UNITED NATIONS COUNTRY TEAM VIET NAM

DISCUSSION PAPER No. 2

Health Care Financing for Viet Nam

UNITED NATIONS VIET NAM

Ha Noi
June 2003

The Mission of the United Nations in Viet Nam

The United Nations, in partnership with the government and people of Viet Nam, works to ensure that all Vietnamese people enjoy an increasingly healthy and prosperous life with greater human dignity and expanded choices. Collectively and through its individual agencies, the United Nations cares and creates opportunities for the poor and most vulnerable, and for youth, to whom the future belongs.

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Ha Noi, June 2003

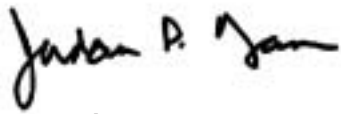
FOREWORD BY THE UNITED NATIONS RESIDENT COORDINATOR

At the core of the mission of the United Nations in Viet Nam is our commitment to work to ensure that all Vietnamese people enjoy an increasingly healthy and prosperous life with greater human dignity and expanded choices. We do this in part by drawing on the extensive and in-depth substantive and technical expertise of the United Nations agencies in the country. We also contribute to debates on issues of importance in Viet Nam's quest for development. This paper, the second in a series of United Nations discussion papers, is designed to spur such debate and the fuller consideration of alternative approaches. The full series of the United Nations discussion papers is available at the UN Viet Nam website at *www.un.org.vn*.

Health is integral to a nation's development prospects. This is widely recognized, including in many of the Millennium Development Goals (MDGs) that target health related issues. Viet Nam enjoys a relatively good record in terms of vital health indicators as compared to its low GDP per capita level. Yet inequities in the Vietnamese health care system are emerging, as has been acknowledged by the Communist Party and the Government of Viet Nam. This poses a significant challenge to the current national efforts of achieving the MDGs, particularly among the most disadvantaged groups. In response to these concerns this paper examines the current situation and offers possible policy options on health financing.

Against the background of the specific issues of health care financing, the Government of Viet Nam should also consider how best to ensure the strict adherence to the "right to health care" for all. The poor should not be turned away or provided low quality care. Overall public administration reform in the health sector is urgently needed. Steps should be urgently undertaken to develop new incentive structures to provide more funds to those that have larger "poor" clientele well served.

We trust that this paper will contribute to developing new efforts to overcome some of the present constraints and barriers in the national health care system. Overcoming these challenges will point the way to a healthier and more prosperous future for all the people of Viet Nam.



Jordan D. Ryan
UN Resident Coordinator

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LIST OF ABBREVIATIONS

ARI	Acute respiratory infections
CHC	Commune Health Centre
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
FHCP	Free Health Card for the Poor
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
NGO	Non-governmental organization
PHC	Primary health care
RRPSE	Revenue raising public service entities
SHIS	School health insurance scheme
SME	Small and medium sized enterprise
VFIS	Voluntary Family Insurance Scheme
VHI	Viet Nam Health Insurance
VHW	Village Health Worker
VSI	Viet Nam Social Insurance
WHO	World Health Organization

EXECUTIVE SUMMARY

The "*doi moi*" reforms launched in 1986, marked a shift from a centrally planned to a "socialist oriented market economy under State management". Although this process led to marked improvements in overall well being for most of the people of Viet Nam, many still live at risk of falling back into poverty. Evidence of a widening disparity between urban and rural populations is a cause for concern as is the need to include ethnic minorities fully in the development process.

The health sector has been successful in providing preventive health services, controlling key communicable diseases and in achieving relatively good health statistics. Until the mid-1980s, Viet Nam's health system was fully subsidized. Today, as in most countries, three mechanisms are used to finance health care: government budget allocations; fees for service; and prepayment schemes or health insurance. Recently, the Communist Party and the Government have reiterated the need to "enact policies on health allowances and insurance for the poor, (and) gradually advance toward universalisation of health insurance...". This position was also reflected in the Comprehensive Poverty Reduction and Growth Strategy. Nevertheless, there is no defined strategy or master plan for the phased implementation of these long-term goals.

The review of various health financing options indicates that, in the present economic conditions, the best course of action is to increase the government health budget and to expand health insurance coverage further. This is also the most appropriate way to contribute to protect the legacy of past achievements, improve equity and move towards the goal of universal coverage.

Key challenges affecting the expansion of the current health insurance scheme include: strengthening the legislative framework; capacity building of the social insurance agency, redefining the role of the Ministry of Health and improving coordination within a framework that promotes satisfaction among both providers and consumers of health care.

The paper concludes that universal coverage can be achieved in the next 20 years provided that there is sufficient political support, as well as an increase in government budgets complemented with additional resources from official development assistance and other sources of sustainable financing. The need for effective partnerships among all stakeholders is also highlighted. This achievement will lead to tangible improvements in health and decreased inequalities and do much to assist Viet Nam meet the Millennium Development Goals.

The cost of ill health can be profoundly destabilizing

Nha's family has 12 members. They used to be one of the richest families in the village but now they are one of the poorest. They have suffered two shocks in recent years. Firstly his father died 2 years ago. So there are now only 2 main laborers in the family - Nha and his mother who is 40 years old. Nha has two young children. Two years ago, his daughter Lu Seo Pao also had a serious illness and had to be operated on in the district and province hospital. His family had to sell 4 buffaloes, 1 horse and 2 pigs to cover the expenses of going to get treatment and the operation cost several million dong but still she is not cured. All the people in his community helped but no one can support more than VND20,000. Moreover, Nha's younger brother - Lu Seo Seng, who was studying in grade 6, had to leave school in order to help his family. Nha says that "If Lu Seo Pao was not ill, his family would still have many buffaloes, he could have a house for his younger brother and Seng could study further (Lao Cai Province).

Source: Viet Nam Voices of the poor, World Bank 1999

I. Overview of development challenges

In a little more than a decade and a half, Viet Nam has undergone a dramatic economic and social transformation. The "*doi moi*" reforms marked a shift from a centrally planned to a "socialist oriented market economy under State management" characterized by the development of the rule of law and implementation of an open door policy with regard to foreign countries. Major reforms have included a return to household-based farming in agriculture, the removal of certain restrictions on private sector activities in commerce and industry, and rationalization of state-owned enterprises.

It is generally accepted that this process, launched in 1986, has led to considerable improvements in the overall well being of the vast majority of Vietnamese people. Real GDP per capita growth averaged more than 6 per cent annually over the decade and Viet Nam has graduated from being a rice importer to the world's second largest rice exporter. One of the country's outstanding social achievements has been the reduction of poverty from an estimated 70 per cent in the mid-1980s to 36 per cent in 2001, according to the World Bank's internationally comparable poverty line. Nevertheless Viet Nam remains a poor country, with an average GDP per capita of US$ 400 in 2000. As many as 28 million people continue to lack the minimum income necessary to provide a decent standard of living. Many people still live just above the poverty line and the risk of falling back into poverty remains high. In 1999, 48 per cent of the population still lacked access to safe water, of which 56 per cent were in rural areas. In the same year, around 33 per cent of children under 5 years old were still underweight. The disparity between urban and rural welfare is widening and ethnic minorities in mountainous and remote areas have benefited only marginally from the development process. Inequalities are increasing rapidly; the difference in income distribution between the poorest and the richest quintiles increased from 4.9 in 1992 to 8.9 in 1999.

Much remains to be done to consolidate, sustain and build upon recent achievements. The challenges are daunting. As noted in the Ten-year Socio-Economic Strategy for 2001-2010, continuing the upwards momentum of reform, investment and economic growth will be crucial for Viet Nam's development into the next decade. However, the main challenge will be to ensure that all regions, provinces, population groups and ethnic minorities participate in and gain from the development process. As well as macro economic reforms, public administration reform needs to be carried out, the rule of law strengthened, social protection developed, social sectors enhanced and civil society empowered. As far as public administration reform is concerned, the most pressing issue is civil service pay. Salaries remain too low compared with average monthly household

expenditure, and poor performance and corruption driven by the need to meet basic living expenses are therefore difficult to correct and contain.

II. Health Situation

Although the country is still poor, its vital health indicators are comparable to those of middle-income countries. Life expectancy, for instance, is ten years longer for Vietnamese women than might be expected from the country's level of development. Infant mortality in 2001 (36.7 per 1000 live births) is comparable to that in middle-income countries like Brazil, Peru and Turkey (see Table 1). Viet Nam was very successful long before the Alma-Ata International Conference on Primary Health Care in 1978 in providing preventive health services, controlling the spread of communicable diseases and in achieving good health statistics. This was due to an extensive health care delivery network which was very strong at the primary health care level (e.g. 9806 commune health centres and more than 600 district hospitals), large numbers of health workers and very well organized national public health programmes such as the Expanded Programme on Immunization (EPI). High literacy rates for both men and women were also an important factor in promoting these results in health.

However, despite these achievements, Viet Nam is still faced with a high prevalence of chronic malnutrition among the under five population; high prevalence of low birth weight babies; relatively high maternal and neonatal mortality rates, mainly among ethnic minorities and in remote areas; and a high

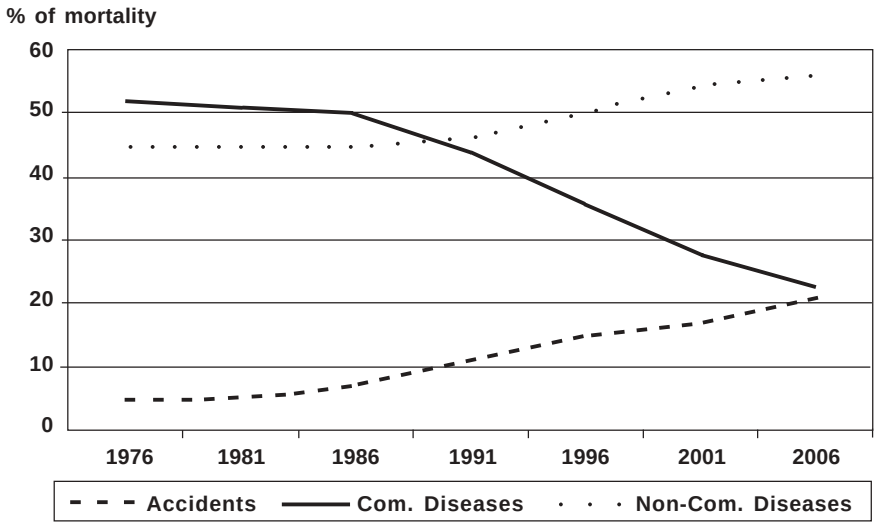
Table 1: Health indicators and GNP per capita of some selected countries

Countries	GNP/capita	Life expectancy at birth	Infant Mortality Rate (‰)	Under 5 Mortality Rate (‰)	Maternal Mortality Ratio (‰)
Brazil	4420	67	33	40	160
Viet Nam	**370**	**68**	**34**	**42**	**160**
Peru	2390	68	40	47	270
Turkey	2900	69	38	42	na
South Africa	3160	63	51	83	na

Source: World Development Report, World Bank 2000

rate of induced abortions. There is still an unfinished agenda in communicable diseases (e.g. acute respiratory infections and parasitic diseases in children, hepatitis B, and food-borne related problems) although these now represent less than 30 per cent of the causes of mortality. In addition, there has been a steady increase in non communicable diseases such as cardiovascular diseases, cancers and diabetes; an increase in new or re-emerging diseases such as tuberculosis, HIV/AIDS, dengue fever and Japanese encephalitis; and an increase in life-style related diseases and accidents (e.g. tobacco-related diseases, alcohol and drug abuse, injuries from road accidents, violence, suicide, mental health). Accidents are set to overtake infectious diseases as the most common cause of mortality – they already account for more than 20 per cent of total mortality and are the first cause of premature mortality. Although no data are available, anecdotal evidence suggests that young male adult mortality is growing. (See Figure 1).

Figure 1: Evolution of mortality by cause



Source: MoH 2001, UNDP 2001

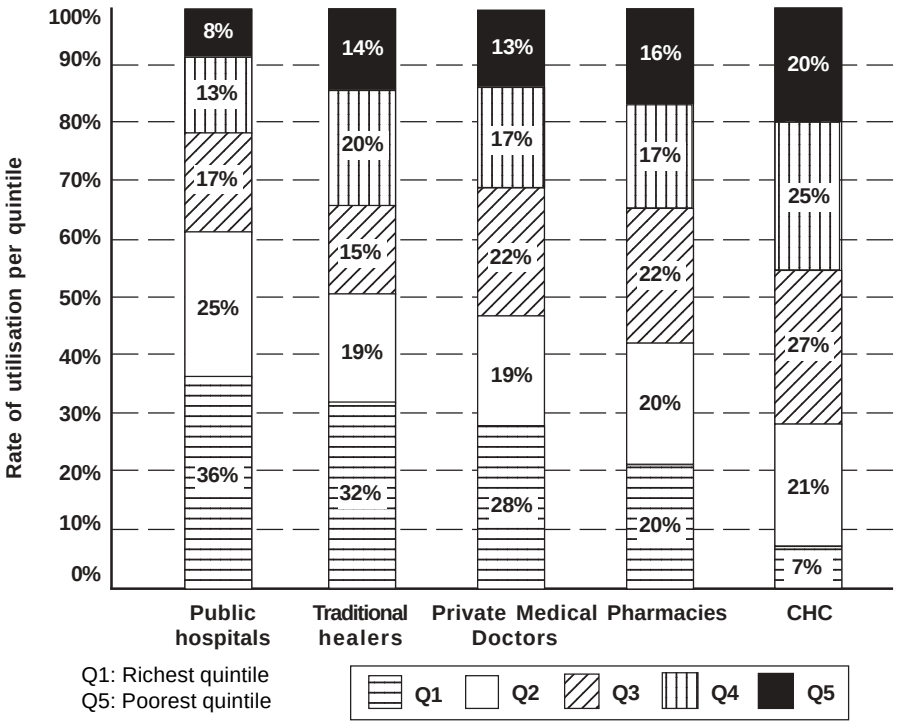
In addition, there are considerable disparities in health status between different geographical regions and between population groups. In general, health indicators in the Mekong River Delta, the Central Highlands and the Northern Uplands are much worse than in the rest of the country. Maternal and infant mortality rates among ethnic minorities are much higher than the national average. Income and social inequalities have increased steadily during the 1990s. This has already

had an impact on health, and research shows that infant mortality in the poorest 20 per cent of the population is increasing.

Many of the *doi moi* reforms affected the health sector. The health service networks at village and commune levels declined with the dismantling of agricultural co-operatives, which had previously provided financial support for basic health services, including the salaries of the village health workers. Funding from the People's Committees was insufficient and the primary health care system, which had been one of the main reasons for the relatively good health indicators of the Vietnamese population, was in a state of steady, if not rapid, decline. In addition, lack of resources had a negative impact on hospitals at all levels. Faced with this situation and with limited resources, the government introduced important health sector reforms. These included paying the salaries of health workers at commune level, creating a social insurance system, introducing user fees for health services, legalizing private medical practices and deregulating the pharmaceutical market. The number of private providers increased rapidly, but the government was not well equipped to regulate and monitor the quality of services. This, combined with an under-funded public sector, had serious negative consequences on access to health care for a large part of the population as well as on the quality of health care.

Low public health spending, user fees in public facilities, important informal payments in the public sector and the emergence of private practitioners and drug sellers have led to a very high level of out-of-pocket spending on health. Most people today have to pay for health care, either through formal or informal payments. As the exemptions system is not implemented effectively and social health insurance covers only a small portion of the population (mostly those who are the better off), the poor do not make extensive use of health services and instead self-medicate. Data on utilization and access to health care services confirm the increased inequalities between rich and poor in this regard (see Figure 2). The poor use public health facilities less, spend less on health care, access poorer quality health services and tend to find that these services are not responsive to their needs. There is an overall under-utilization of commune health centres (CHCs) for curative services, probably due to the perceived poor quality of care and the availability of alternative suppliers. However, preventive health programmes continue to be successfully delivered through CHCs. Finally the lack of both a strong legal framework for the private sector and enforcement capacity, mainly in the pharmaceutical sector, have led to an irrational use of resources that may seriously compromise health outcomes. For example, resistance to antibiotics, mainly due to the irrational overuse of medication, has become a major public health issue.

Figure 2: Utilization of health services by quintile



Source: MoH, World Bank 2001

Viet Nam therefore faces serious health-related challenges. The main issue is how best to protect the positive achievements and legacy of the past in terms of health outcomes, while adapting to the new realities. Many issues need to be addressed including: quality of care, human resource development, low government investment in health, and the role of the government in regulating and supervising the public and private health system. Empirical evidence shows that government policies on health financing have important implications for access to health care and the health of the population.

This paper is intended to contribute to the debate on the most appropriate way to finance health care now and in the future. The current health financing system in Viet Nam has led to increasingly inequitable access to health care and to health inequalities. This has resulted in many people being pushed back into poverty. If Viet Nam is to achieve an efficient, equity-oriented health sector, health financing will be a major and urgent area for health policy reform.

III. Health care financing options currently used in Viet Nam

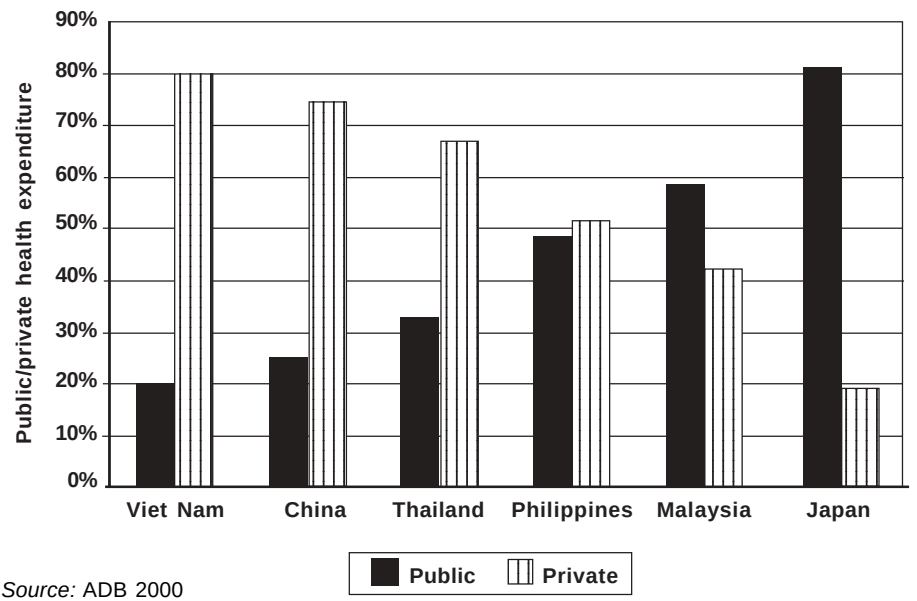
Globally, three main options exist for financing health: (1) a government budget allocation; (2) out-of-pocket payments; and (3) prepayment schemes or health insurance. Government budget allocations come from general tax revenues, both direct and indirect taxes. Studies show that low-income countries have a smaller tax base and that their governments are less able to collect taxes. The amount of the allocation therefore depends on the extent to which revenues can be collected and on the importance given to health in comparison with other sectors. Out of pocket payments include fees paid directly by patients when they seek treatment, e.g. consultations, traditional medicine, and pharmaceuticals. Patients are not reimbursed by another party. User fees/direct payments are easy to administer and are an important source of revenues for health facilities and providers. However, people who cannot afford to pay are denied access to care. In addition, user fees and direct out-of-pocket payments foster inappropriate utilization of health services. Prepayment schemes/health insurance includes mandatory insurance, which tends to be relatively progressive (in other words, they are usually linked to income so poorer people pay less), and voluntary insurance, which tends to be relatively regressive (payments are not determined by income, meaning that poorer people pay a higher percentage of their income). Mandatory insurance leads to greater financing fairness, so the main challenge is to expand prepayment schemes and health insurance to the informal sector, the rural population and the poor.

Until the mid-1980s, the health system in Viet Nam was fully subsidized by the government. In 1989, it became clear to the government that additional ways of financing health care were needed to reduce the erosion of social services that had been occurring following the termination of the fully subsidized governmental system. Like most countries, Viet Nam is now using the three options described above to finance national health expenditure

Government budget. To support the economic transition, including a gradual shift from state to private entrepreneurship, a sound income tax system had to be developed, which could cover both the formal and informal private sectors. The ability of the government to collect taxes is still limited and there are many competing needs for government expenditure. It is, however, clear that allocation for health is not a government priority as shown by the low government health budget: less than US$ 4 per capita per year in 2001 (less than 1 per cent of GDP). This figure includes central, provincial and commune budgets. This is one of the lowest in the world and places Viet Nam behind China, Thailand and the Philippines (see Figure 3). In addition to a low budget, allocation of resources from the central level is based on number of beds and providers in health facilities

for curative care and on the population of the province for preventive services, thus favouring hospitals in the urban and richer areas of the country and highly densely provinces. Better-off provinces receive more funds as provincial health budgets are higher in these provinces. The budget allocated from the central level does little to redress this inequality between provinces and within provinces. The lack of cross-commune redistribution of resources within provinces leads to disparities between communes in their ability to provide basic services to the local poor**.** Controls on the use of high technology equipment, laboratory services and pharmaceuticals are low, limiting the effectiveness and efficiency of the use of the resources. Moreover, the government budget and overseas development assistance (which amounts to US$0.50 per capita per year) concentrates on capital costs instead of recurrent costs, the patients having to pay for much of the recurrent costs, including additional remuneration for the health workers.

Figure 3: Public/private health expenditure in some selected countries



Source: ADB 2000

Out-of-pocket payments. Such payments are by far the most important source of financing in Viet Nam. They amount to nearly US$ 23 per capita per year and include formal user fees, informal payments to public services, payments for private services, self-medication and pharmaceuticals prescribed by health providers. The introduction of user fees has generated additional income for the public health sector (US$ 0.40 per capita per year in 2001). Provinces have

discretion over the level of fee to be applied. All fees are required to be paid in advance. Fees are higher for hospital-based care and in the higher-income regions. In addition to the burden on middle- and low-income families (in urban as well as rural areas), health professionals are discouraged from going to the poorer regions as their income is subsidized by user fees. The impact of this erosion can be seen in the change in the utilization of many public health facilities over time.

It was recognized at the outset that transferring the burden of financing directly to the population through user charges for services could undermine equitable access to health care and indeed lead to poverty because of the high proportion of household expenditure being spent on health care. However, user fees remain a major source of health financing and the recently-issued Decree 10 on revenue-raising public service entities may reinforce the trend, if it is applied to health services.

In addition to official user fees, a very large part of the revenues of hospitals and providers comes from informal payments by individual patients. Households report paying 14 times as much in user fees at public health facilities as the government reports in user fee revenue collection. In addition to financing public and private health services through formal and informal user fees, out-of-pocket expenses account for most of the pharmaceutical consumption in the country. This is estimated to amount to between US$ 15 and US$ 20 per capita per person and it is therefore the major component of the national health expenditure. The government has not put sufficient safeguards in place to prevent hospitals and health personnel from collecting informal payments from patients or from receiving commissions from the pharmaceutical industry.

To reduce the major barrier that user fees pose to access for the uninsured to public hospitals, and especially access by the uninsured poor, the government introduced a formal policy for fees to be waived for the poor. However there is considerable evidence that this system is not working, and that hospital providers discriminate against people for whom fees are waived and those with free insurance cards (the poor) and even sometimes against those who hold insurance cards. The reason is that part of the income of these hospital providers (mainly the clinicians) is linked to the fees.

Prepayment mechanisms. The government introduced compulsory and voluntary health insurance schemes in 1992. These schemes contribute US$ 0.40 per capita per year to national health expenditure. The aims of these mechanisms are to stabilize the financing of health services and to improve equitable access of the population to basic health care services. Responsibility for the development of both the compulsory and voluntary health insurance schemes was given to Viet Nam Health Insurance (VHI), under the umbrella of

the Ministry of Health. Currently the insurance schemes operate according to the following financing arrangements:

- ✓ ***Compulsory coverage.*** There is compulsory coverage of all active and retired workers in the public sector and all salaried workers in private sector enterprises with 10 or more workers. The coverage of private sector workers remains very low. In 1997, it was estimated that only around 13 per cent of workers in the private sector were covered. The composition of the insured population reflects the failure to reach several target populations: the salaried workers in the private sector and the self-employed and informal sector workers and their families. The ability to cover the private sector is linked to overall issues in the transition to a market economy, including registration of new private enterprises and their stability. However, with a contribution rate of 3 per cent of salary for this category of compulsory insurance (2 per cent paid by the employer and 1 per cent by the employee), the incremental benefit of increasing coverage in the private sector is very significant.
- ✓ ***Voluntary schemes.*** These include health insurance for schoolchildren (SHIS), for which there is a per capita contribution of between 15,000 VND and 30,000 VND. Registration and contribution collection functions are handled through educational institutions and in collaboration with the Ministry of Education and Training at provincial level. The initiative significantly broadened knowledge and exposure to the protection that health insurance can provide; it has, however, delayed a more rational expansion of coverage, which could have been achieved through a more conventional family insurance approach. The other scheme is the Farmer Voluntary Insurance Scheme, under which farmers contribute 30 per cent of prescribed premium and the provincial governments 70 per cent.
- ✓ ***Schemes fully subsidized by the government***. These include schemes for meritorious persons, free cards for the poor, etc. There is, however, evidence that government-subsidized premiums cannot cover the full cost of the schemes and that these social assistance schemes do not always prioritize the most vulnerable.

At the end of 2001, the total number of insured people was slightly less than 10.5 million, or 13.5 per cent of the total population of Viet Nam. Around 62 per cent of the members of Viet Nam Health Insurance (VHI) were covered by the compulsory health insurance scheme and 30 per cent of the members are schoolchildren or students in higher education, all covered on a voluntary basis through the School Health Insurance Scheme. The remaining 8 per cent are poor people covered under the Free Health Card for the Poor (FHCP) Scheme.

The concept of health insurance is relatively new in Viet Nam and there are conflicting views on community attitudes to both compulsory and voluntary health

insurance schemes. A recent review found that VHI members were overwhelming in favour of the scheme, which allows them to pay much less per hospital visit. However there is dissatisfaction with the services provided, primarily because of the time members must wait to receive care and the attitude of staff towards them. For minor problems people prefer to pay fees and not use their cards.

In conclusion, during the last ten years, a number of strategies to increase funds available for health care have been implemented. This has led to relatively high total health expenditure (estimated to be around US$ 28 per capita or around 8 per cent of GDP in 2001). However a review of these health financing strategies shows:

- ✓ very low funding of health by the State, with an inequitable and inefficient allocation of the budget and a lack of control on prices, which leads to uncontrolled private expenditures;
- ✓ very high out-of-pocket expenditure through formal and informal payments, the main expenditure being on pharmaceuticals;
- ✓ insufficient development of mandatory health insurance and social protection;
- ✓ a poorly functioning exemption system for the poor.

IV. Policy options for Viet Nam

Major changes are needed to health sector financing if an efficient, equity-oriented health care system is to be developed. Viet Nam needs to act now, before problems become too deeply rooted. This has been acknowledged by the Communist Party and the Government of Viet Nam, which have expressed their concern about the growing inequities in the Vietnamese health care system. Experience from developed countries shows that the health sector cannot simply be left to market forces; strong policy initiatives are needed.

A new health financing system should be based on a long-term vision. The 9th Party Congress in April 2001 confirmed the central role that social health insurance should play in the future and asked the government to “enact policies on health allowances and insurance for the poor, gradually advance toward universalisation of health insurance...”. This position was reflected in the recent Comprehensive Poverty Reduction and Growth Strategy (CPRGS).

However, although the long-term goal of universal coverage with health insurance has been clearly stated, the means to achieve it still have to be defined. This section outlines strategies which (1) could improve equity, (2) are relevant and

feasible, (3) make the best use of the existing resources and, (4) move Viet Nam toward universal coverage. It also reviews some options currently implemented or planned and their potential impact on the health services and on the health of the population.

Government budget. An increase in government budget from tax revenues is needed if Viet Nam is to face the health challenges that will accompany the epidemiological and demographic transitions ahead. Viet Nam has one of the smallest government health budgets based on GNP per capita. The recent findings of the global Commission on Macroeconomics and Health show that many of the minimum health financing needs, which were estimated by the Commission to be around US$30 to US$40 per person per year, require budgetary rather than private sector financing. Based on these findings and experience from other developing countries, it is clear that the health budget in Viet Nam needs to be increased substantially to cover essential interventions, including the fight against the AIDS pandemic. Although the amount of the increase will depend on many factors, an increase in the recurrent budget by at least 50% seems a reasonable and affordable short-term goal for the country. In the long term, the government budget needs to be 2 per cent of GDP or above, as in neighboring countries.

A number of other measures will help the government to improve equity and efficiency. In order to reduce the budgetary inequalities between the provinces linked to decentralization, the formula used for provincial allocation of the government budget needs to be reviewed, so that disadvantaged provinces receive larger allocations of the central budget. This may not be enough to ensure equity and more complex mechanisms may also be needed to reduce disparities between rich and poor provinces, and within provinces. The relative allocation of resources to preventive and curative care needs to be reviewed and further research carried out. The implementation of a national essential drugs policy and the use of generic drugs will be one of the most effective ways of making better use of resources; huge savings can be made through the application of a well-designed list of essential drugs in all levels of the health services. Such a policy exists in Viet Nam but has not been applied thoroughly.

Many other measures can be used to improve equity and efficiency in the health sector; it is not the intention of this paper to review them in detail, but to stress that, not only are more resources needed, better use needs to be made of the existing resources.

Out-of-pocket payments. User fees covering a wide range of services including drugs were intended to address the inadequate funding of the health sector. However, most international experts and commentators in Viet Nam agree that

user fees have a negative impact on the use of the health care by poor and middle-income households, put excessive burden on household expenditure at the time of illness (when income may be reduced), increase the demand generated by provider incentives to obtain revenues, increase the supply of services that can generate revenue in the absence of national planning guidelines and regulation of supply, and do not address issues related to poor quality and responsiveness to patients needs, in the absence of agreed norms and standards.

It would be irrational to base the health financing strategy of Viet Nam on user fees. The recent Decree No: 10/2002/ND-CP dated 16 January 2002 and Circular No: 25/2002/TT-BTC on "financial regulations applying to revenue-raising public services entities" is therefore cause for concern. The decree reflects the government's interest in reducing public spending for goods and services by shifting to cost recovery from the consumer; however, it is crucial in the case of essential social services to establish social safety nets before the burden is shifted to the consumer. Such safety nets do not yet exist in Viet Nam except for few people who are covered by health insurance and by social assistance schemes. The Prime Minister has recently issued a new decision for the establishment of Health Care Fund for the Poor (decision No: 139/2002/QD-TT). It is too early to assess the impact of this decision on financial access to health services by the poor. However in the mean time, it is recommended that the government does not consider public health providers, including hospitals and medical centres, to be "revenue-raising public services entities". The implementation of the decree will result in harm to the health of both the individual patients and the public; although it will increase the total national health expenditure, there is unlikely to be any obvious improvement in health status except for the health of the better-off. In addition, the decree contradicts the overall direction provided by the Party in the last congress.

A separate set of regulations for the health sector may, however, be considered, which would increase the autonomy of public facilities within clearly defined boundaries and without detrimental effects to the health of the population or to the economy.

Prepayment mechanisms. The adoption of the policy proposed by the Communist Party should be welcomed. International evidence shows that in order to ensure fairness and financial risk protection there should be a high level of prepayment, risk should be spread (through cross-subsidies from low to high health risks), the poor should be subsidized (through cross-subsidies from high to low income), and the fragmentation of pools should be avoided. The following features of the policy environment in Viet Nam will greatly facilitate its implementation:

- ✓ The intention of the government to reach universal coverage through a national health insurance scheme should enable the maximum level of fund pooling and risk-sharing.
- ✓ The extension of coverage under one umbrella organization will allow the maximum continuity of eligibility through the anticipated growing mobility of workers between public and private sectors. It will obviously ease the shift of workers from the public to the private sector if they can remain in the same social health insurance scheme regardless of whether they work in the public or the private sector.
- ✓ The commitment of the government to seek ways to assure coverage of the low-income population, mainly subsistence farmers, who cannot afford the level of contributions applied in the formal labour sector, has increased recently. One initiative is to provide free health insurance cards to 4 million people; the second is to develop community health insurance schemes for rural populations. The intention to cover the informal sector through the same social health insurance system is equally significant. Many countries with new social insurance systems for the formal sector are reluctant to cover the self-employed and the informal sector. This leads to interest in micro-insurance schemes, usually for groups of populations with specific affiliations, and with significant differences in the scope of benefits and level of protection. However, even with a multitude of different schemes, it is very difficult to cover a significant proportion of the target population, or to assure the long-term sustainability of many schemes. A multitude of schemes usually does not promote constructive competition but duplication and inefficiency, and can cause confusion.
- ✓ The extension of coverage to the entire population through an existing mechanism, with operations throughout the country, will benefit from the existing structures. The development of the VHI as a social health insurance organization has been steady, with relatively good professional staff development through training in Viet Nam and abroad. The recent merging of the VHI with Viet Nam Social Insurance (VSI) can also represent an opportunity in the long run as it may decrease administrative costs and allow VHI to mobilize and pay out funds in the most efficient way possible.

Conclusion

Among the various financing options, (1) increasing the government budget and (2) expanding health insurance coverage seem the most appropriate alternatives, given Viet Nam's economic situation. Additional sources of sustainable financing to complement to government budget are also needed to support efforts to reach the eventual goal of universal coverage. However, the challenges are enormous

and some of these are reviewed in more detail below. If the financing gap is to be closed and Viet Nam is to develop a properly structured health delivery system that can reach the poor, Viet Nam will need to both use official development assistance wisely and effectively as well as pursue sustainable mechanism of domestic financing.

V. Challenges and next steps for reaching universal health insurance coverage

This chapter focuses on universal health insurance coverage, as this is where the most important steps need to be taken. The challenges can be grouped in three main areas: the legislative framework, institutional development and the role of the Ministry of Health.

Legislative framework for social health insurance

The current policy is based on the direction provided by the 9th Party Congress. First, consensus must be achieved on the most effective way to reach universal coverage. The process, which has already begun, should lead to the development of a master plan, which will specify the mechanisms for each population sector, using contributory and social assistance mechanisms. The master plan will also set out the basic framework within which universal social health insurance would be implemented, such as the:

- administrative structure and its relationship with government ministries, including reporting and supervision functions;
- relationship with forms of social protection, providing benefits for old age, invalidity and maternity, as well as for work-related injuries and diseases;
- transition from voluntary to compulsory insurance for specific groups (such as self-employed workers);
- pooling of funds for the various population sectors;
- allocation of funds for training and research;
- family rather than individual coverage;
- confirmation of the comprehensive scope of health care benefits, on a strong primary health care base;
- basis for setting contribution rates for self-employed and family enterprises in all sectors (agriculture, commerce and services);
- mechanisms for the coverage of specific population groups, including non-economically active populations and populations with very low

incomes (including populations of the designated mountain village areas, which may have special taxation and economic development benefits over a set period of time); and

- role and regulation of private for-profit health insurance.

Following debate and acceptance of a master plan, it is suggested that the legislative basis for the implementation of social health insurance should be through a law rather than a decree. This will require the drafting and passage of a social health insurance law and regulations, with the current decree to be applied during the lengthy interim period that may be required. There are three major reasons for this suggestion. First, the initial Health Insurance Decree of 1992 has been followed by a series of government ordinances, ministerial circulars and orders, some of which are significant amendments and some of which replace earlier circulars, so there is some confusion as to which are currently in effect. Second, innovations to deal with a range of problems are hampered by the restrictions contained in articles in the original decree. This has been the case with attempts to shift from individual to family coverage and to control expenditure by moving from fee-for-service provider payment to other mechanisms. Third, the limited sanctions of the decree have hampered enforcement, particularly with regard to the registration of workers in the private sector and the collection of contributions.

The need to increase ***compliance*** is a particularly sensitive issue. In recent years, there has been fairly rapid development of private enterprises through joint ventures with foreign or multinational companies. National small and medium-sized enterprises (SMEs) have also become more stable. The private sector workforce should therefore be both larger and more stable. The 3 per cent of salary contributions from workers in the private sector and their anticipated lower health care needs could make a significant contribution to the financial viability of the VHI. Even if their dependants are covered (including young children with greater health care needs), private sector workers tend to have fewer dependants than farmers and low-income families in general.

Membership of private sector workers is important for another reason, which is linked to equity and the nature of VHI. For at least the higher paid staff of the larger enterprises, private for-profit health insurance will be offered, thereby bypassing the VHI and allowing for the creaming off of the highest paid workers. If such a trend becomes established, it could eventually undermine the VHI, which will risk being seen as a health insurance fund for low paid workers and vulnerable populations.

Institutional development for the extension of coverage

The establishment of universal coverage in Viet Nam will be achieved more easily through the extension of an existing scheme, rather than by establishing new schemes for new populations. The fastest way to reach a significant extension in coverage would be to extend benefits to the dependants of covered workers. Such a move would be in keeping with the concept of social health insurance and the emphasis that has always been placed on family and children by the government of Viet Nam. However, this move would cover only a part of the target population. In order to enroll members of the three major groups in the target population — workers in SMEs in the private sector and in the informal sector now covered under the voluntary channel, and the potential recipients of free cards, under FHCP arrangements – major efforts will be needed in administration and promotion, with coordination and support of local government.

To increase compliance in the private salaried sector, mechanisms should be put in place in the new VSI/VHI organization to cooperate in registration and collection of contributions. The VHI and VSI currently collect contributions from the same enterprises for the same working populations to cover social security benefits and both schemes suffer from a similar lack of compliance. The merger of the two organizations will allow the administrative burden to be shared and will be welcomed by employers, who currently have to deal with two social security institutions.

Informal workers, the majority of whom live in rural areas and have unstable incomes, will be the hardest to enroll. VHI currently has very few members in many rural areas, and will need to strengthen its operations at national, provincial, district and even commune and village levels if it is to expand coverage in the countryside. Capacity building activities for these functions will have to include:

- the development of information systems;
- innovative measures in cooperation with other agencies to register the target population and to collect regular contributions without developing an excessive VHI infrastructure at local level;
- the development and use of promotional material through various media and community leaders; and
- training for all these functions.

The majority of the target population for expansion will pay relatively low contributions, and mainly as flat rate amounts rather than as percentages of salary or income. Their initial expected health care needs may be greater than the population currently covered. Therefore, cost containment will take on increasing importance, and will depend to a large extent on the ability to shift to

a provider payment system with most benefits covered by a capitation arrangement with designated hospitals and only special services and emergencies to be covered by a fee-for-service system. In fact fee-for-service provider payment is one of the main obstacles to the development of sound health financing mechanisms, since it provides incentives for the generation of excessive services in order to increase the income of providers. The change to a capitation payment system will mean that VHI will have to develop capacity to ensure that appropriate contractual arrangements are made with accredited providers. An information system, which will support quality assurance, will also be needed. VHI would also benefit from increased actuarial capacity to support changing financing policies.

A third area for capacity building is related to health insurance benefits. As family coverage is anticipated and in any case, the free cards will be given to families, children will represent a higher proportion of the covered population than at present. VHI will need to reconsider the inclusion of specific benefits, such as the current list of pharmaceuticals covered, and preventive services, to accommodate the needs of young members. At the same time, the inclusion of more preventive services to older persons may prove to be cost-effective and promote quality of care.

The role of the Ministry of Health and of the Government

The role of the Ministry of Health in health insurance development in Viet Nam has been complex. The Ministry of Health has had parallel responsibilities including implementation of the decree, administrative supervision of VHI, with a Vice-Minister as Chairperson of the national VHI Board. The Ministry of Health has been responsible for the appointment of senior VHI officials, and was involved in development and approval of technical support provided by the international development partners. At the same time, the Ministry of Health has provided health care benefits to the insured through its own hospitals, polyclinics and health centres.

A review of the role of the Ministry of Health will be essential. Better and more efficient coordination of the various bodies involved, particularly VHI/VSI and the ministry. This could come about through the strengthening of the health insurance policy development and stewardship functions within the Ministry of Health, particularly as coverage expands and health insurance as a source of health care funding grows. For instance, issues like the optimal use of health insurance funds at the provider level, including the improvement of the remuneration of health workers, will need to be addressed jointly by the Ministry of Health and VHI/VSI. The outcome of all the efforts to revitalize and improve health services in Viet Nam will to a large extent be linked to success in dealing with current

pressures on consumers for under-the-table payments to individual health workers and therefore to the development of provider payments methods, other than fee for service.

With regard to the Ministry of Health as a provider, better collaboration between the Ministry of Health and VHI in quality assurance and cost control of the VHI funds, linked to current utilization patterns, is needed. Until health insurance revenues account for a significant part of the revenues for the health care providers, it will be relatively difficult to demonstrate to the generally poorly paid health workers that they too will benefit from the best possible treatment of the insured population. In the past, more efforts have been spent on price setting and the generation of revenues than on reviewing the appropriateness of utilization patterns and assuring satisfaction for both insured and non-insured populations. For instance, in the area of pharmaceuticals, the Ministry of Health and the VHI/VSI need to work together to address the inefficient and dangerous use of pharmaceuticals and to implement the national policy on essential drugs.

A review of utilization would be extremely beneficial if it could be carried out within a quality assurance framework, and ultimately lead to better planning and use of resources by both Ministry of Health and VHI, giving due consideration to the satisfaction of patients and health care professionals. The Ministry of Health will need to improve the use of health insurance revenues at the local provider level, in particular to improve the incomes of the health workers and to invest part of the insurance revenues to improve the comfort and satisfaction of the patients. Positive collaboration between the Ministry of Health and VHI should ultimately lead to a shift in resources to serve the needs of the insured population.

VI. Conclusions

Viet Nam urgently needs to take a number of decisions on health financing in order to protect the legacy of the past, improve the health of the general population and decrease health inequalities. The major challenge lies in the extension of social protection to all population groups through a stable financing mechanism that eliminates financing barriers at the time of use and promotes satisfaction among both providers and consumers of health care in Viet Nam.

As briefly outlined in this paper, the main decisions that need to be taken relate to:

- ✓ **The government budget**. Efforts are needed to increase the total government allocation for health. This should be accompanied by decisions on the priorities for increased government spending, and the

monitoring of changes resulting from the increased level of spending and shifts in resource allocation

- ✓ **Overseas development assistance.** This will continue to be needed to support the health sector. Such assistance can be very effective in subsidizing health insurance for a period of time and covering the contribution burden of individuals or families who are unable to afford their own contributions.
- ✓ **Out-of-pocket fees.** The policy of user fees should be reviewed and user fees for essential health services gradually phased out. Major policy initiatives are needed to improve the use of pharmaceuticals and to redirect expenditures to interventions with clear health outcomes.
- ✓ **Universal health insurance.** The policy to implement universal health insurance should be pursued vigorously. In the long term universal coverage would allow for stable health care financing for personal health care through prepayment. This should include: affordable contributions to be paid by the vast majority of the population, benefits for those who cannot contribute themselves but are supported by social assistance, and the shifting of government resources to improve public health services.
- ✓ **Organization and quality of health services.** Improvements are needed, mainly at grassroots level. This should include the introduction of other modes of payment for providers. For instance, the capitation payment system increases the provision of cost-effective health care, decreases unnecessary services, provides predictable revenues to hospitals and simplifies administration.
- ✓ **Phasing out under-the-table payments.** These efforts will to a large extent be linked to success in dealing with current pressures on consumers for under-the-table payments to individual health workers.

A master plan for health care financing for Viet Nam would enable reforms to be carried out in a managed and structured way. It would need to define information needs and health accounts at local, provincial and national levels. It would also have to include tools to assess health care financing options in terms of equity, effectiveness and quality, efficiency, extension of coverage and extension of benefits.

With political commitment and leadership, increases in international financing, and effective partnership among all partners, universal coverage can be achieved in the next 20 years. Not only would this lead to tangible improvements in the health of the population, it would be a powerful tool to alleviate poverty, to decrease inequalities and to ensure that Viet Nam achieves the Millennium Development Goals.

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Office of the United Nations Resident Coordinator
25-29 Phan Boi Chau, Ha Noi - Viet Nam
Tel: (84 4) 942 1495
Fax: (84 4) 942 2267
E-mail: registry@undp.org.vn
UN Viet Nam Web site: www.un.org.vn