issues of enrollment.

Revising the Health Insurance Law Based on Experience and New Challenges

The experience of four years of implementation of the SHI Law shows institutional inconsistencies, unclear mandates, and responsibilities that limit the organization, management, and governance of SHI from being effective, efficient,

and equitable. This, in turn, makes achieving the goals of universal enrollment, financial protection, and access to health care difficult. Based on this experience, the GoV has decided to review the SHI Law to improve the overall organization, management, and governance of SHI to achieve UC in a fiscally sustainable manner. The government acknowledges the need to introduce corrections within the present multi-institutional structure to make SHI more efficient, effective, and equitable. Revision of the SHI Law is listed for discussion by the Legislative Assembly later in 2014. Those issues related to organization, management, and governance of SHI as discussed in this chapter are critical for this review.

The following suggestions should be considered during the revision of the SHI Law:

1. Define the objective of SHI as “financial protection to access available and needed quality health care goods and services for the population.”
2. Make explicit that SHI is (a) a mechanism to finance the provision of health care goods and services; and (b) that SHI administration is a financial endeavor, not a health matter.
3. Retain in the revised SHI Law the establishment of the SHIA even if it will not be implemented in the immediate future. Once the process of universalization of HI financing and service coverage increases, SHI managerial and governance tasks will be extraordinary and the need for an autonomous, specialized, and competent SHIA will become apparent.
4. Include a transitional provision that states that until the SHIA is established, VSS will perform the role of SHI administrator.
5. Eliminate the long list of SHI beneficiaries. The end purpose of SHI is UC—meaning the whole of the population regardless of classification. The only important distinction will be beneficiaries who are contributors (the contributory regime) and beneficiaries whose contributions are subsidized (the subsidized regime).
6. Include an article stipulating the principle that SHI financial resources are for the financing of health care goods and services included in the standard services package. This would allow for supplemental benefits packages (for example, a hospital package) with additional contributions in the future and for a more efficient SHI administration. There should be a limited use of SHI financial resources for building public health care sector capacity, such as capital investment in building, renovations, ambulances, and equipment. This is a duty of the MoH as owner, or a responsibility of autonomous hospitals with financial resources other than SHI funding. Diverting SHI financial resources to finance other than service packages discourages contributors, as they perceive that the money is used for purposes other than health care financing. Increased enrollment in the coming years will require increased financial resources for financing health care goods and services for more beneficiaries. SHI/VSS has to reserve sufficient financial resources to cope with incremental increases in financial demands.

7. Include an article that stipulates the principle that other funds under VSS management cannot borrow funds from the SHI's financial resources. If this takes place, the borrowed resources should be replenished in the next fiscal year.
8. Include an article that stipulates that any financial surpluses from SHI should not be distributed. Any surplus should be added to reserves to secure financial protection for health care coverage for increased beneficiaries and toward the financing of UHC and financial health protection.

Organization of SHI

Weaknesses in the Current Organizational Framework, Roles, and Responsibilities

The SHI Law envisioned the establishment of a SHIA to administer SHI; however, to date this agency has not been established. The current administration of SHI is complex and fragmented. VSS¹ has been partially assigned the role of SHI implementer but has not been given regulatory, inspection, or enforcement functions. The SHI Law gives the MoH the mandate to manage SHI. In Vietnam the distinction between managing entities and implementing entities makes it difficult to have the unified institutional system that is critical for administering SHI. The VSS is considered an implementing agency whose role is to attend to administration functions but not to intervene in policy and regulation or in managerial decisions. The MoH's role of "managing" health insurance is not legally defined and it is not clear what it entails procedurally. Fragmentation and unclear definitions are potential sources of conflicts of competencies and make implementation performance complex and inefficient. A reformed VSS should be the entity managing health insurance with all the corresponding functions and attributions until the SHIA is established.

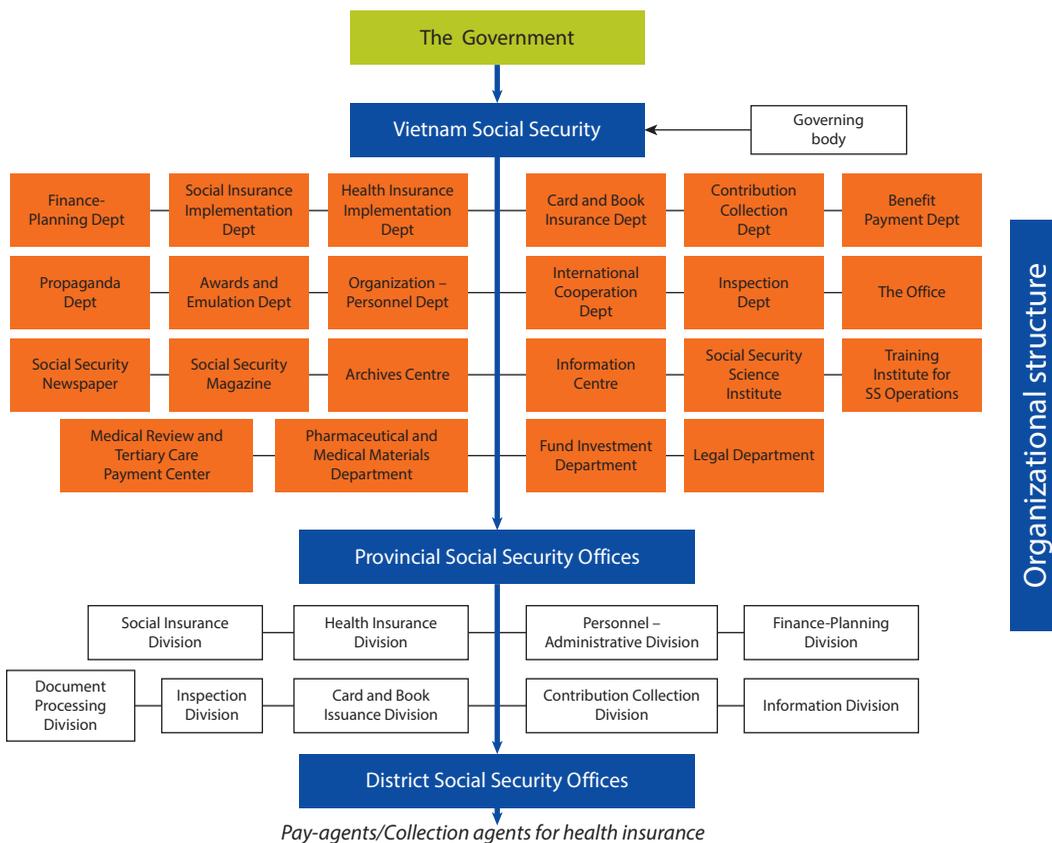
The important role of the MoH in SHI should be of overall SHI health policy, decision making on benefit packages (in consultation with VSS), regulating health care providers and suppliers, and supervising but not managing SHI (table 8.1). Supervision includes overseeing the effectiveness and efficiency of SHI management, and requesting, receiving, and reviewing reports from VSS/SHI on SHI performance on the different health financing/insurance functions (enrollment/registration/SHI ID cards; collection, pooling of financial resources; purchasing and contracting services and supplies; benefits package implementation; claim processing/payments, and complaints/conflict resolution). The MoH also has critical roles that affect SHI, such as health promotion and prevention, enhancing the quality and safety of the health care system by regulating health care providers and suppliers, strengthening the interests of patients, enhancing public health, preparing health care and public health legislation, developing and preparing legislation regarding standards for health care provision, and developing and overseeing the implementation of national and international public health programs.

The current fragmented organization, as illustrated in figure 8.1, generates a complex and less efficient and effective administration of SHI. In addition, this

Table 8.1 Basic Roles of MoH and VSS/SHI in SHI

Agency	
MoH (Policy)	VSS/SHI (Implementation)
Function	
Overall SHI policy	SHI management
Decision making on benefit packages	Performing health financing functions: Enrollment Revenue collection Pooling Resource allocation Purchasing
Regulation of health care providers and suppliers	Managing conflict resolution with providers and suppliers
SHI supervision	Managing complaints from beneficiaries

Figure 8.1 VSS Organization Chart



Source: WHO 2013.

Note: Dept = Department; SS = Social Security.

fragmented institutional environment makes it difficult to meet the main goals for health insurance in Vietnam: (a) expanding coverage to a larger section of the population; (b) deepening coverage to reduce out-of-pocket (OOP) payments by patients; and (c) containing costs.

VSS is a government agency that aggregates all social insurance schemes, managing all kinds of social security funds, such as pensions, SHI, unemployment fund, other social protection funds, and benefits (WHO 2013). VSS is vertically organized, with a central office as well as provincial and district agencies. VSS has about 20,000 staff in 63 provinces, of whom 600 are at the central office, 6,400 in provincial offices, and 13,000 in district offices. VSS staff has civil servant status. Implementing SHI is an added function to VSS and therefore not an exclusive or even dedicated institutional function. As such, Vietnam is one of the very few countries where all social welfare and social protection insurances, including health insurance, are managed by one agency.

SHI financing/insurance functions are also fragmented within VSS. Managerial tasks related to SHI such as enrollment, collection of contributions, planning, expenditures, and internal auditing cut across departments organized for all social insurance schemes, while complex technical issues related to health insurance administration—such as health insurance actuarial studies—get less attention.² Risk management, health care cost information and monitoring, active negotiating with health care providers, strategic purchasing, and counseling to health care users are not addressed adequately or dedicatedly. VSS has a range of health financing functions: (a) collecting SHI revenue from employers, government (central and provincial), households, and schools; (b) bringing funds together (pooling) and managing funds according to MoF's financial management regulation; (c) making payments to providers according to policies and regulations made mainly by MoH (but sometimes in collaboration with MoF for some specific financial issues); and (d) ensuring the SHI fund's solvency and fund growth (investment activities). In terms of fund management and operation, VSS is under strict and direct management of the MoF.

VSS is not an entity that is professionally and competently dedicated to SHI—with only three out of 20 VSS departments having responsibilities for SHI and limited staff numbers. These three departments include the Department of HI Implementation (with 23 staff), the Department of Pharmaceutical and Medical Materials (10 staff), and the Center of Medical Review and Tertiary Care Payment (with 100 staff, who have been moved recently from the Division of Medical Review, Hanoi metropolitan VSS agency) (WHO 2013).³ VSS departments that also deal with other social security issues, as outlined above, are in charge of health insurance collection, enrollment, payment, and planning issues. None of these departments are, however, specifically concerned with monitoring or enforcing SHI enrollment and collection.

As the implementing agency, VSS engages in SHI administrative processes but does not directly intervene in policy and regulation or in managerial decisions proper. The MoH's role in SHI is in policy, "managing," and in rule setting or regulations (called "health insurance policies" in the SHI Law). In most countries

this fragmentation is minimized by separating SHI financing from the functions of the MoH and entrusting them either to a separate autonomous SHIA or by clearly stipulating that the MoH supervises SHI but does not manage it, because of the potential to dilute responsibility and accountability on SHI.

One of the main responsibilities VSS has taken on is the balancing of financial resources for SHI so that total expenditure does not exceed revenues (WHO 2013). It is debatable whether this is a key role for VSS. It is not only important for the SHI Fund to remain solvent (as any financial institution has to), but also to ensure that investments to accumulate large reserves are not favored over the financing of health care services. Furthermore, it is difficult for VSS to fulfill its SHI responsibilities when it is not supposed to make any decisions on the fund's use. This includes defining benefits, contribution rates, and payment rates, as well as penalizing/sanctioning providers or patients for improper use of the funds. In this scenario, it is understandable that the MoH, MoF, and central and provincial government authorities, including the VSS, view VSS's role in SHI simply as one of a financial intermediary.

In order to enhance efficiency, effectiveness, and equity in SHI, VSS should consider introducing certain organizational changes:

- Establish within VSS an SHI Directorate/Division dedicated exclusively to administering SHI. This should be separate to other funds the VSS administers,⁴ with separate accounts and separated reporting requirements, absorbing the current Health Insurance Implementation Department. One option would concentrate all SHI-related tasks presently in various VSS departments into the Health Insurance Implementation Department.
- Establish a Social Health Insurance Board to guide and supervise the SHI Directorate/Division at the level of the suggested VSS/SHI Directorate/Division with annual reporting to the VSS Management Council. Creating an SHI Board would contribute to transparency and accountability as well as bringing into SHI the voice and vote of key stakeholders. The SHI Board's main functions would be operational policy and supervision of the performance of the VSS on SHI rather than managing SHI. An independent chairperson appointed by the government should head the SHI Board. The composition of the Board is to be determined, but should include representatives of MoH, MoF, and MoLISA;⁵ public and private providers and suppliers; beneficiaries, public and private; and the National Assembly's Committee on Social Affairs. The VSS SHI director/department head would serve as Secretary of the Board, with voice and no vote, and have the responsibility to implement the decisions of the SHI Board.
- Establish an SHI organizational structure based on the health insurance functions of enrollment, collection, pooling, and purchasing/contracting/claims management.
- Establish objective conflict resolution mechanisms such as an ombudsman to resolve conflicts between providers and beneficiaries/patients and a Grievances Committee for conflicts between VSS and providers and suppliers, all with independent members.

- Establish a capacity-building and training unit for the development and implementation of a continuous training program for all VSS/SHI staff—both central and local.
- Revise the SHI Law to allow VSS to issue guidelines and regulations to implement SHI with inspection and enforcement powers.
- Develop management information systems for SHI administration.
- Develop the use of mobile transactions for SHI.
- Require post-State auditing reviews and reports on implementation of audit observations and recommendations.

Redefining the Role of the Ministry Of Health

The MoH plays various roles—including policy making, public health, regulator, owner of public health establishments, financing of tertiary hospitals (even though this is marginal with less than 10 percent of revenues coming from the MoH) (WHO 2013), and oversight. Provincial departments of health have stewardship functions, and finance provincial government health service providers.

Three MoH departments are involved in SHI: (a) Department of Health Insurance with 15 staff, many of whom are new and recruited from various provinces; (b) Department of Planning, with a newly established Division of Provider Payment, in charge of health care financing reform, formulating service price schedules, and provider payment mechanisms; and (c) the Department of Legal Affairs, which formulates and develops the legal provisions. It is important to note that SHI is a financial endeavor and not a health matter. The role of the MoH in SHI needs revision because health insurance for financing health care is not a task to be managed by any MoH.

The MoH and DoHs are concerned with ensuring the viability of government providers (especially hospitals) and the welfare of their staff, but these are separate tasks from health care financing. SHI finances the delivery of health care goods and services by providers that have to be qualified and competent. The MoH has the duty to ensure that providers and suppliers (public and private) are licensed, certified, and accredited, as appropriate. The MoH's Department of Medical Services Administration is in charge of hospital performance and quality of care and plays an indirect role because VSS has no supervisory role over the quality of care provided by the services it finances. Due to the absence or weakness of quality standards and supervision SHI entities usually ensure that performance standards will be met through terms and conditions included in contracts with public and private providers. This does seem to be the case with VSS contracts.

MoH and DoHs are involved in domestic pharmaceutical production and distribution, managing the government's substantial shareholdings in these companies. These issues might create a conflict of interest with another core function, which is "to regulate and govern pharmaceutical prices and stabilize drug prices in the market" (MoH Decree 188/2007). In this context, it might be difficult for the MoH and DoHs—as the third-party agency—to act as a neutral facilitator in disputes between providers and VSS. The steward-purchaser-provider split is thus incomplete at both the national and provincial level. In general, there is a feeling

that it is difficult for MoH to maintain an independent or neutral position in its relationship with VSS, on one hand, and providers on the other.

VSS and MoH have different management structures that are not conducive to communication and collaboration, especially between provincial DoH and VSS agencies. This is exacerbated by the fact that within the provincial VSS agency, there is no specific department or unit in charge of health insurance, other than the Department for Medical Review and Tertiary Pay Centre (“Phong Giam dinh BHYT”) (WHO 2013).

Management of SHI

Integrating SHI Management around the Key Health Financing/Insurance Functions

The institutional instruments needed to strengthen SHI management are critical. A Directorate/Division for Management of SHI within VSS would aggregate all current SHI-related functions in other VSS departments. SHI/VSS would have a director/department head and typical supporting units (legal, accounting, human resources, auditing, information, information technology (IT), and the like) and units dealing with the health financing/insurance functions. A new SHI Board would report on its work to the VSS Management Council but would not be a dependency of the Council. The SHI director/division head would be the ex-officio Secretary of the Board, preparing the agenda and reports for Board meetings as well as implementing the decisions of the SHI Board, but would have no vote. The key health financing/insurance functions to consider are enrollment, revenue collection, pooling, allocation, and purchasing.⁶ Enrollment is added to the list of SHI management responsibilities explicitly in order to speed up compulsory and voluntary enrollment for universal financial protection and services coverage. Managing these functions properly is fundamental, especially when a mix of financial instruments is used. Interestingly, most if not all developing countries face constraints in their ability to manage these functions.

Enrollment Function

The enrollment function needs to be given priority to bring the whole population into the SHI system in the near future (five years). Enrollment, therefore, has to be a simple and efficient process. In Vietnam beneficiary fragmentation into different membership groups and individual membership makes enrollment managerially difficult (WHO 2013). Only in the case of the poor (as a membership group) is the enrollment unit the family. All beneficiaries fall into two categories—contributory or subsidized—making the listing of groups of beneficiaries complicated and impractical.

In spite of the mandatory enrollment requirements in the SHI Law, noncompliance is widespread. Many private employers do not enroll, or underreport the number of, employees (and/or their employees' salary). VSS monitoring of enrollment is weak due to a lack of staff and of incentives that are necessary to detect noncompliance. Unfortunately, there is little cooperation between

the VSS and tax collection, or with provincial Departments of Industry and Commerce.

Given the need to improve enrollment in the short term, this task should be entrusted to an Enrollment/Beneficiaries Unit under SHI/VSS. Functions would include the identification of beneficiaries (and their families/households as appropriate), determination of SHI status (either contributory or subsidized), registration of beneficiaries, issuing of SHI ID cards, and keeping full databases of enrollees/beneficiaries. The database should also keep a record of beneficiaries who change their place of residence or of work to maintain the integrity of their ID card portability.

Revenue Collection Function

The revenue collection function is complex and should not be fragmented. This is an important and often underestimated function. Revenue collection in SHI is the process and procedures to receive funds from various sources: private employers (for salaried workers); government offices (for government employees); central and provincial financial departments (for children, poor, and socially assisted groups); households and schools (for informal sector and school children); and subsidies from the state budget to cover the financing of noncontributors (informal sector, the poor, the near-poor, and others as regulated).

Revenue collection is currently undertaken by the VSS and will most likely remain with VSS for the time being; however, the international trend is to coordinate and integrate tax and social contributions. The collection of social contributions should be integrated into the core processes of a tax system built on self-assessment principles (filing of returns, returns and payments processing, enforced collection, and post-assessment audit). The normal tax and employer returns are used as the basis for the information for assessment and payment collection—amended to incorporate new information fields needed for social contribution payments. Systems must be designed to capture specific information relating to contributors and transfer this to the SHIA in a form compatible with its IT systems.

While revenue collection remains with VSS/SHI, SHI revenues should be recorded and kept in separate accounts from other VSS funds. VSS/SHI should be able to contractually delegate parts of the collection process to banks, post offices, cooperatives, and others, while retaining the legal responsibility for the collection function.

Pooling Function

Funds are not currently “pooled” but are merely brought together in the absence of formal regulation or a mechanism for risk sharing across regions/provinces or beneficiary groups. This function should remain within VSS under SHI/VSS as suggested. The main technical and equitable task of risk pooling, however, has to be incorporated into the work of VSS. VSS has to acquire the expertise and competence to properly conduct this critical task of risk pooling and not merely

distribute resources without risk pooling. In the future it may be possible to transfer the pooling function from the 63 provincial VSS agencies to the national VSS/SHIA.

Resource Allocation Function

One critical political and policy decision is to have one universal benefits package, or have a minimum package free for all that is financed by SHI and tax revenues and have additional packages with user fees. Overly generous packages are unrealistic and difficult to finance and deliver, and create false expectations in the population. In the case of Vietnam it would be politically and socially difficult to downsize and limit the current basic package in spite of the fact that most of the items included in the basic package cannot be delivered, services have limited availability, and in some cases services and supplies are not available at all. Box 8.1 provides a summary of the questions that need to be answered with regard to the benefits package.

The resource allocation function has to be vested in SHI/VSS in one Purchasing/Contracting Unit. The decision-making process for resource allocation has to be done jointly with the MoH in terms of defining health needs and services to be financed and the level of subsidies from the state budget. SHI/VSS has to have a critical role as the responsible administrator of the SHI financial resources and as a financial entity (solvency). This requires new and revised rules and regulations relating to resource allocation from the national level to provincial and provider level that ensure equitable access to, and equitable delivery of, health care services to beneficiaries. Optimal resource allocation ultimately has implications for the provider payment mechanisms, especially on the current capitation payment mechanism and the calculation of capitation amounts for

Box 8.1 Allocating Resources to Benefits Packages: Questions to Answer

- Who should determine the content of benefits packages, select the needed services, and set priorities for health insurance financing of health care goods and services?
 - MoH;
 - The VSS/ National Insurance Fund; or
 - An independent institution.
- Should there be one universal package of health care goods and services or one universal and free minimum package, with additional packages with user fees?
- Who should determine the cost of the benefits packages and which criteria should apply?
- Who should be in charge of updating the benefits packages?
- Which criteria should guide such updating?
 - A mix of available financial resources, delivery capacity, management capabilities; or
 - The addition of clinical and cost-effectiveness for health outcomes.
- Who should be in charge of assessing the effectiveness of the benefits packages in terms of population needs and epidemiological concerns?

various membership groups. Such a shift of functions will also affect the organization and management of tasks undertaken by the provincial VSS agencies.

Purchasing Function

The purchasing function is the key to moving from “passive” purchasing (or simply paying provider invoices) to “strategic” purchasing, which means paying for performance and health needs. The purchaser needs a stable, predictable flow of funds to be able to enter into contracts with providers and suppliers that need to be honored in full and on time. The purchasing function is exercised (both in the public and private sectors) through an intricate system of contracting. SHI contracting is important (a) for more effective and efficient use of scarce public resources; (b) to incorporate flexibility into the usually rigid public sector contracting mechanisms (public procurement); (c) in attracting the participation of the private sector in the implementation of public policies more effectively (in the provision of goods and services); and (d) in making purchasing between public agencies more effective.

Contracting requires a legal framework⁷ and effective mechanisms of enforcement. There is a need to minimize political interference as well as the undue influence of professional associations in decision making. Health care professionals and sector managers sometimes lack skills and understanding of the legal and financial aspects of health care contracting. Delivery of health care goods and services should take place under a clear, transparent, accountable, and enforceable contracting system (norms and procedures). Contracting implies selecting providers, defining what to purchase from whom, contract negotiations, monitoring of contract compliance (especially performance targets), claims management, inspections, and conflict resolution. In most countries, contracting is the core component in the management of the purchasing function.

The purchasing/contracting function should be fully entrusted to SHI/VSS. Performing this function requires more authority in contracting with providers and suppliers to ensure that beneficiaries receive quality health care services. This entails moving away from being a passive purchaser to become an active and strategic purchaser. Developing a competent operational capacity for the management of SHI should be an immediate priority for VSS. This has to be accompanied by eliminating the current intrinsic legal constraints to the exercise of its implementing functions. VSS needs inspection powers, operational regulations, and the attributions or powers to properly conduct a purchasing/contracting system, and process claims in a proactive manner, not just passively paying bills.

Claims review and payment to providers needs to be better organized and competently managed (WHO 2013). Provider claims review by VSS is where most of the tension arises between the VSS and providers. VSS is seen by providers simply as a payer of claims sent in by providers and providers generally believe that they should have substantial clinical autonomy in deciding what to do and what to bill for. In the absence of information technology, specific clinical guidelines, and expertise in clinical fields, it is challenging for VSS staff to review claims and conduct a dialogue with providers to control costs. A conflict

resolution mechanism such as an independent Grievances Committee is needed to resolve disputes between VSS and providers.

Enrollment, revenue collection, strategic resource allocation with well-designed and realistic basic packages, and proper purchasing procedures all have important implications for cost, access, quality, and consumer satisfaction. For this to take place efficiently and effectively, however, the institutional setting (currently VSS) has to be revised and enhanced in terms of functions, powers, and responsibilities, but mostly in avoiding fragmentation.

SHI Governance

Governance Brings Consistency to SHI and Ensures Fairness, Transparency, and Accountability

Governance is a concept that has various meanings, but the suggestion is made to broadly define it as all the relevant factors that influence behavior of an organization. Corporate governance largely refers to the laws, entities, rules, and processes under which government and private businesses operate, are regulated and controlled. In a simpler way, governance refers to the “control” mechanisms that are used to hold the organization accountable (Savedoff and Gottret 2008). For SHI, governance is a means to “direct, administer and control the system” (Fattore and Tediosi 2013), to ensure that the objectives of the SHI system are met. Governance, therefore, can be attained using legal and financial tools, information control processes, influencing behaviors, and keeping involved actors accountable and working toward a common social goal. Governance also relates to the design and organization of the SHI system, to fair and sufficient but not burdensome regulations, and to competent supervision.

Because health insurance, public and private, is a legally regulated financial activity, the concepts and principles of corporate governance apply to the SHI or agency as well as to private health insurance companies. In Vietnam, regardless of the current structure of SHI, the administration of SHI, its organization, management, and governance are those of a financial institution, thus corporate governance rules apply.

Governance also refers to internal factors such as the conduct of management and staff, and to external forces such as consumer groups, clients, and government regulations. For the OECD (2004), “corporate governance involves a set of relationships between a company’s management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined. Good corporate governance should provide proper incentives for the board and management to pursue objectives that are in the interests of the company and its shareholders and should facilitate effective monitoring.”

SHI schemes pool, manage, and spend large amounts of financial resources and employ, directly and indirectly, large numbers of people in the health care and supply sectors, and conduct vast legal transactions through contracts with

providers and suppliers. SHI performance, however, is not always satisfactory. There are concerns about the wise and prudent use of resources, operational transparency and accountability, and the quality and quantity of services financed and provided to the population. Many of the problems come from the way in which SHI is organized, managed, and governed. The legal and regulatory framework, roles of various government entities, public information, and the behaviors of SHI administrators, providers and suppliers, beneficiaries, and political parties and politicians play very important roles, positive and negative.

Good governance has to promote the rule of law and be participatory, transparent, and accountable. SHI governance involves the state, the private sector, and civil society, and has to contribute to the best use of health care financing resources for quality and equitable care for all. This is why it is so important for Vietnam to properly structure the SHI system around health financing/insurance functions and follow good standards of governance. Only then can VSS continuously monitor SHI performance to correct unavoidable deviations and distortions, which are inevitable in implementing such a massive program as SHI.

Analysis of Governance

The analysis on governance herein follows the analytical framework in Savedoff and Gottret (2008) that encompasses five main dimensions of SHI: (a) a coherent decision-making structure, (b) stakeholder participation, (c) supervision and regulation, (d) consistency and stability, and (e) transparency and information (figure 8.2). These five dimensions contain essential conditions for transparency and accountability of the SHI system to the government, beneficiaries,

Figure 8.2 Governance Analytical Framework



Source: Adapted from Savedoff and Gottret 2008.

Note: HI = health insurance.

contributors, and regulators, and are fundamental for SHI success and acceptance. At the same time, these dimensions help identify options for improving the performance of the Vietnam SHI system against the objectives of universal financial protection and access to available and needed quality health care goods and services.

Coherent Decision-Making Structure

Coherent decision making is a fundamental condition for good SHI governance. It implies that (a) the division of tasks among existing key players is appropriate, with clear definition of roles and responsibilities and minimal conflicts of interest; (b) all essential SHI functions and tasks are consistently implemented; and (c) legal, financial resources, institutional capacity, regulation, and supervision are in place. In the current structure of SHI in Vietnam the division of tasks is unclear in terms of authority and responsibility. This is particularly the case for VSS and the MoH where SHI functions are not the base for organization and management, and capacity and tools (institutional and regulatory) are scant and inconsistent.

One suggestion to make decision making more coherent is to aggregate SHI functions within VSS into a specialized Directorate/Division on SHI (SHI/VSS) with a specialized SHI Board that would greatly contribute to coherent decisions. This option could be complemented with institutional change within the MoH regarding SHI. The option could be an SHI Technical Department at the MoH that would combine the SHI functions of the three MoH departments that currently deal with SHI issues. This MoH Technical Unit could play an important role to enhance coordination and collaboration among VSS and key ministries and other stakeholders and contribute to the development of more coherent decisions on health financing rules and regulations with the final objective of enhancing financial risk protection and equitable access to services. For this option to succeed, consensus between MoH and VSS is necessary to clarify the SHI policy aspects under the MoH and the implementation process to be decided by VSS. SHI/VSS should be granted a more formal role in implementing regulations on the SHI functions, such as the design of the provider payment mechanism and in setting remuneration rates.

Stakeholder Participation

Stakeholder participation should involve SHI-related actors, the state, employers, providers/suppliers, patients, and the general public, in making decisions and in monitoring SHI implementation. Active stakeholder participation can prevent decisions being made that favor certain interest groups, thus contributing to transparency and accountability, and helping control corruption and conflicts of interest.

In Vietnam, stakeholder participation in decision making is rather limited due to the nature of government and societal organization. The posting of key policy documents on the Internet for one to two months for public comments before final approval has proven ineffective. The VSS Management Council (WHO 2013) does have members representing various ministries (government), the

Medical Association (providers), trade union (workers), Chamber of Industry and Commerce (employers), as well as representatives of mass organizations such as women's and farmers' unions (public). Many of these latter members, however, are not active participants in decision making and in governing SHI and, because the VSS Management Council oversees all of the funds under VSS, there is no dedicated attention given to SHI. This lack of a special and specialized body for SHI may explain the apathy of the Council in SHI matters. The governance role in protecting the interests of contributors (employers) and beneficiaries is, therefore, weak.

Wider proactive stakeholder participation enhances transparency and accountability as a value in itself and as an important basis for coherent and widely accepted decisions. An SHI Board under VSS could deal with implementation issues where representation of beneficiaries, health care providers and suppliers, and patients is important. No more than 15 members would make an effective Board in terms of size.⁸ The SHI Board would work specifically on SHI issues. Well-designed stakeholder participation provides possibilities for Board members and consumers to be listened to, especially in the case of conflicts of interest.

Supervision and Regulation

The SHI Law lists the supervisory bodies for HI implementation as the health inspection department (MoH), financial inspector (MoF), and Provincial People's Committee; however, their supervisory roles are not defined. Decree 94/2008 states that VSS is governed and supervised by VSS's Management Council, but the nature and extent of this supervisory role is not defined. In practice, a fundamental state activity of profound social impact like SHI is largely unsupervised. Supervision and regulation should contribute to strengthening accountability. Toward this end it is important to determine to whom VSS is accountable. It is also necessary to clarify the authority and the supervisory role of Provincial People's Committees in relation to the provincial VSS agency in terms of health insurance implementation.

Regulatory mandates are fragmented and VSS is given a regulatory mandate only on health cards. Implementing SHI requires multiple regulations that have to be updated continuously and amended, revised, and derogated as implementation proceeds and more complex issues come to attention. There are many types of regulations, some more formal than others, but all have the same purposes: to interpret, define, solve inconsistencies, and lay down rules and procedures. Regulations are necessary, but should not be burdensome, should address serious issues and not minutiae, and take into account the cost of regulatory compliance for providers and suppliers, the impact on beneficiaries, and on VSS's administration.

Consistency and Stability

Consistency and stability, including legislative and regulatory stability, are key conditions for effective governance (WHO 2013). SHI implementation is affected

by HI policies and by related health policies on hospital autonomy, as well as prices for health care services and pharmaceuticals and consumables. In pursuing increased financial protection and access to quality health care goods and services for the population at affordable cost, policies about the price of services and pharmaceuticals should be designed carefully to encourage providers to be rational and efficient in prescribing services and drugs, and not to oversupply them. Health policies in general should align and be consistent with SHI policy.

Implementing SHI is a continuous process that requires regular assessments and modifications based on experience and the ability to respond to increasing health care needs by the population as universality in enrollment and access to health care goods and services are expanded. In this scenario, SHI administration becomes increasingly more complex and legislative and regulatory changes have to be consistent, well thought out, clear, and unambiguous to avoid confusion and misunderstandings that make interpretation and implementation difficult. In the past 20 years, there has been one health insurance law and six decrees, followed by a number of circulars that also introduce a number of new rules and procedures that are normal in the process of developing and institutionalizing SHI, particularly in a large, diversified, and populous country such as Vietnam.

It is useful to regularly (for instance every three to five years depending on the number of new regulations) review the body of laws and regulations (decrees, circulars) and analyze their consistency, validity, and possible contradictions. After the review a volume of revised, consolidated, and harmonized health insurance regulations should be released.⁹ To improve governance, capacity building would be needed for all health care financing actors as well as for the overall health system. Training on managerial and technical capacity with both short- and long-term training courses could be provided in the Vietnamese language for the existing VSS and MoH staff, central and local, and for providers and suppliers. Finally, the entire SHI system and its governance require sustained efforts on health financing policy and regulation, and continuous improvement of the SHI system with analyses, actuarial studies, costing, health technology assessment, and policy discussion workshops.

Transparency and Information

Transparency and information is a golden principle to follow for SHI governance to be effective. It refers to the necessary and comprehensive information made available to policy makers, financial managers, legislative bodies, payers (employers), beneficiaries, and the general public. Information provides transparency and transparency helps reduce corruption.

Since SHI objectives are not clearly stated in legal documents, it is difficult to communicate in understandable terms the meaning and scope of SHI, and information and transparency are weak. A key element of transparency and governance is informing the public about SHI, its features, benefits, procedures, rights and obligations, and how it develops in achieving the objectives of universal financial protection and access to health care goods and services. The population

has to internalize that SHI is a tool for quality of life and be aware of its meaning and importance. The public should also be informed of fraud and abuses and how these are dealt with to ensure that SHI and its financial resources are properly used and protected. Media material should be in simple but precise language, using radio, TV, and social media.

A requirement to provide information to the public on HI benefits is not clearly stated and service providers do not communicate this information either. In the context of unregulated and unsupervised hospital autonomy and health care market liberalization, it is common for insured patients to pay out of pocket on top of copayment, even for services covered by SHI. This leads to patient confusion and distrust in the SHI system. Public information campaigns should be conducted at all levels and continuously. Information on level of service utilization by different population segments and on actual cost of health care and pharmaceutical use is limited because reporting requirements (forms/templates) are not specified/institutionalized in HI legislative/regulatory documents, which makes SHI evaluation and assessment difficult.

SHI/VSS is required to have their accounts audited by State Audit and by external auditors, publish annual financial plans accessible to the public, and develop comprehensive and clear reporting formats to increase the flow of updated information to the government, involved actors, and the public. Operationalizing SHI generates conflicts that need prompt, fair, and objective solutions. Conflicts between patients/beneficiaries and providers should be resolved by an independent SHI ombudsman financed by SHI. An independent SHI Grievance Committee financed by SHI should resolve conflicts between SHI and providers and suppliers. Improving and upgrading the IT system is critical for effective information management and increased transparency. It allows for the establishment and formalization of horizontal information exchange channels between the DoHs and provincial VSS agencies, and the collection of hospital financial data and reports with clear and timely financing information, amounts and use of SHI funds, and billing for better and more transparent hospital planning and management.

The Social Health Insurance Agency

The future SHIA—already wisely considered in the present SHI Law—is the right design for the future administration and management of SHI in Vietnam. As indicated previously, achieving universal health financial protection and universal health coverage with actual access to health care goods and services by competent providers is a challenging task. SHI requires a strong, competent, and independent agency performing its duties under simple but efficient supervision. The SHIA does not act alone but performs its duties in coordination with the MoH, the MoF, and other institutions, both central and local. What is important is that SHIA is independent and autonomous.

For the SHIA to develop to its full potential, a new SHI Law will be needed in due time defining and stipulating the functions, duties and responsibilities,

and powers to make the SHIA operate efficiently. The new SHI Law has to define the level of autonomy of the SHIA and translate government policy in this matter into the provisions of the new SHI Law. The SHI Law will have to be complemented with rules and regulations as appropriate that will ensure that the level of autonomy is exercised according to the rule of law, and that there is no fragmentation or contradictions.

The Autonomy Arguments

For the SHIA, independence or autonomy means having legally assigned decision-making powers to properly administer and manage SHI (WHO 2013). Institutional autonomy does not imply complete independence from government and other public bodies. It refers to the power to develop and design its own institutional setting and operational methodologies and processes. The SHIA requires a reasonable level of protection against attempts by other institutions to interfere in its core tasks and to access funds under SHIA management to ensure the objectivity and neutrality of SHIA in decision making.

Institutional autonomy of the SHIA is needed for the following reasons:

- To define the internal institutional setting of SHIA for the optimal management of the health financing/insurance functions, including governance (SHI Board) and the architecture of the SHIA at all levels, national, provincial, and district;
- For objective and effective financial management of SHI funding, regardless of the source of income, contributions, budgetary transfers, and subsidies based on guidelines by the SHIA Board and not subject to external demands;
- For contractual autonomy that is indispensable to the proper exercise of the purchasing/contracting function for spending on health care goods and services;
- For the relationships with other public and private entities with formal independence from government institutions;
- To set internal and external rules or normative autonomy with regard to the core functions and to regulate relations with providers and for contract implementation;
- The SHIA needs autonomy to act objectively in the pursuit of its purposes and not be subject to politically motivated decisions or having to use SHI financial resources to purchase equipment for the MoH or for capital investments in public facilities;
- SHI is a form of prepaid insurance that is both special and specialized. SHI is special because it is different from other traditional forms of health insurance such as indemnity insurance.¹⁰ SHI is specialized because its purpose is to finance the provisions of health care goods and services included in state health care benefit packages primarily and other related aspects such as health promotions and prevention, and lifestyle campaigns that lead to changes in behaviors.

- Autonomy under the rule of law is critical for proper, transparent, and accountable management of the vast financial resources under SHIA management. SHI pools and manages an enormous mix of public and private income that includes budgetary transfers and subsidies, private contributions by beneficiaries, and user fees, as applicable. The amounts of financial resources are substantial, making the SHIA a foremost financial manager.
- The magnitude of the purchasing/contracting power of the SHIA is of enormous importance and, if not properly and autonomously managed, the exercise of this contracting power can be open to influence and corruption if external influences are allowed. In fact, when fully operational, the SHIA will be one of the major, if not the major, contractor of services in Vietnam with a critical indirect contribution to employment generation.
- The autonomous management of these large pools of financial resources has to be objective, clear, neutral, and conducted under guidelines and regulated standards, and not be subject to external influences to use the SHI resources to cross-subsidize other social entitlements or to finance activities outside its legal purpose and mandates.

In sum, the new SHI Law establishes and defines the autonomy of the SHIA, but this independence is not absolute. The SHIA is subject to the rule of law operating with neutrality under the provisions of the new Health Insurance Law. An SHI Board with broad representation of the government, the private sector, and beneficiaries will govern the SHIA. The SHIA will be part of the state structure. It will be supervised and subject to strict reporting, accounting, and transparency norms stipulated in the SHI Law and in internal rules and regulations. The SHIA, therefore, needs the autonomous institutional status that will allow it to perform its functions objectively without interference in decision making, with transparency under clear rules and regulations, and subject to accountability standards. This excellence cannot be attained if SHIA is a dependency of another institution that can obstruct proper management.

Road Map for Institutional Reform

SHI Reform Stages

The recommendation of this report is to reform the present SHI institutional structure in two stages as follows:

- Firstly, by consolidating all SHI functions into a VSS specialized Directorate or Department¹¹ called in this document SHI/VSS. These changes should be incorporated in the revisions to the present SHI Law in 2014 and come into effect six months after the amendments are approved. This process and its strengthening would take from one to three years. During this time preparation for the drafting and approval of a new comprehensive SHI Law¹² should take place.

- The second and subsequent stage under the new SHI Law will finally establish and make operational the SHIA already envisioned in the current SHI Law as an autonomous legal person incorporating into the new SHIA the functions of the reformed SHI/VSS. The new SHI Law should take into account the positive and adverse experience of SHI/VSS in the management of the health financing/insurance functions, in particular, and in actually enhancing enrollment, the financing of health care goods and services, and in standardizing the functioning of public and private providers and suppliers under SHI/VSS purchasing/contracting. The SHIA will take one to three years to become fully operational and up to seven years in total to consolidate. Since SHI implementation is a dynamic and continuous process, there may be a need to introduce amendments into the new SHI Law to address implementation problems and to respond to increased enrollment, actual access to health care, and new health care demands.

Road Map toward a Reformed SHI/VSS

The decision of the government to amend the current SHI Law should be used to include the suggestions made in this document toward the transitional establishment within VSS of a Directorate or a Department exclusively dedicated to the management of SHI.

The following steps could be considered in the meantime:

- A joint resolution (in the appropriate legal form) by MoH and VSS to establish the SHI/VSS Directorate or Department within VSS to manage SHI. It may be possible that the MoF would also want to participate in preparing and issuing this resolution given the importance of MoF subsidies for SHI.
- The SHI/VSS will become the foundation for the new SHIA once established. This transition may take some time until a new SHI Law is approved and the SHIA is made operational. A rough time estimate would be one to three years.
- The joint MoH and VSS resolution will also establish an SHI Board at the level of the SHI/VSS Directorate/Department.
- The joint resolution should establish the composition of the transitional SHI Board and the corresponding appointments. The Board should include representation from the MoF, MoH, the VSS, the Ministry of Labor, health care providers, and beneficiaries. A membership of 15 is suggested.
- Integrate into SHI/VSS all functions and staff currently working on SHI-related matters in various VSS departments.
- Integrate into SHI/VSS all SHI financial functions and staff currently performing these functions at the MoH.
- Organize SHI/VSS along health financing/insurance functional lines.
- Prepare a set of internal rules for the operation of the SHI/VSS as a single SHI manager.
- Structure SHI/VSS into the central, provincial, and district administrative divisions of the country.
- Define the relations between SHI/VSS and the MoH, DoHs, and others.

- Establish basic unified procedures and guidelines.
- Prepare rules for the SHI Board.

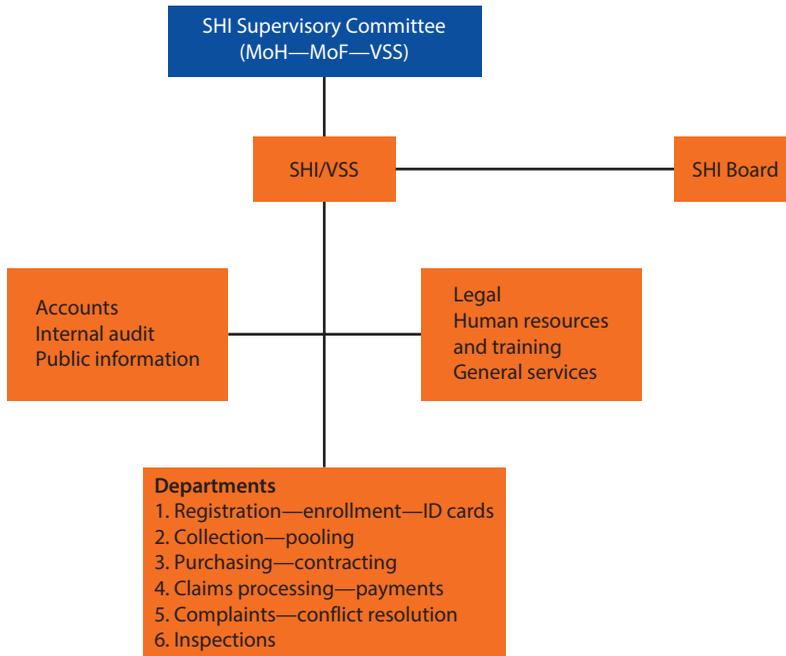
To answer the question of who should supervise SHI/VSS as a transitional entity, there are several options:

- One option is to have SHI/VSS supervised by the current VSS Management Council. As mentioned in the analysis in this chapter, the composition and role of the VSS Management Council has not, and most likely will not, make it a suitable supervisor for SHI. SHI is both a special and highly specialized type of insurance and its supervision cannot be just one more of the tasks of the VSS Management Council, which is already burdened with responsibility for supervising VSS and the management of several social insurance schemes.
- A second option is to have the MoH supervise SHI/VSS. This option will only increase tensions between VSS and the MoH. SHI is not a health entity—it finances the provision of health care goods and services. It does not provide those goods and services. Furthermore, the MoH does not have a function as a financial supervisor.
- A third option is to have SHI supervised by the Ministry of Labor. This option will create an unnecessary tension with VSS. Furthermore, SHIA is not a labor matter. It includes all of the population, those in the formal and informal labor markets, and also all dependents, the poor, and near-poor. As is the case with the MoH, the Ministry of Labor does not have a function as a financial supervisor.
- A fourth option is a compromise option for an SHI Supervisory Committee composed of the MoF, the MoH, and the VSS (figure 8.3). The Committee will have formal representation from the MoF, MoH, and the VSS, namely the Minister of Finance, the Minister of Health, and the Director-General of VSS as the primary formal representatives. Each of them can appoint a representative to participate in meetings where the principal cannot attend.

Road Map toward the SHIA

The following steps could be considered toward the establishment and operationalization of the SHIA:

- Drafting of a new Health Insurance Law that could contain some of the following:
 - A definition of the purpose of SHI;
 - Definition of the objectives of universal health financial protection and access to UHC;
 - Definitions for the purposes of the Law and specifically for the implementation and interpretation of the SHI Law;
 - Reference to SHI/VSS to be the foundation of the new SHIA and the legal transfer of functions, and staff to SHIA;

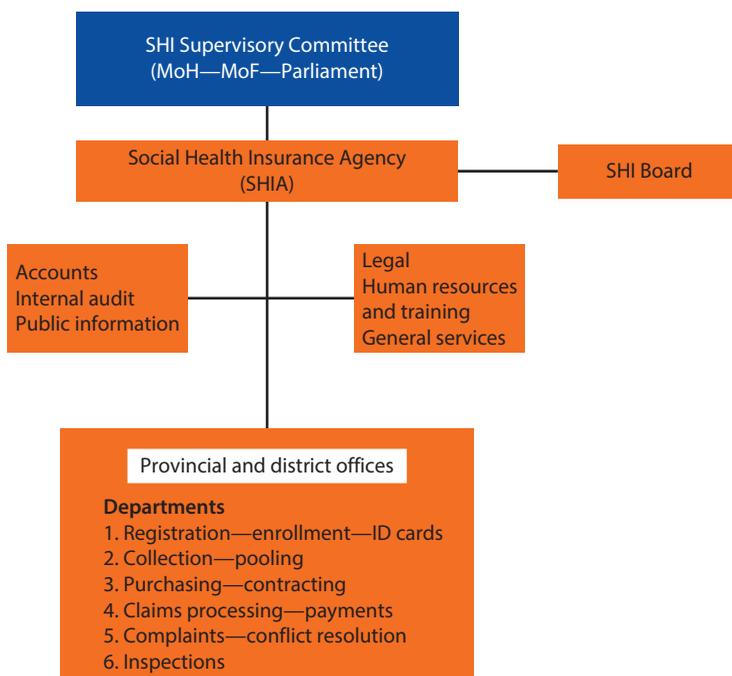
Figure 8.3 Transitional Supervision of SHI/VSS by Supervisory Committee

- A chapter on the establishment of the SHIA, the level of autonomy, governance, functions, attributions or powers, duties and responsibilities, among others, to provide the legal, institutional, and financial foundations for the SHIA;
- A chapter on SHI funding;
- Supervision of the SHIA including the SHI Board;
- A chapter on private health insurance could be considered; and
- Some of the amendments to be included in the revision of the current SHI Law to take place in the course of 2014.
- Definition of the institutional architecture of the SHIA.
- Once the new SHI Law is approved, steps need to be taken to make the SHIA operational and to absorb the functions of SHI/VSS. This process could take from one to three years.
- Supervision of the SHIA as illustrated in figure 8.4, would be by a SHI Supervisory Committee composed of the MoF, MoH, and a representative of parliament. This will replace VSS in the transition period, although VSS would be represented on the SHI Board.

Recommendations

Recommendation 1 on revision of the SHI Law:

- Define the objective/mandate of SHI as the financial instrument to achieve UC;

Figure 8.4 Final Supervision Arrangements for the SHIA

- State the objective or mandate for the SHI Fund/Agency (in the interim VSS) “to collect and pool revenues from individuals, employers, and the government (transfers and subsidies) to finance the purchase and payment of predetermined packages of health care goods and services;” and
- Delegate effective regulatory and monitoring powers to VSS within the overall SHI supervision by the MoH.

The purpose of this recommendation is to have a clear understanding of the role and mandate of the VSS as an effective implementer of SHI and its relationship with the MoH. It is critical for the state entities, national assembly, VSS in managing SHI, providers and suppliers, beneficiaries, and the population at large to clearly understand the roles and mandates of VSS and MoH in SHI.

Recommendation 2: Revise and define the roles and mandates, responsibilities, and authorities of key agencies (MoH, VSS) in SHI to reduce institutional fragmentation and dual mandates.

The purpose of this recommendation is to ensure VSS is an effective implementer of SHI. To achieve this, it needs defined health financing/insurance functions (beneficiaries’ enrollment and registration, collection, pooling, purchasing, and payment of providers and suppliers) and implementing powers. The idea is to strengthen VSS and to consolidate functions and expertise within VSS to

manage SHI as a special and specialized type of insurance that requires specific technical and administrative skills. The MoH retains its overall policy and regulatory role, regulation of providers and suppliers, public health, and supervision to minimize conflicts of interest.

Recommendation 3 on SHI organization:

- Provide for VSS to manage SHI with a specialized SHI Division until an SHIA is established; and
- Provide for an SHI director to be appointed by the government to manage the VSS/SHI unit or department. Alternatively legislate for the VSS Management Council to appoint the SHI director.

The purpose of this recommendation is to give SHI an institutional identity within VSS. It will provide for the unity of the SHI system under VSS until the SHIA is established with its central office and local branches, and require VSS to have an organizational structure based on the health financing/insurance functions.

Recommendation 4 on SHI management:

- Provide for the VSS/SHI Division to have an SHI Board as the SHI decision-making and supervisory body, with proper representation. Alternatively, have the VSS Management Council establish an SHI Management Committee as the managing council for SHI; and
- Provide for the director of SHI to report to the SHI Managing Committee and perform as its ex officio secretary (or by reason of the position) and participate in the Board with voice and no vote.

The purpose of this recommendation is to institutionalize a dedicated governance structure for SHI implementation, performance, guidance, and supervisory functions.

Recommendation 5 on SHI governance:

- Require VSS to have separate accounts for SHI to avoid cross-subsidizing from pensions and social assistance;
- Establish within VSS an SHI conflict resolution system for managing complaints by providers, suppliers, and beneficiaries;
- Require VSS to include information on complaints and conflict resolution in Annual Reports; and
- Define clearly the situations that merit penalties, the level of penalties, and the authority to impose and enforce penalties (should be VSS).

The purpose of this recommendation is to clearly stipulate and require the establishment of systems that assure government, providers, suppliers, and beneficiaries that SHI is managed fairly, openly, and responsibly.

Recommendation 6 on SHI accountability:

- Require that state and external auditors audit VSS/SHI accounts annually; and
- Require SHI/VSS to prepare and publicize annual reports on SHI funding, coverage (including enrollment and services financed and provided), and other matters to be determined by the Management Council/SHI Board.

The purpose of this recommendation is to ensure clear, objective, and accountable management of SHI financing responsibilities to the government, providers and suppliers, and to beneficiaries.

Notes

1. Until 2002, the Vietnam Health Insurance Agency was attached to, and under the responsibility of, MoH. Thereafter it was merged into the VSS Agency (SS, the national agency responsible for implementing pension insurance, health insurance, and other short-term allowance schemes (sickness, maternity allowances). The rationale for this move was to reduce the number of government agencies that undertake similar tasks to reduce duplication and to improve administrative efficiency. The government's Organization Committee (today Ministry of Internal Affairs) considered that health insurance and pension insurance have very similar work. The prime minister decided to merge the Vietnam Health Insurance Agency into the Vietnam Social Insurance Agency (WHO 2013).
2. Discussed in chapter 4.
3. By way of comparison, in Chile (population 17.4 million) the National Health Fund has 239 budgeted staff and 1,175 staff under services contracts; and in Montenegro (population 630,000) the Health Insurance Fund has 114 staff.
4. Since the SHI Law establishes that MoH manages SHI, here the broader term "administer" is used to refer to the role of VSS regarding SHI and to avoid confusion. This role will be complemented later under Management and Governance sections of this chapter.
5. MoLISA: Ministry of Labour—Invalids and Social Affairs.
6. The SHI Law partially addresses the many issues regarding the operation of the key health financing functions: (a) *Revenues*. The SHI Law defines the contribution rates and subsidies for the various subjects/beneficiaries of mandatory and voluntary health insurance, and their affiliation or enrollment into the health insurance system (Articles 12–15); (b) *Pooling*. The SHI Law states that contributions and subsidies are paid/transferred to the Health Insurance Fund; and (c) *Purchasing*. The SHI Law refers to agreements or contracts between the implementing agency and providers, but does not elaborate on the main issues of the purchasing function such as strategic purchasing and selective contracting.
7. Building the proper legal contractual framework requires (a) a thorough revision of the existing public sector purchasing/procurement legal framework to introduce amendments to existing public sector legislation. For example, if the purchaser is a state agency that has to abide by the public sector procurement norms without the flexibility of contracting under private civil and commercial codes, the contracting process has serious inherent limitations; and (b) an assessment of how the current contracting is taking place: how autonomous contracting is from political interference,

how transparent, how accountable, and how effective it is in terms of value for money and in the quality of the services contracted and delivered.

8. In the Republic of Korea, the SHI Board of Directors has 18 members, in Estonia, 15, and in Montenegro, 13.
9. In Chile all laws (especially on health, pensions, and labor) are regularly updated and inexpensively published and sold in kiosks at subsidized prices for all the population to have access and be properly informed.
10. In this sense, social health insurance is similar to private prepaid insurance that is also a special form of health insurance.
11. The title VSS SHI Directorate or SHI Department should be decided by the government. In this document it is called SHI/VSS as it is assumed that it will have high-level management within VSS.
12. The new SHI Law should be *comprehensive*, meaning that it should refer to SHI in all its aspects, purposes, definitions, Health Insurance Agency, health financing/insurance functions, roles of the MoH, MoF, and regulation and supervision, among others. The same law could even contain a chapter on private health insurance.

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An Implementation Road Map for Moving toward Universal Coverage in Vietnam

Achieving universal coverage (UC) is a key policy goal for many countries around the world, but one that is fraught with challenges. At the World Health Assembly in 2013, President Kim of the World Bank called upon the members of the Assembly to be the generation that delivers UC (Kim 2013). Indeed, there is no shortage of political commitment to this goal across countries. Nonetheless, attaining UC and sustaining it have proved to be a formidable challenge for high-income countries, let alone for low- and middle-income countries.

Even countries like Thailand that succeeded in expanding coverage to the entire population have struggled to sustain high levels of coverage in the face of cost pressures arising from the demographic and epidemiological transitions, technological advances in health care, and evolving population demands for health care. Countries that have realized UC have invested decades in gradual developments, with policy and institutional changes, experimenting with different modes of funding and of financing health care. This report represents an independent assessment of Vietnam's Social Health Insurance (SHI) carried out by the World Bank, WHO, UNICEF, and the Rockefeller Foundation in the lead up to the revision of the SHI Law. It documents the substantial progress made by Vietnam to date in attaining key UC-related goals, analyzes the shortcomings and potential challenges, and provides a series of recommendations.

This chapter brings together the recommendations contained in chapters 2–8, focusing on the main UC-related goals of (a) expanding the breadth of coverage, (b) increasing equity and financial protection, and (c) financing UC in a sustainable manner. The last goal implies mobilizing resources in a fiscally sustainable manner, reducing fragmentation in pooling, and strengthening resource allocation and purchasing. A fourth cross-cutting goal is to strengthen the organization, management, and governance of SHI.

What follows is an implementation road map specifying the reforms or measures needed to implement the recommendations contained in this report.

The implementation road map organizes the reforms and measures needed into three groups and separates out the short-term and medium-term proposals in each case:

- *legislative and regulatory measures needed;*
- *health systems strengthening measures needed; and*
- *data and information gaps that need to be addressed.*

Legislative and Regulatory Measures¹

The legislative and regulatory measures needed to achieve each one of the UC objectives are listed below. In each case, the main bullet point refers to changes to the Law itself. The subbullet points refer to regulatory changes needed through the issue of regulations and other means.

To Expand Breadth of Coverage

In the Short Term (2014–15)

- Establish and strengthen Vietnam Social Security's (VSS) responsibilities for enrollment and enforcement of mandatory enrollment and provide VSS with powers to issue and enforce penalties.
- Establish the State's obligations to subsidize SHI contributions for individuals or households, specifying increases in the subsidies to 100 percent (by 2020) for groups such as the near-poor as a State budget commitment.
- Delegate to Ministry of Finance (MoF)/Ministry of Health (MoH)/VSS responsibility for determining the level of the subsidy and issue regulations to gradually increase the subsidy, taking into account macroeconomic conditions.
- Define households/families, specify the subsidies, and mandate the enrollment of families in SHI in the revised SHI Law:
 - Issue joint MoF/MoH/VSS regulation on the subsidy for family enrollment where the household contribution rate for the near-poor would be subsidized in full or partially.
- State that SHI is an entitlement and the SHI card a right in the Law:
 - Issue regulations to issue SHI cards with minimal bureaucracy.

In the Medium Term (2016 and Beyond)

- Define tax incentives for employers to encourage enrollment for families, which may also need amendment to tax laws.
 - Issue joint MoF/MoH/VSS regulation on employer subsidy for family rates for employees below an income threshold (to be defined), subsidy that could be tax deductible.

To Improve Equity and Financial Protection

In the Short Term (2014–15)

- Delegate authority for regulating procedures, rates, collection, and use of copayments to MoH/VSS regulations:

- Issue joint MoH/VSS regulation on copayments, that would include (a) copayment policy, the payers (who should pay), the exempted (clearly identified poor and other vulnerable populations and included in the health insurance card), and requirement for payment at cashiers only with receipt; (b) the requirement of posting in all health care establishments the copayment policy, payers and exempted, amount of copayment per case/intervention, and grievance rights and procedures; and (c) sanctions for providers that do not comply.

In the Medium Term (2016 and Beyond)

- Establish in the Law a conflict resolution system at VSS with regulations on grievance procedures.
- Introduce catastrophic coverage and give the mandate to MoH/VSS to develop it by 2016, and delegate to MoH/VSS the development of implementing regulations once catastrophic coverage is approved:
 - MoH/VSS should develop regulations specifying how the caps would be varied by income.

To finance UC in a sustainable manner by mobilizing resources in a fiscally sustainable manner, reducing fragmentation in pooling, and strengthening resource allocation and purchasing

In the Short Term (2014–15)

- Reference excise taxes on tobacco and alcohol that would be introduced or raised following changes to relevant tax laws, with a clear indication that the income generated by these taxes will be used to finance SHI. This would also have to be included in tax legislation and regulations.
- The Law already provides for increasing the contribution rate:
 - Issue regulations to gradually increase the contribution rate, taking into account efficiency gains in the health sector achieved to date, economic outlook, and stakeholder views.
- Reduce the number of insurance categories listed in the SHI Law, ideally to two categories: members in the contributory regime or subsidized regime.
- Clearly establish the responsibilities for benefits package design and implementation: MoH for clinical content, and relevant technical agency, as well as VSS and MoH, for determining the cost-effectiveness and implementation costs.
- Establish the concept that health care goods and services to be financed by SHI are those included in a basic package of goods and services.
- Institute a transparent process for determination/revision of the benefits package:
 - Issue a revised joint MoH/VSS regulation on the benefits package. Definition of intervention to be included (for example, primary health care, prenatal and postnatal care, deliveries, nutrition services, and other maternal and child health services not covered by targeted programs, ambulatory care, hospitalization for basic specialties, and care for the elderly). Criteria should

be a combination of clinically effective interventions based on burden of disease, treatment and prevention, and societal values (elderly), cost-effectiveness, and implementation capacity (health care facilities, health care personnel, drugs, availability of equipment, transportation and communication). The benefits package should be delivered at point of residence (permanent, and temporary) as the entry point for access to health care services. Benefit packages should be revised annually.

- Revise the regulation on payment systems based on the findings of the Provider Payment Diagnostic Assessment. Delegate to MoH/VSS regulation details on provider payment mechanisms:
 - Issue joint MoH/VSS comprehensive regulation on provider payment mechanisms including revision of (a) capitation payments with new base rate and adjustment coefficients; and (b) fee-for-service (FFS) by streamlining the fee schedules and bundling services.
- Review current policies and regulations on pharmaceuticals and the current state of importing/manufacturing, storage, distribution, and pricing.

In the Medium Term (2016 and Beyond)

- Further strengthen legislation on sin taxes.
- Revise the Law to transfer the pooling function from the 63 provincial VSS agencies to the national social health insurance agency (SHIA).
- Establish or strengthen VSS's implementing powers to include (a) effective regulatory functions, (b) participating in defining the benefit package and pricing of services, (c) billing control with billing regulations and monitoring compliance of billing, and (d) carrying out inspections and imposing penalties. These powers would be critical for enforcing the copayment policy and any catastrophic caps that are introduced, and for addressing balance billing.
- Incorporate clinical protocols, clinical governance, and the evaluation of benefit packages, including clear institutional responsibilities for each.
- Continue to revise regulations on payment systems based on the findings of the Provider Payment Diagnostic Assessment.
- Establish or strengthen VSS's implementing powers to include (a) establishing the purchasing policy and contracting mechanisms, (b) purchasing health care goods and services, (c) drafting and issuing contracts, (d) negotiating with suppliers, (e) processing claims and management payment systems, and (f) carrying out inspections and impose penalties.
- Revise SHI Law regulations relating to pharmaceutical procurement and pricing mechanisms.

The majority of these changes presuppose a strong, independent SHIA with a mandate to enroll, collect premiums, pool revenues, and purchase services. Such an agency would be critical for implementing SHI Law and regulations. The legislative and regulatory reforms needed to achieve this are below.

To Strengthen Organization, Management, and Governance of SHI In the Short Term (2014–15)

- Introduce a new article in the revised SHI Law specifying (a) SHI as the financial instrument to achieve UC, and (b) the objectives of the SHIA: to collect and pool revenues from individuals, employers, and the government (transfers and subsidies), and to finance the purchase and payment of predetermined packages of health care goods and services.
- Delegate effective regulatory and monitoring powers to VSS within the overall SHI supervision by the MoH.
- Revise and define the roles and mandates, responsibilities, and authorities of key agencies (MoH, VSS) in SHI to reduce institutional fragmentation and dual mandates. VSS needs clearly defined functions that are in line with the SHI functions (beneficiaries enrollment and registration; collection; pooling; purchasing, payment of providers and suppliers) as well as implementing powers. MoH would retain its overall policy and regulatory role, regulation of providers and suppliers, as well as provision of public health services to minimize conflict of objectives.

SHI organization:

- Provide for VSS to manage SHI with a specialized SHI division until an SHIA is established; and
- Provide for an SHI director to be appointed by the government to manage the VSS/SHI unit or department. Alternatively, legislate for the VSS Management Council to appoint the SHI director.

In the Medium Term (2016 and Beyond)

SHI management:

- Provide for the VSS/SHI division to have an SHI Board as the SHI decision-making and supervisory body, with proper representation. Alternatively, it could have the VSS Management Council establish an SHI Management Committee as the managing council for SHI.
- Provide for the director of SHI to report to the SHI Managing Committee and perform as its ex officio secretary (or by reason of the position) and participate in the Board with voice and no vote.

SHI governance:

- Require VSS to have separate accounts for SHI to avoid cross-subsidizing from pensions and social assistance.
- Establish within VSS an SHI conflict resolution system to address complaints by providers, suppliers, and beneficiaries. Include the principle and right to grievance procedures in the SHI Law, with rules and procedures delegated to regulations:

- Issue joint MoH/VSS/Ministry of Justice regulations on grievance procedures.
- Require VSS to include information on complaints and conflict resolution in Annual Reports.
- Clearly define the situations that merit penalties, the level of penalties, and the authority to impose and enforce penalties (should be VSS):
 - Issue revised joint MoH/VSS regulation on strict penalties for noncompliance with health insurance laws and regulations. Require full enforcement of penalties from monetary fines to reduction in reimbursements.

Accountability within SHI:

- Require that State and external auditors audit VSS SHI accounts annually, and prepare and publicize annual reports on SHI funding, coverage (including enrollment and services financed and provided), and other matters.

Health System Strengthening Measures

This refers to broader health system strengthening measures beyond SHI reforms, which are critical for improving efficiency and equity of health service delivery. This includes short-term measures to improve efficiency of outpatient and inpatient specialist services by changing incentives and strengthening lower-level hospital services, and a longer-term strategic plan to strengthen primary care. These reforms should be implemented in the medium to long term, alongside the legislative and regulatory changes proposed above to make substantial progress toward UC:

- Strengthen availability and quality of primary care services to deliver the primary care benefit package under the new payment mechanisms.
- Create/strengthen a cadre of primary health care professionals by modernizing the training curriculum, retraining existing staff, creating new cadre, and providing the right incentives to work in poor, rural areas.
- Strengthen quality of care at all levels of the system through licensing and accreditation, issuing of clinical practice guidelines (including for drugs), and continuous quality assurance. This includes addressing the problem of irrational drug use through clinical practice guidelines.
- Good management information systems (MIS) are needed to (a) effectively monitor compliance by enrollees, (b) avoid duplicate enrollment by those who fall into multiple categories, and (c) provide for the portability of insurance. The MIS would include unique identifiers, the ability to carry out real-time coverage checks between providers and VSS, and a revenue collection database which links individual identifiers to the employer identifier. Good systems are also needed to limit balance billing and effectively implement the copayment policy as well as the catastrophic coverage caps. Challenges associated with introducing catastrophic cost coverage include having accurate information on an enrollee's out-of-pocket (OOP) payments during the month or year in

order to assess whether the catastrophic limit has been reached. This is difficult in a setting where the health insurance MIS is weak, and where individuals may seek care from several different hospitals. Again, unique patient identifiers are key for making this work. VSS could invest in MIS for social insurance more broadly, or develop MIS specifically for health.

Data and Information Gaps That Need to Be Addressed

In the Short Term (2014–15)

- Family enrollment is strongly recommended, but little is known about how much the premium should increase by, what increase in the premium would be affordable for both Government of Vietnam (GoV) and employers, and its impacts on wages and employment. Simulations and analyses are required to set the premiums and subsidies for family enrollment at appropriate levels.
- Arrange actuarial costing and projections for SHI, including more precise estimates of the behavioral responses of both consumers and suppliers to changes in insurance coverage.
- Expand the evidence base on costs and cost-effectiveness to support the above process. UNICEF is already supporting efforts to develop and cost a package of interventions for women and children.
- Initiate pilots of portable insurance policies in large cities like Hanoi and Ho Chi Minh City.
- Analyze successful primary care models from other countries that are relevant to Vietnam.

In the Medium Term (2016 and Beyond)

- Survey of providers and patients to get a better understanding of the extent of balance billing practices.
- Needs assessment and cost impact of the drugs on the Health Insurance Reimbursement List (HIRL), using data from other countries with advanced health technology assessment (HTA) systems.
- Analysis of the distribution of hospital revenues to staff through pay-for-performance, social mobilization, public-private partnerships (PPPs), and other mechanisms.
- Data on quality of service provision.
- Data on the provision of unnecessary care at facilities.

Note

1. Regulatory measures include circulars and decrees.

Reference

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Health System Overview¹

Health Financing

Total health expenditures were 6.9 percent of gross domestic product in 2010, or US\$85 per capita. Households account for the largest share of total health expenditures—57 percent in 2001—although this has declined from 67.1 percent in 2005. Figure A.1 illustrates the financing flows in Vietnam. Government supply-side subsidies are channeled through the Ministry of Health (MoH) or provincial health bureaus, while demand-side subsidies are channeled through Vietnam Social Security (VSS).

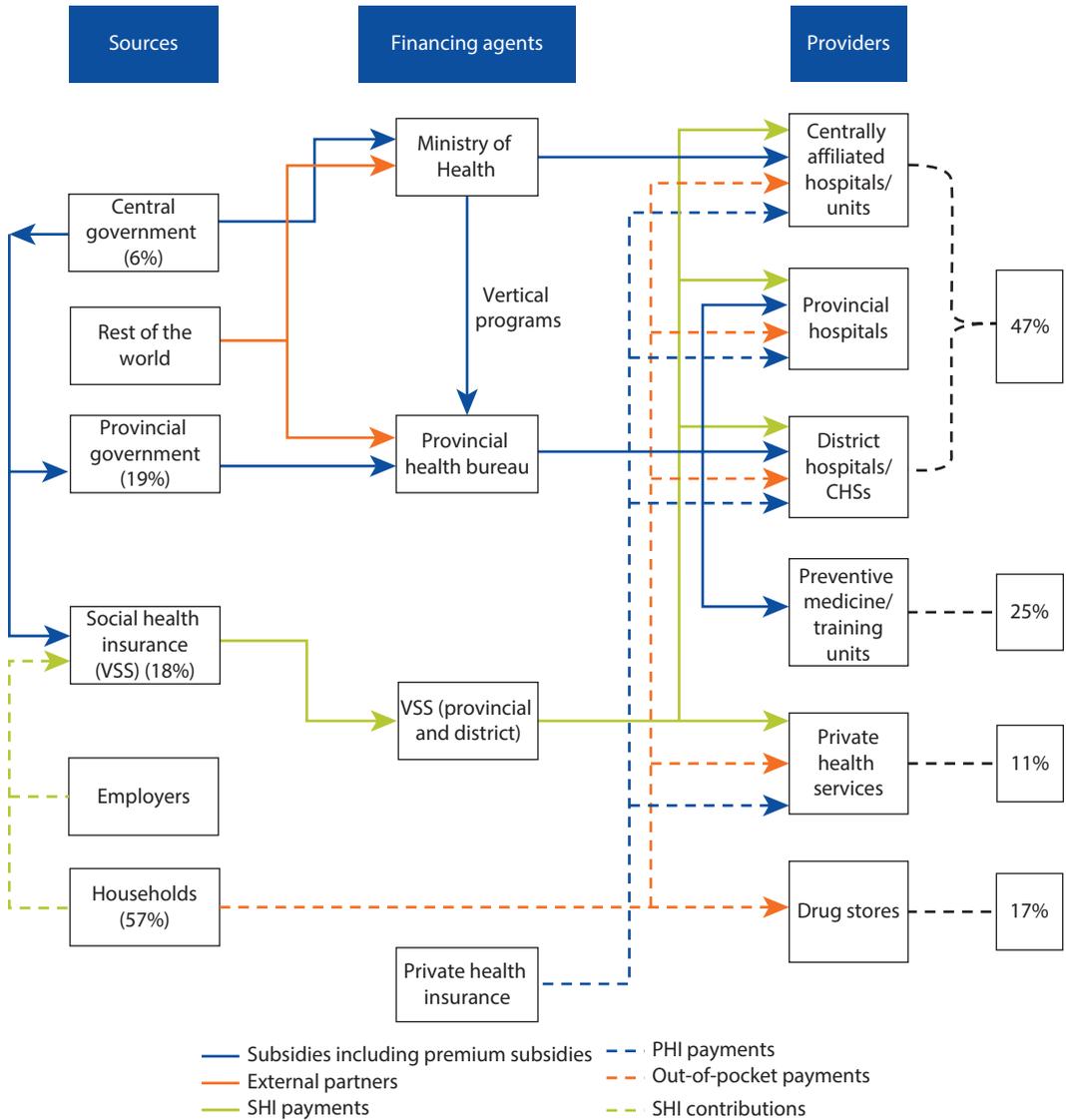
Delivery of Services

Vietnam has a mixed delivery system, with the public sector dominant in the provision of hospital care services, and the private sector dominant among smaller ambulatory care providers and the sale of pharmaceuticals. The public sector delivery system consists of central and specialized hospitals, provincial and district hospitals, commune health stations (CHSs), and village health workers. Private providers of primary care consist of drug vendors, general practitioners, private pharmacies, and nursing homes.

The private hospital sector is relatively underdeveloped, with private hospital bed numbers accounting for only 4 percent of the total beds. In 2010, public sector hospitals and CHSs accounted for nearly one-half of all health expenditures. Private health care providers accounted for 12 percent and drug stores for 17 percent of total health expenditures.

All public providers were automatically approved to participate in social health insurance (SHI) prior to November 2011, while private providers needed certification and permission. In recent years, no provider has lost the right to participate. From November 15, 2011, onward all public and private providers were required to obtain certification and permission to practice medicine.

Figure A.1 National Health System Financing Flows (2010)



Note: PHI = private health insurance; SHI = social health insurance.

Primary Care and Referrals

The CHSs are the first point of contact for much of the population, especially in rural areas, but do not provide many of the services they are designated to provide. There are more than 10,000 CHSs in the country, one for each commune, each of which covers about 10,000 people. Recent studies have found that many services such as malnutrition programs, child health exams, and diagnosis and treatment of noncommunicable diseases (NCDs), which should be delivered at the

CHS level, are not actually provided. Possible reasons for this include lack of personnel (35 percent of CHSs do not have doctors), limited drug availability, and poor-quality equipment. CHS health workers also have limited access to continuing medical education, which impacts the quality of services provided.

Primary care is also provided by intercommune clinics, district hospitals, and polyclinics at the district level, all of which admit inpatients, and provide emergency services and basic treatment for common illnesses. District hospitals have 80 beds on average, but are characterized by large variations in technical sophistication and quality of services provided. Poor quality at the lower levels worsens inequalities in access to services. A survey in 13 provinces in the Mekong region showed that 61.3 percent of patients in the poorest quintile selected CHSs, compared to only 35.5 percent among the richest quintile (Nguyen Hoan Yen et al. 2013).

According to the referral guidelines set out in a 2009 MoH Circular,² insured members can only use health services from the CHS or district hospital where they are registered, and must be referred to secondary or tertiary hospitals. Insured patients who bypass lower-level referral facilities must pay a higher copayment rate, depending on the level at which they access health care (30 percent at district hospitals, 50 percent at provincial hospitals, and 70 percent at central and tertiary hospitals). In practice, the referral mechanisms remain ineffective because of relatively poor quality at the primary level facilities.

Supply-Side Infrastructure

There are large regional variations in the number of beds per capita. The North Central and Central Highlands regions have far fewer beds per capita, and in particular fewer provincial beds than other regions. The rural/urban population ratio is highly positively correlated with the district/provincial bed ratio, implying that the more rural the province, the greater the reliance on district hospitals.

In recent years, the government has made significant investments into improving the public health infrastructure, with some emphasis on primary care. Since 2008, the government has used the sale of government bonds to finance the upgrading of CHS and district hospitals.³ In addition, a 2008 project for upgrading district and general hospitals received Vietnam dong (VND) 3,750 billion (US\$202 million) and VND 3,000 billion (US\$162 million) respectively. In 2009, VND 500 billion (US\$26.9 million) from government bonds was allocated for building and upgrading specialist provincial hospitals and general hospitals in disadvantaged provinces.⁴

The allocation of supply-side subsidies is largely based on historical norms. The MoH allocates subsidies to tertiary hospitals and specialized hospitals, and the provincial governments allocate subsidies to provincial, district, and commune-level health services through the provincial health bureaus. Both types of budget subsidies are allocated based on historic spending norms and bed numbers, with the exception of preventive care subsidies, which are capitation based.

VSS manages SHI revenues, and purchases services for the insured using a combination of payment methods. SHI premiums from employers (4.5 percent

Box A.1 Calculation Formula for Capitation Rate

SHI members are divided into six specific groups, with a group-specific capitation rate calculated for each group for each of the 63 provinces using the following formula:

$$R_{ij} = (Exp_{ij}/N_{ij}) \times K,$$

where

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

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

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

K is the annual adjustment coefficient to account for fluctuations in medical care costs, inflation, and changes in other related factors in the subsequent year.

of the minimum salary) and demand-side subsidies from the government for the poor, near-poor, and other vulnerable groups (4.5 percent of the basic minimum salary) are managed by VSS. Provincial Social Security offices handle payments at the provincial level.

Capitation-based mechanisms are used for outpatient and inpatient care provided at CHS and district hospitals. Box A.1 provides an explanation of the method used to calculate the capitation rate. Nearly 60 percent of all district hospitals have, to date, switched to capitation. Extending capitation to all district hospitals is a key policy priority. SHI members must enroll either at a CHS or at a district hospital contracted by VSS. The capitation funds cover all costs incurred by the capitated district hospital and CHS, as well as referral costs at secondary and tertiary hospitals for members registered at the district hospital.

The capitation fund is limited to 90 percent of the revenues collected from registered members. When there is a surplus in the capitation fund in any one year, district hospitals can use up to 20 percent at the hospital and return the remainder to the health care fund. When there is a deficit, the provincial social security office will reimburse at least 60 percent of the deficit or pass it on to VSS. Fee-for-service (FFS) is the payment method used for all secondary and tertiary hospitals and certain high-cost services that are excluded from capitation payment.

Expenditure caps are in place to control costs. For district hospitals with capitation-based payment, the capitation fund must not exceed 90 percent of the health care fund of the district hospital. The health care fund of the district hospital is 90 percent of the premium revenues collected from members registered at the district hospital; the remaining 10 percent goes into a reserve fund. For secondary and tertiary hospitals with FFS remuneration, the cap is based on historical expenditures adjusted for inflation.⁵ In addition, there is a cap per episode on the maximum benefit that the SHI fund will cover, defined as 40 months of the minimum monthly salary (approximately US\$35 in 2010) for high-tech and high-cost services.

Notes

1. Material for this appendix is taken from Somanathan, Dao, and Tien (2012).
2. Circular No. 10/2009/TT/BYT guiding the registration of the first point of care for insured patients and referral mechanisms.
3. Decision No. 47/2008/QDDTg from the prime minister approved project investment for building and upgrading health facilities using government bonds from 2008 to 2010.
4. In this report the following exchange rate has been applied: US\$1 = VND 18,518.
5. Cap for inpatient expenditures = average expenditure per admission last year \times 1.1 \times number of admissions per month. Cap for outpatient specialist care = average expenditure per outpatient visit last year \times 1.1 \times number of visits per month.

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- Nguyen Hoang Yen, Nguyen Huong Giang, Nguyen Dang Vung, Tran Duc Thach, Nguyen Quang Ninh, and Pham Thi Huong. 2013. *Report on the Implementation of "Health Care for the Poor" and "Free Health Care for Children Under Six" Policies in Ethnic Minority Areas*. Hanoi: Centre for Health Consultation and Community Development and UNICEF.
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APPENDIX B

The Consultation Process for the Health Insurance Review

<i>No.</i>	<i>Consultation events</i>	<i>Presenters</i>	<i>Date</i>
1.	Inception Workshop to agree on the scope of the study, and responsibilities of different stakeholders with Ministry of Health (MoH) and Vietnam Social Security (VSS). Representatives of the Committee on Social Affairs also participated in the meeting.	World Bank	February 2012
2.	Technical discussion with the MoH-related departments and VSS on provider payment mechanism.	World Bank, World Health Organization (WHO)	August 2012
3.	Technical discussion with the MoH-related departments and VSS on the preliminary findings of the report.	World Bank, WHO, UNICEF, Health Strategy and Policy Institute (HSPI), Hanoi Medical University (HMU)	October 2012
4.	Report on preliminary findings of the report in two national workshops (Hanoi and Ho Chi Minh City) to discuss options for Health Insurance Law (HIL) revisions with MoH-related departments, VSS, related ministries, and provinces.	World Bank, WHO, UNICEF	November and December 2012
5.	Report on main findings of the report at two national-level workshops in Hanoi and Ho Chi Minh City with participation from central level and 63 provincial representatives.	World Bank	June 2013
6.	Technical discussion with the MoH-related departments and VSS on main findings of chapter 8.	World Bank	October 2013
7.	Technical discussion with National Assembly members, organized by the Social Committee of the National Assembly.	World Bank, WHO	January 2014
8.	Final dissemination workshop at national level.	World Bank, WHO, UNICEF	January 2014

Details of Universal Coverage Costing Simulations

Estimating the cost of achieving universal coverage (UC) requires information on the breadth of population coverage as well as on unit costs related to the scope and depth of coverage provided in the benefits package. The basic formula for UC costing can be summarized as

$$\text{Population Coverage} \times [P \times Q + A] = E,$$

where

P = unit cost of service per person;

Q = quantity of service per person (that is, utilization);

A = administrative costs; and

E = total health expenditure under UC (Guerard et al. 2011).

In actuarial analyses, the unit cost of providing a particular service included in the UC benefits package is often estimated as a “direct” cost derived from insurance claims data (that is, from the price paid for a given service). From a societal perspective, however, the unit cost should also include “indirect” costs such as those related to supply-side budgetary transfers as well as any related out-of-pocket (OOP) payments not covered under insurance claims, both reflecting cost-sharing arrangements that may implicitly or explicitly be in place. Furthermore, the UC costing formula above is not static. Costs will evolve based on the demand response to increasing coverage, the current availability of services, supply responses over time, changes in health-care technology, the provider payment mechanisms, as well as improvements in efficiency and other cost-control mechanisms that may be put in place (Guerard et al. 2011).

<i>Statistic</i>	<i>Current (2010)</i>	<i>Scenario I^a</i>	<i>Scenario II^b</i>
Coverage rate (%)	59.8	70.0	70.0
Total population	88.3 million	93.7 million	93.7 million
GDP	VND 2,158 trillion	VND 4,681 trillion	VND 4,681 trillion
GDP per capita	VND 22,444,728	VND 43,330,424	VND 43,330,424
Total government expenditure	VND 648 trillion	VND 1,174 trillion	VND 1,174 trillion
VSS outpatient utilization (number of visits per member per year)	1.79	—	—
VSS outpatient unit cost	VND 98,670	—	—
VSS inpatient utilization (number of admissions per member per year)	0.16	—	—
VSS inpatient unit cost	VND 1,151,741	—	—
<i>SHI expenditures</i>			
VSS outlays	~VND 20 trillion	~VND 99 trillion	~VND 110 trillion
VSS outlays share of GDP (%)	1.0	2.1	2.4
Government expenditures subsidizing VSS (SHI demand-side)	~VND 8 trillion	~VND 39 trillion	~VND 45 trillion
Proportion of VSS outlays financed by government (%)	41.0	39.0	41.0
<i>Non-SHI government expenditures</i>			
Non-SHI government expenditures on health (supply-side)	~VND 33 trillion	~VND 80 trillion	~VND 80 trillion
Total government expenditure on health (GHE)	~VND 41 trillion	~VND 119 trillion	~VND 125 trillion
GHE as share of total government expenditure (%)	6.3	10.1	10.6
GHE as share of GDP (%)	1.9	2.5	2.7

<i>Statistic</i>	<i>Current (2010)</i>	<i>Lieberman-Wagstaff Model II (2015)</i>	
		<i>Scenario III^c</i>	<i>Scenario IV^d</i>
Coverage rate (%)	59.8	70.0	70.0
Total population	88.3 million	93.7 million	93.7 million
GDP	VND 2,158 trillion	VND 4,681 trillion	VND 4,681 trillion
GDP per capita	VND 22,444,728	VND 43,330,424	VND 43,330,424
Total government expenditure	VND 648 trillion	VND 1,174 trillion	VND 1,174 trillion
VSS outpatient utilization	1.79	1.88	1.88
VSS outpatient unit cost	VND 98,670	VND 285,981	VND 285,981
VSS inpatient utilization	0.16	0.17	0.17
VSS inpatient unit cost	VND 1,151,741	VND 3,314,777	VND 3,314,777
<i>SHI expenditures</i>			
VSS outlays	~VND 20 trillion	~VND 123 trillion	~VND 123 trillion
VSS outlays share of GDP (%)	1.0	2.6	2.6
Government expenditures subsidizing VSS (SHI demand-side)	~VND 8 trillion	~VND 49 trillion	~VND 49 trillion
Proportion of VSS outlays financed by government (%)	41.0	~40.0	~40.0
<i>Non-SHI government expenditures</i>			
Non-SHI government expenditures on health (supply-side)	~VND 33 trillion	~VND 80 trillion	~VND 119 trillion
Total government expenditure on health (GHE)	~VND 41 trillion	~VND 129 trillion	~VND 168 trillion
GHE as share of total government expenditure (%)	6.3	11.0	14.3
GHE as share of GDP (%)	1.9	2.7	3.6

Note: GDP = gross domestic product; SHI = social health insurance; VSS = Vietnam Social Security.

a. Key assumptions: Contributions 4.5%; Minimum wage VND 1,500,000 (increasing by 30% per year thereafter); support for near-poor: 70%, students: 50%, farmers: 30%.

b. Key assumptions: Contributions 5%; Minimum wage VND 1,500,000 (increasing by 30% per year thereafter); support for near-poor: 70%, students: 50%, farmers: 30%, and then 50%.

c. Key assumptions: Increase in inpatient and outpatient utilization rates and costs; increases in Vietnam Social Security (VSS) outlays to absorb OOP spending.

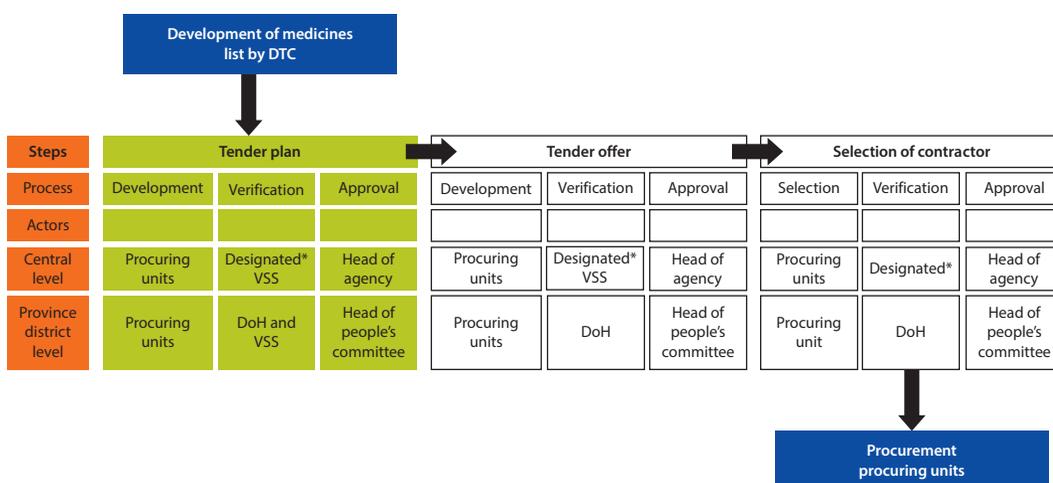
d. Key assumptions: Increase in inpatient and outpatient utilization rates and costs; increases in VSS outlays to absorb OOP spending and increases in supply-side spending.

Reference

- Guerard, Y., M. Wiener, C. Rokx, G. Schieber, P. Harimurti, E. Pambudi, and A. Tandon. 2011. "Actuarial Costing of Universal Health Insurance Coverage in Indonesia: Options and Preliminary Results." HNP Discussion Paper, World Bank, Washington, DC.

Inefficiencies in Pharmaceutical Spending

Figure D.1 Pharmaceutical Procurement: Process and Agencies Involved

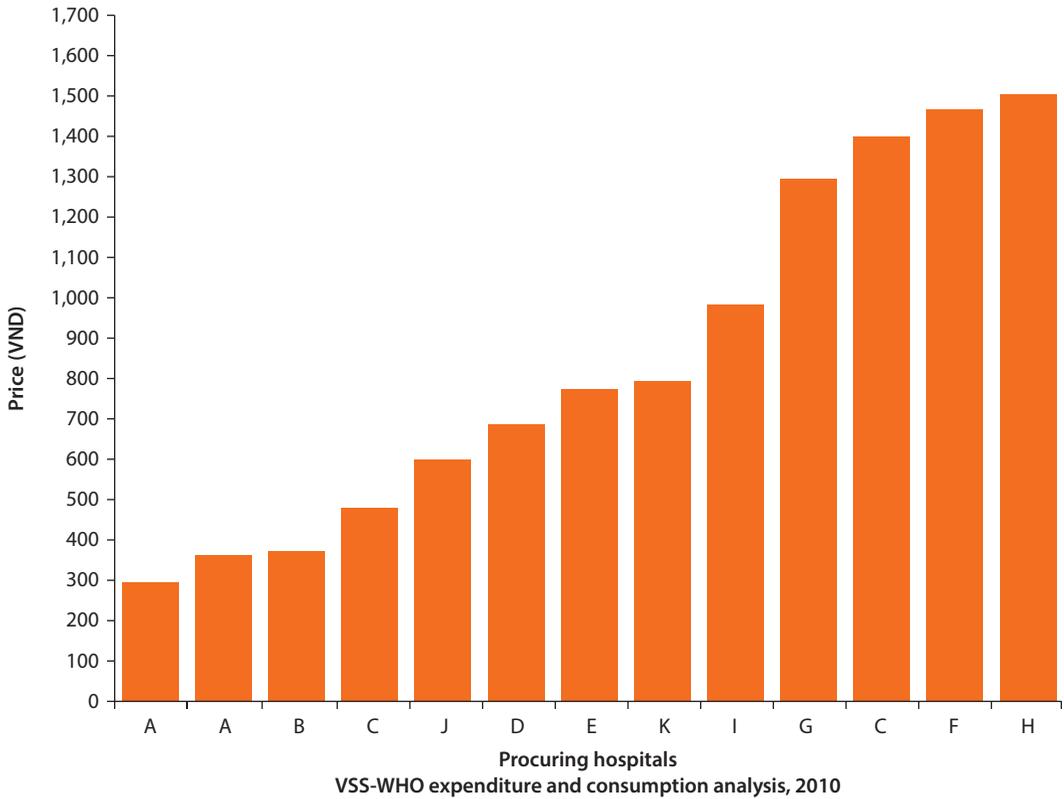


Source: Escalante 2012.

Note: DTC = Drug Therapeutic Committee; DoH = Department of Health (Province); VSS = Vietnam Social Security; Procuring units = hospitals and polyclinics.

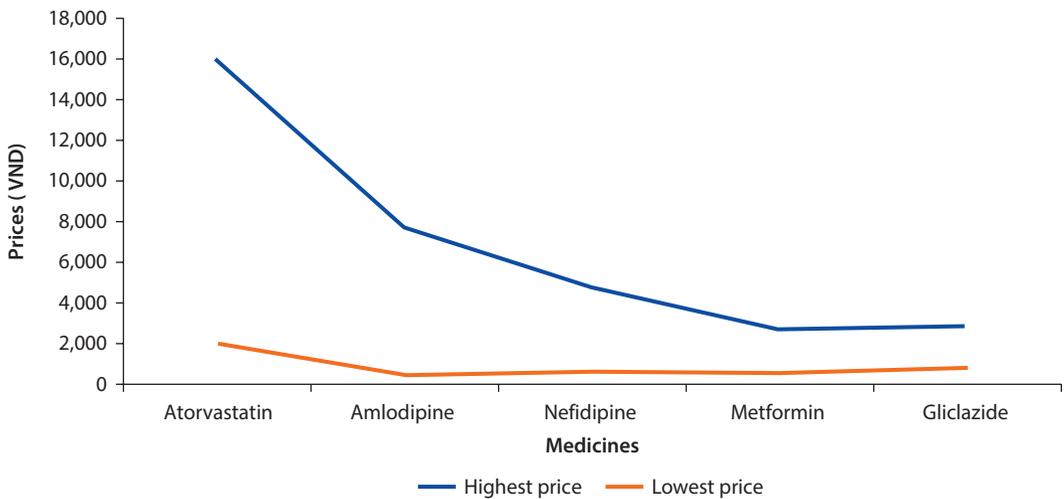
* The head of agency designates a person or a unit to undertake verification.

Figure D.2 Procurement Prices of Amoxicillin 500mg across Hospitals



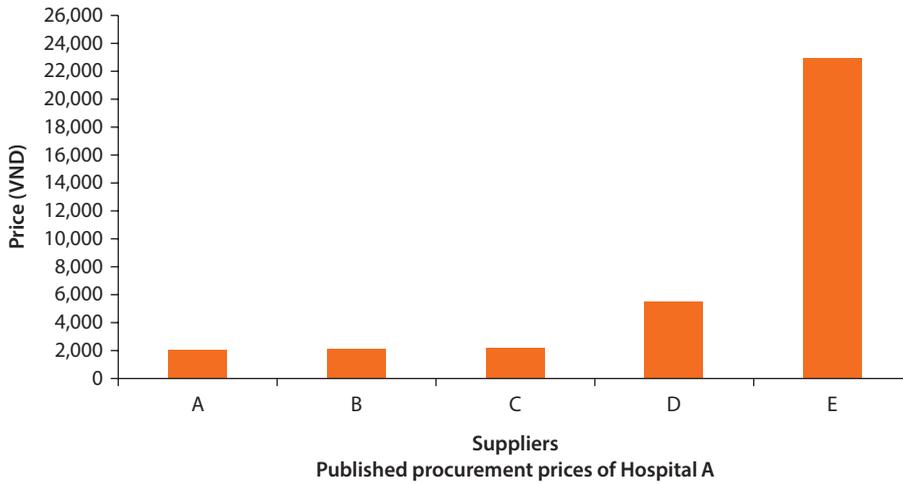
Source: Escalante 2012 (VSS-WHO Expenditure and Consumption Analysis).

Figure D.3 Procurement Prices of NCD Medicines (2010)



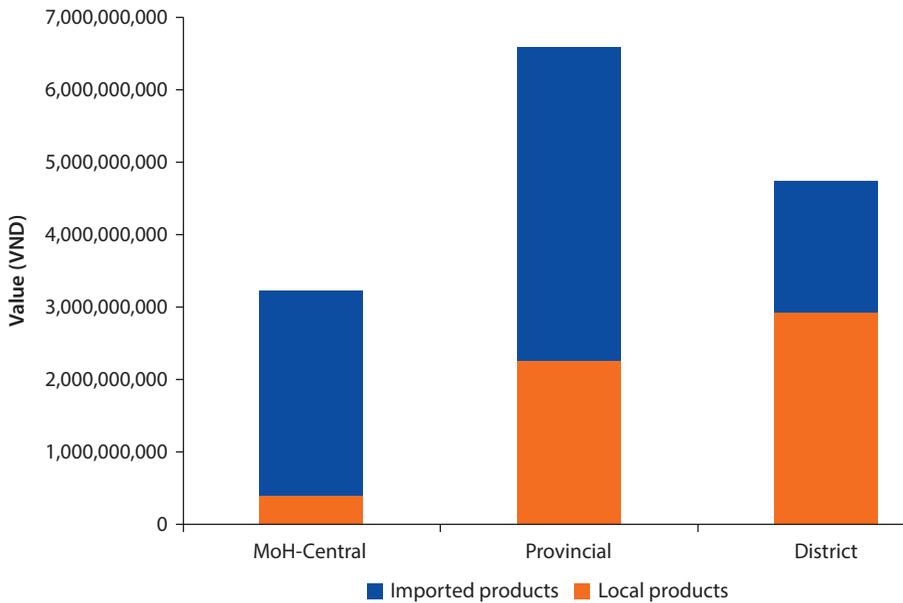
Source: Escalante 2012 (WHO and VSS data on procurement prices at nine central and provincial-level hospitals).

Figure D.4 Procurement Prices of Atorvastatin, 20mg in Hospital A (2011)



Source: Escalante 2012 (Published procurement prices of winning bids).

Figure D.5 Total Procurement Expenditure on Imported and Local Drugs (by Public Hospital Category) (2009–10)



Source: Escalante 2012 (WHO analysis based on hospital procurement reports submitted to Ministry of Health [MoH]).

Reference

Escalante, S. 2012. “The State of Medicine Use in Vietnam: Determinants for Improving Efficiency.” Background paper produced for the report, *Moving towards Universal Coverage of Social Health Insurance in Vietnam: Assessment and Options*.

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Over the past two decades, Vietnam has made enormous progress toward achieving universal coverage for its population. Enrollment rates are still low, however, and significant equity challenges remain. Ensuring financial protection also remains an elusive goal. The Master Plan for Universal Coverage approved in 2012 directly addresses these deficiencies.

Expanding the breadth of coverage, particularly for those hard-to-reach groups such as the near-poor and the informal sector, would require substantially increasing general revenue subsidies and fully subsidizing the premiums for the near-poor. High enrollment rates would, however, have little impact on financial protection and equity if out-of-pocket costs remained high. Achieving universal coverage will require sustained efforts to improve efficiency in the system and gain better value for money from available budgetary resources.

There is considerable scope for improving efficiency in Vietnam. An overly generous benefits package; an oversupply of services caused by provider payment mechanisms and the mix of incentives facing providers; the high prices, overconsumption, and inappropriate use of pharmaceuticals; and the structure and incentives embedded within the delivery system are all inefficiencies in resource allocation and purchasing arrangements.

Moving toward Universal Coverage of Social Health Insurance in Vietnam contains recommendations to expand coverage, generate efficiency savings, and strengthen institutional arrangements, as well as the specific measures needed to implement the recommendations.



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