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# VIETNAM: LEARNING FROM SMART REFORMS ON THE ROAD TO UNIVERSAL HEALTH COVERAGE

DISCUSSION PAPER

AUGUST 2014

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**WORLD BANK GROUP**  
Health, Nutrition & Population



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**Helene Barroy, Eva Jarawan, and Sarah Bales**

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## Vietnam: Learning from Smart Reforms on the Road to Universal Health Coverage

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**Abstract:** Universal Health Coverage is a powerful framework for a nation aiming to protect their population against health risks. However, countries face multiple challenges in implementing, achieving and sustaining UHC strategies. Sharing and learning from diverse country experiences may enable to foster global and country progress toward that goal. The study seeks to contribute to the global effort of sharing potentially useful lessons to address policy concerns on the design and implementation of UHC strategies in LMICs. Vietnam is one of the LMICs that have taken relatively quick and effective actions to expand health coverage and improve financial protection in the last two decades. The country study, first, takes stock of UHC progress in Vietnam, examining both the breadth and the depth of health coverage and assessing financial protection and equity outputs (Chapter 1). Chapter 2 includes an in-depth analysis of some of the major success strategies and policy actions that the country took to expand health coverage and financial protection for all, including for the poor. Chapter 3 focuses on some of the UHC-related challenges that the country faces in pursuing expansion and sustaining UHC. Vietnam’s experience suggests that, moving toward greater UHC outputs, the system must be constantly adjusted, and that UHC strategies must be adaptive—those used in the past to cover the formal sector and the poor may turn out inadequate to reach the uninsured in the informal sector.

**Keywords:** Universal Health Coverage, Vietnam, health system reform, human resources for health, health financing

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank Group, its Executive Directors, or the countries they represent.

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## **PREFACE**

This study is part of the Japan–World Bank Partnership Program for Universal Health Coverage (“the Program”), which documents lessons from UHC reforms across the globe. The Program was conceived as a joint effort by the government of Japan and the World Bank to support low- and middle-income countries in their aspirations for Universal Health Coverage (UHC), following the 50th anniversary of Japan’s own achievement of UHC in 1961.

## ACRONYMS

EPI	Expanded Program on Immunization
FFS	Fee for Service
HRH	Human Resources for Health
IMF	International Monetary Fund
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Affairs
OOP	Out-of-Pocket
SHI	Social Health Insurance
UHC	Universal Health Coverage
VHI	Voluntary Health Insurance
VSS	Vietnam Social Security Agency

## INTRODUCTION

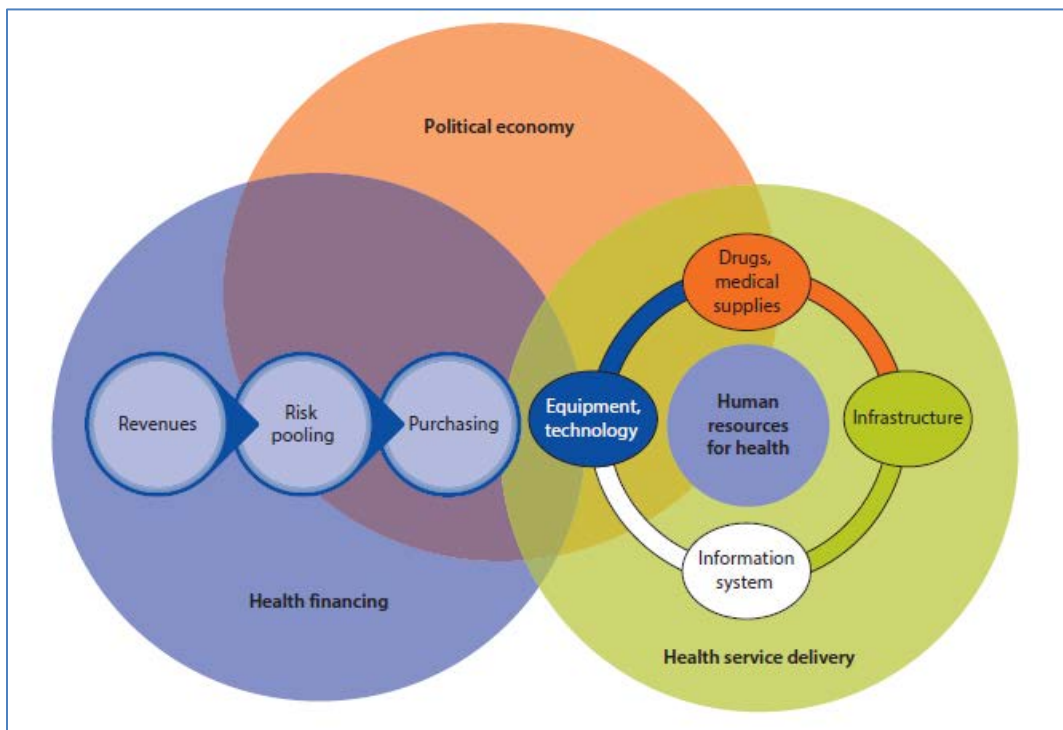
Nearly all high-income countries have achieved universal health coverage (UHC), and some 30 developing countries have made notable progress toward it. In 2005, representatives of 180 countries to the World Health Organization (WHO) Annual Assembly committed their countries to the goal of UHC “to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them.” There is significant and growing interest among low- and middle-income developing countries (LMICs) to incorporate UHC as one of the goals of their national development plans.

Health coverage has several dimensions, including (i) breadth of coverage to ensure access to health services across different population groups (Who is covered?); (ii) depth and scope of coverage in the range of benefits and services offered (What is covered?); and (iii) effective financial protection against catastrophic health events (financial protection). A UHC-related goal is to establish an inclusive and sustainable health system—one that ensures equitable and affordable access to health care for all members of society, provides adequate financial protection, and contributes ultimately to the well-being of individuals and of society as a whole (Kutzin 2011; Kutzin and Cashin 2002). Countries as diverse as Brazil, France, Japan, Thailand, and Turkey, which have achieved UHC, are showing how UHC programs can serve as vital mechanisms for improving the health and welfare of their citizens, and lay the foundation for economic growth and competitiveness grounded on the principles of equity and sustainability. LMICs face multiple constraints in expanding health coverage, for instance limited financial resources from public and private sources, or low quality of care and productivity of services.

Because of the complexity of interactions that influence and determine health coverage, identifying the key constraints and designing feasible solutions to overcome these barriers is daunting. Toward that end, a good understanding of the key components of the health system, and their interactions both within the health system and with factors outside of the health system, is necessary. Figure A.1 provides a schematic view of the major subcomponents of the health system affecting health coverage, namely the health financing system, service delivery system, and demand-based programs.

Following that analytical framework, this report seeks to contribute to the global effort of sharing potentially useful lessons to address policy concerns on the design and implementation of UHC strategies in LMICs. Vietnam is one of the LMICs that have taken relatively quick and effective actions to expand health coverage and improve financial protection.

**Figure A.1 Major Subcomponents of the Health System Contributing to Health Coverage**



Source: Maeda et al., 2014.

Vietnam is a development success story. Political and economic reforms (Doi Moi) launched at the end of the 1980s have transformed the country from one of the poorest in the world to a lower middle-income country, with per capita income of \$1,130 (WDI 2012). Over the past 10 years, Vietnam has achieved great strides in economic development with average annual economic growth of nearly 8 percent. The poverty rate declined from 58 percent in 1993 to 11 percent in 2012. About 28 million people are estimated to have been lifted out of poverty over roughly two decades. Economic development and innovative policy interventions have also led to large gains in health outcomes and access to health care, although large disparities still persist between the rich and the poor, and between the poorer and better-off regions of the country. As an example of the progress, infant mortality declined from 30 to 15 per 1,000 live births, and under-five mortality from 42 to 23 per 1,000 live births, between 2001 and 2012.

Lessons shared from Vietnam’s experience with health coverage will interest other countries that aim for equitable and sustainable options to achieve UHC. Vietnam has shown strong and sustained political commitment toward UHC over the last two decades, and made it a national goal in 2008. The country has made impressive headway in expanding health coverage in recent years, so that over 60 percent of the population is now covered. A set of policy measures and quick actions, including prioritization of health in government spending and proactive consolidation and harmonization of insurance schemes, have been implemented, boosting coverage expansion and financial protection.

The main aim of the study, in line with the Japan Partnership Program, is to show progress, take stock, and provide in situ analysis of the underlying actions that were critical to enhance health coverage.

## **LESSONS FROM VIETNAM'S EXPERIENCE WITH UNIVERSAL HEALTH COVERAGE**

The following points summarize the lessons from Vietnam's experience to date with Universal Health Coverage:

1. Over 60 percent of Vietnam's population is covered under social health insurance, a sixfold increase in 20 years.
2. A targeted policy approach has enabled the country to cover around 90 percent of the poor through state subsidies.
3. The country has invested heavily in curative and preventive care services, which are now delivered under social health insurance, as part of the benefit package, or through public health programs.
4. Financial protection has substantially improved, although the population remains vulnerable to catastrophic health spending.
5. National ownership, sustained political commitment, and legislative regulation are among the key enabling factors that have allowed UHC policy reforms to be bold and consistent over the last two decades.
6. Increased fiscal space for health through continued high economic growth, a robust ability to generate revenues (with no earmarking), and prioritization of health in government spending were at the core of the health coverage expansion strategy.
7. Although multiple funds and schemes were created over the course of the reforms, Vietnam has taken steps to consolidate these into a national insurance program to enhance harmonization and redistribution.
8. Despite sizable investments to strengthen service delivery, human resources for health remain a core concern for effective health coverage. Recent policy initiatives have helped increase the availability of practicing health professionals, particularly in poorer regions, but quality remains an issue.
9. While much has been achieved to finance coverage expansion in the last two decades, efforts are still needed to expand coverage for the remaining 40 percent or so of the population, most of whom work in the informal sector, and to improve overall financial protection through contained out-of-pocket spending.
10. Strategies used to expand coverage in the past two decades may turn out inadequate to reach the insured without robust expenditure management and the right incentives to shift the system toward cost-effective interventions.

## **ORGANIZATION OF THE REPORT**

This report is divided into three sections. The country study, first, takes stock of UHC progress in Vietnam, examining both the breadth and the depth of health coverage and assessing financial protection and equity outputs (Chapter 1). Chapter 2 includes an in-depth analysis of some of the major success strategies and policy actions that the country took to expand health coverage and

financial protection for all, including for the poor. Chapter 3 focuses on some of the UHC-related challenges that the country faces in pursuing expansion and sustaining UHC.

# PART 1: ANALYZING MULTI-DIMENSIONAL PROGRESS TOWARD UHC

## 1.1 COMPREHENSIVE AND EQUITABLE POPULATION COVERAGE

Most of Vietnam’s population is covered by social health insurance (SHI). Nearly two-thirds of the population (63.7 percent) is now entitled to health coverage. The country has integrated its different programs, including those for the poor, into a single national insurance program. Still, four main population categories continue to coexist for which copayments and contributions vary (Table 1.1).

First, a contributory scheme includes the employed and those receiving monthly social security benefits. The contribution rate for the employed is 4.5 percent of salary, with one-third paid by the employee and two-thirds by the employer. For those on monthly benefits, the contribution rate is 4.5 percent of benefits and is paid from the social security fund. The copayment rate for this group is 20 percent. The contributory scheme covers 20 percent of the population.

Second, a noncontributory scheme provides fully subsidized coverage to the poor (34 percent of the population). For people who performed meritorious service to the nation and for children under age six, the copayment rate is 0 percent. For poor or ethnic minorities in disadvantaged areas and for social welfare beneficiaries, the copayment rate is 5 percent.

Third, a “co-contributory” scheme covers about 22 percent of the population. Under this, both the state and the beneficiary contribute. The contribution amount is 3 percent of the minimum wage for school pupils and university students and 4.5 percent of the minimum wage for the near-poor. The state budget subsidizes 50 percent of the contribution for school pupils and 70 percent for the near-poor. The copayment rate for these groups is 20 percent.

Fourth, a voluntary insurance scheme is still available to cover the remaining 24 percent of the population, notably those from the informal sector. The contribution amount is 4.5 percent of the minimum wage and is paid by the individual. A discount is offered on the contribution to reward participation by multiple members of a household. The copayment rate for this group is 20 percent.

**Table 1.1 Population Coverage under SHI**

	Population coverage (%)	Source of funding	Population category
Compulsory scheme	75.8		
Contributory	64.5	Wages + copay	Formal workers
Noncontributory	91.8	State budget (limited copay)	Poor, meritorious, and ≤ age 6
Co-contributory	61.5	State + wages + copay	Near-poor and school pupils/students

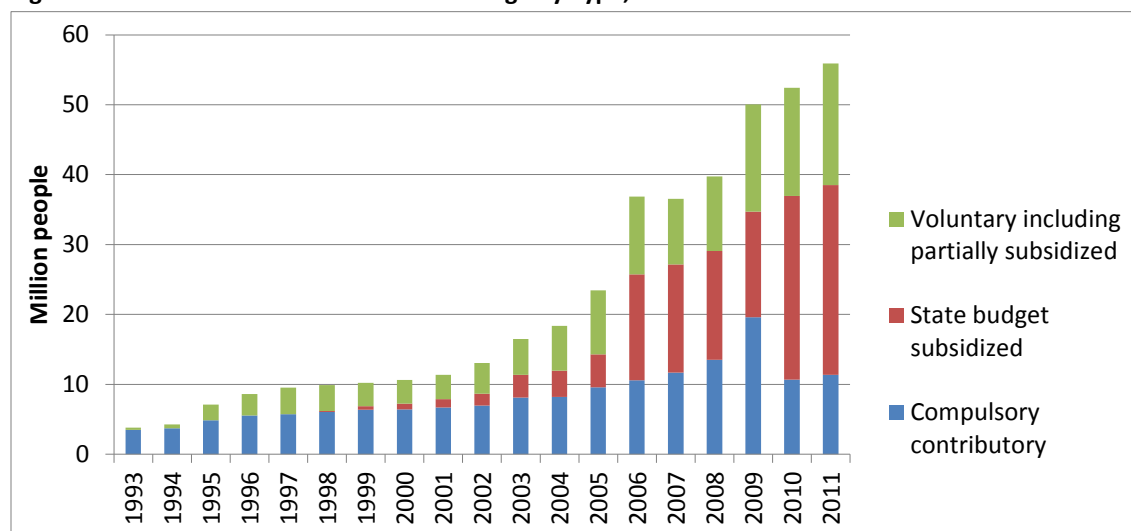
Voluntary scheme	26.0	Wages + copay	Informal sector
Overall	63.7		

Source: Authors, adapted from Ministry of Health (MoH) data, 2012.

From historical trends, the expansion of health coverage in Vietnam seemed largely due to increases in (state-subsidized) coverage for the poor and for “meritorious” people (people with merit, on social assistance, and military officers) in the 2000s. More than 90 percent (91.8 percent) of the noncontributory groups are now covered—evidence of a definite and effective targeting approach. The fully subsidized (27 million) include the means-tested poor (14 million), children under six years (8 million), and meritorious people.

Although expansion of coverage has been impressive (Figure 1.1), 36 percent of the population remains uncovered, including large numbers of employed workers in the informal sector, the near-poor, and self-employed individuals and their families. They must make all or part of the social insurance contribution through contributory, co-contributory, or voluntary schemes.

**Figure 1.1 Trends in Health Insurance Coverage by Type, 1993–2011**



Source: Authors, computed from MoH data 2012.

## 1.2 A LARGE BENEFIT PACKAGE INCLUDING PREVENTIVE AND CURATIVE SERVICES

The benefit package is large and has been gradually extended, both for curative health care under SHI and preventive health care through direct budget support. The package of curative services covered by health insurance is defined in the Law on Health Insurance (2009)<sup>1</sup> to include medical examination and treatment, rehabilitation, periodic antenatal checkups, delivery, and screening and early detection of some diseases (Table 1.2). Recent reforms have deepened depth of coverage, and all members—including the poor—are eligible for the same package, although not everyone benefits equally.

<sup>1</sup> Passed on November 14, 2008 and coming into effect on July 1, 2009.



**Table 1.2 List of Services Included in Benefit Package for Insured**

Type of benefit	Details of coverage
Inpatient services	Birth delivery Emergency services Other inpatient hospital services
Outpatient services	Outpatient primary care contacts Outpatient specialist contacts Pharmaceuticals for outpatient services Clinical laboratory tests for outpatient services Diagnostic imaging for outpatient services—basic + MRI, CT Scan
Other services	Dental care—basic Mental health/behavior Dialysis or transplants

Source: Adapted from Somanathan et al. 2013.

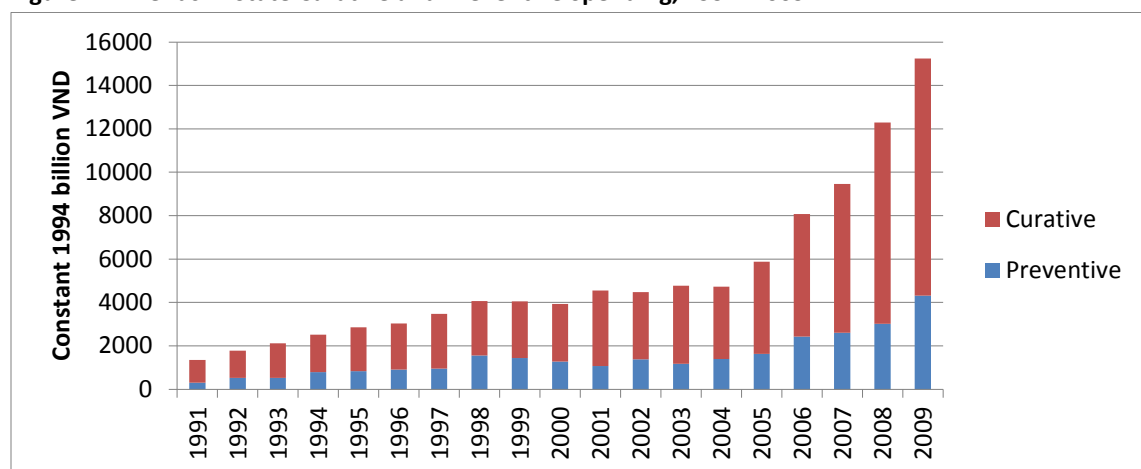
The list of curative services is defined in a series of decrees that provide explicit definitions of the maximum service package.<sup>2</sup> Some items are explicitly excluded from health insurance benefits. One set of exclusions includes items already paid for through other sources such as infectious diseases covered under state-funded preventive medicine programs or occupational diseases that are legally the responsibility of the employer (although compliance in the informal sector is not widely enforced). Another set of exclusions relates to vision, hearing, or other disabilities such as treatment of myopia or refractive errors; or the use of medical implants or prosthetics like artificial limbs, dentures, eyeglasses, hearing aids, or mobility devices in rehabilitation and treatment. Other excluded items include long-term care, health checkups, treatment of injuries related to illegal behavior, forensic medicine, and clinical research.

Some priority groups are entitled to additional curative service coverage. For certain meritorious or disadvantaged groups and children, in cases of emergency or necessary referral to a higher technical level, patient transport is also covered. For a few groups including patients who have had insurance continuously for 36 months or more, children under age six, and retired officials from the Ministry of Defense or Ministry of Public Security as part of their retirement package (Joint Circular No. 9/2009/TTLT-BYT-TC), there is an additional entitlement to 50 percent coverage of costs related to payment of approved cancer and anti-organ-rejection drugs that are not on the insurance list. For high-tech services (for most groups), health insurance covers at the normal copayment rate but only to a maximum amount equivalent to 40 times the minimum wage for one-time use of the service. For a small number of meritorious groups and children under six, there is no such cap on using high-tech services.

Health coverage also includes a relatively large set of preventive services. The preventive and public health service package is provided predominantly through direct state budget funding, with little or no copayment from patients, and therefore managed externally to the SHI funds. Investments in preventive care have increased over time (Figure 1.2).

<sup>2</sup> Specifically, these include the insured drug list (Circular no. 31/2011/TT-BYT including 900 active ingredients and 57 radioactive markers), traditional medicines (Circular no. 12/2010/TT-BYT), medical consumables and implants (Decision no. 21/2008/QĐ-BYT), medical services including diagnostics and treatment services (Joint Circular no. 03/2006/TTLT-BYT-BTC-BLĐTĐ&XH and updated in Joint Circular no. 04/2012/TTLT-BYT-BTC), and lists of rehabilitation services and average length of stay for disease groups covered by insurance.

**Figure 1.2 Trends in State Curative and Preventive Spending, 1991–2009**



Source: Authors, computed from MoH and WHO data, 2010.

Preventive care programs include the expanded program on immunization (EPI), and control and prevention of infectious diseases (malaria, tuberculosis, leprosy, HIV/AIDS, dengue fever) and of non-communicable diseases (mental illness, hypertension, diabetes, cancer, COPD/asthma). In addition, reproductive health and maternal and child health services are widely available at the commune and village levels, including tetanus vaccination, antenatal care, assisted delivery, sexually transmitted and reproductive tract infection screening, malnutrition monitoring and treatment, diarrhea, and acute respiratory infection control. In addition, Vietnam has a long history of epidemiological interventions to investigate and stop the spread of epidemics; and has gradually put in place an expanded set of public health measures in the areas of food safety, clean water and sanitation, health promotion, and risk reduction (smoking, alcohol, drugs, and safe sex).

Coverage of various long-standing infectious disease and reproductive health programs is reasonably high. Awareness of HIV transmission from mother to child is high at 92 percent of women age 15 to 49. However, unmet need for contraception is low at 4.3 percent for women age 15 to 49. Almost 94 percent of women age 15 to 49 who gave birth in the two years prior to a survey<sup>3</sup> reported receiving antenatal care from a trained health worker, and 92.4 percent of all deliveries occurred in a medical facility. Long-standing programs for infectious disease control and EPI generally report high coverage and effectiveness (95 percent immunization rate for BCG, 84 percent for measles, and 53 percent for hepatitis B). Over 95 percent of households have mosquito nets, and over 94 percent of mothers and children use them for protection while sleeping.

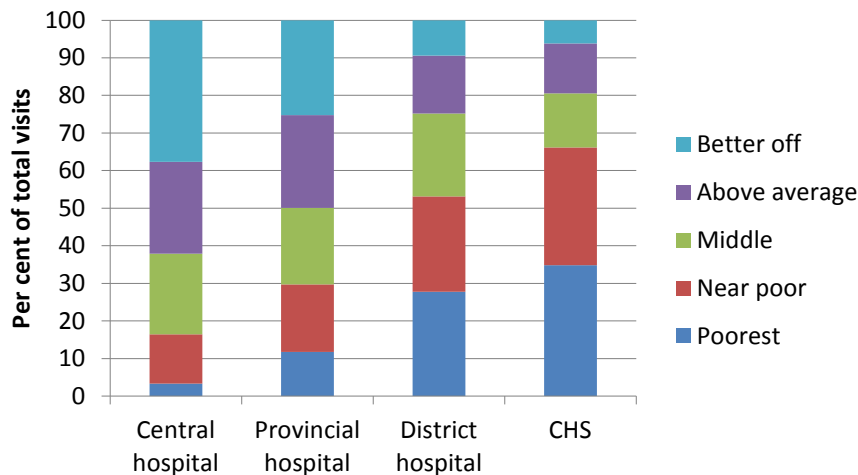
Still, wide economic disparities in coverage and use of public, preventive, and reproductive health programs persist. Immunization rates for children in the lowest wealth quintile tend to be far lower than in the other four quintiles. In the case of BCG, 88.4 percent of children in the poorest quintile had been immunized, against 97–98 percent in the other quintiles. Similar patterns exist for other vaccines. Use of improved drinking water is lowest in the poorest quintile

<sup>3</sup> Vietnam Multiple Indicator Cluster Survey 2011.

at 75 percent, increasing to 92 percent for the near-poor, and 99 percent for the wealthiest. Only 42 percent of the population in the lowest quintile use improved sanitation facilities, versus 66 percent and higher as living standards rise. While 20 percent of the poorest women had no antenatal care visits, only 3 percent or fewer women in the other wealth quintiles did not receive antenatal care. Disparities in quality of health care are also evident: only 17 percent of women in the poorest quintile received a health services package including urine and blood tests and blood pressure measurement; the numbers increased from 29 percent to 74 percent when moving from the near-poor to the wealthiest quintile (GSO 2011a).

The same is true for curative services: their utilization is higher among the better off and skewed to higher levels of care (Bales and Tuong 2012). The commune and district facilities with more limited service packages are widely frequented by the lower end of the living standards distribution, while provincial and central hospitals are heavily used by the top two quintiles (Figure 1.3).

**Figure 1.3 Living Standards Profiles of Users at State Curative Care Facilities, 2010**



Source: Bales and Tuong 2012.

Beyond socioeconomic determinants, many health system factors also influence whether people receive the comprehensive insurance package they are entitled to. In particular, the recently introduced capitation payment system tends to perpetuate those inequalities. Its design, which relies on historical expenditures, differentiates six different capitation amounts at provincial level, then allocates them to facilities based on the mix of beneficiary groups registered for care. Because the poor tend to have lower capitation rates, health facilities respond by further underproviding care to these groups, perpetuating the cycle of underutilization and underprovision (Somanathan forthcoming). Referrals of patients to higher level care is also discouraged as facilities where the insured register for care are fund-holders, responsible for (but with little control over) the costs of care at referral facilities.

### 1.3 BETTER FINANCIAL PROTECTION OVER TIME BUT LITTLE IMPROVEMENT FOR CATASTROPHIC SPENDING

As financial resources from prepayment and pooled mechanisms increased over the last two decades, out-of-pocket (OOP) expenditure, as a share of total health spending, declined, though it remains high. The level of OOP spending dropped from 66 percent in 2000 to 51 percent in 2009 (Table 1.3).

**Table 1.3 Distribution of Sources of Funds for Total Health Expenditures, 2000–09 (%)**

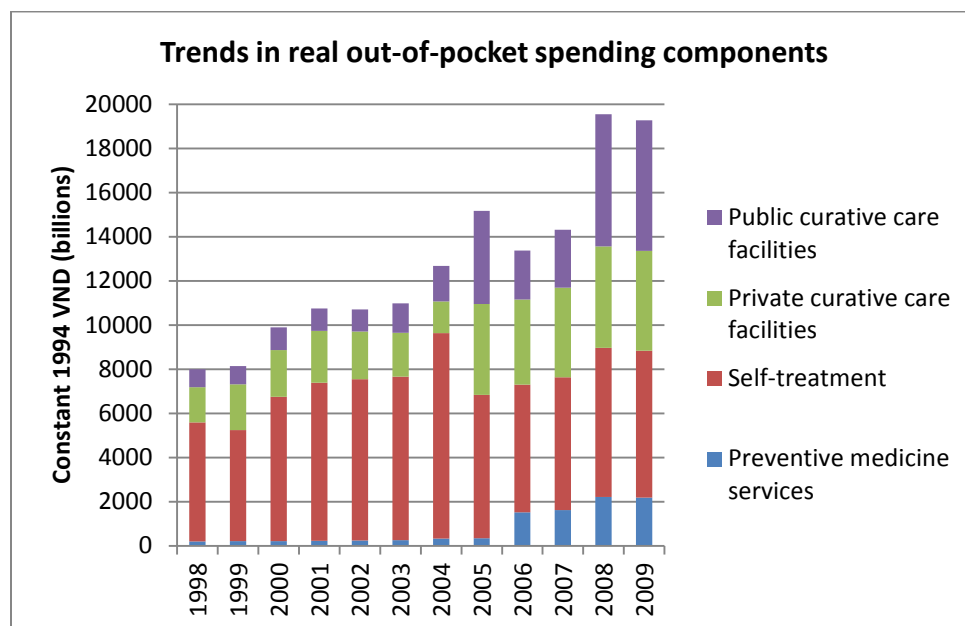
	State direct subsidy	OOP	Pooled share
2000	23	66	31
2005	17	68	26
2008	29	54	38
2009	34	51	42

Source: Authors, computed from MoH data 2011.

Note: The authors distinguish here state budget, OOP, and pooling. State budget and pooling for health insurance overlap in the table (summing to over 100%) as a share of pooling for health insurance originates from the state budget (for the poor).

Over the same period, the pooled share of total health spending increased as well as state direct subsidies, respectively, from 31 percent to 42 percent and from 23 percent to 34 percent in 10 years (2000–09). Jumps in state spending on health insurance correspond to key policy changes including the Health Care Fund for the Poor in 2002–03, compulsory subsidized insurance for the poor in 2006, and for children under six in 2009. Although declining, OOP spending still represents a concern for financial protection. Most of the OOP expenditure results from seeking care for self-treatment and private services outside of the covered services (Figure 1.4).

**Figure 1.4 Trends in Structure of Real OOP Spending by Health Service Activity**



Source: Authors, computed from data from MoH and VSS, 2012.

In 2008, catastrophic health spending accounted for 18.7 percent of households that spent more than 10 percent of their total consumption on health, and 6 percent of households that spent over 40 percent of nonfood consumption. For the share of households that spent more than 10 percent of total household consumption on health, OOP has remained stable over time, at around 19 percent. According to the alternative nonfood measure, in 1993, about 48 percent of households spent more than 10 percent of nonfood consumption on health and 8.3 percent spent more than 40 percent, but these figures had fallen by 2008, to 38.9 and 6.1 percent respectively. Catastrophic payments were highly concentrated among the wealthy when using the total household expenditure measure, but concentrated among the poor when using the nonfood measure (Table 1.4).

**Table 1.4 (a) Trends of Catastrophic Health Spending using Total Household Consumption, 1993–2008**

CATASTROPHIC OUT-OF-POCKET SPENDING <sup>3,4,6,7,8,9,10</sup>	Threshold share of total household consumption				
	5%	10%	15%	25%	40%
1993-94 <sup>6</sup>					
Headcount	38.7%	19.2%	9.8%	3.8%	0.4%
Concentration index	-0.014	0.006	0.019	0.026	0.320***
1997-98 <sup>7</sup>					
Headcount	34.5%	15.0%	8.3%	2.7%	0.6%
Concentration index	-0.032***	0.020	0.099***	0.271***	0.611***
2002 <sup>8</sup>					
Headcount	27.2%	13.0%	7.7%	3.0%	0.8%
Concentration index	0.003	0.085***	0.154***	0.281***	0.503***
2002-03 <sup>3</sup>					
Headcount	30.3%	17.9%	12.2%	6.2%	2.9%
Concentration index	0.003	0.085***	0.154***	0.281***	0.503***
2004 <sup>9</sup>					
Headcount	34.6%	17.5%	10.4%	4.4%	1.5%
Concentration index	0.025***	0.077***	0.149***	0.290***	0.471***
2006 <sup>4</sup>					
Headcount	30.0%	15.1%	8.8%	4.0%	1.2%
Concentration index	0.034***	0.087***	0.148***	0.289***	0.508***
2008 <sup>10</sup>					
Headcount	34.9%	18.7%	11.4%	5.0%	1.8%
Concentration index	0.003	0.069***	0.099***	0.226***	0.411***

**Table 1.4 (b) Trends of Catastrophic Health Spending using Share of Total Nonfood Consumption, 1993–2008**

CATASTROPHIC OUT-OF-POCKET SPENDING <sup>3,4,6,7,8,9,10</sup>	Threshold share of nonfood consumption				
	5%	10%	15%	25%	40%
<b>1993-94<sup>6</sup></b>					
Headcount	678%	477%	34.5%	19.2%	8.3%
Concentration index	-0.06***	-0.09***	-0.09***	-0.12***	-0.11***
<b>1997-98<sup>7</sup></b>					
Headcount	64.2%	43.2%	29.8%	14.8%	5.5%
Concentration index	-0.097***	-0.132***	-0.133***	-0.117***	-0.024
<b>2002<sup>8</sup></b>					
Headcount	54.0%	32.0%	21.1%	10.9%	4.5%
Concentration index	-0.112***	-0.121***	-0.102***	-0.059***	0.030
<b>2002-03<sup>3</sup></b>					
Headcount	46.2%	38.6%	31.9%	21.0%	13.5%
Concentration index	0.057***	0.046***	0.041***	0.045**	0.072**
<b>2004<sup>9</sup></b>					
Headcount	56.8%	36.0%	25.1%	13.3%	5.4%
Concentration index	-0.065***	-0.078***	-0.072***	-0.018	0.101***
<b>2006<sup>4</sup></b>					
Headcount	52.2%	31.8%	21.3%	11.5%	5.0%
Concentration index	-0.058***	-0.061***	-0.058***	-0.009	0.081***
<b>2008<sup>10</sup></b>					
Headcount	57.4%	35.9%	25.1%	13.7%	6.1%
Concentration index	-0.074***	-0.084***	-0.054***	-0.028	0.026

Source: World Bank, Equity and Financial protection datasheet, 2012.

Note: The concentration indices in the second line of the table show whether there is a greater tendency for the better off to have out-of-pocket spending in excess of the payment threshold (when it takes on a positive value), or whether the poor are more likely to have out-of-pocket spending exceeding the threshold (when it takes on a negative value).

## **PART 2: LEARNING FROM COVERAGE-ENHANCING REFORMS TOWARD UHC**

### **2.1 LESSONS FROM AN INCREMENTAL POLICY APPROACH WITH SUSTAINED COMMITMENT FROM LEADERSHIP**

Political commitment to expanding health coverage and protecting the poorest against health risks has been strong and consistent. National consensus is broadly reflected in the Constitution, in key Communist Party resolutions, in laws and resolutions of the National Assembly, and in government decrees and action plans. While structural change was introduced at the time of the Doi Moi reforms in the 1990s,<sup>4</sup> the UHC-oriented reforms have followed an incremental approach in the last two decades (Figure 2.1). Thus “learning by doing” was a driving feature of the political process, allowing the country to make gradual fixes to system deficiencies. A retrospective look at the sequence of reforms may be helpful for other countries.

#### **Constitution-based Right (1990s)**

The legal right of citizens to health protection and the priority placed on ensuring health care for vulnerable groups was enshrined in article 61 of the Constitution of 1992.<sup>5</sup> A year later, the country officially launched a national Health Insurance Program.<sup>6</sup> This included a compulsory health insurance scheme for the formal public and nonpublic sectors, including pensioners and people on disability benefits under the social security system. A Voluntary Health Insurance (VHI) scheme was stipulated for other groups. Regulations on school fee collection in 1993 aided the development of voluntary health insurance for school pupils and students.<sup>7</sup> Revisions to health insurance regulations were stipulated in 1998,<sup>8</sup> replacing unfunded exemptions with state-subsidized health insurance coverage for meritorious groups and social welfare beneficiaries (the unsupported disabled, the elderly, and orphans).

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<sup>4</sup> Prior to Doi Moi reforms, health care used to be free of charge at the point of service delivery, fully subsidized by the state, but with limited depth of service coverage and poor quality.

<sup>5</sup> Official translation from [http://www.vietnamlaws.com/freelaws/Constitution92\(aa01\).pdf](http://www.vietnamlaws.com/freelaws/Constitution92(aa01).pdf).

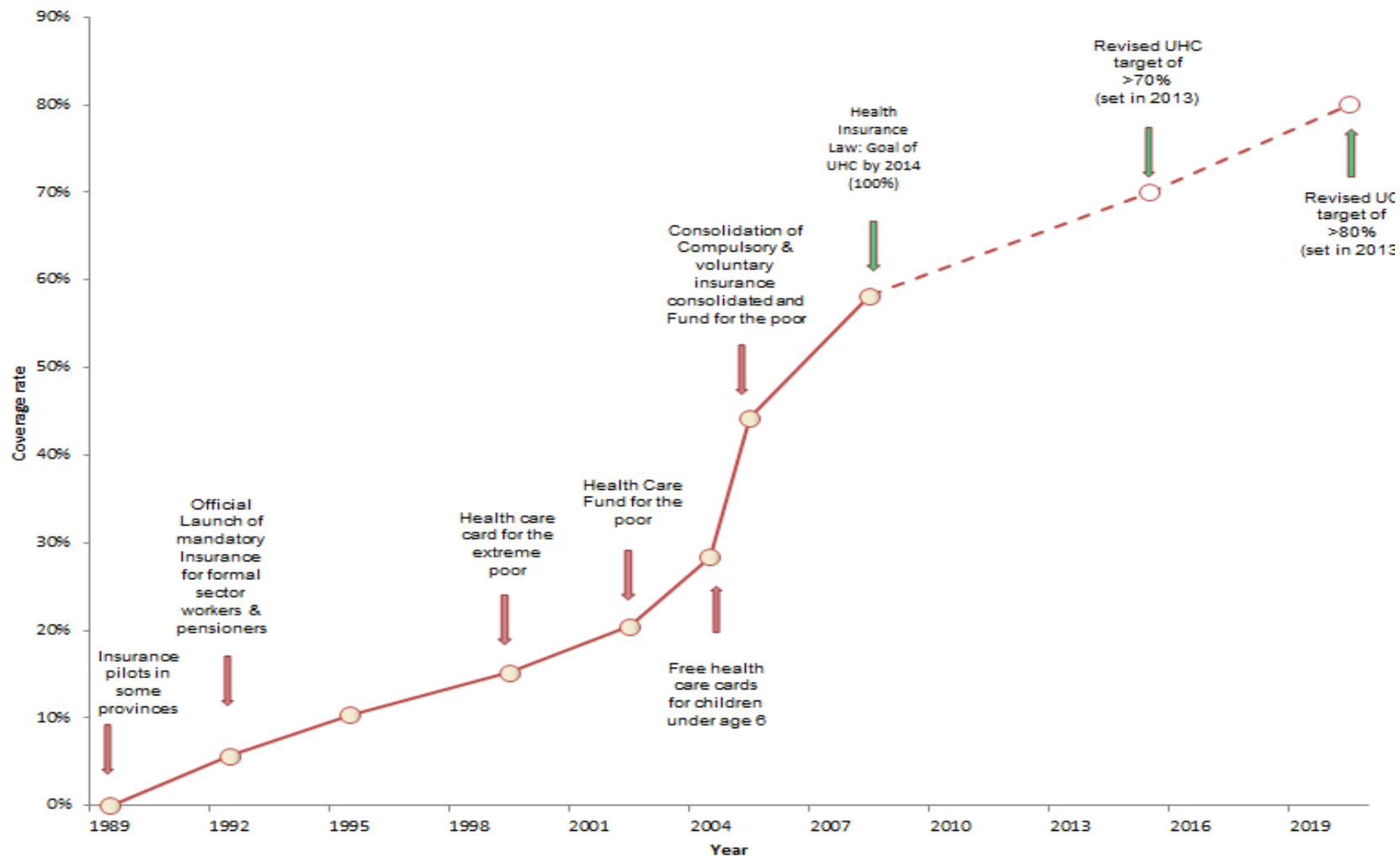
<sup>6</sup> Council of Ministers Decree 299.

<sup>7</sup> Prime Ministerial Decision 241.

<sup>8</sup> Government Decree 58.



Figure 2.1 Sequence of UHC-oriented Reforms



Source: Authors.

## Active Legislative Regulation (2000s)

At the end of the 1990s, greater attention was paid to ensuring funding for health care coverage for the poor. In 1999 a government subsidy to pay premiums for health insurance coverage for the extreme poor was introduced<sup>9</sup> to replace unfunded exemptions. In 2002, a new decision<sup>10</sup> was approved by the prime minister to provide state budget funding either for payment of health insurance premiums or for free health care cards ensuring reimbursement of health care services for all people certified as poor by the Ministry of Labor, all ethnic minorities in specified disadvantaged communes, and all residents of disadvantaged communes.

Concern about funding for health care of the elderly, disabled, and children also increased at the end of the 1990s.<sup>11</sup> For children under six, the initial unfunded exemptions were replaced in 2005<sup>12</sup> by free health care cards entitling them to health care that would be reimbursed directly from the state budget.

## Strategic Consolidation (late 2000s)

While multiple funds, schemes, and pools used to coexist and to be managed by different stakeholders following incremental coverage expansion, Vietnam has taken steps to consolidate pools and funds and to take advantage of a harmonized approach. Legal consolidation of all population groups under a single, universal, compulsory, SHI program was legislated in the 2008 Law on Health Insurance with the goal that it would be achieved in 2014. The law included the three schemes described earlier (contributory, noncontributory, and co-contributory). For groups not covered by compulsory insurance when the law was passed, voluntary health insurance was still an option, and all remaining groups were to be incorporated legally into the contributory scheme by 2014.

## National Ownership Through Explicit Goal Setting

UHC was first set as a national goal in 2008 with the initial intention to achieve it by 2014.<sup>13</sup> As difficulties arose in achieving this goal, a new project law (Đề án) was developed and approved to extend the deadline to 2020, and, more feasibly, to define universal coverage as 70 percent of the population in 2015 and 80 percent in 2020.<sup>14</sup> However, Vietnam's experience with coverage expansion indicates that reforms, prior to the 2008 Law, on both the demand and supply sides, drove the country to achieve UHC far before the policy was officially announced.

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<sup>9</sup> Joint Circular 05.

<sup>10</sup> Decision 139.

<sup>11</sup> Ordinance on the Disabled (1998), Ordinance on the Elderly (2000), the Law on Child Protection, Care and Education (2004), Law on the Elderly (2009), and Law on the Disabled (2010).

<sup>12</sup> Government Decree 36.

<sup>13</sup> However, Vietnam committed to universal insurance coverage, whose definition limits coverage to insurance entitlement.

<sup>14</sup> Prime Ministerial Decision 538, of March 29, 2013, approving the project to implement the roadmap toward universal health insurance coverage for the period 2012–15 and 2020.

## **A Relatively Top-down Policy Process for UHC Reforms**

This was led by government authorities, notably the prime minister and the minister of health. The Communist Party was influential in setting the strategic vision but did not play a role in defining insurance policies. The vision's goals were determined by national evidence about inequalities in access and use of health services in underserved regions and among disadvantaged population groups (Bui Thi Thu Ha et al. 2013).

Among government leaders, the prime minister played a crucial leadership role in maintaining the UHC agenda and ensuring that the action plan took effect (through decrees). The MoH directed the development of decrees at central level, while the Ministry of Labor, Invalids and Social Affairs (MOLISA) identified target groups. Although UHC emerged on the global health agenda in the mid-2000s, Vietnam initiated UHC-orientated reforms much earlier. By taking ownership of the UHC concept, the prime minister and MoH helped shape UHC as a pivotal national goal and anchor it to the political agenda.

The design of the 2008 Law on Health Insurance led to a more inclusive political process. Drafting involved the MoH as well as the Vietnam Social Security Agency (VSS), the Ministry of Finance, and MOLISA. The National Assembly played a key role in refining the provisions of the law, so that the law passed in November 2008 was very different from the initial draft (especially on reform of copayment rates and number of target groups). Decentralization allowed new actors to emerge in the policy development process at the province and district levels. International agencies played an important part in exposing the Vietnamese to new ideas to expand UHC.

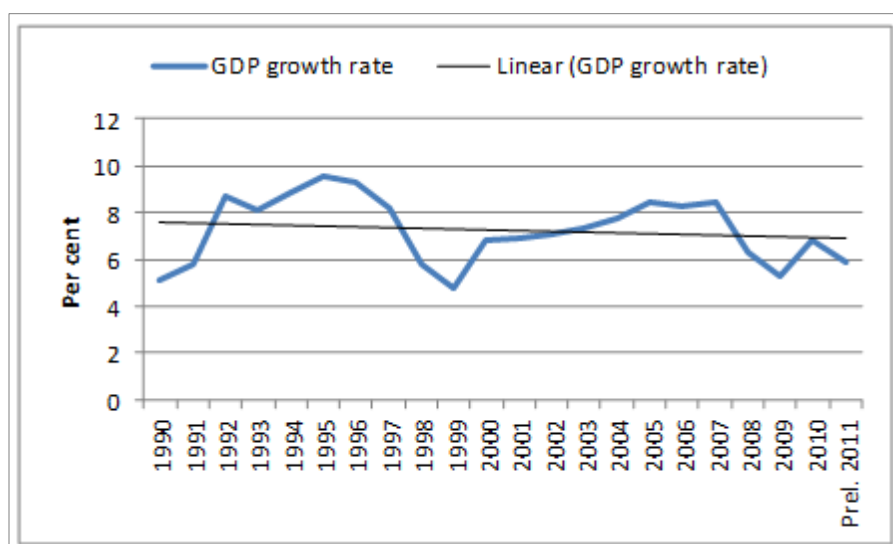
Lessons were drawn from health reforms in, particularly, China, Indonesia, Sri Lanka, Thailand, Eastern and Western Europe, and Africa. External partners (WHO, World Bank, and bilateral agencies) contributed during the commenting process of the health insurance decrees, although very few were directly involved in implementation. The media and direct users, including those that went through civil society organizations, played an increasingly active role in the health insurance policy process (Bui Thi Thu Ha et al. 2013). Three years after introduction, the Health Insurance Law appears perfectible and the different stakeholders are working on a revised version. As Vietnam's health system is moving toward more sophistication, technical complexity has to be managed in a more diverse and less consensual environment.

## **2.2 INCREASING FISCAL SPACE FOR HEALTH AS A KEY STRATEGY TO ENHANCE HEALTH COVERAGE**

### **Growth and Increased Tax Revenues**

Rapid economic growth over 20-plus years has provided substantial resources for all sectors, including health. Annual growth has fluctuated at 5.0–9.5 percent between 1990 and 2011 (Figure 2.2). In purchasing power parity (PPP), gross domestic product (GDP) reached \$3,360 per capita in 2011—a threefold increase in real per capita GDP over the period. The proportion of the workforce in the informal sector has fallen, improving the ability to withhold taxes and contributions for social insurance.

**Figure 2.2 GDP Growth, 1990–2011**



Source: Authors, from IMF data 2012.

Government revenues have been generally healthy due to this rate of growth. While there was a worrying decline in the mid- to late 1990s, this reversed and government revenues stabilized at about 27–28 percent of GDP. The sources of government revenues shifted over time, and taxes have accounted for a growing share (from 69 percent in 1992 to 87 percent in 2011). This reflected the government’s ability to mobilize resources through taxes. Corporate taxes and value-added tax (VAT) increased sharply, from 10 percent in 1992 to 27 percent and 28 percent in 2011 (Table 2.1).

**Table 2.1 Trends in Sources of Revenues, 1992–2011 (%)**

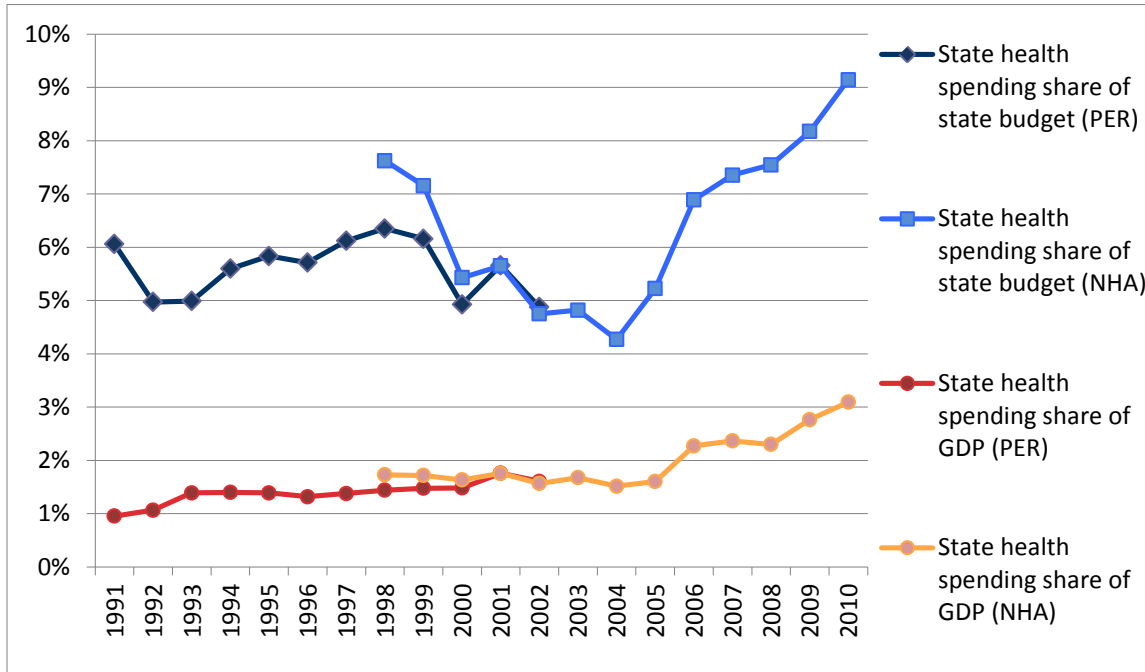
	Total taxes	Type of taxes				Fees, charges, and other nontax revenues	Grants	Total revenues and taxes
		Corporate income tax	VAT (turnover tax through 1998)	Export-import tax	Other taxes			
1992	69	10	10	10	39	27	4	100
2000	72	24	19	15	14	26	2	100
2005	76	33	21	11	12	22	1	100
2008	86	32	22	14	18	12	2	100
2011	87	27	28	12	20	12	1	100

Source: Compiled from IMF data, 2012.

## Health Prioritization in Government Spending

Besides the additional resources available to the state budget, there has also been an effective prioritization toward health within government expenditure. Between 1991 and 2010, government health spending increased 13 times in real terms. The share of state budget spent on health increased from 6 percent to 9 percent over the period. The most rapid increase appears to have begun around 2006 (Figure 2.3), reflecting political will.<sup>15</sup>

**Figure 2.3 Public Health Spending as a Share of Overall State Budget and GDP, 1991–2010**



Source: Authors, reconciled from PER and NHA reports (2011).

There is a clear shift upwards in the elasticity of government health spending to GDP growth, starting around 2005–06. The 2005–10 average elasticity is 4.07, suggesting that government health spending increased much faster than GDP (Table 2.2).<sup>16</sup>

<sup>15</sup> A politburo resolution No. 46 (2005) on protection, care, and promotion of people's health was reported to be instrumental in shaping state interventions in health spending. Formal prioritization of health care in the state budget is found in National Assembly Resolution 18 (2008), which called for government health spending to increase at a higher rate than increases in overall government spending. This requirement has been incorporated into the guidelines for budgeting sent out each year by the Ministry of Finance.

<sup>16</sup> What consisted of a successful investment in the 2000s to finance coverage expansion can, however, appear as an unsustainable strategy in the long run.

**Table 2.2 Elasticity of Government Health Spending to GDP Growth**

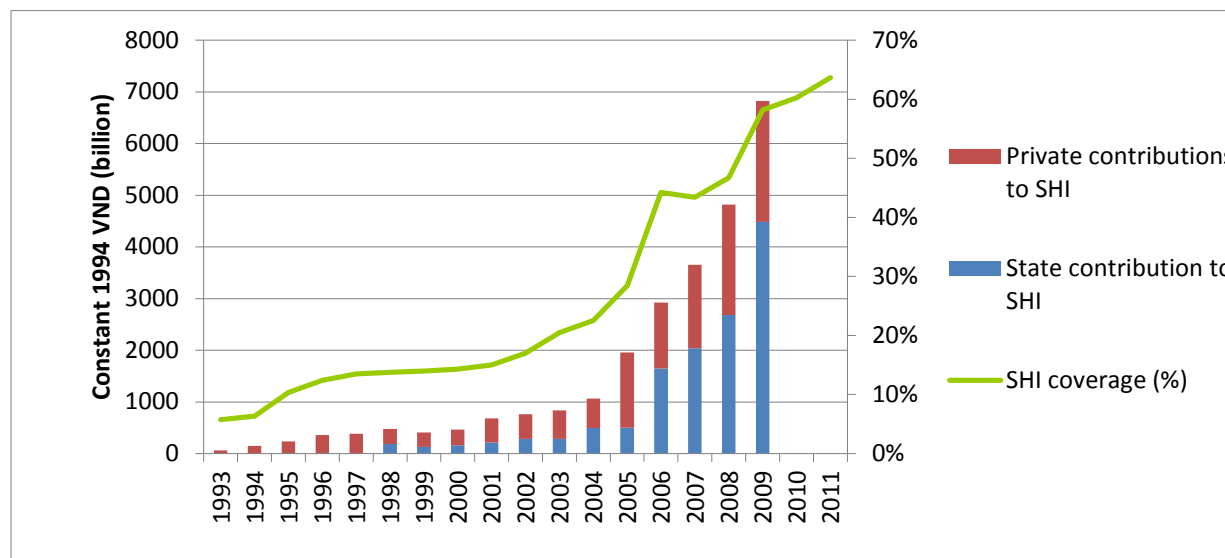
	Increase in real GDP (%)	Increase in real state health spending (%)	Elasticity of state health spending with respect to GDP
1999	4.77	5.29	1.11
2000	6.76	-1.23	(0.18)
2005	8.44	16.03	1.90
2008	6.31	23.77	3.77
2010	6.78	25.46	3.75
Average 1999–2005	0.69		
Average 2006–10	4.07		

Source: Authors' calculations, from MoH and Ministry of Finance data, 2012.

### Attraction of Private Spending

The strategy to expand fiscal space for health also relied on a theoretical attraction of private spending through mandatory contributions. Although the process for capturing private contributions moved slowly, coverage expansion was leveraged when private contributions increased in 2005. However, it appears that the rapid expansion of coverage, especially since 2005, has been largely associated with increased state budget allocations, notably to poor subgroups. Although private contributions have also risen, state contributions to mandatory schemes escalated from 5 percent in 2005 to 40 percent in 2009 (Figure 2.4).

**Figure 2.4 Trends in Health Insurance Coverage and Health Insurance Contribution Sources, 1998–2009**



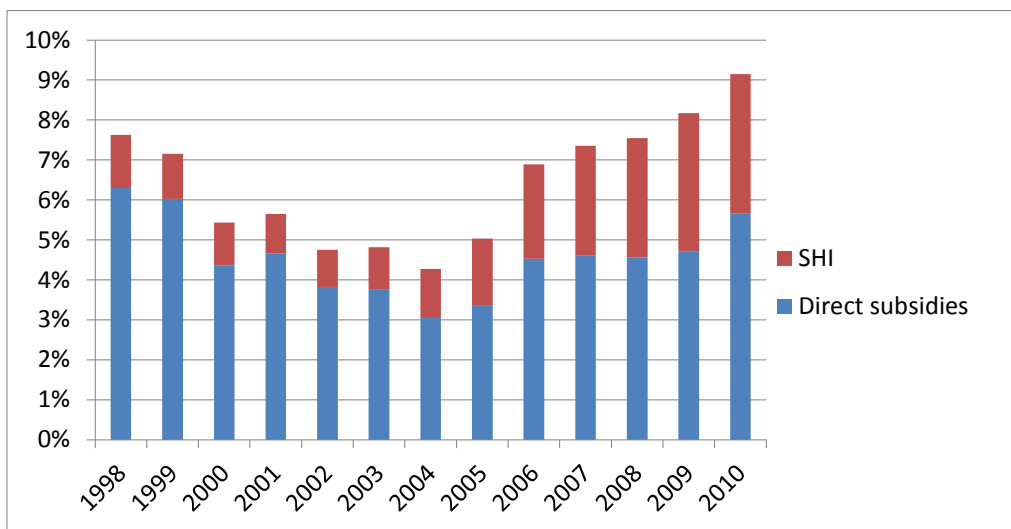
Source: Authors, compiled from MoH and WHO data, 2012.

## Shift in Resource Allocation

State funding has shifted from supply- to demand-side subsidies. The share of state budget spending (central and local) funneled through health insurance as a demand-side subsidy increased from 1 percent of total health expenditure to 12 percent, while the share for supply-side subsidies declined from 26 percent to 22 percent of such spending, between 1998 and 2010 (Figure 2.5).

The impetus for this change reflected the government's call for a gradual shift in recurrent budget spending from direct subsidies to facilities toward direct support to users of health services. Decree 85 (2012) laid out a roadmap for reducing direct subsidies further, thus releasing state budget funds for higher priority use—for preventive medicine and toward coverage expansion for priority groups. This shift from direct supply- to demand-side subsidies was initiated by the Government Action Plan of 2005 to Implement Resolution 46 and remains emphasized, although in practice direct subsidies are still growing.

Figure 2.5 Trends in the Share of the State Budget Spent on Health, 1998–2010



Source: Authors, compiled from MoH and WHO data, 2012.

## 2.3 STRATEGIC CONSOLIDATION AND INTEGRATION FOR HARMONIZING COVERAGE

While Vietnam created multiple schemes and funds to expand health coverage to associated group populations over the course of the reforms, the country has taken recent steps to harmonize health coverage. Consolidation of insurance schemes and funds into a single insurance program and the subsequent creation of a single payer (the VSS) has been a key strategy.

Between 1992 and 1998, each province had separate health insurance funds. This fragmentation did not allow for cross-provincial risk pooling, and some funds failed. The 1998 policy revision allowed central pooling, demand-side cost sharing with copayments, and supply-side cost controls through caps. Coverage of disparate groups under SHI began to be consolidated

effectively in the 2005 revisions to the health insurance regulations.<sup>17</sup> In particular, the government decree eliminated the free health care card scheme and included the poor under state budget-funded health insurance. However, it did not at this point incorporate the free health care card scheme for children under six. Legal consolidation of all population groups under universal compulsory SHI was then legislated in the 2008 Law on Health Insurance. Key benefits of this policy were enhanced harmonization of the benefit package and less fragmentation in managing the various schemes. The policy has also rendered contributions more uniform by imposing similar contribution rates on all groups, and using the minimum wage as the income basis for determining contributions for groups without income or with hard-to-determine incomes, such as the near-poor.<sup>18</sup>

Although funds operate within a single pool, effective risk pooling remains limited across income levels and population groups in Vietnam. First, collected through a diversity of sources, insurance revenues are ineffectively pooled across insured groups; there is no system of risk adjustment between the rich and the poorest.

Second, earlier studies (Somanathan et al. 2013) have shown that risk pooling across provinces did not happen. Health insurance funds were managed by the provinces and the value of the fund in a given province was capped at 90 percent of contributions of members in that province, implicitly setting initial resources based on ability to pay rather than a more explicit redistribution of fund resources across provinces according to need. If a province ended up with surplus, 60 percent could be retained for investment, but 40 percent should be sent back to central level to add to the reserve fund. Because surplus provinces tended to be those with lower access and lower capacity to provide high-quality care, the system retained the risk that funds will flow from poor to rich provinces.

Third, capitation rates (based on contribution amounts for different groups) restrict the solidarity principle of SHI and do not provide an adequate risk-adjustment mechanism. Capitation rates are calculated separately for six different beneficiary groups<sup>19</sup> based on historical expenditure and utilization patterns, which reflect barriers to access faced by certain groups. For example, civil servants and employees have a capitation amount double that of the poor, despite having age- and sex-adjusted risks of incurring medical costs likely similar. For the poor, capitation amounts are highest in the Red River Delta, Southeast and South Central Coast, probably reflecting greater ease at accessing services and availability of high-tech services than in other regions. Pensioners and social security recipients have the highest capitation amount in the Southeast, where high-tech services are widely available. The grouping is not based on principles of risk adjustment to ensure fair payment to facilities based on the case-mix risk of insured patients they manage because there is substantial heterogeneity of risk among the different subpools. Care is

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<sup>17</sup> Government Decree 63.

<sup>18</sup> While all schemes are now consolidated into one overall program with a uniform service benefit package and with one agency in charge of administration, the policy still permits a certain flexibility in allocating entitlements to needy or meritorious groups by allowing a range from 0 to 20 percent copayment rates, or in exempting certain meritorious groups from the general caps on benefits.

<sup>19</sup> These are: civil servants and formal sector workers; pensioners, meritorious people, beneficiaries of social security/protection allowances and veterans; the poor and near poor; children under six years; school children and students; and all remaining members, including voluntary members.



therefore rationed to the six groups, perpetuating historical inequalities in capitation rates across groups (Somanathan et al. 2013).

A purchaser-provider split, introduced at the end of the 1990s, separated functions and roles between MoH and VSS to enhance strategic purchasing and ultimately efficiency in health spending. The purpose of such a split was to stimulate competition between providers by making fund flows dependent on performance (patients served, quality of services, and service prices). While health insurance regulations allow the insured to change the facility where they register for care, geographic barriers inhibit competition in some areas. Active purchasing that allows purchasers to set incentives to achieve goals for quality, efficiency, and equity, to monitor performance, and to reward desired provider behaviors can be more effective than simply continuing historical budget allocations. Unfortunately, though, this split of functions has not generated the anticipated gains in quality and efficiency.

Differences in management structures and levels of authority have also created challenges for communication and collaboration between VSS and MoH. Four departments within MoH deal with and are in charge of health insurance matters, but many other functions (including local oversight of health insurance) are devolved to provincial level. Another organizational challenge is the mismatch between VSS's functions and its authority or decision-making capacity. The VSS is seen as, and is actually restricted to play, the role of government financial intermediary that only manages funds and pays providers, rather than as an active and technical actor that (strategically) purchases services from providers. Despite the trend toward single-payer and demand-side financing, almost all state health facilities still receive at least part of their operating budget from direct state subsidies paid per bed rather than for performance. This arrangement allows facilities to continue operating in more remote areas even when they are inefficient, but also insulates facilities from market pressures that could promote quality and efficiency.

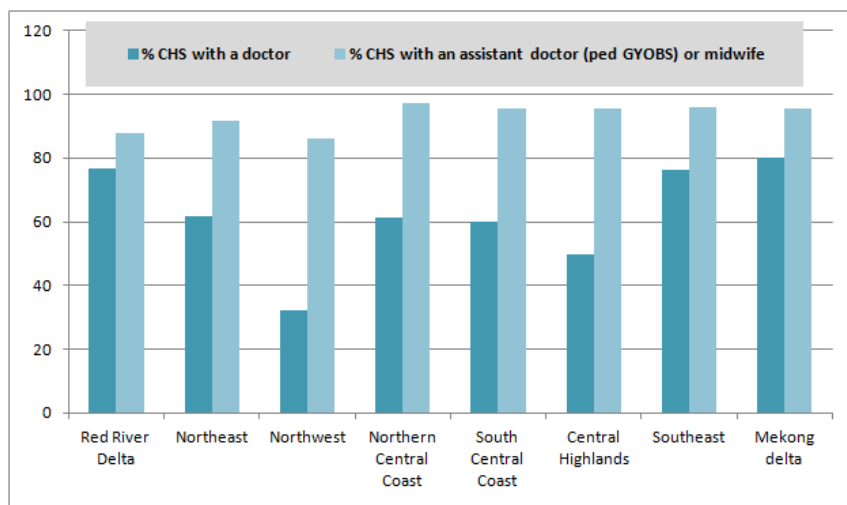
## PART 3: CLOSING THE GAP TO SUSTAINABLE HEALTH COVERAGE

The chapter highlights a series of core challenges that Vietnam is facing on the road to UHC and that may represent threats to expanding efforts in the short and medium term.

### 3.1 SERVICE DELIVERY: HUMAN RESOURCES FOR HEALTH (HRH) AS A CORE CONCERN

Expanding and strengthening health service delivery is at the core of countries' strategies for improving access to and coverage of health services in many LMICs. HRH are a fundamental component of quality service delivery, including at the lowest levels of care. HRH density (availability) in Vietnam is insufficient, despite recent increases. Moreover, the structure of the health workforce creates strong imbalances in skill mix with acute shortage of nurses and midwives,<sup>20</sup> of preventive and family medicine practitioners, and in some specialties including pediatrics (MoH and HPG 2012). There is also a maldistribution of health workers, to the detriment of remote and mountainous areas. While only 27 percent of the general population is urban, 59 percent of medical doctors practice in towns. The physician rate per 10,000 falls to 4.70 in the Southeast, but is 6.59 nationally. Finally, imbalances within provinces are high to the detriment of the lowest levels of care: only one-third of communes have medical doctors (Figure 3.1). Overall, the quality of education in the 24 medical schools is reported uneven, and there is a lack of both an accreditation system and a continuing education program for professionals to enable them to maintain quality throughout their careers.

Figure 3.1 Distribution of Health Professionals at Commune Level



Source: World Bank 2012.

In response, a draft master plan for HRH development was developed for 2011–20, in particular to strengthen retention of personnel in rural areas and to improve medical education. Before this national plan, several initiatives had been launched, including better staff retention. The first provided financial incentives to health workers,<sup>21</sup> of up to 70 percent of basic salary, for both

<sup>20</sup> The ratio of nurses to doctors is 1.3:1 (MoH).

<sup>21</sup> D 64/2009.

recruitment and retention in rural areas. Another instrument was the “rural pipeline” strategy, which provided training for assistant doctors from rural areas who wished to become medical doctors in rural areas.<sup>22</sup> A similar policy was 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 in 2007–18. A short-term rotation system from higher to lower facility level<sup>23</sup> was also proposed to boost quality at commune level and foster interaction between urban and rural health workers.

Recent HRH initiatives have increased the overall production of health professionals in the last 10 years. While there were 230,000 health workers in 2001, nearly 300,000 were practicing in 2009. The number of doctors increased from 6.2 per 10,000 population in 2005 to 7.1 in 2010; and the number of nurses increased from 6.3 per 10,000 population in 2005 to 9.5 in 2010.<sup>24</sup> As a critical factor for enhancing production, the number of medical schools increased from nine in 1997 to 14 schools in 2014. Admission to medical schools almost tripled between 2001 and 2012. Graduates in general medicine increased by around 60 percent from 1,550 in 2006 to 2,450 in 2012. The number of nursing schools is increasing even more rapidly. There are 14 undergraduate nursing programs (four-year training) and 29 nursing colleges (three-year training). Three of the 14 programs were established by the private sector. The undergraduate nursing programs enroll around 1,430 students each year, for a 10-fold increase over 10 years. Increases in the density of HRH tend to benefit poorer regions more. The HRH initiatives favoring disadvantaged regions seem to have more equitably distributed health staff, particularly in rural and disadvantaged areas. Density for physicians, nurses, and midwives increased far faster in rural and remote areas, in particular the Northern midlands and mountainous regions, in 2002–11. The number of physicians and nurses increased for those provinces with larger proportions of poor. For example, it rose fastest for Bac Kan province (a remote and poorer area), where the poverty rate is as high as 45.97 percent, whereas the trend was much modest in Binh Duong, where it is only 7.82 percent.

Although the density of HRH has increased, the quality and skills of the health workforce remains a core challenge (MoH 2012). Increases in the number of schools and students were not matched by investments. Clinical practice sites are limited to central and some provincial hospitals that cannot absorb the growing number of students. Investment in medical/nursing skill laboratories—essential teaching sites—is still limited. Although Vietnam has produced a knowledge, attitude, and practice book as a basis for standardizing the medical curriculum, the quality of the curriculum as implemented varies by school.

The situation is similar for nursing education. The country has slowly embarked on improving the quality of medical and nursing graduates (the flow to the health care system), the existing stock of health professionals is ill prepared to respond to the demand for increased coverage. In general, medical training is hospital-based and there is little preparation and incentive to practice at the primary care level and in the grass-root health care network, especially at commune level. Even when enough health staff work in commune health centers, they often lack

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<sup>22</sup> C 06/2008.

<sup>23</sup> D 1816/2008.

<sup>24</sup> Statistical Handbook of Vietnam 2011 (Statistical Publishing House).

the skills to perform designated services and deal with emerging health problems—to identify, manage, refer, and coordinate patients. They also have limited decision rights to prescribe or perform medical interventions. The government has taken steps to enhance quality<sup>25</sup> but much remains to be done.

### 3.2 Fiscal Sustainability at Risk

Vietnam has recovered well from the global economic crisis. However, macroeconomic instability experienced in the late 2000s threatened the attainment of additional fiscal space to continue expansion of health coverage. The crisis hit Vietnam hard and led to large fiscal deficits from 2009 to 2011 and to a major increase in public and publicly guaranteed debt from 43 percent to 51 percent of GDP in 2009 (but back down to 48.3 percent in 2011). Even if projections indicate that the economy will rebound in the medium term (IMF 2013) and growth is expected to return to precrisis rates (6–8 percent), the International Monetary Fund recommends stabilizing government spending so as to create an additional fiscal cushion that would leave the country in better shape to deal with future shocks. It is estimated that an additional 0.7–1.6 percent of GDP is needed to meet the UHC goal in the short term (Somanathan forthcoming). Vietnam could expect additional fiscal resources for health of about 0.4 percent of GDP by 2015, provided economic growth rebounds to precrisis rates and the high income elasticity of government expenditures on health is sustained. The largest possible sources of fiscal space for UHC may well be through efficiency gains (Table 3.1).

**Table 3.1 Sources of Potential Additional Fiscal Space for Health**

Fiscal space source	Key information	Prospects for fiscal space
Macroeconomic conditions	Growth rates expected to rebound to pre-crisis 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 used 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

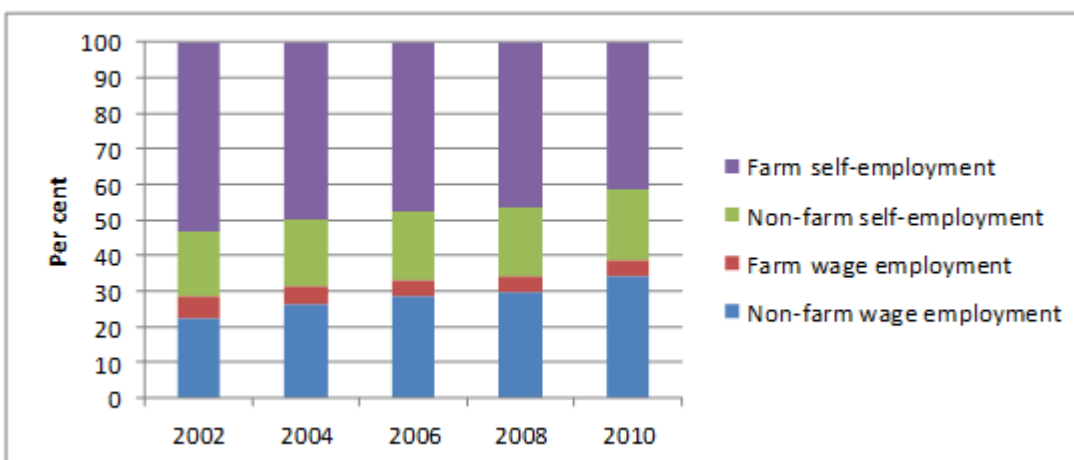
<sup>25</sup> The government has adopted several directives for strengthening the grass-roots health network. Directive 06-CT/TW (2006) of the Central Party Committee emphasized the importance of investing in human resources, infrastructure and stable financing for recurrent activities at grass-root level. The National Strategy for People’s Health Care and Protection focuses on health workforce development, particularly at the grass-roots level. Moreover, National Assembly Resolution No11/2011/QH13 (2011) calls to: (i) strengthen the Health Sector at the district and grassroots level to reduce hospital overcrowding; and (ii) implement reforms in human resource development. Similarly, the government’s National Benchmarks for Commune Health Care (2011–2020) aims to ensure that “all CHS have adequate number of health workers with staff continuously trained or retrained.”

Efficiency gains	Misuse of drugs, overprescription, and misallocation of revenues	Very good
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Source: Adapted from Somanathan et al. 2013.

The mobilization of public resources to expand coverage to priority groups has so far been largely successful, yet mobilizing contributions from employers, employees, and households has proved difficult. The slow formalization of wage employment (Figure 3.2) constitutes a major challenge to increasing coverage and financial protection. Administrative costs of identifying individuals, collecting premiums, detecting and punishing noncompliance—given a largely fragmented workforce—are prohibitive. The potential to increase the contribution rate to the social insurance fund is limited by the risk of further depressing compliance among the employed and by the general lack of understanding of the solidarity principle inherent in social insurance.

**Figure 3.2 Trends in Workforce Structure for Population 15 and older, 2002–10**

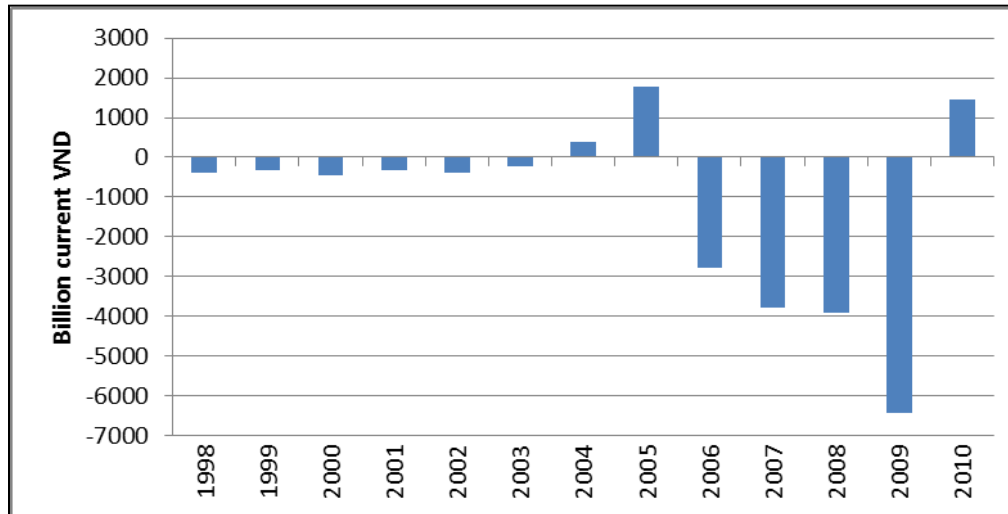


Source: Authors, compiled from Ministry of Finance and Labor data, 2012.

Costs escalation has led to increased deficits for the SHI fund in recent years. Until 2006, the fund was balanced and even yielded a substantial surplus in 2005. From 2006 to 2009, it used up the entire surplus and accumulated a deficit of VND3 trillion (Figure 3.3).<sup>26</sup>

<sup>26</sup> Ministry of Health, Draft Project on Implementing the roadmap toward Universal Health Insurance Coverage for the Period 2012–15 and 2020, August 2012, p. 10.

**Figure 3.3 Annual Net Balance of SHI Fund, 1998–2010**



Source: Authors, computed from VSS data, 2012.

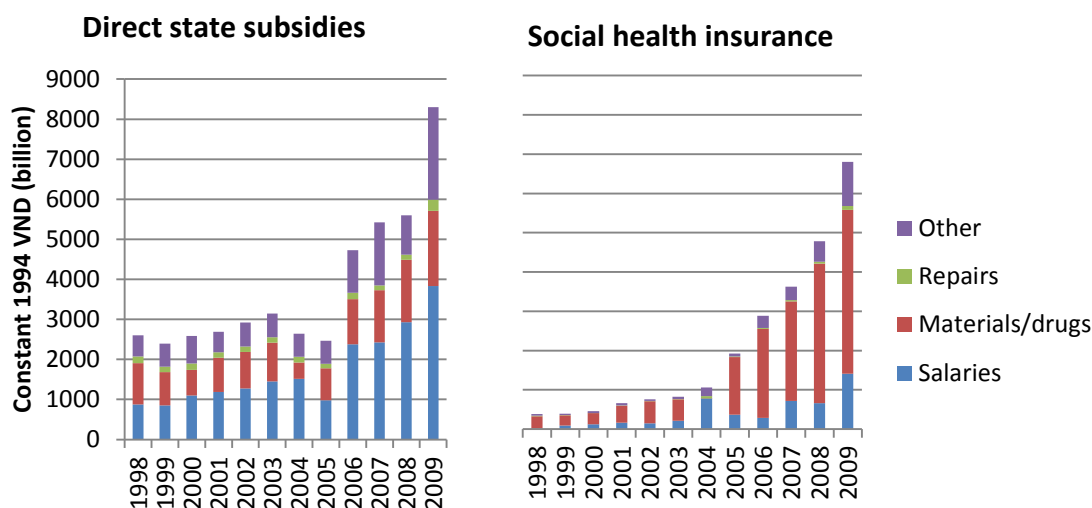
The fund imbalance in 2006–09 is attributed mainly to the following: a rapid increase in medical care costs; the revised user fee schedule;<sup>27</sup> supply-side incentives to overprovide using fee-for-service (FFS) payments; and on the demand side, suspension of copayments for a couple of years.

The Law on Health Insurance reinstated copayments, increased contribution amounts, and began reforming provider payments. By 2010 surpluses were once again achieved. However, a jump in medical price inflation from the 2012 revision to the user fee schedule may once again threaten the fund's balance.

A major obstacle to sustaining and expanding health coverage is the rapid escalation of drug costs and the difficulty of negotiating and controlling these costs. Drug and medical price inflation have exceeded general inflation and contributed to rapid medical cost escalation in recent years (1999–2001, 2003–04, and 2012), as reflected in their growing share in SHI expenditures for instance (Figure 3.4).

<sup>27</sup> The user fee schedule added 993 service items not included in the earlier schedule; and the insured drug list, which in 2005 covered 646 drugs, and by 2012, 900.

Figure 3.4 Trends in Direct State Subsidies and SHI Expenditures, 1998–2009



Source: Authors, based on data from MoH and WHO, 2012.

The main underlying reasons for drug costs escalating are driven in part by high prices for pharmaceuticals. In addition are inefficiencies in the procurement system as well as overconsumption and inappropriate use of drugs. The hospital autonomy policy has increased pressure on hospitals to generate revenues and cover costs, and may thus have also encouraged overprovision (Somanathan forthcoming). Policies to manage health care costs are not yet in place, or have been implemented to little effect. Regulatory instruments relying on technical criteria to limit services (for example, evidence-based treatment protocols or care pathways) and use of cost-effectiveness assessments for lists of drugs and services in the insurance package have not yet proved useful.

Measures on the demand side, including copayment and caps for high-tech services, have had little effect on patient demand for services as patients lack information to know which services are needed. Provider payment reforms moving away from FFS toward capitation and case-mix payments are afoot, with the expectation that financial incentives will reduce overprovision. Hospital overcrowding and lack of associated control measures are other core challenges. The most prominent and politically taxing is overcrowding: occupancy rates are especially high in central and provincial specialty hospitals, ranging from 120–200 percent (MoH 2011a). Self-referral by patients is common with rates as high as 93 percent in specialist hospitals. Copayments or other financial mechanisms to dissuade self-referrals have proved insufficient. A number of underlying reasons for overcrowding have been advanced: (i) increase in demand because of population aging, increasing NCD morbidity, increased health insurance coverage, general economic development, and inappropriate use of hospitals for basic health care; (ii) revenue-enhancing incentives (and consequent behaviors) resulting from hospital autonomy policy, payment mechanisms and private investment in medical equipment for profit in public hospitals; (iii) deficient and low-quality supply at lower levels, including the perception of poor quality by users; and (iv) inefficient referral, clinical, and patient-flow management. Addressing concern (iii) will be part of the next efficiency agenda item on the road to UHC.

### 3.3 NEW THREATS TO FINANCIAL PROTECTION

While Vietnam aims to expand coverage to the remaining 40 percent of the population, newly introduced measures—notably to control costs—have potentially negative effects on financial protection, especially for the poorest. Incentives for cost escalation inherent in FFS policies, health-facility autonomy, and social mobilization of investment resources are threats. Financial autonomy and social mobilization policies in the mid-2000s have created strong incentives for revenue generation in curative and preventive medicine facilities of the public sector (MoH and World Bank 2011). Tax and other incentives have promoted development of the private health sector, with the tendency to compete not on price but on quality, where quality assessed by households tends to be related to the presence of expensive medical technologies. The 2012 revision in the official user fee schedule<sup>28</sup> and plans for full cost recovery user fees in 2018 have strongly boosted the price incentive for suppliers to supply even more services, although it has reduced the distorting disincentive to provide basic services.

On the demand side, uninsured patients face greater barriers to access, but also greater incentives to join SHI. Severely ill insured patients paying higher user fees will end up paying higher copayments and more rapidly reaching the coverage ceiling. The SHI fund revenues were not increased to cover the additional costs due to increased user fees, nor are they in a position to control supplier-induced demand stemming from the higher user fees.

The copayment rates are another potential threat for low-income groups. The rate varies across population groups, depending on whether the patient goes through the gatekeeper facility or bypasses it. Copayment is implemented as a percentage of total charges for drugs, consumables, bed days, and diagnostic and therapeutic service user fees. According to VSS data, some 55 percent of the insured in 2011 were subject to a 20 percent copayment. An additional 26 percent were subject to a 5 percent copayment rate and the remaining 18 percent had no co-insurance. The copayment amount can be quite substantial, particularly after the 2012 user fee increase. Higher rates of copayment apply when individuals bypass the facility where their health insurance is registered for primary level care. The rates are 30 percent if they bypass to go to the district hospital, 50 percent if they go to the provincial facility, and 70 percent if they go straight to the central level. Standardization of facility capacity has not yet been achieved, so bypassing a less well-equipped facility to avoid delays in treatment is common, with negative consequences on financial protection. A policy vehicle is in place for local mobilization of funds for the health care fund for the poor in order to pay the copayment for the poor and ethnic minorities in disadvantaged areas, but little has occurred since the policy introduction (Prime Ministerial Decision 14 of 2012).

Caps on benefits are in place to control costs, but have been criticized for potential negative effects on financial protection (Somanathan forthcoming). For high-tech services, the 2005 coverage limit of VND20 million has been increased to 40 times the minimum wage. For referral care, reimbursement is limited to the average of the cost per referral in the previous year,

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<sup>28</sup> The initial user fees were intended to achieve partial cost recovery, but lacked a transparent basis. The 2012 revision gathered expert advice from state hospitals on the material inputs for each service. These packages were combined with market prices to obtain the materials costs. From 2013 through 2018, additional cost items such as salaries, utilities, depreciation, interest on equipment loans, training and research costs will be added in till user fees represent full cost recovery and in principle, direct subsidies can be removed (Decree 85 of 2012).



allowing a 10 percent cost increase. There is some evidence that this does not help with cost control because facilities simply balance-bill patients.<sup>29</sup>

### 3.4 Solidarity and Redistribution: The Next Step

State subsidies to health insurance are relatively pro-poor, in contrast to direct support to facilities. However, an ineffective risk pooling and capitation system perpetuates inequalities and limits redistribution. Equalizing transfers offers some positive prospects to close the gap, though. That state subsidies to SHI are relatively pro-poor is seen in the fact that nearly one-half of the overall state budget subsidy (47 percent) for SHI is allocated to the defined poor and ethnic minorities, although they represent 26 percent of the insured and 17 percent of the total population. The other half is not targeted toward groups with low ability to pay, but to groups classified as national priorities (Table 3.2). Some 37 percent of the state subsidy for health insurance is allocated to children under age six, school pupils, and university students. The remainder is channeled to meritorious groups (13 percent) and the near-poor (4 percent).

**Table 3.2 Distribution of Subsidized Insurance Coverage, 2011 (%)**

	Poor and ethnic minorities	Near-poor	Children under age six	School children and students	Meritorious groups	Total
Insured						
Share of insured	26	3	15	18	7	70
Share of subsidy	47	4	26	11	13	100
Population						
Share of population	17	7	12	15	5	56

Source: Adapted from MoH data, 2012.

Direct subsidies to facilities—and, for instance, hospitals—remain pro-rich, however. A benefit incidence analysis using 2010 data on distribution of health services used by groups in different living standards quintiles shows that while the poorest 20 percent of the population account for only 7.5 percent of total consumption, they receive 27 percent of the benefits of social insurance subsidies but only 12 percent of the direct subsidies to facilities. In contrast, the richest quintile—accounting for 43 percent of societal consumption—receive 17 percent of health insurance subsidies but 28 percent of the direct subsidies to facilities (Table 3.3). This pro-rich distribution is a major motivation for the country’s leadership to shift toward subsidies through health insurance for the poorest.

<sup>29</sup> Ministry of Health, Draft Project on implementing the Roadmap toward universal health insurance coverage for the period 2012–2015 and 2020, August 2012. Original data from Report 1833/BHXH-CSYT dated 16/5/2012 of VSS. p. 14.

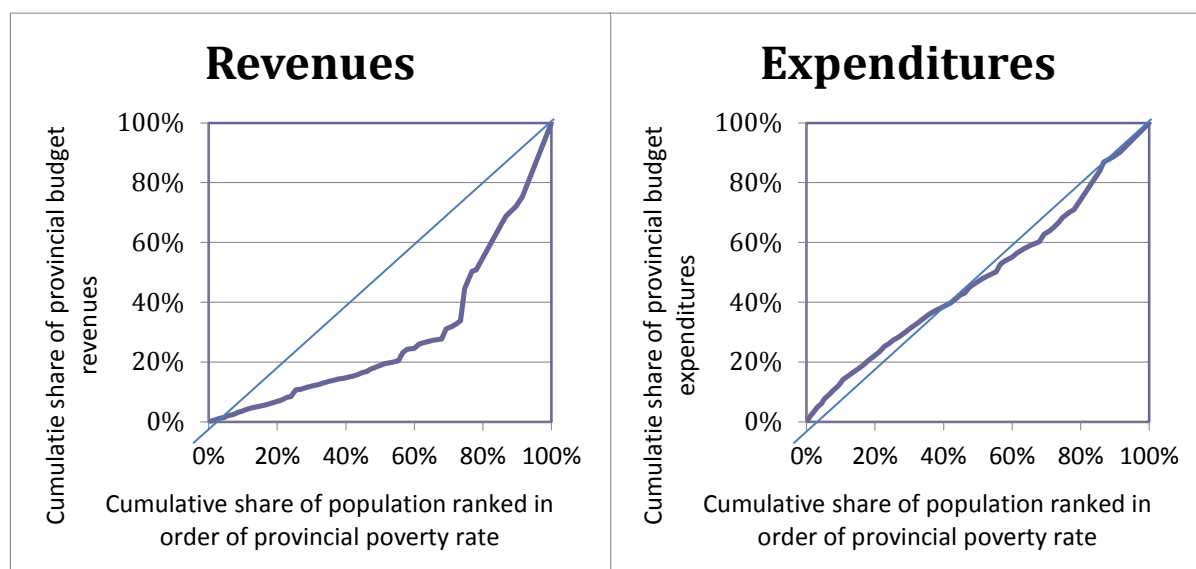
**Table 3.3 Living Standards and Benefits from State Subsidies, 2010 (%)**

	Consumption of services	Benefits from social insurance subsidy	Benefits from direct state subsidies to facilities
Poorest quintile	7.5	27.2	12.2
Near-poor	11.7	21.2	16.4
Average	16.0	16.9	19.5
Above average	21.7	17.3	23.5
Better off	43.1	17.4	28.4
Total	100	100	100

Source: Bales and Tuong 2012.

To reduce inequalities in budget subsidies across provinces, the Budget Law allows for “equalizing transfers” between provincial and central budgets and earmarks transfers for specific objectives such as national target programs. In 2000, only five provinces (Hanoi, Ho Chi Minh City, Dong Nai, Binh Duong, and Ba Ria Vung Tau) were required to transfer a portion of their budget surplus to the central level in practice, while the other provinces all received transfers from the central budget to balance revenues and expenditures. In 2004, additional provinces were required to submit part of their budget surplus to the central budget (Hai Phong, Quang Ninh, Vinh Phuc, Da Nang, Khanh Hoa, and Can Tho). Several provinces in 2004–06 contributed a very small proportion to the central budget, but returned to net transfer recipients by 2007 (Tay Ninh, Long An, Tien Giang, and Vinh Long). In 2011 Bac Ninh and Quang Ngai were required to submit a share of revenues to the central budget. Our analysis has shown that the “equalizing transfers” policy has the potential for better redistributing government revenues in practice. On the revenue side, one can see that 20 percent of the population living in the wealthier provinces account for almost 40 percent of total tax revenues, but receive only 20 percent of national budget spending. Vice versa, 55 percent of the population living in the poorest provinces account for only 20 percent of total revenues, yet benefit from 55 percent of national budget spending (Figure 3.5).

**Figure 3.5 Concentration Curves of Provincial Budget Revenues and Expenditures after Equalizing Transfers**



Source: Authors, based on Ministry of Finance budget reconciliation data, 2012.

While there is a general equalization in funds for overall budget spending between localities, the extent to which this equality exists within provinces and between districts and communes is unclear. Data on public spending by provinces, districts, and communes were not readily available.

### 3.5 Provider Payment: An Unfinished Reform

Provider payment is a core concern for the health sector, especially coverage expansion. It is generally a key lever for expanding coverage and improving efficiency and equity of a health system (Langenbrunner, Cashin, and O’Dougherty 2009). FFS was the dominant payment method for providers in Vietnam until the mid-2000s although this method was strongly criticized for escalating costs and for its lack of equity. From 2004, new payment mechanisms have been piloted. Capitation payment was introduced for district hospitals to contain costs and counteract other negative impacts of FFS. Case-based payment is being piloted in two Hanoi hospitals.

The results of an assessment of seven sampled provinces on the functioning of provider payment methods and of professionals’ views of these at facility level have highlighted that the methods have not yielded full benefits, for two main reasons (Phuong Nguyen Khanh 2013). First, there is a high degree of complexity and fragmentation in the provider payment system. Four different methods are used: global and line-item budgets, FFS, and capitation. Most hospitals receive payments from two different purchasers through three different payment methods, creating conflicting incentives (Table 3.4).

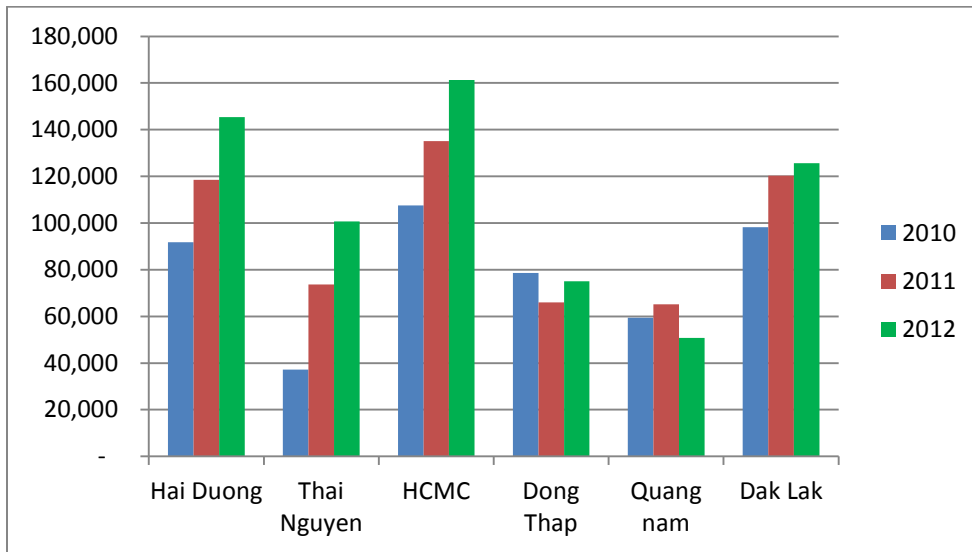
**Table 3.4 Provider Payment Methods by Health Purchaser**

Types of provider	Purchaser and payment method			
	MoH	Provincial health department	Other ministries	VSS
Central hospitals	Global budget			FFS Capitation
Provincial hospitals		Global budget		FFS Capitation
Provincial preventive center		Global budget Line item budget		
District hospitals		Global budget		FFS Capitation
District health centers		Global budget Line item budget		
Commune health stations		Line item budget		
Other ministry hospital			Global budget Line item budget	FFS Capitation
Private clinic				FFS Capitation
Private hospital				FFS Capitation (rare)

Source: Phuong Nguyen Khanh 2013.

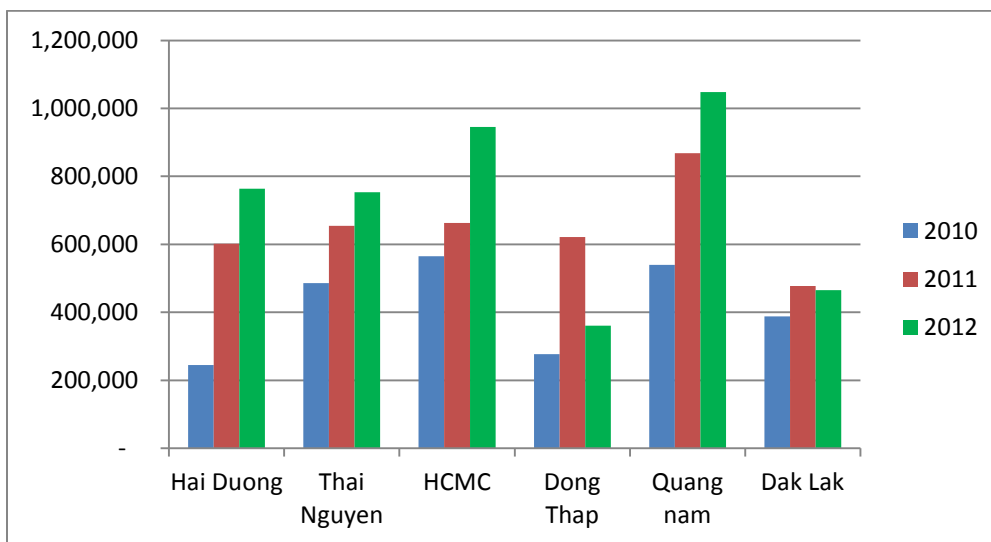
Second, none of the payment systems is viewed by the professionals as augmenting health system performance. Although the budget payment mechanism is regarded as most fair and equitable, the chronic underfunding of the budget made it the least likely to be regarded as incentivizing quality or as responsive to patients. The FFS system is seen as giving incentives for quality, but that system is also strongly associated with excess and high-cost services. It is perceived as being most fair in the distribution of resources to providers but least fair in the distribution across population groups. The capitation payment, despite its intent, does not help control costs. The average cost per outpatient visit and inpatient admission at district hospitals increased in nearly all the study provinces in 2010–12 (Figures 3.6 and 3.7).

**Figure 3.6 Average Payment by VSS to District Hospitals per Outpatient Visit, 2010–12**



Source: Phuong Nguyen Khanh 2013.

**Figure 3.7 Average Payment by VSS to District Hospitals per Inpatient Admission, 2010–12**



Source: Phuong Nguyen Khanh 2013.

In brief, the current mix of payment systems is not viewed as highly beneficial to the health system, and any advantages come with steep trade-offs. Budgets are credited with bringing equity but not with enhancing quality. FFS is perceived as giving incentives for quality, but causes deep concern about unnecessary services and cost containment. 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.

Thus better leveraging of provider payment systems is crucial if Vietnam is to continue expanding coverage. Without creating incentives and mechanisms to shift resources and services

to the grassroots level, it may be difficult to provide effective coverage even if entitlement to coverage expands. Provider payment is one key element in a comprehensive strategy to make better use of resources and provide meaningful coverage to the whole population.

## 4. CONCLUSIONS

Vietnam's relatively high health coverage—over 60 percent—relies on a mix of mandatory and voluntary insurance and on subsidized schemes for the poor. Substantial investments have been made over the last two decades to ensure reasonable quality of services and provision of preventive and curative packages. The system strongly relies on state subsidies, but OOP spending remains rather high (half of total health spending).

Rapid economic growth, which translated into increased revenues for the state, has been among the key driving forces for health coverage expansion. Successive governments have also ensured that health is given a net prioritization within government expenditure. A shift from supply- to demand-side subsidies is recognized for allowing the state to cover costs of the poor and near-poor, and thus ensure better equity in public spending.

National ownership and consensus toward the imperative of health coverage, sustained political leadership as well as active legislative production and regulation have been among the key enabling factors of the UHC policy process. Proactive governance reforms, such as the consolidation of insurance funds, have also been an important feature of success. Still, challenges remain for improving risk pooling and payment mechanisms.

Vietnam's experience suggests that, moving toward greater UHC outputs, the system must be constantly adjusted, and that UHC strategies must be adaptive—those used in the past to cover the formal sector and the poor may turn out inadequate to reach the uninsured in the informal sector. While aiming to cover the remaining 40 percent and to improve the quality of service delivery, the country now must also redouble efforts on the expenditure side to ensure fiscal sustainability, through improved cost management and sound payment mechanisms. Ultimately, a new set of reforms might be needed to shift the system to more cost-effective interventions and improve financial protection.

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Universal Health Coverage is a powerful framework for a nation aiming to protect their population against health risks. This Vietnam country study seeks to contribute to the global effort of sharing potentially useful lessons to address policy concerns on the design and implementation of UHC strategies in low-and middle-income countries (LMICs). Vietnam is one of the LMICs that have taken quick and effective actions to expand health coverage and improve financial protection in the last two decades. The country study takes stock of UHC progress in Vietnam, examining both the breadth and the depth of health coverage and assessing financial protection and equity outputs (Chapter 1). Chapter 2 includes an in-depth analysis of some of the major success strategies and policy actions that the country took to expand health coverage and financial protection for all, including for the poor. Chapter 3 focuses on some of the UHC-related challenges that the country faces in pursuing expansion and sustaining UHC. Vietnam's experience suggests that, moving toward greater UHC outputs, the system must be constantly adjusted, and that UHC strategies must be adaptive—those used in the past to cover the formal sector and the poor may turn out inadequate to reach the uninsured in the informal sector.

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