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VIET NAM

HEALTH PARTNERSHIP GROUP

JOINT ANNUAL HEALTH REVIEW 2008

Health Financing in Viet Nam

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The "Joint Annual Health Review 2008" is the outcome of cooperation between the Vietnamese Ministry of Health (MoH) and the Health Partnership Group (HPG). We hope that this review, the second one of its kind, will contribute effectively to the annual planning process of the MoH and enhance the effective cooperation between the health sector and its international partners.

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The Editorial Board

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Abbreviations and acronyms

AAA	Accra Agenda for Action
ADB	Asian Development Bank
ARV	Anti-retroviral therapy
AusAID	Australian Government's Overseas Aid Programme
BOT	Build, operate, transfer
CCBP	Comprehensive Capacity Building Programme on ODA Management
CT	Computerized tomography (scanner)
DAD	Development Assistance Database
DFID	Department for International Development (UK)
DRG	Diagnostic related groups (payment mechanism)
EC	European Commission
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
HEMA	Health Sector Support in the Northern Uplands and Central Highlands
HIV/AIDS	human immuno-deficiency virus
HPG	Health Partnership Group
IEC	Information, Education and Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INGO	International Non-governmental organization
JAHR	Joint Annual Health Review
JBIC	Japan Bank for International Cooperation
KfW	Kreditanstalt für Wiederaufbau
MMR	Maternal mortality rate
MoH	Ministry of Health
MTEF	Medium term expenditure framework
NGO	Non-governmental organization
NUP	Northern Uplands Project
ODA	Official Development Assistance
PEPFAR	Presidents Emergency Plan for AIDS Relief
PMU	Project Management Unit
PPP US$	Purchasing Power Parity dollars
Sida	Swedish International Development Cooperation Agency
TB	Tuberculosis
U5MR	Under 5 Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VND	Vietnamese Dong
VSS	Viet Nam Social Security (Agency)
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

Introduction

Inception and objective of JAHR

In 2007, the Health Partnership Group (HPG), which includes the Ministry of Health (MoH), together with international and external organizations giving health care support to Viet Nam, agreed to conduct, on a yearly basis, a Joint Annual Health Review (JAHR).

The *Objective* of the JAHR is to assess the situation and identify priority health sector issues in order to formulate an instrument to support annual planning of the MoH and to create a platform for the choice of focal issues for cooperation and dialogue between the Vietnamese health sector and external stakeholders.

As part of efforts to implement the above agreement, in 2007, the first JAHR was completed. The JAHR 2007 comprehensively addressed the major segments of the Vietnamese health care system, including: 1) Health status and health determinants; 2) Organization and management of the health system; 3) Health human resources; 4) Health financing; and 5) Provision of health services. Based on a situation analysis and problem assessment of the health sector across the five segments mentioned above, the review made recommendations on possible solutions to issues of priority for 2008 and subsequent years.

Contents and structure of JAHR 2008

After numerous discussions, the HPG agreed that the JAHR 2008 should focus on: **"Health Financing in Viet Nam"**, as the analysis will go into great depth on issues relating to health financing – arguably one of the most contentious and vital topics which, if addressed successfully, could resolve many of the other issues facing the health system of Viet Nam.

JAHR 2008 begins with a general update on the situation in the Vietnamese health sector in 2008 and outlines the tasks of the health sector in 2009.

Next, the review moves into the focal topic of the JAHR 2008, which includes: an overview of the Viet Nam health financing system; status and issues in mobilizing funds from different sources, e.g. state budget, health insurance, external aid, household out-of-pocket payments, other social resources; issues relating to management modalities of health financing, e.g. financial autonomy, hospital reimbursement methods, and financial support for those entitled to social policy support for medical services.

The final part of the review includes general conclusions, summarizing the major findings on the status of health financing in Viet Nam, major challenges and solutions for the priority issues in the plan for 2009 and subsequent years. This is the part of the document that aims to support the annual planning process of the MoH and offers inputs to dialogue and cooperation between the Vietnamese health sector and external partners on issues relating to health financing. In addition, the recommendations will be conveyed to policy makers including the Party, National Assembly, Government and concerned Ministries for coordination, particularly on issues pertaining to macro policy reform.

In addition, the annexes of the 2008 review present a table outlining progress made in implementing recommendations on solutions for those issues identified as priorities in 2007, another summarizing priorities and solutions based on analysis for the JAHR 2008, and a third table presenting data on monitoring indicators for the health care sector.

Organization and implementation

As in 2007, JAHR 2008 was formulated under the coordinated leadership of the MoH and HPG. The human resources making this review possible include:

The *working group*, which includes some HPG members, leads and monitors the development process of the report and makes sure that relevant resources are provided for related activities.

The *secretariat*, which includes MoH representatives, an international coordinator, a local coordinator and other assisting staff, is in charge of day-to-day operational, managerial and administrative tasks, organizing workshops, synthesizing the comments, ensuring that multiple stakeholders contribute to the review and editing and revising the report.

The *consultant group*, which includes qualified national and international experts with knowledge and experience related to health financing, takes responsibility for drafting chapters in the review, soliciting comments from stakeholders and fine-tuning the chapters in conformity with the acquired comments and findings.

Review approach

The report was generated mainly through a process of analysing and identifying major issues, priorities and solutions with the participation of multiple stakeholders. The key approaches used included:

- Undertaking desk studies of available documents, including policies, laws, studies, surveys, etc.;
- Exploiting the knowledge and experience of local and international consultants familiar with the Viet Nam health care system;
- Inviting both formal and informal comments from stakeholders;
- Holding workshops on each chapter with representatives from related Ministries, MoH managers, health services, local and international consultants;
- Conducting a final stakeholder workshop, to have more in-depth discussions about specific issues, conclusions and recommendations.

In the method to approach this situation analysis and evaluation, to identify priorities and to propose recommendations, it was necessary to consider the following: (1) the current socio-economic environment and situation of the health system in Viet Nam; (2) the underlying perspectives and criteria for achieving goals of equity and effectiveness in the health sector in general and health financing in particular; (3) the successes and failures of other countries, especially those with conditions similar to Viet Nam.

Many issues discussed in the report are based on concepts of “health equity”, “basic goals of the health system” and “criteria for an equitable and effective health financing system”, which we clarify below:

Health equity

Health equity is defined as "the absence of systematic disparities in health between advantaged and disadvantaged social groups" [1]. The advantages for some in society can be created by wealth, power or social status. These factors, especially wealth and income, are the bases for categorizing different social groups.

The concept of health equity is influenced by values and principles and represents the expectations and beliefs of a society regarding the issue of health, i.e. expressing the desire that everyone should have equal opportunities to recover and improve their health.

This notion of equity, from the perspective of health and health systems, differs from the concept of equity from the perspective of economics and the market system. In the market system and from an economic perspective, access to and the quality of goods acquired usually corresponds to ability to pay. However in a society in pursuit of equity in health, there is a belief that access to and the (clinical) quality of health services[1] should not depend on ability to pay.

This concept of health equity also paves the way towards various methods of measurement of equity in health – that is, the systematic comparison of the health status of various groups in society. These groups can be classified by income, gender, place of residence, etc. The degree and depth of disparity in health between such groups, sustained over many years, would suggest inequity in health.

Finally the concept of equity in health assumes that the health status of various population groups does not just depend on the health system, but also on many other factors closely correlated with health such as nutrition, clean water, environment, living standards and working conditions, etc.

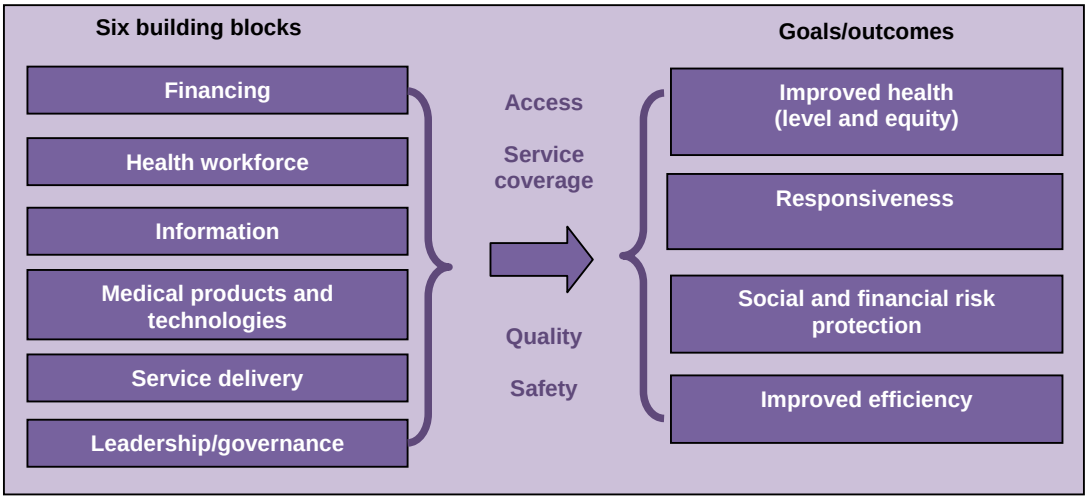
Basic goals of the health system

An equitable, effective and developed health care system requires equitable and effective health financing policies. According to the World Health Organization (WHO) [2], a health care system has four basic goals (Figure 1):

- To improve the people's health
- To improve responsiveness [3], i.e. the ability of the system to respond to patients' needs other than health, e.g. to satisfy expectations about health workers' attitudes, the way patients are welcomed and treated, confidentiality of patient information, sanitation, hospital environment, etc.
- To protect the people from financial risks (i.e. that the people will not have to pay exorbitant costs that may affect the financial integrity of their family)
- To raise the efficiency of the entire system (i.e. to cut down on administrative and clinical waste; to achieve expected health improvements at the lowest financial cost).

[1] Health service quality is comprised of two components: clinical quality and service quality. However, the emphasis here is on clinical quality.

Figure 1: WHO health system framework



Source: WHO. Strategic Plan for Strengthening Health Systems in the WHO Western Pacific Region. March 2008 [2]

The health financing system clearly affects almost all the goals of the health care system and determines who has access to services and quality care, how many people may fall into poverty because of their health care costs and whether medical costs can be controlled.

Criteria of an equitable and effective health financing system

The above analysis indicates that the basic criteria, which are also the goals that Viet Nam's health financing policy strives to achieve include:

1) to ensure that per capita health expenditure is maintained at a reasonable level, through appropriate mobilization of social resources;
2) to guarantee that public financial resources account for a larger proportion than private funds in total national health expenditure;
3) to reduce the percentage of households falling into poverty due to expenditures on health care;
4) to improve the effectiveness in allocation and use of health financial resources, increasing both efficiency (lowering costs) and service quality.

Chapter I. Update on the health sector

1. Development of the health sector and major developments in 2007-2008

Health system structure. In 2007, the Government promulgated Decree No. 188/2007/ND-CP stipulating again the function, tasks, authority and organizational structure of the MoH. The major changes in this Decree include the transfer of responsibility for population-family planning and some health insurance duties to the MoH, and specifying more details on regulations for drug management, food hygiene and safety, health human resource training and management. At the district level, Government Decree Nos. 13/2008/ND-CP and 14/2008/ND-CP and Circular No. 03/2008/TTLT-BYT-BNV have created more flexible conditions for the organization of medical services and preventive medicine at the district level, and stipulated more clearly the responsibility for management of health care at the commune level.

The ***grassroots health network*** has wide coverage, with health workers available in 100% of communes and wards, including doctors in 65.1% of communes (a decrease of 4% compared with 2005); a midwife or obstetric/paediatric doctor's assistant in 93.3% of communes; and health workers in 86.8% of villages (a decrease of nearly 6% compared with 2004). Nearly 55% of communes have met national commune benchmarks [4] (a twofold increase compared with 2005). The national health target programmes have been well implemented in the health care network, facilitating the people's access to basic and quality health services, especially for the poor and ethnic minorities. A majority of communes/wards (estimated at 65%) are able to receive health insurance reimbursements for health care they provide. As many as 97% of women giving birth were assisted by health workers; 92.6% of pregnant women were vaccinated against tetanus (2 shots or more); the MMR was reduced to 75/100,000 live births; 78% of couples accepted use of contraceptives; the population growth rate in 2007 was 1.21% (a decrease of 2% compared with 2006), but with few signs of decreasing substantially in 2008. The Prime Minister has issued Decision No. 950/QD-TTg on developing commune health stations in disadvantaged areas for 2008-2010 and Decision No. 47/2008/QD-TTG on government bonds for investment in district and inter-district regional hospitals.

Preventive medicine has been actively promoted; health facilities have focused on disease surveillance, stockpiling drugs, consumables, biochemicals for epidemic prevention, early detection and prompt treatment of diseases. As a result, no large epidemic outbreaks have taken place; the human A H5N1 flu epidemic has been limited; and the recent dangerous diarrhoea epidemic was quickly put under control. The Government has promulgated Decree No. 79/2008/ND-CP, stipulating the organization, management, inspection and testing of food hygiene safety, which helps reinforce and further develop regulations and implement food quality control measures under new rules. National target programmes on control of tuberculosis (TB), leprosy, malaria, dengue fever, etc. have also been on-going and effective. HIV/AIDS prevention and control activities have been widely implemented, with access to ARV therapy becoming more and more convenient for patients. Implementation of methadone replacement therapy for drug addicts has begun.

Medical service provision. Many solutions have been implemented by the health sector to improve medical service quality and prevent overcrowding through improving the quality of diagnosis and treatment to reduce treatment time, increasing the number of hospital

beds, investing in new construction and upgrading of facilities, and enhancing technical support and guidance for the lower level hospitals.

The public hospital system has been strengthened and developed and taken the first steps towards overcoming the deterioration in physical infrastructure and a shortage of hospital beds. Basic diagnostic and treatment equipment has been supplied to district hospitals and some modern specialized equipment has been procured for provincial and central hospitals. Transfer of technology, through higher level facilities mentoring lower level facilities, has helped many lower level hospitals strengthen their professional capacity and the quality of diagnosis and treatment. Higher level hospitals have successfully applied more advanced techniques, contributing to treating severe illnesses and saving lives. Besides the solutions that facilitate development of the curative care system, the MoH is also drafting the Law on Examination and Treatment to present to the National Assembly, aiming to complete the legal framework for the health sector in the near future (jointly for the public and private sectors).

The private health sector has received more attention to promote its development. To date, the entire country has 74 non-public hospitals with 5,600 beds (accounting for just over 3% of the total number of hospital beds in the country), and just over 30,000 private clinics; over 21,600 private pharmacies, and 450 traditional medicine production facilities. In addition, 22 private hospitals have been licensed and are being constructed. However, all these non-public health facilities are generally small in size. In order to promote development of non-public health care services, the Government has directed localities to prioritize private health facilities through allocation of land for development, setting more favourable tax rates, providing investment credit, and ensuring greater equity between the public sector and private sector in the public recognition of service and training of health staff..

In order to meet the growing ***demand for human resources*** in both public and non-public facilities, despite the limited investment provided to training institutions, the Government has issued directives to strengthen and upgrade the system of public medical schools through improving the quality of instruction, issuing new standards for secondary and junior college medical training, opening up the number of specialized training fields, increasing the quota for students each year, and encouraging non-public training facilities to develop medical training. In order to meet the diverse training needs of the health sector, in addition to formal pre-service training, the Government has approved a project proposal to provide training for about 600 people to become doctors to work in the Central Highlands based on a contract between the provinces and the training establishments; and a project proposal for in-service medical training to meet the needs for medical staff in disadvantaged and mountainous regions of the North, Central Coast, Mekong Delta and Central Highlands regions (it is estimated that by 2018, this programme will have trained 11,760 medical workers). At the same time, the State encourages the expansion of training with costs covered by trainees or localities sending people for training rather than the central budget. Consideration has also been given to the need for training in specialized medicine; each year health workers are sent as interns to find out about and become familiar with new medical technology and improve their management skills.

With the aim to support human resources at the lower levels, and facilitate improvement of professional qualifications of staff at grassroots levels, the MoH has issued Decision No. 1816/QD-BYT to approve the Project proposal for “Rotations of health professionals from upper level hospitals to support lower level hospitals in improving

medical service quality". Through this Project, medical workers in lower level hospitals will receive temporary human resource support and technical support from upper level hospitals. This also forms the basis for the Government in the future to promulgate regulations on "Social responsibility and obligations for doctors". It is felt that doctors, after graduation and during their professional careers, should work at the grassroots level for a specific period of time. This should not only ensure the sustainable coverage of doctors at grassroots levels, but is also intended to ensure that all doctors should be equally eligible for promotion.

Health investment and financing. In recent years, the Government has increased state budget spending on health through allocating funds for the health care of people with meritorious service to the nation, the poor, farmers, ethnic minority people, and people living in socio-economically disadvantaged and extremely disadvantaged regions. The State continues to permit the issuing of government bonds in order to invest in upgrading district general hospitals and inter-district regional general hospitals (Decision No. 47/2008/QD-TTg). The National Assembly passed Resolution No. 18/2008/NQ-QH12 on "Strongly promoting the implementation of policies and legislation on social mobilization to improve the quality of health care for the people". This resolution clearly stipulated that the State should "increase the share of the annual state budget expenditure for health care, ensuring that the growth rate of health spending is higher than the growth rate of overall spending from the state budget and reserving at least 30% of the state health budget for preventive medicine." Along with investment from the state budget, in recent years, the orientation towards mobilizing the public and other economic sectors to participate in the people's health care under the guidelines of "*social mobilization*" has been promoted, most recently at the 3rd meeting of the 12th session of the National Assembly (2008) [5, 6].

Health insurance has continuously expanded. By the end of 2007, nationally about 36.5 million people were covered by health insurance (about 42% of the total population) [7]. Health insurance represents an ever increasing share of total social health spending. Many non-public health facilities have met conditions for being reimbursed for care they provide to insured patients; 70% of commune/ward health stations are receiving health insurance reimbursements for their services. Very recently, the Government has issued documents to revise the subsidy for monthly health insurance premiums for those who are entitled to social benefits, with the amount now equivalent to 3% of the current minimum salary. The state budget will contribute a minimum of 50% of health insurance premiums for members of near-poor households.[2] These policies have contributed to facilitating easier access to medical services covered by health insurance for some disadvantaged target groups [8, 9].

2. Difficulties and challenges

Although many significant achievements have been made, Viet Nam's health care system still faces many difficulties and challenges, including the central problem of how to improve the health care system to move towards greater equity, efficiency and development in a socialist-oriented market economy. The main difficulties and challenges that the health care system has to face are as follows:

Disparities in health between regions of the country, and between income groups have been increasing in recent years. The child malnutrition rate, infant mortality rate (IMR),

[2] According to Prime Ministerial Decision No. 117/2007/QD-TTg, dated 27 August, 2008, on adjusting the health insurance contributions for social policy target beneficiaries, near poor households are those with per capita household income up to and including 130% of the poverty threshold.

under 5 mortality rate (U5MR), and maternal mortality rate (MMR) are still high in poor, mountainous, and remote regions.

Changes in disease patterns tend towards an increase in non-communicable diseases and injuries, while morbidity from communicable diseases remains high. In addition, some new and/or unpredictable diseases have emerged such as SARS and Avian influenza A (H5N1). Environmental health, especially issues such as medical waste and food hygiene and safety will continue to be major challenges for the health sector in the near future.

Regarding ***management and administration*** under the market mechanism, the pace for revising or amending health policies that are no longer appropriate has been slow. The appropriate model for organizational structure of the health system at the local level has not yet been resolved as many localities have not yet implemented Decrees Nos. 13 and 14, nor Circulars Nos. 03 and 05. The implementation of health policies, strategies and plans has encountered many problems. The health management information systems are not internally consistent, and as a result there are often many overlaps. The system for managing service quality is still only in its initial stages of development. The inspection of service quality in both the state and private sector remains weak. The potential role of the medical associations in managing the quality of medical and pharmaceutical practice has not yet been fully exploited. Drug price controls continue to be adjusted to deal with drug price increases, however in the near future continued challenges resulting from the crisis of global inflation are expected.

Regarding ***human resources***, there is a severe shortage of health workers in remote and disadvantaged areas. Preventive medical staff, university trained pharmacists, medical technicians, and nurses are all still in short supply compared with need. Investment in training and human resource development has not met the specific needs of the health sector. The medical staff remuneration policy is still inadequate. The shift of medical staff moving from public to private sector and from lower levels to upper levels has become even more noticeable. In addition, training programmes have not been updated regularly. Methods of training have yet to be reformed in a uniform manner throughout the system. One point worth noting here is the shortage of health staff at the grassroots level. This is not only due to the limitation in numbers available but also due to the fact that some trainees received poor quality training (e.g. in-service training doctors, secondary nurses trained in some mountainous provinces) and as a result were not offered jobs after graduation despite the unmet need for health human resources in the locality.

On ***health financing***, the share of public financial resources (including state budget, grant aid and health insurance, and social insurance) devoted to health remains relatively low compared with the total amount the society as a whole spends on health. Direct out-of-pocket spending by households remains high, and has negatively impacted equity in health care. The percentage of the population covered by health insurance is still limited, unsustainable, and contribution levels remain low compared to health service costs. Nevertheless, even when premium levels are still relatively low most people find it extremely difficult to contribute to health insurance. The proportion of wage earners covered by health insurance remains low (50%). Some 64.5% of total health insurance fund revenues are contributions from the state budget (including purchasing health insurance cards for the poor and for those with entitlements to social benefits, and for government staff). The policy on voluntary health insurance has been amended to expand eligibility criteria and increase attractiveness through increasing the benefits for voluntary health insurance card holders, however this has made the

health insurance fund balance more precarious due to adverse selection among health insurance participants. The state budget allocation to medical facilities is still based on the number of planned beds, not on performance of the facility, which has also caused problems in the planning and administration of hospitals. Investment expenditure remains low, resulting in many public health facilities falling into disrepair. The user fee policy has not yet been revised and does not fully account for the costs of providing services, leading to lack of incentives for efficient use of financial resources. The "fee for service" method of payment creates incentives for abuse of health services. The absence of effective mechanisms for controlling drug prices and the lack of a more scientific procedure in the selection of the list of drugs to be paid for by health insurance are seen as important contributors to overspending of health insurance funds.

On ***health service delivery***, one of the main difficulties is the overcrowding faced in provincial and central hospitals. This situation is largely due to the following: limited health service quality at lower levels, service users' expectations and need for high quality health services, convenience of travelling, low differences in hospital fees between levels, etc. Another reason for overcrowding is related to the financial management mechanism. As a result of their financial autonomy, upper level hospitals are exploring ways to attract patients, including patients with only mild diseases. Implementation of the financial autonomy policy in public hospitals is facing many difficulties because of the limited management capacity and out-of-date equipment and infrastructure. Moreover, the combination of private-public partnerships in mobilizing social resources in public hospitals has been given insufficient regulation and guidance. This has led to increases in the overuse of drugs and use of high-tech medical equipment to increase revenues, resulting in the increased burden of direct costs for patients. The private medical sector is predominately developing in wealthier areas and focused on providing out-patient services or higher-priced medical procedures. Overall supervision of the activities of the private medical sector is very limited. The organization of the preventive medicine system, the professional skills of staff and the equipment available for preventive medicine are all limited, especially at the grassroots level. The ability to supply health care services and the quality of care and activities of the commune health stations, especially in remote areas, face many limitations and needs to be improved. Strengthening and developing the village health worker networks, together with strengthening military-civilian medical cooperation are very important in implementing PHC for people in the remote and extremely disadvantaged areas.

3. Orientation for development of Viet Nam's health care system in the coming years

Based on the policies of the Party and the Government, the Vietnamese health sector will continue its development in the coming years in line with the following guidelines:

- Reforming and completing the medical system with an orientation towards equity, efficiency and development, aiming to create advantageous opportunities for the protection, care and promotion of the people's health with ever improving quality, appropriate with the socio-economic development of the country.
- Increasing state budget investments to go along with social mobilization for health care and effective implementation of assistance to state policy beneficiaries and the poor in caring for and promoting their health.

- Reforming and refining health financing policies with an orientation toward rapidly increasing the share of public health finance (including state budget and health insurance), gradually reducing direct out-of-pocket payments from patients.
- Capacity building and increasing the number of health staff at the grassroots level.
- Strengthening effectiveness of state administration in order to improve efficiency in health sector activities with an orientation towards equity, efficiency and development.

In accordance with the orientating guidelines outlined above, the main tasks which need to continue to be implemented in 2009 include [10]:

1) *To satisfactorily implement Resolution No. 46-NQ/TW* of the Politburo and Resolution No. 18/2008/QH12 of the National Assembly. Continue to formulate and refine draft laws for Tobacco control, Food hygiene and safety and Examination and treatment with associated legal documents in order to develop the health system and improve the quality of health services, strengthen health care for the poor, the people living in disadvantaged areas, including proposals to increase the norm for funds allocated to cover costs of care for children under age 6, strengthen information, education and communication (IEC), motivate and assist the near poor to purchase health insurance, strengthen training of human resources, promote medical ethics and accountability of health workers, and intensify social mobilization in order to mobilize resources for health.

2) *Regarding preventive medicine and food hygiene and safety*: To strengthen the information and reporting system, develop the epidemic early warning system and rapid response system; conduct surveillance and early management of epidemic reservoirs, minimize the mortality rate and contain large epidemic outbreaks. To properly implement national target programmes, overcome difficulties encountered by the expanded programme on immunization (EPI) and promote activities on nutrition. To conduct communication activities so as to make the public understand and proactively implement self-protection activities against diseases, carry out the development of the healthy–cultural village movement, and the rural sanitation movement with three projects, namely clean water, hygienic latrines and bathrooms, in order to limit and gradually eliminate harm to people's health stemming from unhealthy and unhygienic customs and lifestyles or contaminated environments, and ultimately to reduce the morbidity and mortality rates associated with epidemic diseases.

3) *Regarding curative care and rehabilitation*: To continue enhancing implementation of the MoH Directive No. 06/2007/CT-BYT on the improvement of medical service quality, with special attention to be paid to the reduction of overuse of drugs, paraclinical testing and high-tech services, which lead to unnecessary costs for patients; and the carrying out of education to raise medical ethics. To strengthen technical/professional training and refresher training and technology transfer for the lower levels in order to enhance effective utilization of the infrastructure and equipment in health care facilities, especially in hospitals at grassroots level which have benefitted from recent investments, and thus to address the situation of overcrowding or hospital bed sharing in hospitals at the central level and in the larger cities. To mobilize sources of financial investment and more fully utilize the current infrastructure in order to increase the number of hospital beds; establish new hospitals, and develop private hospitals.

To develop traditional medicine in both the public and private sectors on the basis of the appropriate implementation of Prime Ministerial Decision No. 222/QD-TTg and Party Central Committee Secretariat Directive No. 24.

4) *Regarding organizational structure and human resource development*: To continue elaboration of the health care facility system from the central level to local level pursuant to Decree No. 188/2007/ND-CP; Decree Nos. 13 and 14/2008/ND-CP on the organizational structure of professional bodies in localities; and Decree No. 79/2008/ND-CP on the organizational system of management, inspection and testing of food hygiene and safety, vaccines, medical biological products, and injury prevention. To increase investment in upgrading health human resource training institutions; increase the quota of student intake by a minimum of 30% in comparison with 2008; promote contract training and expand other forms of training in order to ensure the quantity and labour structure for the human resources of health facilities in the forthcoming period. To continue implementing MoH Decision 1816 in 2008 on rotating health professionals to work at lower level health facilities.

To strengthen scientific research activities and the application of research findings in medical examination and treatment, preventive medicine, pharmaceutical, vaccine and biological product manufacturing, training, state management, policy making, etc.

5) *Regarding activities in population/family planning and reproductive health care*: To continue strengthening and stabilizing the organizational structure at provincial and district levels. To enhance IEC activities and carry out a consistent set of interventions to control the population growth rate, improve the quality of pilot interventions and the scaling-up of socio-economic and technical intervention models and solutions, with the aim of reaching the targets set for fertility rates and sex ratios at births as well as improving population quality.

6) *Regarding the pharmaceutical sector*: To ensure the adequacy of essential drugs for medical services and to conduct effective measures to stabilize drug prices. To intensify monitoring and supervision in drug quality assurance. To enhance implementation of measures for the safe and rational use of drugs, thus gradually reducing the overuse of drugs in treatment at public and private health facilities. To develop the master plan for pharmaceutical, materials and traditional medicine industry development. To guide localities and units to properly carry out the competitive bidding process for drug procurement as regulated, moving towards collective competitive bidding within provinces to contribute to drug price stabilization.

7) *To implement the Project on "Renovation in performance and financial mechanisms, including salary and health care service prices, for public health service facilities"*: To accelerate implementation of comprehensive autonomy in accordance with Government Decree No. 43/2006/ND-CP. To issue a circular giving specific guidance regarding Decree No. 69/2008/ND-CP on joint ventures in public hospitals, especially clearly identifying an appropriate public-private financial mechanism in this field.

To focus on the investment and upgrade of district and inter-district regional general hospitals in line with Prime Ministerial Decision No. 47/2008/QD-TTg; to develop and submit to the Prime Minister for approval the Project proposal on investment in upgrading provincial general hospitals in mountainous and disadvantaged areas, commune health stations, TB, psychiatric, paediatric, and cancer hospitals with government bonds for implementation in 2009; to initially develop examination and testing centres sufficient to operate in accordance with Prime Ministerial Decision No. 154/2006/QD-TTg and

Government Decree No. 79/2008/ND-CP; to increase investment to upgrade, consolidate and complete the provincial preventive medicine system and district preventive medicine centres.

8) *To continue to expand international cooperation* bilaterally and multilaterally, with governmental and non-governmental organizations (NGO), banks, and financial organizations in order to attract investment resources, access new and advanced technology in the world, and contribute to the acceleration of the integration process in the medico-pharmaceutical area. To efficiently implement projects supported by official development assistance (ODA) or NGOs.

9) *Regarding state administration and inspection*: To focus on intensifying administrative reform, bringing democracy into full play at the grassroots level, and applying information technology in the management of public service facilities. To enhance health inspection activities, and increase the effectiveness and efficiency of state management.

The above offers a brief assessment of some of the progress and changes in the health sector in recent times and the orientation and tasks for developing the health sector in the forthcoming period. This assessment identifies some of the many pressing problems facing the health sector, particularly related to health policies and financial mechanisms. Viet Nam has decided to apply a health financing model which involves pooling and cross-subsidies from low risk to high risk groups and from the rich to the poor. This will be achieved through increasing the share of total health expenditure that comes from public sources, effectively distributing and using these resources and implementing mechanisms to enhance accountability and transparency in the health financing mechanism. The implementation of this orientation will be particularly challenging, and will require a step-by-step resolution of difficulties through the reform of the health financing policy in a positive and appropriate direction. Therefore, the MoH and the HPG have agreed on health financing as the main topic of the JAHR 2008.

Chapter II. Overview of health financing in Viet Nam

This chapter provides an overall description of the Vietnamese health financing system, financial resources which are being mobilized for health, financial mechanisms being applied, and levels of health expenditure. Some basic concepts in health financing used in this report are also introduced. This chapter also provides some international comparisons and projections on Viet Nam health financing to the year 2010.

1. Basic concepts and features of the health financing system

1.1. Health financing system objectives and functions

The health financing system is an important component of the health system, with four main objectives:

- To mobilize sufficient financial resources for health care;
- To manage and allocate resources in line with the orientation of equity and efficiency (allocative efficiency);
- To promote quality improvement and effectiveness in service delivery (technical efficiency);
- To protect the people from financial risks caused by health care costs.

In order to achieve the above objectives, the health financing system should undertake the three following main functions:

- *Mobilizing financial resources* through the tax collection system of the Government, health insurance premium collection and other mechanisms such as taxes or fees imposed on use of tobacco, alcohol, means of transportation, to obtain an adequate financial pool, mobilized in an equitable manner, to be used for health care of the community.
- *Accumulation/Pooling/Financial fund* management to ensure effective management, avoidance of leakages, a stronger voice for purchasers when negotiating with providers, ensuring sufficient financial resources for health priorities of society and risk pooling among community members.
- *Services payment or purchasing and allocation of funds to providers* to achieve the highest possible health outcomes, satisfy the people's health needs at lowest cost, and assist the people, especially the poor, to avoid financial risks; payment mechanisms that create appropriate financial incentives to improve quality and efficiency of service provision.

Of the above-mentioned functions, pooling is important for ensuring the objective of risk sharing and household financial protection. In order to undertake this function, employers, businesses, and households must make contributions in advance (pre-payment) before illness or service utilization. Examples of prepayments include contributions from households or businesses to taxes (where part of tax revenues are allocated to health care), or health insurance (all revenues used for health care). Pre-payments allow for a financial intermediary to collect, accumulate and pool funds. When the fund management agency reimburses service providers, it also means that the financial costs of care for an individual are paid from a fund collected from many contributors. This also means that risks have been

shared. The level of pre-payment and the capacity for pooling are the two basic factors to ensure risk sharing and financial protection. In contrast, if an ill patient must pay all medical costs directly, no pooling or risk sharing occurs. When the fund holding agency purchases services in a *strategic* manner, representing a large part of the population, it also means that the fund holding unit has greater power to negotiate quantity, quality and service price with service providers. This is not possible when each household pays its own health care costs.

The approach used to undertake the three functions of the health financing system above has a significant impact on the health care system because the health financing system will determine who can get access to services, what the quality of the service will be, how many people could fall into poverty due to health care costs, and whether or not the government can control the costs of the health care system.

1.2. Health financing mechanisms

The way that a country chooses to exercise the three functions mentioned above will create different health financing mechanisms. Common health financing mechanisms employed around the world at present include:

- Tax-based health financing– the state budget is directly allocated to the service delivery system;
- Social health insurance –employees and employers pay the compulsory premiums based on employees' incomes. Health insurance can also be expanded to cover other population groups in the society such as the poor, children, and those who are entitled to social security, etc. with health insurance premiums paid through a government subsidy or other sources of contribution;
- Private health insurance based system – a form of for-profit, privately managed voluntary health insurance. However, unlike the social health insurance system, private health insurance premiums are assessed based on the health risks of individuals or groups (for example, the elderly and people suffering from chronic diseases may have to pay a higher premium. In addition, the cost of treatment for pre-existing conditions may not be reimbursed, and in some cases high-risk individuals may be denied coverage in a particular health insurance scheme.)
- Community-based health insurance – usually small-scale, covering small communities, involving voluntary participation, and with premiums and benefit packages determined by consensus in the community. Such models are mostly self-managed by the community. Due to their small size, the pooling and risk sharing aspects are usually limited.
- Direct out-of-pocket payments by households to health service providers at the time the household uses or purchases goods or services.
- Health financing from external sources (loans and external aid coordinated by the state). Extremely poor and disadvantaged countries may be largely dependent on this mechanism. This financing source is often allocated directly to providers to implement priority health programmes.

1.3. Equity in the health financing system

The way that a country undertakes the three functions of health financing affects the level of equity in the health system in general (see the concept of health equity in the

Introduction section of this report). In health financing, two aspects of equity are often considered: equity in financial contribution and equity in benefitting from use of health services.

In principle, equity in financial contribution means that contributions are made based on the ability to pay. People with higher income contribute more while those with lower income contribute less. Thus, contributions to the health system through income tax are considered to be an equitable form of contribution. Contributions to social health insurance, paid in proportion to worker income, are also considered to be equitable. Those who have low income or no income are either exempt from having to pay premiums or are offered subsidies from the government. Meanwhile, equity in receiving benefits means beneficiaries receive health services according to their need for medical care. Benefits do not depend on the amount contributed. The benefits received refer to both access and the quality of care (technical quality)[3]. This, then, is the difference between the concept of health equity compared to the concept of economic equity in the market economy.

Of the financial mechanisms mentioned above, the first two, namely tax-based health financing and social insurance, are much more equitable than the mechanism relying on direct household out-of-pocket spending on health care. The first two financial mechanisms are based on the principle of pre-payment, accumulation and pooling, with a clear separation between level of contribution and benefits, which is what allows for risk sharing. In contrast, the mechanism of direct out-of-pocket household health expenditures (such as direct payment of hospital user fees) do not incorporate pooling or risk sharing. With this mechanism, without assistance from the State, people who cannot afford care will not be able to access services, will receive services of poor quality, or will impoverish themselves when paying the costs of care. Private and community-based health insurance do incorporate pooling and risk sharing, but to a more limited extent because households with high risk or inability to make contributions are excluded.

1.4. Total national health expenditure, public and private health expenditures

Total national health expenditure

Total national health expenditure represents the total expenditure of society on health, and consists of two main sources, namely public and private expenditures on health care.

> ***Total national health expenditure*** **= Public health expenditure + Private health expenditure**

Put simply, when a service is paid for from state tax revenue, social health insurance funds or from an ODA source (coordinated by the Government), that expenditure is called public expenditure.

> ***Public health expenditure*** **= State budget expenditure on health (excluding state budget expenditure through health insurance)** [4] **+ Social health insurance fund expenditure + ODA expenditure**

[3] Quality of health services consists of 2 components: clinical quality and service quality. In discussions of equity we emphasize clinical quality.

[4] State budget contributions to health insurance are excluded to avoid double counting as these are already included in health insurance expenditures.

Direct expenditure made by individuals or households to the service providers when they fall ill and use services, or purchase drugs and health-related equipment or materials is called private expenditure. According to this definition, hospital fees and other co-payments (made by medical examination and treatment under health insurance) paid directly by the patient out-of-pocket at either public or private hospitals are considered private expenditure. In addition, private expenditure also includes health expenditures made by businesses, social and charitable organizations, although these tend to be small. Expenditures from private for-profit health insurance funds is also considered private expenditure.

> ***Private health expenditure*** **= out-of-pocket household health expenditure + health expenditure of charitable organizations and businesses (excluding contributions from businesses to social health insurance)** [5] **+ Private health insurance expenditure**

The two concepts of public and private health expenditure help answer the question "Who pays for health services?", and are not related to "who provides health services." In reality, public health expenditure usually pays public providers, but it can also be used to pay private providers (such as when social health insurance reimburses private hospitals). Similarly, private expenditure can go to public providers (such as user fees paid by patients to hospitals) or private providers. Globally, almost all countries have developed a health financing system based on a mix of public and private expenditures. Strategically, however, to attain the objective of equity in health care, most countries are increasing the public expenditure share while decreasing the proportion of people paying health care fees out-of-pocket. Public expenditure is usually more equitable (in contributions), embodies a greater degree of sharing (in benefits). Private expenditure, especially out-of-pocket expenditures of households when suffering illness, are considered to be very inequitable, and the cause of economic difficulties and impoverishment.

2. The Vietnamese health financing system

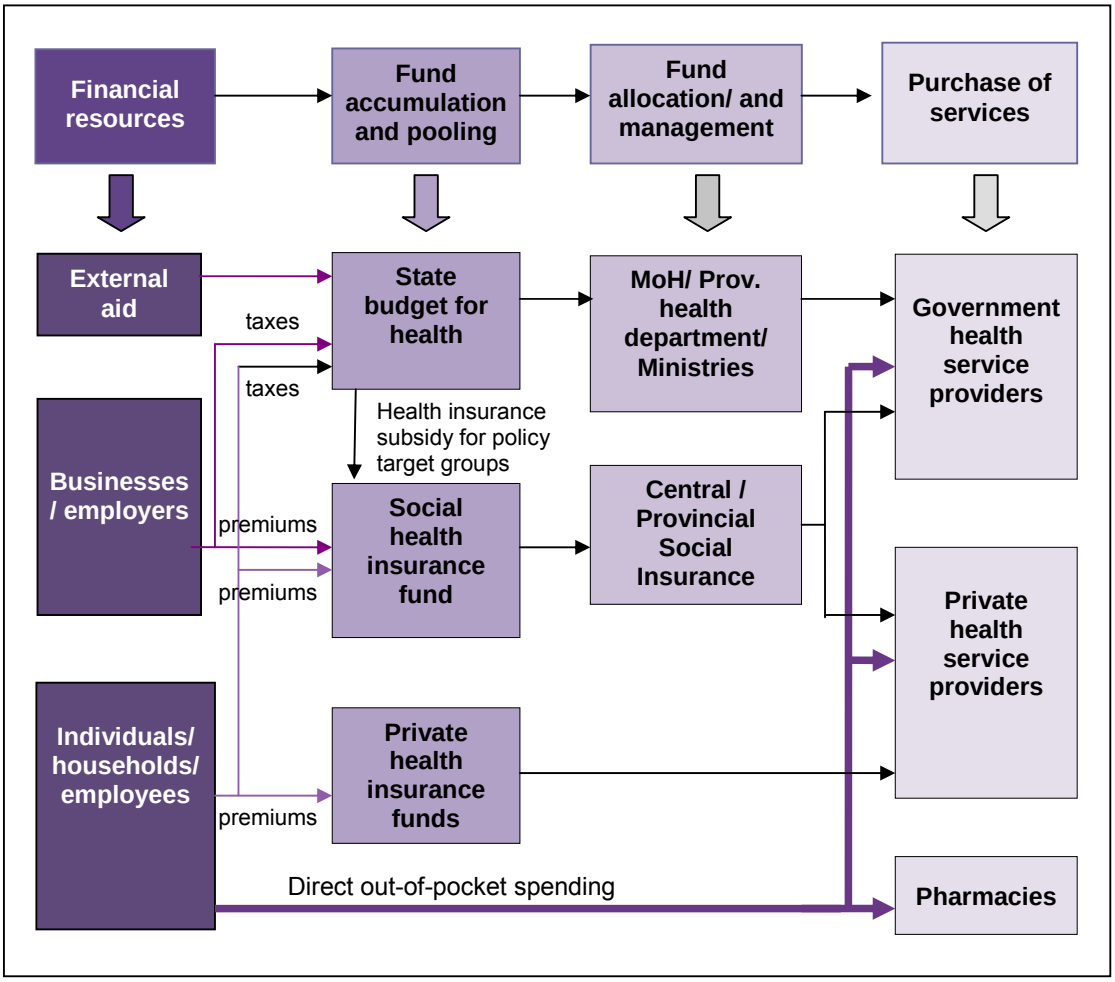
2.1. Health finance flows and mechanisms

Health financing flows in Viet Nam are described in Figure 2, and show the financial flows from the contributors (the people, enterprises) to the fee collecting/pooling units, to the fund management units and finally to the service providers. There are two major public financial flows that supply funding to health care in Viet Nam, namely the state budget allocated directly to service providers, through the MoH and Provincial Health and Finance Departments, and the flow from the social health insurance fund. In recent years, in order to provide improved health care for the poor, the Government has allocated state budget to the health insurance fund as a way of purchasing health insurance for the poor and those eligible for social policy entitlements. Apart from those two public finance mechanisms, another relatively large financial flow is household direct out-of-pocket payments to service providers or to pharmacies to buy drugs when ill. This financial flow is reflected by the bold line, representing the payments from households directly to providers (Figure 2). At present, the health financing system in Viet Nam is heavily dependent on those direct payments. Other financial flows (ODA, private health insurance, other private expenditure) are currently a relatively minor proportion of total health expenditures.

[5] Contributions by entreprises to health insurance are not counted here to avoid double counting because these expenditures were already counted in health insurance expenditures

In recent years, social mobilization of health activities has been advocated by the Government in order to mobilize all available resources in the society (including financial resources) at a time when public investment in health falls short of need. Under this policy, private investment in the health sector has increased. However, as this is private investment, there is pressure for these investments to yield a profit. This has led to both positive and negative effects on the health system; effects the Government would like studied more comprehensively in order to appropriately revise policies [11]. While implementing the social mobilization policy in the health sector, the Government continues to affirm that that it will increase the state budget for health in order to achieve the objectives of equity and efficiency in the health sector.

Figure 2: Health finance flows in Viet Nam

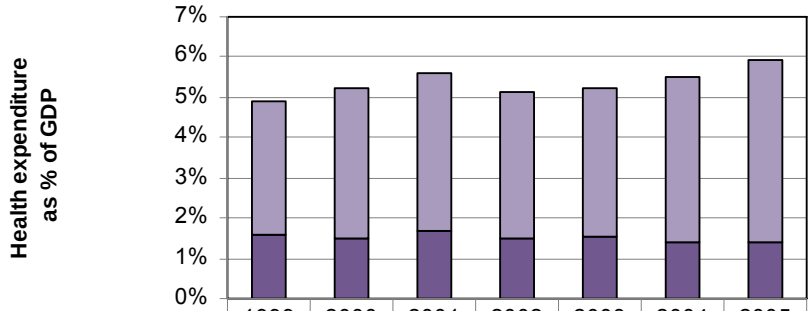


2.2. The level of health expenditures

In total, health spending in Viet Nam amounts to approximately 5% - 6% of GDP on health care and this trend has shown steady growth in recent years from about 4.9% of GDP in 1999 to 5.9% of GDP in 2005 (see Figure 3). This is basically in line with other countries in the world with low and middle income (i.e. those with per capita GDP of $500 – 2,000) who also spend between 5% and 6% on health care on average. Therefore, Viet Nam's total

health expenditure is not considered as low. However, public expenditure on health care[6] accounts for only about 30% of total health expenditure. This proportion is considered very low among low and middle income countries.

Figure 3: Health financing trends in Viet Nam, 1999 – 2005



	1999	2000	2001	2002	2003	2004	2005
Private expenditure	3.28%	3.78%	3.91%	3.64%	3.65%	4.13%	4.49%
Public expenditure	1.60%	1.47%	1.68%	1.50%	1.56%	1.39%	1.42%

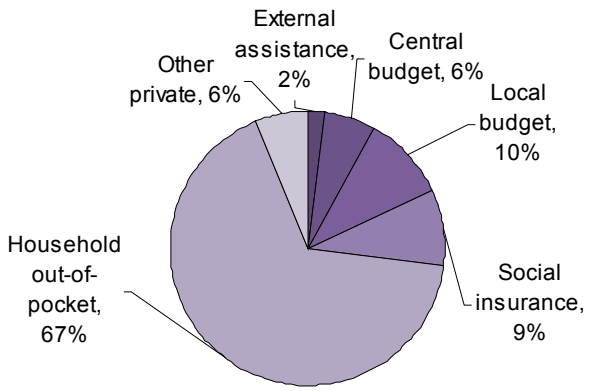
Source: National Health Accounts, MoH, 2008 [12]

2.3. Structure of health expenditures

Figure 4 depicts the structure of health expenditure in Viet Nam by source and financing mechanism in 2005 (the latest year for which complete data are available). The figure indicates health financing in Viet Nam is highly dependent on household out-of-pocket expenditures (accounting for some 67% of total health expenditure) while health care expenditure from public financial sources accounts for some 27% (including the central budget 6%, local budget 10%, ODA 2%, and social insurance, primarily health insurance about 9%). In 2006, with the implementation of Decree No. 63 on Health insurance, in which the health insurance benefit package was expanded and the number of health insurance card holders was increased (the poor, voluntary health insurance members), it was estimated that expenditure from health insurance funds accounted for 13% of total health expenditure [12]. In practice, this proportion is still too low to ensure that health insurance becomes a strong enough agent to strategically purchase health care services for more than 30 million health insurance card holders.

[6] Public expenditure here includes state budget expenditures, expenditures of the health insurance fund and ODA.

Figure 4: Structure of sources of health expenditures in Viet Nam, 2005



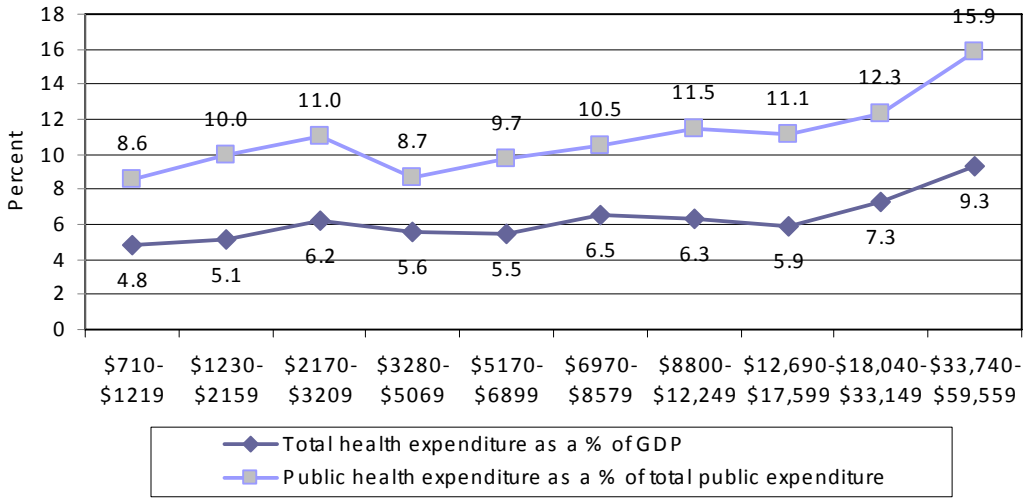
Source: National Health Accounts, MoH, 2008 [12]

Monitoring and projecting the structure of health expenditure over time can help to analyse the process of change in sources of funding, and effects of health policies, especially health financing policies. Policy planners can monitor the structure of health expenditure to have a basis for dialogue or to propose recommendations on health financing policies to the Government and concerned sectors.

2.4. International comparisons

Globally, when countries become more affluent and GDP per capita increases, governments also allocate more funding to health (Figure 5). In middle and high income countries (groups 5 to 10), public health expenditure accounts for 10 – 15% of the total government expenditure. Currently, Viet Nam is ranked in group 4 by GDP/capita (PPP US$ 3,300). However, public health expenditure only accounts for about 5% of total public spending while this spending in other countries in the same income group accounts for some 9%. It is estimated that Viet Nam will join the middle income countries (group 5) by 2010. This is one of the reasons for considering that the proportion of Viet Nam's public expenditure on health should be increased in order to reach the average level of other countries with similar levels of income.

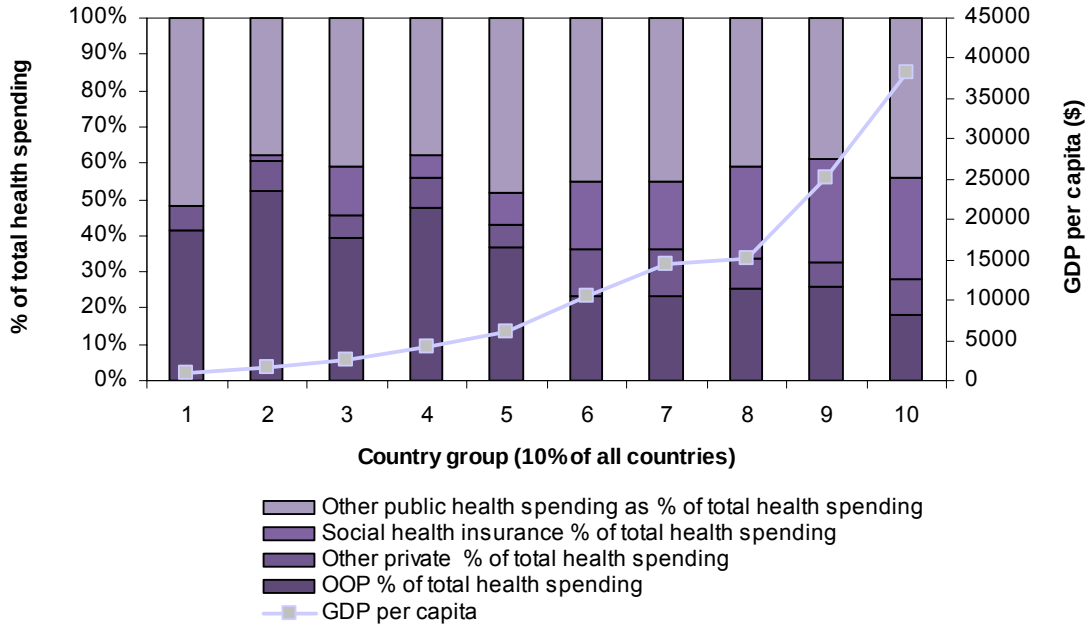
Figure 5: Health expenditures of the nations of the world, 2005



Source: WHO Statistical Information System (WHOSIS), 2008 [13]

Figure 6 depicts the structure of health expenditure of the nations of the world in groups ranked by GDP/capita in US$ in 2005. One general comment to note is that the higher the income level, the greater the public expenditure share in total health expenditures through maintaining the share of state budget health expenditures, while increasing health insurance expenditures to gradually replace household out-of-pocket spending. In the fourth income group (which contains Viet Nam), public expenditure accounts for about 45% of the total health expenditure while private spending (mostly direct household spending) accounts for 55%. According to 2005 data (Figure 4), the proportion in Viet Nam is about 27% for public expenditure and 73% for private expenditure (including household out-of-pocket expenditure and other private spending). Therefore, the private expenditure level in Viet Nam is significantly higher than that in other countries in the same income group. Similarly, as analysed in section 2.2 above, with the current economic growth rate, the health financing situation in Viet Nam could be improved in the coming years.

Figure 6: Structure of sources of health expenditure in the nations of the world, 2005



Source: WHO Statistical Information System (WHOSIS), 2008 [13]

3. Health financing projection for Viet Nam to the year 2010

3.1. Strategic objectives of health financing development in Viet Nam

Over the past few years, the Party and the Government of Viet Nam have oriented development of the health care system towards equity and efficiency. In 2005, Politburo Resolution No. 46 clearly set the strategic objective for health financing in Viet Nam, namely "To renovate and refine the health financing policy with an orientation towards rapidly increasing the share of public financial resources (including state budget and health insurance), thereby gradually reducing direct payments by the patient". During the May 2008 session, the National Assembly passed Resolution No. 18 resolving to "Increase the share of the annual budget for health care services".

3.2. Factors influencing health financing need in Viet Nam

Objective factors

Viet Nam has witnessed high economic growth rates in 2006 and 2007, at 8.2% and 8.5%, respectively, while investment and public spending by the Government have increased substantially in many areas, including health care. However, 2008 has seen a decline in the economic growth rate, as a result of which pubic spending has also had to be restricted in a concerted effort to contain inflation. It is estimated that the economic growth rate in 2008 will be below 7%. The year 2009 is expected to see a continued decrease in inflation, but the economy is unlikely to recover immediately as a result, and thus the economic growth rate is unlikely to surpass 7%. The economy is likely to see stable development in 2010, with a relatively high growth rate, and thus Viet Nam would have opportunities to invest more in health care and other social security measures.

Along with economic growth, improvement has also been made in the incomes and living conditions of the people. The higher the ability of the people to pay for services, the higher the need to improve the living conditions and health of the people. The health service provision system, especially the private health system, will develop considerably, both in terms of quality and quantity. New and modern technologies will be utilized in medical services. This is a factor that will lead to increases in total national health expenditures.

The disease patterns among the Vietnamese population are changing, with an increasing trend toward non-communicable chronic or lifestyle-related diseases such as cardiovascular disease, diabetes, cancer, HIV, mental illness, injuries, etc. The cost to cover these disease groups is an additional burden, while the health system still has to deal with and control communicable disease and emerging diseases.

Policy factors (normative)

In recent years, many important guidelines and policies have been issued by the Party and the Government on health care system development in general and health financing policies in particular. Policies issued recently, and ones to be issued in the near future, which are likely to impact on health financing include:

Policies on state budget allocation:

- Issuing government bonds to invest in and upgrade district and inter-district regional general hospitals (Decision No. 47/2008/QD-TTg), commune health stations (Decision No. 950/2007/QD-TTg), hospitals specializing in TB, mental illness, cancer, paediatrics, and some provincial hospitals in the mountainous and disadvantaged areas. It is projected that as much as 3,750 billion VND and 9,750 billion VND will be disbursed in 2008 and during 2009-2011, respectively. Thus, spending from the state budget for health will be increased (especially investment spending).
- National Assembly Resolution No. 18/2008/NQ-QH12 in 2008 on increasing the proportion of annual budget allocation for health care and increasing growth of the health budget faster than growth in the overall state budget. If localities commit to implementing this Resolution, then spending on health from the central and local budgets will increase.

Policies on Health Insurance:

- Applying the increase in state subsidized health insurance premiums for social policy beneficiaries to 3% of the current minimum salary [8]. As planned, the minimum salary is expected to increase in the near future. Thus health financing from health insurance is likely to increase.
- Implementing the policy to subsidize at least 50% of the health insurance premium for the near poor, if the near poor participate in health insurance, then both revenues and spending through health insurance are likely to increase.
- The Health Insurance Law was passed by the National Assembly at the end of 2008, heath insurance coverage will be expanded, first of all to children under age 6, the near poor, and then to students (to cover both school pupils and university students) and dependents of employees in the formal sector. This will increase both revenues and expenditures through the health insurance mechanism.

- With implementation of the newly passed Heath Insurance Law, compliance by businesses, especially private businesses, is expected to increase, the premium for compulsory health insurance may increase to as much as 6% of salary, therefore, both the number of people involved and contributions from the formal sector could be increased – increasing both revenues and expenditures through health insurance.
- If the user fee schedule is adjusted to cover full costs, and if the current "fee-for-service" provider payment mechanism is maintained by Vietnam Social Security Agency (VSS) – spending through the health insurance fund will be increased.

Policies on hospital management and finance reforms:

- Accelerating social mobilization of resources through joint-ventures, collaborations, and mobilization of private investment resources for health will lead to increased revenues at health facilities, and may lead to increased out-of-pocket payments by households.
- Implementing the hospital financial autonomization policy may encourage provider-induced demand to increase extra-budgetary revenues, and is likely to lead to increased out-of-pocket health spending.
- Modernizing and upgrading medical technologies is another factor that will lead to medical service costs rising in general.
- The private health care system is encouraged to expand so the people can access more services, which will lead to increased health expenditure, much of which will come from household out-of-pocket expenditures.

3.3. Projection of health financing trends to the year 2010

Figure 7 provides a health financing trend for the period 2002-2010, with relatively optimistic predictions, and reflecting basic changes from the period 2002-2005 to the period 2006-2010. In this model, the 2002-2005 data are taken from the finalized account information in the National Health Accounts, 2006-2007 data are estimated, and 2008-2010 data are a projection.

This projection is made based on the following assumptions. From now till the year 2010:

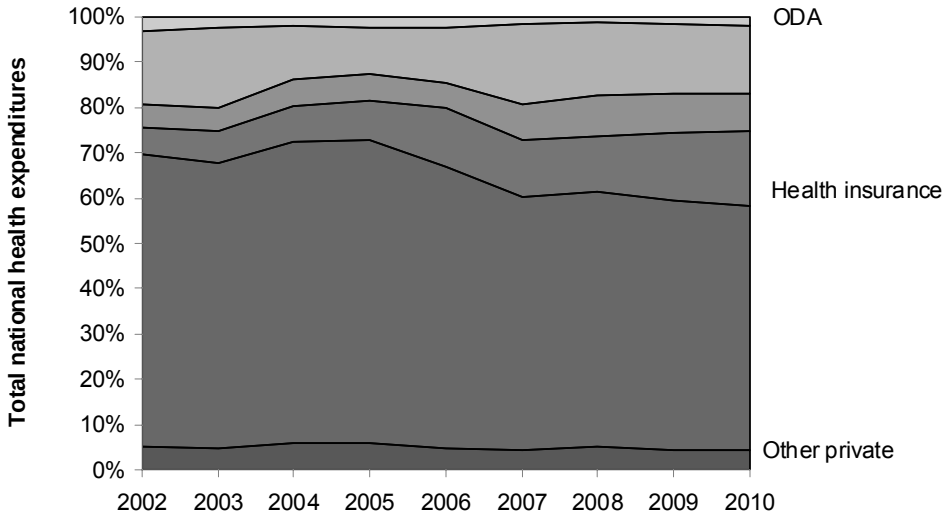
- The Vietnamese economy will overcome the recession in 2008 and develop and grow more stably in the following years.
- Local state budget for health will increase substantially (especially for investments in basic infrastructure construction to upgrade health facilities at district and commune levels, and in disadvantaged areas, through issuing government bonds), accounting for 15% of the total health expenditure (10% in 2005).
- The central budget allocation will continue to increase, with an expectation that it will reach 8.5% of total health expenditure (6% in 2005).
- Rapid growth in the health insurance fund, with an increase in expenditures for groups subsidized by the State and with the participation of the near poor. Participation of workers in the formal sector is also expected to increase. Expenditure through health insurance will account for 16.5% of the total health expenditure (an increase from 9% in 2005). If the Government expands health insurance coverage for the dependents of

employees in 2010, health insurance fund expenditures in the future may increase even further.

- Public health expenditures grow faster than household direct out-of-pocket spending, leading to a decline in the relative share of expenditures from household out-of-pocket spending from 67% in 2005 to 53.5% in 2010.
- The Government issues sound policies to control medical service costs and drug costs, in both private and public sectors.

The data shown in Figure 7 indicate that in such an optimistic context, while there is an increasing absolute need (increase in total national health expenditure), the proportion of public spending in the total health expenditure will also increase. If Viet Nam sustains this trend, it is projected that by 2015, public health expenditure will account for over 50% and become the key financial resource in the health financing system, with the aim of achieving equity in health care.

Figure 7: Projected trends in the structure of Viet Nam health expenditures, 2002–2010



The assumptions above could come true if they are supported by concrete financing policies and solutions and if there is a strong determination among both central and local authorities to implement them. However, if the above conditions are not met as expected, or the Vietnamese economy continues to encounter difficulties, or the level of growth in public health expenditure is difficult to achieve, then the predictions for the health financing situation will be little different from the period 2002-2005.

Chapter III: State budget for health

Like in many other low and middle income countries, Viet Nam's health financing system is a mixed one, in which funding from the state budget plays a critical role in implementing the state functions of protecting public health and ensuring equity in health care. As was discussed in Chapter II, state budget funds allocated to the health sector are one component of public health expenditure. Other components – health insurance fund and external assistance- will be discussed in other chapters of this report. This chapter will focus on analysing the current situation of state budget expenditure on health, the current allocation and use of the state health budget, and highlight achievements and shortcomings. Based on this analysis recommendations for the development of short and medium term financing plans will be made in order to augment and increase efficiency in using state budget expenditures on health.

1. Overview of policies concerning the state budget for health

1.1 Prioritized use of state budget for health

During the process of reforming the Vietnamese Health Sector since 1989, the health financing system has witnessed multiple policy reforms for the purpose of mobilizing different financing sources for health care, such as the policies on hospital user fees, health insurance, social mobilization for health, financial autonomy, etc. Throughout the reform process, the Party and Government have reaffirmed their policy of prioritized allocation of the state budget for health.

Resolutions from the 6th, 8th, and 9th Party Congresses, as well as the 10th Party Congress (2006) clearly indicate the desire to: "Increase investment from the state budget and initiate a major drive to upgrade the grassroots health care network and health care system; issue policies to support policy target groups, the poor and low-income people to access health care services; develop a preventive medicine system; and provide knowledge and skills for people so that each citizen can actively prevent disease and promote good health". The Politburo issued Resolution No. 46-NQ/TW dated 23/02/2005, which clearly states "Protection, care and improvement of the people's health is one of the priorities of the Party and Government. State investment in health is considered as investment for development…". The National Strategy for People's Health Care and Protection during 2001 - 2010 also states: "Investment in health from the state budget must play a decisive role among all health care financing sources. Strive to increase recurrent expenditure for health out of total state budget expenditure. Prioritize investments in poor, mountainous, remote and isolated areas, and in preventive care, traditional medicine, primary health care at the grassroots level, health care for the poor and target groups, 'mother and child' health". Government Resolution No. 05/2005/NQ-CP on the promotion of social mobilization for health, education, culture and sports also states that "the government shall continue to increase its investment in health to assure sufficient budget for public health".

Most recently, National Assembly Resolution No. 18/2008/QH12 on strengthening implementation of social mobilization policies to improve the quality of health care for the people resolved to "increase the share of annual state budget allocations for health, ensuring that the rate of increase in budget spending on health exceeds the average rate of increase of overall state budget spending …".

1.2. Prioritized allocation of state health budget for disadvantaged areas, grassroots health care, and preventive medicine

Relevant documents of the Party and Government explicitly indicate priorities for allocating the state budget for health to disadvantaged regions, remote areas, preventive medicine and primary health care at the grassroots level. National Assembly Resolution No. 18/2008/QH12 clearly states the need "to allocate at least 30% of the total state health budget to preventive medicine". Norms for allocating state budget for health services under Prime Ministerial Decision No. 151/2006/QD-TTg, dated 29 June 2006, also clearly reflect the policy priority towards remote areas; as the norm for mountainous areas, ethnic minority areas in the lowlands and remote areas is set at 1.7 times that of urban areas, and for extremely high areas and islands it is set at 2.4 times that of urban areas. The maintenance of state budget allocations for the implementation of national target health programmes (from 1996 to date) have demonstrated the Party's and the State's concern regarding public health and preventive medicine.

Investment capital has also been allocated to the grassroots health care network. In 2005, the Prime Minister promulgated Decision No. 225/2006/QD-TTg on upgrading district and regional general hospitals with total funding for the period 2005 – 2008 valued at 8,350 billion VND and Decision No. 950/2007/QD-TTg on investment in construction of commune health stations in the disadvantaged regions for the period 2008 – 2010 with total funding estimated at about 500 billion VND to be mobilized through sale of government bonds. In 2008, Prime Ministerial Decision Nos. 24, 25, 26, 27 were issued regarding a variety of mechanisms and policies to support socio-economic development until 2010 for provinces in the North Central Coast, the South Central Coast, the Central Highlands, the Mekong River Delta, and the Northern Midlands and Mountainous regions, with stipulations that village/hamlet health workers in those regions should be entitled to a stipend equivalent to 50% of minimum monthly salary. The above policies reflect the State's determination to prioritize allocation of funds to disadvantaged areas, grassroots health care and preventive medicine.

1.3 Prioritized allocation of state budget to support social policy target groups

In line with the government orientation to redirect direct budget allocations away from health facilities towards consumers of health services, a series of important policy initiatives has been promulgated. In 2002, Prime Ministerial Decision 139/2003/QD-TTg was promulgated to establish a health care fund for the poor in each province using national budget funds; this marked a major turning point in support for the poor, increasing the number of beneficiaries covered and the benefits they are entitled to. According to Government Decree 63/2005/ND-CP, all beneficiaries of Decision 139 were issued health insurance cards, increasing insurance coverage for the poor by some 15 million people, accounting for 43.4% of the total number of health insurance card holders. In early 2008, the Prime Minister issued Decision No. 289/QD-TTg, dated 18 March 2008, increasing the premium paid by the government to purchase health insurance for the poor from VND 80,000 per capita per year to VND 130,000 per capita per year and subsidizing at least 50% of the health insurance premium for members of near poor households who enrol in the voluntary health insurance scheme. This was followed by Prime Ministerial Decision No. 117/2008/QD-TTg, dated 27 August 2008, which increased the amount paid by the government to subsidize health insurance premiums of social policy target group members to 3% of the minimum salary (given the fact that current minimum salary is VND

540,000/month, the subsidized health insurance premium is now VND 194,000 per capita per year). This policy clearly reflects the Government's concern about ensuring equity in health care.

According to Government Decree No. 36/2005/ND-CP, children under 6 years old are entitled to free health care at government health care facilities. Currently, free health care for children under 6 years is being implement through issuing free health care cards with direct reimbursements to state-run health facilities for services used.

National Assembly Resolution No. 18/2008/QH12 reaffirms the need "…To pay attention to allocating budgets for providing health care to meritorious people, the poor, farmers, ethnic minorities, and people living in the new economic zones, etc."

1.4 Improving effectiveness in use of the state budget

A number of policies have come into effect intending to raise the efficiency of state budget use, notably the preparation of the medium term expenditure framework (MTEF) and the autonomization policy (Decrees No. 10 and 43). The implementation of the MTEF is considered a vital change in the process of budget planning, which will help increase effectiveness in allocation and use of the state budget for health care in relation to predetermined objectives based on accurate, consistent and transparent information. Preparation of the MTEF will assist in a more effective allocation of resources according to both health sector priorities and objectives as well as socio-economic development goals in the country as a whole. Delegation of autonomy to state health care facilities, primarily hospitals, started in 2002 under Decree No. 10/2002/ND-CP with later adjustments under Decree No. 43/2006/ND-CP. This is considered an initial step in the decentralization of authority and accountability of service units in the use of state budget, strengthening financial management towards greater efficiency and control.

2. Current situation of the state budget allocated for health

2.1 Achievements

Increasing trend in the state budget allocated for health care

In recent years, the state budget allocation for health care in absolute terms has undergone clear improvements, better satisfying the funding needs to provide health care for the poor, children under 6 years, implementation of national health target programmes, epidemic control and district health system upgrades.

Table 1 shows a steady annual increase in total state budget for health care, on average at 22% for the period 2002-2006, with 2006 achieving the largest increase at 50%, more than double the 2002 allocation. Such growth can be explained in part by the increases in the allocation norms for financial support to the poor in accordance with Prime Ministerial Decision No. 139/2002/QD-TTg and changes in the mechanism to use this funding through purchase of compulsory health insurance for the poor under Decree No. 63/2005/ND-CP. Furthermore, the disbursement rate of funds used for free health services for children under 6 years of age in 2006 also increased considerably compared to 2005. Funding for provision of health services at all levels also recorded a significant boost in 2006.

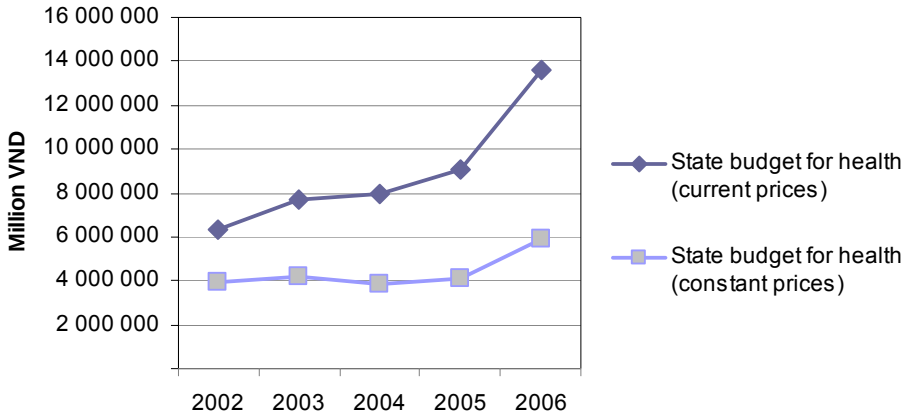
Table 1: State budget for health, 2002 – 2006 (million VND)

Year	State budget allocated to different levels of health services	State budget allocated via health insurance	Total state budget for health
2002	5,840,730	451,111	6,291,841
2003	7,201,414	514,223	7,715,637
2004	6,930,263	1,026,827	7,957,090
2005	7,968,197	1,112,889	9,081,086
2006	11,233,000	2,391,074	13,624,074

Source: National Health Accounts, MoH, 2008 [12] and calculation results based on revenue and expense figures from Viet Nam Health Insurance, 2007 [14]

Figure 8 shows that during 2002 – 2006, the amount of state budget for health care, in terms of current prices, increased each year, although at different rates. However, when one examines state budget for health in constant prices, a decrease is seen in 2004 compared to 2003 (see Figure 8). It is also noteworthy that the constant price figures for state budget are much lower than those in current prices indicating that inflation in general and health specific inflation in particular have had clear effects on the allocation of state budget in the health sector.

Figure 8: State budget for health in terms of current and constant prices, 2002 - 2006



Note: State budget includes direct reimbursement given to health facilities and state budget allocation for social health insurance premiums

Source: National Health Accounts, MoH, 2008 [12]

In the past few years, efforts to increase the state budget allocation for health care have been debated in various forms and at different levels, such as via the mass media or through direct communication with policy makers in the National Assembly and the Government. The outcome of this advocacy process was that the 12th National Assembly, at its 3rd session, ratified Resolution No. 18/2008/QH12 on strengthening implementation of social mobilization policies to improve the quality of health care for the people. The Resolution resolved to "increase the share of annual state budget allocations for health, ensuring that the rate of increase in budget spending on health exceeds the average rate of increase of overall state budget spending …".

Strengthened decentralization of management of state budget for health

The state budget for health is allocated through the central budget and local budgets. Analysis of the structure of state budget spending by level indicates a relatively high level of decentralization in health financing. According to the 2005 National Health Accounts, the national level accounted for 36.8% of total state health budget expenditures, while the provincial level accounted for 44.7%, the district level 16.2% and the commune level 2.3%. This is consistent with financial management requirements under the State Budget Law.

The state budget plays a crucial role in development investment for the health sector. Of total social health expenditures, the proportion spent on development investment was only 8.7%. However, the majority of this development investment expenditure (some 70%) came from the state budget. Development investment in the entire health sector as a share of state budget health expenditure is 37%, with higher shares spent at the national and provincial levels, 46% and 51% respectively [12]. This means that there is virtually no state budget funding for development investment of the grassroots health care network. This explains the weaknesses in terms of physical facilities and equipment at the district and commune levels. This issue has nevertheless been recognized by the Government and solutions have been sought through the issuance of two Decisions on capital investment for the districts and communes, i.e. Decision No. 225/2005/QD-TTg regarding upgrades of district and inter-district general hospitals with an accumulated fund of VND 8,350 billion earmarked for the period 2005 – 2008 and Decision No.950/2005/QD-TTg on the establishment of commune health stations in disadvantaged areas for 2008 – 2010 in a bid to achieve national standardization of the commune health system.

Increased efficiency in use of the state budget for health care

State budget spent on health services

The efficiency of budget allocations depends on the process of budget planning and allocation. Recently, as part of the Project on public financial management reform, the MoH has developed a MTEF for 2006 – 2008. According to the Ministry of Finance, this is seen as a new element in the process of state budget planning. Currently, health care budget planning and allocation conforms with the provisions of the State Budget Law, which is clearly decentralized. The local budget for health is allocated to localities based on the population with coefficients to adjust the amount by region – Prime Ministerial Decision No. 151/2006/QD-TTg. When the budget is transferred to the local level, specific allocations, e.g., to preventive or curative care, to various hospitals and preventive medicine facilities, are decided by the Provincial People's Committee – based on government norms and local financial and socio-economic conditions – and submitted to the People's Council for approval. Overall, population-based budget allocations for localities rely on local peoples' needs for health care with balancing adjustment coefficients across regions in order to guarantee equity.

The autonomy given to public fee-collecting service institutions by Decree No. 10/2002/ND-CP and later Decree No. 43/2006/ND-CP has resulted in an important change in financial management mechanisms for many institutions, including public hospitals. This policy allows hospitals greater autonomy in financial issues and in the hiring of staff, in arranging unified management of revenues and expenditures, facilitating increases in facility revenues to cover operating costs. The benefits of the policy are that it creates stronger economic incentives for staff; it expands the scope of management within health services;

and promotes technical efficiency in the provision of health services. In this context, the shift in budget allocation from service providers towards service users by means of health insurance card payment support seems an effective method to guarantee equity and effectiveness in utilizing the state budget for health care.

At present, almost 60% of the total recurrent state budget allocated to health care is used for payment of salaries, allowances and a portion of social insurance for health workers. According to USAID recommendations on health system assessment indicators, a share of state spending on staff salaries lower than 60% is considered appropriate.

State budget spent on target programmes

Apart from expenditure for health services costs, the state budget is also allocated to achieve specific objectives, such as health care programmes for the poor, health care services for children under 6 years old, national target programmes for prevention and control of some social diseases, dangerous epidemics and HIV/AIDS, etc. To a certain extent, one could say that the state budget used for purposes of assisting users through payment for health insurance cards for the poor or using the state budget to attain specific objectives in the national target health programmes, reflects optimal efficiency in use of state budget resources. Under this approach, state budget allocations are determined based on outputs such as the number of beneficiaries (the poor, children under 6 years) or other desirable targets like reduction in infection and mortality rates, etc. (in the case of national health target programmes). In addition, these supporting programmes are all very highly equity oriented as their target groups are vulnerable categories among health service beneficiaries, namely the poor, children, inhabitants of remote and mountainous areas.

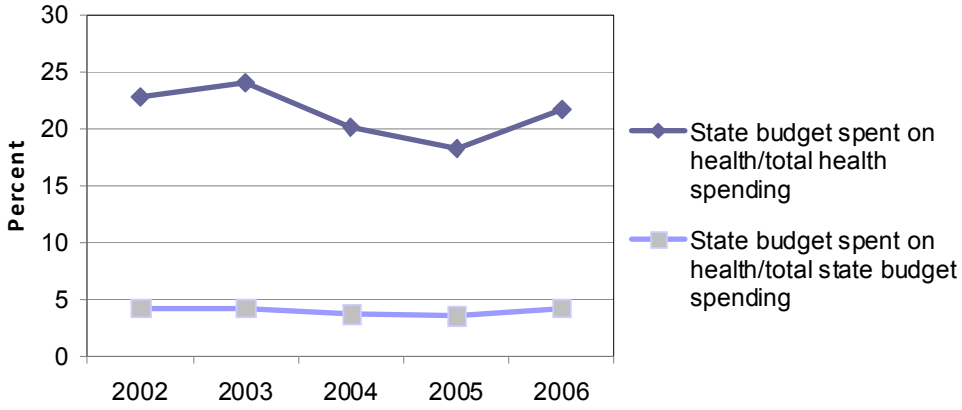
2.2 Shortcomings

Increased state budget allocations for health do not yet meet actual need

Although the state budget allocated to health has increased in absolute terms, trends of indicators in relative terms do not indicate any special priority given to the health sector in allocating state budget, nor in satisfying the actual needs of the sector.

In 2006, the state budget spent on health care was only 1.4% of Gross Domestic Product (GDP) [12]. As indicated by the National Health Accounts, the share of state budget spent on health care during 2002 – 2006 never surpassed the 5% benchmark. According to informal estimates of the Ministry of Finance, this share has increased over the past 2 years, reaching 7.1% of total state budget spending in 2007. Yet according to the World Health Organization, to ensure that essential health services are provided to people in developing countries, state budget spending on health care must reach at least 10% of total state budget expenditure [15]. Compared to the overall social health expenditure, state budget spending on health accounted for only 21.7% in 2006. Throughout the five-year period 2002 – 2006, state budget funding for health care never equalled more than 25% of the total health expenditure (see Figure 9). In addition, according to WHO, in order to maintain equity in health care financing, public health spending (mainly from the state budget for health care) should reach at least 50% of social health spending [15].

Figure 9: The state budget for health compared to total health expenditure and total state budget expenditure, 2002 – 2006



Source: National Health Accounts, MoH, 2008 [12]

Table 2 provides comparative data on specific determinants associated with state budget funding for health care in Viet Nam in relation to some other countries in the South-East Asia region, based on WHO data for 2008. State budget for health care here includes the entire portion of social insurance spent on health care. The data reveals that Viet Nam has achieved a relatively high ratio of overall health-related expenditure, given the development level of the national economy. State budget funding for health care in comparison to total health expenditure and total state budget expenditure in general, however, remains low in comparison to other countries (see Table 2).

Table 2: Comparison of selected health financing indicators in Viet Nam with selected countries in the region (2005)

Country	Total health expenditure / GDP (%)	Public health expenditure / Total health expenditure (%)	Public health expenditure / Total public expenditure (%)
China	4.7	38.8	10.0
Malaysia	4.2	44.8	7.0
Indonesia	2.1	46.6	5.1
Philippines	3.2	36.6	5.5
Singapore	3.5	31.9	5.6
Republic of Korea	5.9	53.0	10.9
Viet Nam	6.0	27.0	5.2

Source: WHO Statistical Information System (WHOSIS), 2008 [13]; and National Health Accounts, MoH, 2008 [12]

The structure of state budget spending is not focused enough on priority areas

Despite much concern and more investment, state budget spending on health care in Viet Nam is still low compared with the international average of other countries with similar income levels, as well as in comparison with the financial requirements to perform the basic public health functions.

Structural analysis of the state budget by fields of operation, levels of care and geographic region shows that the state budget, especially at sub-national levels, has yet to be adequately channelled towards areas of priority and aligned with the health-related roles prioritized by the State, e.g. preventive health, grassroots health care and support to disadvantaged areas.

According to the State Budget Law, the MoH only manages and regulates budgets of affiliated units and state budget allocations for targeted support to localities. The allocation of budgets and financial management in localities are determined by the People's Councils and People's Committees at the various levels (i.e. province, district, commune). With the management mechanism and budget allocation stipulated by the State Budget Law, it is difficult for the MoH to ensure effective execution of activities due to the fact that tasks assigned by the MoH to health care units are not linked with budget or financial allocations, especially in the area of epidemic control. Data from selected provinces indicates that the share of provincial budget allocated to health varied across localities, accounting for 5 to 8% of the total state budget expenditure. The share of budget allocated to health depended on the ability to raise revenues locally and the level of concern of local authorities towards health. During the process of budget allocation in localities, priorities are usually focused on infrastructure, economic development, education, environment, etc., with some localities finding it hard to give priority to increasing their health budget.

Analyses across fields of operation in the health sector reveal spending on preventive medicine from the state coffers at 27.7% of total state budget health spending in 2005. A difference exists, however, in the breakdown of expenses on curative care and preventive care between the national and sub-national levels. At the national level, expenditure on preventive care was measured at 38.5%, while sub-national counterparts spent only 21% of state health budget on preventive care [12]. Preventive medicine activities are primarily implemented at the grassroots and provincial level while state budget allocations for epidemic control is budgeted for the central level or for national target programs at the provincial level, leading to an insufficient budget for regular preventive health activities at the local level. Therefore, spending on preventive care from the state budget in general, and local health budgets in particular, remains much lower than the 30% norm prescribed in National Assembly Resolution No. 18. If not addressed promptly, further financial decentralization may result in an even greater tendency for lower priority to be given to preventive medicine. The fact that most health care resources are spent on curative care is typical of the situation in developing countries, when the available health care financing resources do not yet meet the health care needs of the population. Meanwhile, health economic evaluations have indicated that the cost-effectiveness of investing in preventive interventions is often much higher than curative measures. That is why allocation between the preventive and curative areas needs to be rebalanced to make sure that public health targets are achieved.

State budget spending for health care at the district and commune levels accounts for a very low proportion, only 18.5% of the total state health budget expenditure, yet the state budget is the primary financing source for this community-based network to function. Due to this budget allocation mechanism, the grassroots health care network often finds itself short of operational funding including allowances for village/hamlet health workers, and regular budget expenditures for commune health stations. As a result, most district and commune health services are operating in conditions of inadequate physical facilities, difficulties with human resources, low remuneration, and low budget for recurrent expenditures, all of which have led to poor technical quality.

Clear regional disparities in state budget spending on health care

Analyses of state budget funding for health care by regions reveals clear disparities in per capita state budget spending on health care between regions and localities in the country. The 2005 National Health Accounts data showed that the Red River Delta and the Southeast regions of the country had the highest spending levels, at VND211,000/person and VND196,000/person respectively, while the Mekong River Delta had the lowest per capita state budget spending on health care at just VND45,000/person, or a quarter that of the region with the highest expenditure. Per capita state health spending in the Central Highlands was relatively low, at VND62,000/person, just ahead of the Mekong River Delta. This is proof that in spite of the adoption of balancing transfer coefficients prioritized towards mountainous and remote areas, inhabitants of these locations actually enjoyed much lower support from the state budget than more economically developed areas.

The 2004 Public Expenditure Review also indicated a striking variation in state budget spending on health care between regions and provinces. Furthermore, large disparities exist in state budget spending within provinces, between districts and communes [16]. The MoH has yet to define standard norms for intraprovincial budget allocations. In practice, many provinces still use traditional allocation methods, either according to population, patient beds or number of health workers. The 2002 Budget Law gives provinces greater authority in allocating budgets to the lower levels, thus if reasonable allocation criteria are not applied, greater freedom to make intraprovincial budget allocations increases the risk of greater differentials in the intraprovincial allocations across provinces.

Slow reform in the mechanism for management and use of state budget for health

The current state budget for health is allocated through two major methods: allocation by norms (mainly norms based on number of beds) and fee-for-service payment. Neither of these payment methods encourage the effective use of the state budget funds. The current practice of budget allocation is still input-based (planned beds, number of government paid staff…) and not outcome-based (i.e. considering hospital performance). The fee-for-service payment method encourages the abuse of lab-tests, and drugs by service providers, which directly affects the technical efficiency of service provision.

State budget allocations for local health care are also facing problems. First, while provincial budgets have been approved by the National Assembly, many provinces have failed to secure the total amount in the approved budget. Although the per capita allocation norms are low and insufficient to meet need, some localities are still unable to secure this level of funds for spending. Second, the budget allocation at the local level is mainly concentrated on curative care, with the budget share for preventive care being very low, about 12-13% of the total health budget in some localities. In addition, the allocation of funding to hospitals also relies on the number of planned beds by type of hospital, not by the volume and quality of services provided and/or hospital performance. The budget allocated to preventive medicine is only sufficient to cover administrative management and general labour costs, without any budget allocation norms for preventive medicine activities that need to be implemented. Hence, in the current framework of financial decentralization, the issue of central budget balancing transfers, as well as the monitoring role of the MoH to ensure achievement of targets in the sector alongside its governance role in health, should receive special attention.

Autonomization of revenue collecting state health facilities in recent years has been an important measure for implementing decentralization of management in general and health

financing management in particular. This issue will be analysed in detail in Chapter 8 of this report.

A large portion of the state budget for health care is being used to pay the salaries of health workers. The remuneration and allowance packages for health workers, however, still follow the general salary regulations, without any emphasis on performance-based remuneration, which should be an incentive to boost staff performance, in administration, curative and preventive care. Furthermore, the salary and allowance package does not reflect any special consideration for health occupations, which are distinguished by conditions and characteristics deserving of higher remuneration as indicated in Resolution No. 46.

Funding for programmes subsidized by the state budget is usually lower than requirements. With regards to the policy of procuring health insurance cards for the poor, the official cost norms for the purchase of health insurance cards has been raised over the years, reaching VND130,000 per card in early 2008, yet remaining lower than the 2006 average outlays per health insurance card, at VND166,000 per card. Starting 1 October 2008, the subsidized premium was increased to 3% of minimum salary, which should have a positive impact in overcoming the difficulties mentioned above. Provision of free health care services for children under 6 years of age is still being provided through a mechanism of direct reimbursement, rather than through health insurance cards. Actual performance shows that, similar to the early stages of implementing Decision 139, the direct reimbursement approach resulted in a very low disbursement rate (56% in 2005) and complex administrative formalities for budget allocation and management.

Regarding national health target programmes, although the state budget for national health target programmes has increased, it still lags behind actual needs. The annual budget for EPI meets only 60% of programme need. The budget for the malnutrition programme in 2005 was only USD 0.45/child/year while most regional countries had USD 10, even back in the 1960s or 1970s [17]. The district hospital upgrading project under Decision No. 225/2005 also faced funding problems, slow disbursements and low effectiveness. After three years in operation (2006 – 2008), the total paid-in capital reached only VND 2,000 billion, equivalent to 24% of the total estimated capital needed.

Determination of priorities and state budget allocation for target programmes has not been supported by evidence-based information such as cost-effectiveness analysis. Performance monitoring and evaluation of state budget supported programmes has not yet been implemented in a systematic and regular fashion. In addition, results of evaluation of some programmes has often been disseminated in a very limited manner, mostly inside the programmes themselves. Scientific-based evaluation plays a vital role in improving the performance of programmes and helps inform policy revisions and development in general, especially those associated with more effective and rational state budget allocation and utilization.

Inconsistent health financing data

Documentation and analysis of data on state budget health spending reveals disparities between sources from the Ministry of Finance and MoH (National Health Accounts). Ministry of Finance data shows that state budget expenditure on health care (including health system services but not including revenues from health insurance) in 2006 was VND18,585 billion, accounting for 5.8% of the total state budget expenditure, while the National Health Accounts data shows that the total state budget expenditure portion for health

system services in 2006 was only VND11,233 billion, or 3.5% of total state budget expenditure. Harmonizing concepts, calculation methods and data sources to generate consistent state budget figures from different sources is very much needed, in order to facilitate the effective estimation and allocation of the state budget to satisfactorily meet the people's health care needs.

2.3. Priority issues

The situation analysis above reveals various short-comings pertaining to the allocation of state budget for health care, both in terms of funding gaps to meet need and limitations in use and management of the funds allocated. Among the abovementioned shortcomings, it is possible to identify priorities requiring solutions in the near future, specifically:

1) The state budget for health care does not yet meet the people's health care needs.
2) Effectiveness in utilization of the state budget is still limited.
3) Investment capital for basic infrastructure, medical equipment, training, as well as regular expenditure, has not met the need for quality service provision in the poor and remote areas.
4) The remuneration system for health workers is irrational, especially at the grassroots level and has not yet created sufficient motivation to attract qualified staff to work in grassroots levels, in remote, isolated and poor areas.
5) Resources for preventive medicine are still inadequate.

Chapter IV. Health Insurance

In addition to state budget funding, social health insurance is a very important health financing resource in Viet Nam, contributing to the achievement of equity in health care. Health insurance coverage continues to increase, with the ultimate goal being to achieve universal health insurance coverage. This chapter focuses on health insurance issues and seeks to answer the questions: "Where is Viet Nam on its path towards universal health insurance coverage? What are the achievements to date and difficulties and challenges in the road ahead?" Based on the answers to these questions, recommendations can be made regarding urgent priority health insurance issues in 2009 and beyond.

1. Selected concepts

Social health insurance is a health insurance scheme where the premium is generally calculated in proportion to the income level of workers, while curative care benefits are received based on health care needs, not level of contribution. The social health insurance fund was established from the contributions of workers, employers and the Government. The social health insurance scheme is compulsory by law and is therefore also called compulsory health insurance. The financial resources provided by the social health insurance fund are considered a public financing source and have a particularly important role to play in guaranteeing equity in financial contributions through a risk sharing mechanism.

Universal health insurance coverage is a social health insurance scheme that covers the entire population. In some cases, it is announced that the target of universal coverage has been achieved, even when the coverage is below 100%, on the condition that the remaining uninsured are protected from the risks of illness through other secure health financing systems.

Commercial or private health insurance is a scheme that operates for profit. The premium is set based on the probability of illness among people or groups of people enrolled in the insurance scheme. In contrast to social health insurance, the benefits to the insured depend on the level of premiums paid. Usually, governments do not organize commercial health insurance services but rather leave it in the hands of the private sector, hence it is also called private health insurance. Commercial health insurance operates on a voluntary basis, therefore, in some countries, it is also referred to as voluntary health insurance.

Voluntary health insurance in this review (JAHR) refers to a not-for-profit health insurance scheme run by the VSS until the Health Insurance Law comes into effect in 2009, with flat premium levels for each insured group in different regions. This health insurance scheme operates on a voluntary basis and is completely different from the concept of commercial (voluntary) health insurance found in some other countries.

2. Overview of health insurance policies

2.1 Health insurance coverage

The first health insurance regulation, issued in Council of Ministers Decree No. 299/HDBT, dated 15 August 1992, valid during the period 1992 – 1998, stipulated that those earning a salary from the state budget, working in state-owned enterprises, pensioners, people entitled to work disability benefits, Vietnamese workers in international organizations in Viet

Nam and employees of non-state-owned enterprises having 10 or more employees shall enrol in the compulsory health insurance scheme.

Since 1998, Decree 58/1998/ND-CP, and its implementing circulars, added a few new member groups to the compulsory health insurance scheme. Starting on 1 July 2005, Decree 63/2005/ND-CP came into effect and widened eligibility for coverage to include some groups already participating in the compulsory scheme under various legal documents, but who were not specifically indicated in the health insurance regulations issued with Decree 58/1998/ND-CP. In addition, Decree 63 also added some new groups to be covered by the compulsory health insurance scheme, including workers in non-public enterprises with less than 10 employees, workers in organizations established and operating legally in Viet Nam, and members of poor households and ethnic minorities entitled to benefits under Prime Ministerial Decision 139/2002/QD-TTg.

One important policy change set out in Decree 63 is that workers in non-state enterprises employing as few as one worker should participate in the compulsory health insurance scheme, replacing the previous requirement of enterprises with 10 or more workers. Another important change is that the poor and ethnic minority people now participate in the compulsory scheme with assistance from the state budget.

The most notable recent policy change in enrolment to the voluntary health insurance scheme is the elimination of the minimum percentage enrolment in the community. According to Joint Circular 06/2007/TTLB-BYT-BTC dated 30 March 2007, one of the required conditions to enrol in the voluntary health insurance scheme was that a minimum of 10% of households in a commune or students in a school (or university) had to be enrolled for anyone in that commune or school to be allowed to enrol in the voluntary health insurance scheme, with a view towards mitigating adverse selection (i.e. situation in which only the sick enrol). However, on 10 December 2007, the Ministries of Health and Finance issued Joint Circular 14/2007/TTLB-BYT-BTC to eliminate the above condition: ”Eliminate the condition that 100% of household members, 10% of households in a commune and 10% of students in a school must enrol.”

In addition to the voluntary health insurance scheme for households or students, the Government also issued an implementing document for the health insurance scheme for members of near-poor households with state budget support to cover at least 50% of health insurance premiums [18].

2.2 Premium levels

In previous years, compulsory health insurance premiums for workers earning salaries have been maintained at 3% of their base salary (which includes salary based on the government wage scale and several specific allowances according to regulations). For those not earning a salary, the health insurance premium was either equivalent to 3% of minimum salary (for those without a stipend) or equivalent to 3% of the stipend (for those receiving a stipend).

For the poor, the health insurance premium (subsidized by the state budget) has increased from VND 50,000/person/year to VND 80,000, and now from VND 130,000 in early 2008 to VND 194,000 starting at the end of 2008 (3% of the general minimum salary). This premium level is expected to be applied to members of near-poor households enrolled in the voluntary health insurance scheme in 2008, with 50% of the premium subsidized by the state budget.

Premiums for the voluntary health insurance scheme, implemented since 2005 according to Joint Circular 22/2005/TTLT-BYT-BTC, vary across group and urban/rural residence, ranging from VND 30,000 – 50,000 for students and VND 70,000 – 160,000 for other groups. These premium levels were increased quite significantly from the end of 2007 under Joint Circular 14/2007/TTLT-BYT-BTC, which specifies: "Premiums of individuals enrolled in the voluntary health insurance scheme: Urban areas at VND 320,000/person/year; Rural areas at VND 240,000/person/year. The premiums for students enrolled in the voluntary health insurance scheme: Urban areas at VND 120,000/person/year; Rural areas at VND 100,000/person/year".

2.3 Benefit package

Since 2005, the benefit package for people participating in health insurance was adjusted according to the new Health Insurance Regulations, issued with Decree 63/2005/ND-CP. Major changes include:

- Elimination of 20% co-payment of health care costs for all health insurance members;
- For high-tech, high cost medical services, insured patients (except for a few designated insured groups) are only entitled to partial refund of the costs by the health insurance agency, with the rest to be paid for out of their own pocket[7];
- Costs of treating injuries from traffic accidents are now covered by health insurance.

In addition, some health insurance members are now entitled to reimbursement of their transportation costs, in case they are referred to a different level of care.

As for voluntary health insurance members, between 2003 and 2005, the insured had to pay a 20% co-payment of health care costs up to a ceiling of 1.5 million dong per year, and were not required to pay copayments if health care costs were less than VND 20,000/visit. However, major costs could only be covered when the insured had maintained health insurance coverage continuously for at least 24 full months, and only up to a maximum reimbursement amount (e.g. for open heart surgery, health insurance would reimburse no more than VND 10 million a year; for renal dialysis insurance would reimburse no more than VND 12 million a year).

In 2005, regulations on voluntary health insurance benefits were adjusted (Joint Circular 22/2005/TTLT-BYT-BTC), as a result, benefits for voluntary health insurance members are now basically the same as for compulsory health insurance members. With regard to high-tech medical services alone, high health care costs of VND 7 million or more will be reimbursed up to 60%, but only to a ceiling of VND 20 million per health service use, with the remainder to be paid out of the patient's pocket to the health service provider.

From April 2007, according to Joint Circular 06/2007/TTLT-BYT-BTC, guiding the implementation of voluntary health insurance, people with voluntary health insurance jointly pay 20% of the treatment costs (the co-payment is eliminated if outpatient care costs are less than VND 100,000). For people who have been covered by voluntary health insurance continuously for 36 months or more, the VSS will pay 50% of some drugs which are not on the regular list of drugs covered by health insurance, for example some drugs for cancer treatment or for prevention of rejection of organ transplants. In addition, in case the patient

[7] Health insurance members pay all remaining charges, irrespective of the level of these charges.

uses expensive, high tech services (for which the list was established by the MoH), the total amount covered by health insurance will not exceed VND 20 million.

Regulations allowing co-payments to vary by type of insurance coverage, rather than on the severity of the illness, continue to create inequity between groups covered by health insurance.

2.4 Provider payment mechanism

During the past few years, provider payment methods for health care costs of the insured have changed following each of three revisions in the Health Insurance Regulations. Nevertheless, the fee-for-service provider payment mechanism, one with many shortcomings with regard to health financing, is still the most widely used for paying health services used by the insured. Government Decree No. 63/2005/ND-CP provides for several different provider payment methods, including fee-for-service, capitation, diagnostic-related group (DRG) or other modes of payment. Joint Circular 21/2005/TTLT-BYT-BTC, dated 27 July 2005, gives detailed instructions for two modes of payment between the health insurance fund and health service providers, namely capped fee-for-service payments for expensive high-tech services and capitation. Health care service providers select the appropriate payment mechanism in order to sign a contract with VSS. For voluntary health insurance, Joint Circular 22/2005/TTLT-BYT-BTC, dated 24 August 2005, similarly states "Health care providers choose either fee-for-service or capitation reimbursement methods as instructed in Joint Circular 21/2005/TTLT-BYT-BTC dated 27 July 2005 of the Ministries of Health and Finance, guiding the implementation of compulsory health insurance".

2.5 Policies on commercial health insurance

The 2000 Law on Insurance Business defines health insurance as one of the non-life insurance business subsectors. In 2007, the Government issued Decree No. 45/2007/ND-CP, as the first implementing guideline for this Law, some seven years after the Law on Insurance Business had come into effect. However, this Decree did not touch upon health insurance business activities.

According to unofficial data, in 2006 there were some 37 registered insurance business organizations in Viet Nam with a combined turnover accounting for 1.8% of GDP [19]. Foreign insurance companies have signed more than two million contracts for health-related insurance. The domestic insurance companies, such as Bao Viet, Bao Minh, Pjico, have implemented some commercial health insurance schemes focusing on students, which cover several million students throughout the country. Bao Viet Insurance Company claims to control 70% of the market share for student health insurance with more than eight million students participating in their comprehensive health insurance scheme. Some provinces have more than 75% of their students enrolled in Bao Viet's comprehensive insurance scheme (e.g. Binh Thuan during the 2006-2007 school year). However, to date, there has been no official research assessing the level of coverage, benefit packages, and reimbursement of commercial health insurance schemes in Viet Nam. Hence, there is no reliable data to assess the financial contribution of commercial health insurance to total health care expenditure in Viet Nam.

Regulation of this industry is still limited due to the existence of only cursory legal documents to regulate the commercial health insurance business (it is only mentioned in one line of the 2000 Law on Insurance Business, and without any supplementary guidelines on the management of commercial health insurance schemes).

As such, although commercial health insurance is among the types of insurance business with the largest number of clients in Viet Nam, to date, besides general regulatory documents covering life and non-life insurance, there is a lack of necessary guidelines for regulating specifically health insurance business activities.

2.6 Potential for universal health insurance coverage by 2014 - 2015

Three factors that strongly influence Viet Nam's roadmap towards achieving universal health insurance include:

- The structure of Viet Nam's workforce by the time the target is expected to be achieved (i.e. 2014, according to the Health Insurance Law);
- The growth of the state budget in the next five years (i.e. by 2013-2014);
- The development of the service delivery system from now to 2014: development in the direction of a not-for-profit public service delivery system, or profit-driven business?

Predictions of the above three factors require a research study beyond the scope of this report. However, it is possible to provide a summary analysis as follows:

- *The structure of Viet Nam's workforce by 2014*: Current targets for the year 2010 envisage that the agricultural workforce will account for less than 50% of the total labour force, falling to 30% by 2020 [20], when Viet Nam has basically become an industrial country. Therefore by 2014, the share of the workforce in agriculture will be only 40-42%.[8] The high number of casual rural and urban labourers remaining in 2014-2015 is a hindering factor for ensuring participation in the health insurance scheme.
- *Capacity of the state budget:* Viet Nam's GDP is expected to reach USD 1000 per capita by 2010 and possibly USD 1500 per capita by 2014 (in current prices). If Viet Nam can maintain health expenditures at 5% of GDP, the per capita average health expenditure by 2014 will be USD 75 (In 2006, per capita total health expenditures were USD 45 according to the National Health Accounts). With 40% of the population unable to afford health insurance premiums (comparable with some Eastern European Countries, at 50% in 2002), the state budget needs around USD 2.8 billion[9] to ensure their health care needs. Thus, to achieve the universal coverage target, a strong political commitment and a sufficient tax-based budget will be required to finance the health care needs of that portion of the population unable to pay health insurance premiums.
- *Trend in development of the public health service delivery*: To date, there is no sign of containment of the trend towards service provision for profit (formally or informally) at certain public hospitals. Private investment in public hospitals as part of the process of public hospital autonomization continues to rise, spawning profit-driven business activities in this sector. Health insurance systems tend to be more vulnerable and less

[8] To reduce the agricultural workforce from about 50% in 2010 to 30% in 2020 (when Vietnam becomes an industrial nation), annual reductions of 2% will be required. Therefore, by 2014, the share of labour in agriculture is estimated at 50%-(2%x4)=42% of the social workforce.

[9] USD 75 x (40% x 93.5 million people) = USD 2.8 billion

sustainable when they have to buy health services from profit-driven health service businesses.

Preliminary predictions about the above three factors imply the need for active measures in order to launch a health insurance scheme that can cover people working in the agriculture, forestry, fishery and salt production sectors (by 2014 according to the Health Insurance Law). At the same time, starting from now, it is necessary to have appropriate policies to develop a "health insurance friendly" health service provision system in line with the orientation towards equity and efficiency. Finally, strong political unity and commitment is needed to make sure that the state budget from taxes can sufficiently cover health expenses for that segment of the population that cannot afford health insurance premiums when universal health insurance coverage is implemented.

3. Outcomes from implementation of health insurance policies

3.1 Coverage

In 2007, it is estimated that about 36.5 million people were covered by health insurance, accounting for about 42% of the population. The poor account for over 41% of the insured and voluntary health insurance members account for a further 25.7%. The number of people with health insurance coverage increased sharply from 2005, mostly as a result of government policy promoting the purchase of health insurance cards for the poor (Table 3).

Table 3: Number of health insurance members nationwide, 2005 - 2007

		2005		2006		2007 (estimates)	
		Members	%	Members	%	Members	%
Compulsory	Non-poor	9,154,308	39.8	10,568,123	28.6	11,606,569	31.8
	Poor	4,726,324	20.5	15,178,025	41.3	15,498,284	42.5
Voluntary		9,133,134	39.7	11.120.275	30.1	9,379,349	25.7
Total		23,013,766	100.0	36,866,423	100.0	36,484,742	100.0

Source: VSS

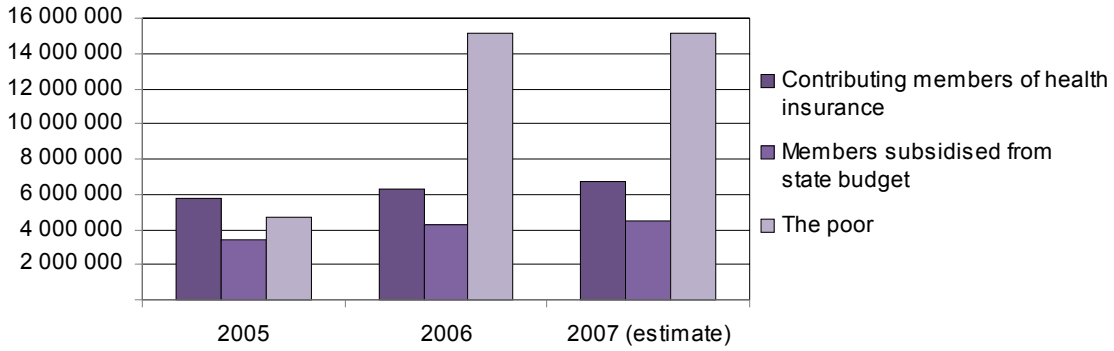
According to the current health insurance regulations, all wage workers (estimated at about 12 million people according to data from the Ministry of Labour, War Invalids and Social Affairs) are subject to compulsory health insurance. In fact, only 50% of wage workers are currently covered by health insurance (Statistics indicate that the number of formal employees registered with compulsory health insurance, as of 31 December 2006 was 6.3 million). Compliance with compulsory health insurance regulations is lower in the non-public sector than in the public sector. For professional associations and household enterprises, by 2006 only 5,320 people were covered by the compulsory health insurance scheme.[10]

Analysis of the structure of health insurance membership in terms of premiums being withheld from salaries, indirectly or directly supported by the state budget shows that the insured whose premiums are withheld from their income represent a very small share of the

[10] From information calculated based on VSS data for 2006: Wage workers actually contributing to health insurance premiums accounted for 7 million people in 2006, the group for which the state budget paid contributions indirectly including meritorious groups (veterans, revolutionaries, Agent Orange victims, the elderly, etc.) added up to over 4 million people and the group including the poor for which the state pays contributions to insurance directly accounted for some 15 million people.

total. Hence, in the compulsory health insurance scheme, the Government is itself the biggest premium payer, paying for the majority of the insured, even without including the Government payment of health care costs for children under 6 years old (see Figure 10).

Figure 10: Number of contributing members of health insurance compared to the number whose premium was subsidized by the state budget, 2005 - 2007

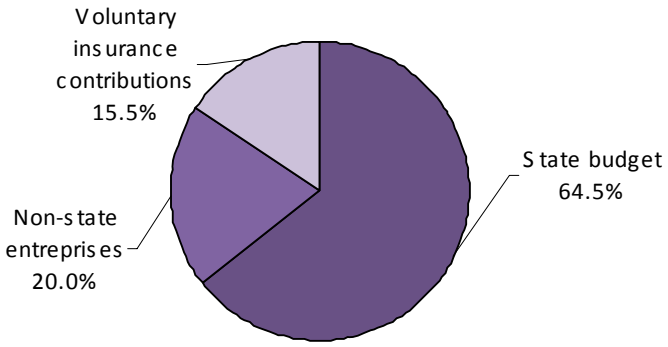


Source: VSS

An analysis of the structure of sources of premium payments to compulsory and voluntary health insurance funds makes it even more apparent that "the Government is the biggest payer of health insurance premiums" (see Figure 11).

In 2006, of the total VND 4,800 billion collected from health insurance premiums, the payment that came from the public purse (including premiums for the poor, designated priority groups and workers whose salary was paid from the state budget) accounted for 64.5% of the total; health insurance revenue from non-public enterprises accounted for 20%, and that from voluntary insurance members was just 15.5% (while in terms of the number of insured, this group should account for 28%).

Figure 11: Proportion of revenues in 2006 by source of contribution



Source: Calculation from 2006 balance sheet of VSS [21]

The proportion of the total population covered by the voluntary health insurance scheme is small and has remained steady in recent years, covering mostly school pupils and

university students (over 8 million students in 2006). The remainder include over 1 million people covered in the household-based health insurance scheme, nearly 1.5 million people who are members of associations, social organizations and mass organizations, and close to 0.5 million people in the voluntary health insurance scheme for dependants of wage workers. The voluntary health insurance schemes for members of associations, social organizations and for dependents of wage workers were suspended in 2008.

3.2 Health insurance premium levels

In 2006, the groups with the highest average compulsory health insurance premium were employees of foreign-invested businesses and public servants, government employees, Party officials and members of social organizations receiving salaries from the state budget (the average premium from foreign-invested businesses was VND 442,000/person/year, and from the public administrative sector VND 438,000/person/year). Non-public businesses, occupational associations, household enterprises and cooperatives had a significantly lower premium contribution level (the average non-public businesses' premium contribution was approximately 61% of that of foreign-invested businesses).

The low premium payment for over 15 million poor people results in an average premium amount for the compulsory health insurance scheme of VND 170,000/year. The average premium rate of the voluntary health insurance scheme in 2006 was VND 67,000. The combined average premium rate of both voluntary and compulsory health insurance schemes in 2006 was VND 137,000/person/year (about USD 8.5/person/year, see Table 4).

Table 4: Average health insurance premiums in 2006 by member group (VND)

Member	Average premium in 2006	Member	Average premium in 2006
Compulsory health insurance		Social assistance beneficiaries	96,174
State-owned enterprises	387,673	Retired commune, ward officials receiving monthly stipend	111,035
Foreign-invested enterprises	442,306	Veterans	77,306
Non-state enterprises	272,512	Pensioners	330,904
Administration, Party, Mass Organizations	438,482	The Elderly	56,,943
Commune/ward officials	297,080	The Poor	49,527[11]
Cooperatives	197,323		
Peasant's Association, household enterprises	186,561	**Voluntary health insurance**	
Representatives of People's Council	135,074	Households	117,400
Dependents of army officers	94,846	Students	47,523
Victims of Agent Orange	119,694	Association, mass organizations	116,284
Individuals with meritorious contributions to the nation	129,270	Dependants of workers	127,895

Source: Calculation from 2006 balance sheet of VSS [21]

[11] The health insurance premium for the poor supported by the Government budget in 2006 was VND 60,000/head/year. However, data reported by provinces indicates lower premiums paid in some provinces.

3.3 Health insurance fund management and risk sharing

The pooling and risk sharing objectives of the health insurance fund have been adversely affected by the health insurance fund management mechanism in recent years. The insured in some poor provinces and in mountainous provinces tend to use fewer health services (due to many factors including the availability of services and capacity of the service delivery system, geographical/transport factors, culture and especially the ability of the poor to pay for costs not covered by health insurance). Therefore, the expectation that high income groups could support lower income people in health financing through a fund pooling mechanism has not only failed to achieve its objectives, but has also led to a situation in which the health insurance fund from poorer regions has subsidized health care in major cities and wealthy provinces.

In addition, adverse selection (in which primarily sick people participate) is prevalent in voluntary health insurance schemes, especially after the elimination of requirements that a minimum percentage of the target group participate; therefore the risk-sharing principle of healthier people contributing to the fund and supporting sick people has not been realized, and this situation has led to a serious imbalance in the health insurance fund.[12]

3.4 Service provision to insured patients

The health service delivery system has made considerable efforts to facilitate health care access for the insured. Administrative procedures have been reformed, and a majority of commune health stations provide basic curative care services for the insured. The list of drugs covered by health insurance has been expanded and regularly updated, and many new curative care services and procedures have been provided to the insured. Nevertheless, the health service provision system continues to face difficulties adversely affecting the health care benefits of the insured. Examples include the work overload that not only occurs in higher level hospitals but also in commune health stations in lowland areas where health insurance coverage is high; or the dearth of health professionals (both in quantity (number of workers) and quality (clinical skills)) and medical equipment at the communal level of health care; or the meagre financial resources of hospitals. In addition, health insurance provider payment mechanisms (discussed in Section 3.5 below) limit lower level facilities from making referrals.

3.5 Provider payment mechanism

The VSS signs agreements with health service providers and reimburses health care costs using a fee-for-service mechanism, with the fee schedule, prescribed by the relevant state agencies and provincial and municipal authorities, determining specific fees for each type of service. Patients (except certain designated groups) must make co-payments for high tech services without any maximum on how much they pay to help limit their risks. People with voluntary insurance must also make co-payments by paying 20% of health care costs directly to the facility.

As for the public health care system, the health insurance fund applies a capped fee-for-service reimbursement at lower levels, i.e. facilities providing first level health care. At higher level hospitals (provincial and central), the health insurance fund uses uncapped fee-

[12] In 2006 alone, the voluntary health insurance scheme overspent by VND 1 trillion, in 2007 overspending reached VND 1.45 trillion.

for-service reimbursement. Almost all heath facilities are implementing the autonomization policy according to Decree 43, which encourages increasing revenues, including revenues from health insurance. Therefore, higher level hospitals can take advantage of the uncapped fee-for-service payment method to increase their revenues. The consequence is that costs at higher level facilities have increased rapidly, while lower level facilities must limit health insurance benefits to balance the costs within the reimbursement cap.

Given the current fee-for-service reimbursement mechanism, the health insurance fund is not being used efficiently, and cannot avoid abuses of the insurance fund by service providers and users. Capacity for supervising use of the fund is very limited due to a lack of management mechanism (as hospitals fail to use standard clinical guidelines, and the list of drugs covered is too broad) and limitations in capacity of the VSS.

4. Major issues and proposed priorities

4.1 Shortcomings with health insurance

From the analysis of implementation of health insurance policy discussed above, there are eight major challenges that can adversely affect the sustainability of health insurance in Viet Nam, and especially the ability to achieve the universal coverage goal by 2014.

1) Low coverage and compliance among wage workers. Lack of legal regulations aimed at ensuring compliance in making health insurance premium contributions. Workers currently participate as individuals, rather than as households.

2) The health care needs of the insured have yet to be properly met as the health service delivery system has many shortcomings. Overloading not only occurs in higher level hospitals but also at the grassroots level. Disparities continue to exist in quality of care for the insured in mountainous, remote and isolated areas compared to other areas.

3) Insured patients still have to pay many expenses when seeking care. Informal health expenditure by health insurance patients adversely affects access to health care services for low income groups and results in reduced trust among health insurance members.

4) Adverse selection: This remains a major issue affecting the voluntary health insurance scheme. The design of the voluntary scheme lacks measures to control adverse selection; the primary technical solutions available to do this, namely minimum enrolment requirements of 10% for households or students, have been eliminated.

5) Overspending of the health insurance fund. Adverse selection, low premiums for groups receiving social subsidies and the fee-for-service reimbursement mechanism which is widely used in a context of allowing greater financial autonomy, are the main causes of the high level of overspending of the health insurance fund in 2006 (over VND 1200 billion in 2006, equivalent to USD 75 million) and even greater overspending is expected for 2007 and 2008.

6) Limited specialized health insurance management skills of the organization implementing health insurance: The management of insured patients and health care costs is not strict enough. The health insurance fund, pension fund and some other social security funds are managed under one umbrella (VSS) and this stifles professional specialization, administrative capacity and operations management necessary to manage this very special fund.

7) No health-related social security programme exists for those without health insurance coverage. About 50% of the population are without health insurance and end up paying health care costs out of their own pockets. The chances that they may fall into the poverty trap when encountering catastrophic medical expenditures are enormous. Yet, there is no policy solution to protect this group lacking health insurance coverage.

8) Achieving the goal of universal health insurance coverage by 2014 will require overcoming many difficulties. First of all are difficulties in implementing health insurance for casual workers in agriculture, forestry, fisheries and the salt industry, groups that will continue to account for a high share of the population in 2014. Dependents of workers should be covered by health insurance by 2014 (according to the Health Insurance Law), and the requirement that workers contribute premiums for their dependents may constitute a considerable barrier in the strategy to expand coverage in a sustainable manner.

4.2 Priority issues

Of the eight major health insurance challenges mentioned above, the following are the three priority issues that need to be addressed in 2009 and subsequent years:

1) Continuing to update policies to expand health insurance coverage in a sustainable manner.
2) Resolving the health insurance fund imbalance.
3) Upgrading the capacity of the health insurance system.

Chapter V. External assistance for health

In the past few years, external assistance, both financial and technical, has made important contributions to the achievements of the health sector in Viet Nam. It is expected that by 2010, Viet Nam will join the group of middle-income countries. How will this change external assistance? What does the health sector need to do to attract more external assistance and strengthen aid effectiveness? This Chapter will explore the current utilization of external assistance in Viet Nam, offer an overview of the issues and challenges facing the next phase and provide recommendations to the health sector in their short- and medium-term planning for improving the efficiency of external assistance.

1. External assistance concepts

External assistance includes official development assistance (ODA) and support from international non-governmental organizations (INGO) [22]. According to Government Decree No. 131/2006/ND-CP, dated 9 November 2006 various forms of ODA include:

- *Grants:* a form of ODA support that does not require repayment of funds to the donor.
- *Concessional loans* (also called preferential credit): loans provided under preferential conditions in terms of interest rates, grace periods and pay-back periods, in which the 'non-refundable' part (also called the "support ingredient") is guaranteed at a minimum of 35% in the case of conditional loans and 25% in the case of unconditional loans.
- *Mixed ODA:* includes grants or preferential loans provided together with commercial credit, while ensuring that the accumulated "non-refundable portion" covers at least 35% for conditional loans and 25% for unconditional loans.

ODA support modalities include: a) Project support; b) Programme support; c) Sector support; and d) Budget support.

- *Project support:* A "project" is a set of integrated activities carried out to achieve one or several identified goals, in specific locations, within a specified timeline and based on a known amount of resources. Projects may include investment projects and technical assistance projects.
- *Programme and sector-wide support* is an ODA delivery modality, in which the donors provide harmonized support and ensure the sustainable and effective development of an industry or sector, based on the development plan for that industry or sector.
- *Budget support* is an ODA delivery approach in which ODA support funds are not attached to a single or a number of specific projects, but channelled directly to the government budget, where they are managed and used in accordance with the budgetary controls and procedures of Viet Nam.

2. Overview of policies to attract and utilize external assistance

2.1 Legal and policy environment

The Government of Viet Nam, over different periods, has employed different strategies and policies to increase the effectiveness of the external assistance it receives. The following important milestones can be noted:

- 1994: Government Decree No. 20/CP was endorsed and served as the first legal document paving the way for the mobilization, management, and use of ODA;
- 1997 and 2001: Government Decree 87/CP and Decree 17/2001 ND-CP amended, revised and refined the related legal framework, in an effort to strengthen openness, transparency, ownership, partnership and procedural harmony;
- 2006: Decree No. 131/2006/ND-CP and a series of other ODA-related legislative documents were issued and implemented, demonstrating the considerable efforts made by the Government of Viet Nam to raise aid effectiveness and procedural harmony. These regulations were refined with the principle of ensuring the integrity of relevant legal documents, strong decentralization in implementation while improving accountability, openness, transparency and harmony of processes and procedures. To guide the implementation of Decree 131 in the health sector, the MoH issued Decision No. 11/2008/QD-BYT, providing for the management and use of ODA in the health sector.

Sound policies and a strong legislative environment have helped Viet Nam, including its health sector, to attract more external assistance and maintain its share in the investment budget. In addition, this also demonstrates that Viet Nam, in its path toward further integration in the international community, is committed to increasing external aid effectiveness.

2.2 Paris Declaration and Hanoi Core Statement on aid effectiveness

The Paris Declaration was founded with commitments from more than 100 donors and aid-receiving countries, endorsed at a high-level forum on aid effectiveness in Paris in March 2005. Viet Nam was the first country to localize the Paris Declaration commitments to fit with local conditions through the issuing of the Hanoi Core Statement. The Paris Declaration and Hanoi Core Statement on aid effectiveness are built around a five-fold structure: 1) ownership; 2) alignment with country systems; 3) harmonization and simplification; 4) result-based management; and 5) shared accountability. Aid effectiveness commitments were approved by the Prime Minister and passed on to the Ministry of Planning and Investment for implementation. This is the basis for Viet Nam, with the cooperation of donors, to make commitments and develop a roadmap for implementing the Paris Declaration on aid effectiveness, which has been assessed highly by the international donor community in the past few years.

Realization of the commitments on the ground, however, has shown a lack of harmony between related sectors [23]. Implementation in the MoH through engagement in the HPG on aid effectiveness and dissemination of the new Decree on ODA management has been slow. Nevertheless, in August 2008, the MoH completed and presented its plan to implement the Hanoi Core Statement in the health sector in order to strengthen the effectiveness in use of external assistance and bridge the gap between policy development and implementation. Coordination efforts are also getting better results as dialogues between the MoH and development partners are increasingly more open and productive.

2.3 Instruments for public administration in relation to external assistance

In addition to policies creating a legal environment, public administration instruments have also been constantly honed as part of the principle of considering aid as part of the state budget (State Budget Law). Furthermore, it is felt that the management and utilization of

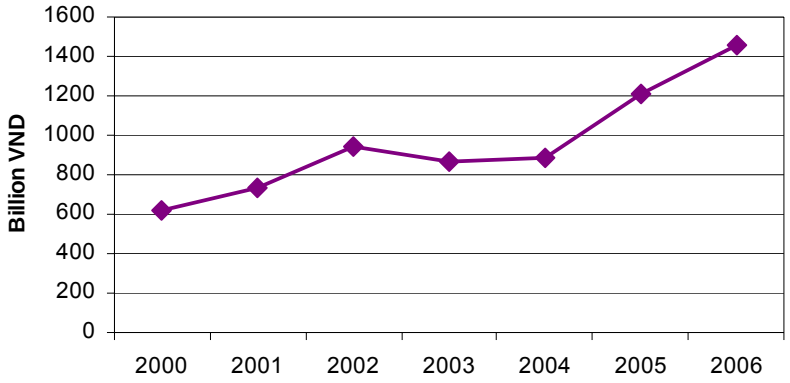
these resources should fall under the jurisdiction of the Viet Nam legal system. The refinement of public administrative instruments includes:

- The health sector has intensified governance of ODA resources by clarifying the functions and responsibilities of the agency responsible for a given project and integrating with the functions of the public administrative system (Decision No. 11/2008/QD-BYT).
- Decentralization is used as an instrument to raise accountability of ODA recipients, managers and users. The MoH has thoroughly implemented decentralization from the central to local levels, clearly identifying the rights and responsibilities of each participating unit. According to Decree No. 131/2006/ND-CP, the MoH is authorized to approve projects belonging to entities under its jurisdiction while Provincial People's Committees shall approve projects that belong to the province. This requires the strengthening of project review at the MoH and developing and consolidating the capacity of other delegated agencies and local authorities.

3. The situation of external assistance for health in Viet Nam

In the past 10 years, external support has grown continually (see Figure 12) and now constitutes approximately 8-10% of the net state budget allocation for health care (see Table 5).

Figure 12: Total external assistance (VND billion), 2000 - 2006



Source: National Health Accounts, MoH, 2008 [12]

Table 5: External assistance as a percentage of state budget expenditure for health and total health expenditure, 2000 - 2007

	2000	2001	2002	2003	2004	2005	2006	2007
External assistance as a % of state budget expenditure	10.4	10.0	13.4	9.9	9.6	11.2	8.0	7.4
External assistance as a % of total health expenditure	2.7	2.7	3.4	2.7	2.2	2.4	2.3	2.1

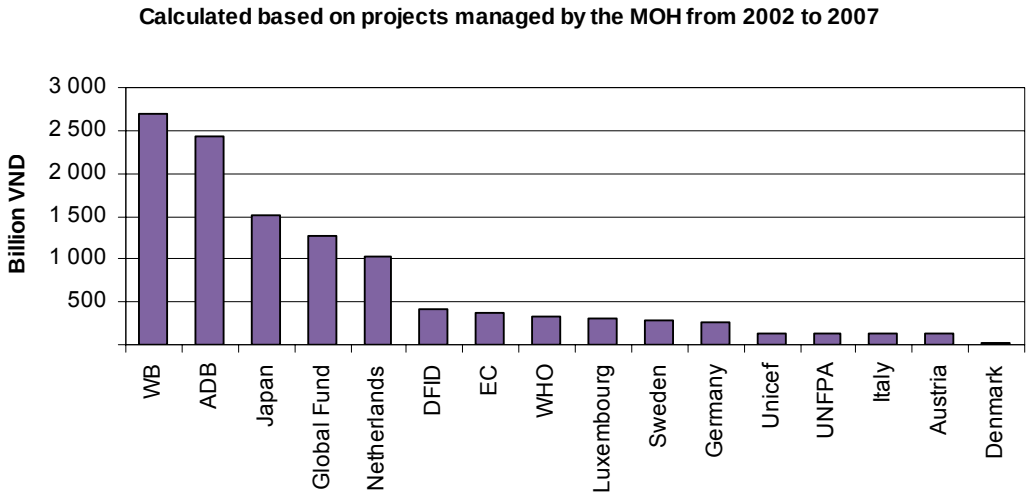
Note: In the National Health Accounts, state budget expenditure for health includes state budget from tax collection, used to pay recurrent expenditures, make investments in development and purchase health insurance

for the poor and other social policy target groups. Public revenues from health insurance, user fees and external assistance are not included in the state budget expenditures for health.

Source: National Health Accounts, MoH, 2008 [12] and estimates of Planning and Finance Department, MoH [24]

According to data from projects under MoH management, leading donors to the health sector include the World Bank, Asian Development Bank (ADB), Japan, Global Fund, the Netherlands, etc. (Figure 13).

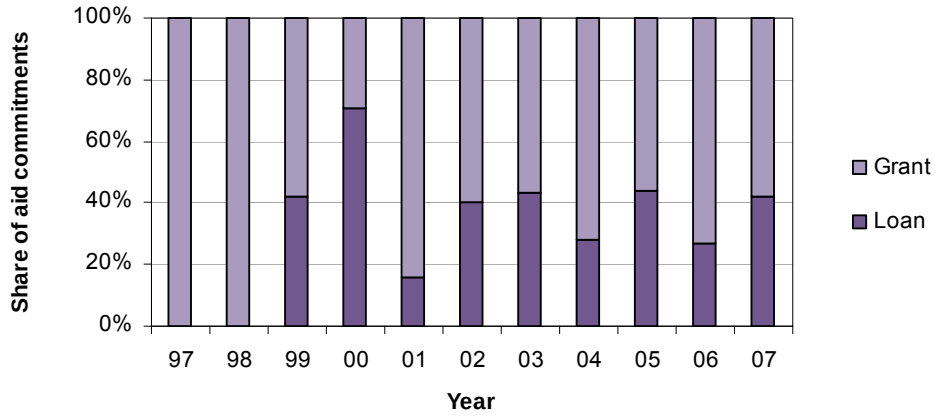
Figure 13: Selected donors by level of aid commitment, 2002 – 2007



Source: ODA management review, Department of Planning and Finance, MoH [25]

In 1996, the MoH had its first World Bank loan project with a total fund commitment of about USD 123.7 million. Loan support has increased since then, to about 40% of total aid commitments at present (see Figure 14). Currently, major projects are being funded mostly by loans from the World Bank and ADB. The MoH intends to increase investment in facility upgrades and equipment procurement from these loans.

Figure 14: Structure of external aid commitments for health



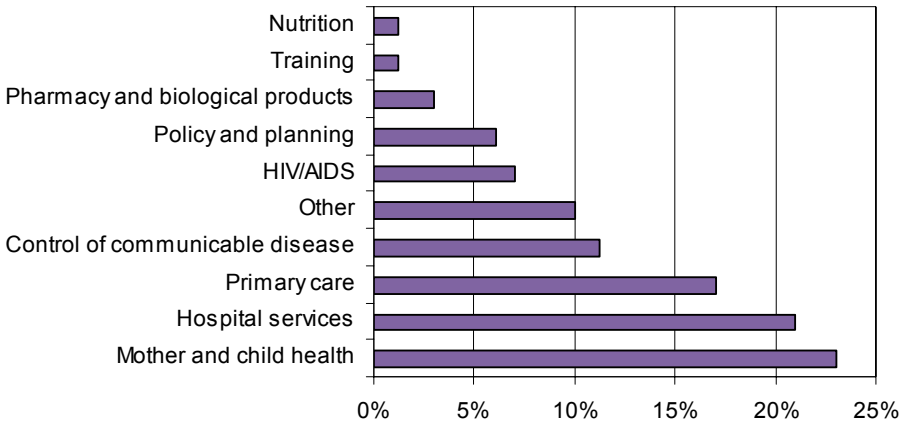
Source: DAD database, Ministry of Planning and Investment [26]

Starting after the year 2000, Viet Nam began to receive support from global partnership organizations and private philanthropic organizations targeting control of global epidemic threats such as HIV/AIDS, TB, malaria and providing support to the EPI.

In 2007, the MoH accepted and approved 18 more projects with a total budget of USD 106 million. As a result, by 2007, the MoH is managing 61 ODA projects with total fund commitments in the amount of VND 10.3 trillion, with an average disbursement rate over total fund commitment of 40%. Actual disbursement in 2007 were 53% against the plan for the year [24]. In the first 6 months of 2008, nearly USD 40 million worth of funds has been disbursed, a figure higher than the same period in 2007. The MoH is currently directing its efforts toward speeding up progress of some key ODA projects, e.g. Regional Blood Transfusion Centres, Health Care in the Central Highlands, Mekong River Delta and Northern Uplands.

Projects have covered many aspects of the health sector and have contributed to upgrading physical infrastructure and technology and improving the quality of health services at all levels, thus contributing to the general achievements of the health sector in caring for the people's health [27]. Areas receiving the most support in the past few years have included mother and child care, hospital services, primary health care, communicable disease control, etc. (Figure 15). In recent times, many projects have also focused on training and development of human resources for health.

Figure 15: Sub-sectors receiving external assistance, 2001-2008



Source: Synthesized from reports of the Department of Planning and Finance, MoH; Statistics of programmes and projects in the health sector, 2001 – 2005; data from donors, 2006 – 2008.

External support for the HIV/AIDS control programme is substantial, accounting for 65% of the total funding for HIV/AIDS, while the state budget cannot meet the programme needs and accounts for only about 35% of the budget (see Table 6). The Global Fund for malaria, TB and HIV/AIDS control has pledged USD 28 million in support for Viet Nam between 2008 and 2012. The PEPFAR programme has also committed USD 59 million in support for Viet Nam (of which 24.5% of the total budget will come under the management of the Vietnamese government agencies) in its 2007 – 2008 budget plan [28].

Table 6: External assistance for HIV/AIDS control, 2007 - 2008

Budget	2007	2008
State budget	35%	25%
External assistance	65%	75%
Total (USD)	32,000,000	35,000,000

Notes: MoH managed external assistance only

Source: Annual report of HIV/AIDS Control Administration of Viet Nam [29]

In addition to ODA, support from INGOs has been provided since the war era for humanitarian purposes under stand-alone or emergency projects and aid. The volume of INGO support and coverage has increased over time. According to data from the Vietnam Union of Friendship Organizations NGO Resource Centre [30], by 2007 there were 600 INGOs working in all 63 provinces and cities covering a large variety of areas (including health care) with total assistance estimated at USD 25 million in 2008 (health-specific data not available). The advantage of INGO support is that it provides direct, versatile and timely aid, although there are limitations in terms of finance and organization [27]. In addition, as

there are a large number of organizations, and a lack of information, the aid activities tend to be fragmented, and are not always focused on development goals of the health sector [31].

In sum, external assistance in health has increased year by year and now constitutes a sizeable share of health expenditure. A recent trend has been the increased use of loans for capital investment including buildings and equipment. A new trend has been the strong rise in support from global organizations in the fight against epidemics of this century. Nevertheless, the low disbursement and effectiveness of fund utilization are areas in need of improvement.

4. Difficulties and challenges in managing and using external assistance for health

4.1 Policy and regulatory framework

The MoH has developed sector development policies, including the National Strategy for Health Care and Protection of the people to the year 2010 and the Master Plan of Viet Nam Health Systems Development to 2010 and the Vision to 2020. The implementation of these policies and plans is determined by the specific goals and activities of related Departments/Administrative units using the specified state budget and donor support. However, these policies and plans also need further revisions to make them more appropriate for the years beyond 2010, and to link them with concrete goals for sub-sectors (e.g. Reproductive Health care Strategy, Adolescent Health Strategy, HIV/AIDS strategy, etc.) and integrate the functions of the health care system (including the information systems, monitoring and evaluation, human resources management and development, etc.). It is important that the development of new policies should be linked to the MTEF under the Government's leadership. Strategies need to be developed and implemented based on priorities identified in the JAHR report through discussions with stakeholders and the donor community. The Department of Planning and Finance and the Department of International Cooperation of the MoH play an important role in coordinating activities of the HPG, with the aim of discussing relevant issues, determining priorities and orienting development of sectoral strategies

4.2 Coordination

Coordination is a concern for both the MoH and donors, from a number of perspectives: within the health sector, between MoH and donors and among the donors.

Some MoH Departments and Administrative agencies are overloaded with projects, while others have none, or only few projects. Many projects are working in the same field, and may even have the same objectives, yet they are implemented relatively independently from each other. This is evidence of the need for a strengthened coordination mechanism, which can guarantee optimum use of resources and integration with public administration functions.

The organization and operation of some project management units (PMU) still face inadequacies in management capacity PMU human resources consist partly of government employees, unable to reserve much time for project management work and partly of short-term contracted staff, who lack accountability and have limited professional capacity. In addition, to these problems are the costs of running a PMU office and difficulties in work relations between the PMU and functional departments. These issues imply the need for reforms in project management and new support modalities to improve aid effectiveness.

Even with its clearly defined strategies and plans, the health sector remains partly dependent on the donors' plans and objectives in negotiations for development of specific programmes and projects.

Inadequate attention has been paid by donors to coordination and commitments in line with sector development goals. Individual donor objectives are prioritized in developing and implementing individual projects. Donors are also often bound by the legislation of their own countries regarding aid delivery and have to take these into consideration before signing mutual commitments.

The HPG, established and operating under the leadership of the MoH, is still limited to the exchange of information rather than coordination of external assistance activities or supporting the MoH to gain greater ownership in developing strategies and plans for use of external assistance [32]. However coordination has been strengthened through the Prime Minister issuing a decision providing guidelines on preparing feasibility studies for projects using ODA funds from the group of five development banks [33]. Currently the development banks (i.e. World Bank, ADB, JBIC, KfW, French Development Agency) have developed a joint monitoring and evaluation framework that includes common monitoring indicators. In addition, indicators and activities discussed and agreed on in the annual JAHR report are also a major improvement in presenting a common voice in developing sectoral strategy.

4.3 Administrative procedures

While improvements in administrative procedures related to aid management have been made in the direction of greater harmonization, there are still inconsistencies between country procedures and donor regulations. However, mechanisms and policies for public administration of ODA still contain many inconsistent and unclear points. The process of reviewing and approving plans and obtaining approvals at the various steps for procurement and bidding remain prolonged. Besides the limitations of project management capacity, these other issues also contribute to low disbursement, averaging at just 50% - 60%.

4.4 Implementation capacity

The capacity to manage external assistance resources of the MoH has clearly improved in recent years. The project management staff have received training and acquired experience in the process of implementing projects. However, units just beginning to participate in management or who are managing a large number of projects still suffer difficulties in the project implementation capacity. In addition, the strong trend towards decentralization in project management is also posing a challenge to implementing agencies, especially at sub-national levels, when organizational and individual capacity is insufficient to ensure project progress and performance. The current management and implementation capacity of some central and provincial PMUs is weak, in part due to lack of monitoring and supervision by relevant Departments/Administrative units, and also due to the absence of staff incentives in the Departments/Administrative units involved in the monitoring of project performance and outcomes. Some projects are in a situation where the PMU is free to do as it wishes without any supervision. Recruitment of staff with appropriate qualifications and experience for managing projects has also faced difficulties, especially in the provinces.

4.5 Cost norms

In budget support, government cost norms are applied, which are generally lower than those of donors. One of the concerns of both the Government and donors is the salary and allowance packages for staff working in programme and budget support projects. During the initial transition from project to program support, there is likely to be little incentive for staff to participate, and some difficulties in finding and recruiting staff with adequate qualifications and experience. The cost norms applied in projects supported by EU and UN agencies do not encourage staff to work actively. The EU and UN are conducting a survey on the labour market in order for the Government and donors to be able to develop norms more suitable with the market. Incentives are a key issue in programme support, not only cost norms but also salaries, working conditions and other incentives to improve performance in the management and effective use of external assistance.

4.6 Monitoring and evaluation

Monitoring and evaluation has been conducted under the guidance of the Ministry of Planning and Investment with projects being tightly monitored in order resolve in a timely manner any problems causing delays in implementation. Guidelines on monitoring and evaluation of ODA programmes/projects for the period 2006 – 2010 have been issued with the aim to establish and operate a monitoring and evaluation system at three levels: the programme/project manager, the line agency in charge and the national management agency [34]. A project management database is being operated by the Ministry of Planning and Investment for all ODA projects via the DAD (Development Assistance Data) website [26].

Despite this guidance, monitoring, supervision and evaluation of projects/programs still suffer from limitations. These activities are generally limited to managing inputs and processes through a large number of control steps and administrative procedures. Activities for supervising and evaluating are mainly at the level of the project or program. The MoH together with some donors has implemented some sectoral evaluations and developed performance indicators (JAHR report).

4.7 Predicting challenges facing Viet Nam on its path to becoming a middle-income country

From 2010, Viet Nam is expected to reach a per capita GDP of USD 1,000 a year. As a result, grants and preferential loans will diminish, to be replaced by ODA loans with fewer concessions [35]. With regards to the health sector, no donor has declared any detailed strategy or commitment to the Viet Nam health sector for the years beyond 2010 [37]. Meanwhile, some long-term donors have withdrawn from the health sector. The general prediction is that external assistance for health will see some changes in structure, form and substance, with new approaches to boost aid effectiveness.

Total government debt in Viet Nam accounts for 37% of GDP [36] and is considered to remain within the safety zone (40% of GDP is the safety threshold recommended by IMF). However, this suggests that Viet Nam has little room for additional loans. Therefore, the search for sources of funds to pay debts and improvements in efficiency are now issues of great government concern. Viet Nam is considered a country not dependent on external assistance. However, the current need to maintain this funding source is apparent. For the health sector, the sudden elimination of this source of assistance could increase the financial burden, particularly on local budgets (especially in disadvantaged areas) and on some

important programmes (e.g. HIV/AIDS). Similarly, the capital investment in the preventive health system largely depends on external assistance funds. More importantly, such assistance plays a critical role in transferring advanced technology and fostering the development of appropriate sectoral strategies.

As such, in its transition towards middle income country status, the Vietnamese health sector will have to face the following major challenges related to external assistance:

- A trend towards reduced amounts and changes in structure of external assistance.
- Challenges in finding and mobilizing domestic resources to gradually replace external assistance.
- Pressure to adopt new external assistance modalities aimed at achieving greater aid effectiveness.
- Challenges in obtaining substantial improvements in efficiency and disbursement rates.

5. Diversification of assistance modalities

According to regulations in Decree 131, there are currently four modalities for external assistance: projects, programme support, sector support and budget support. The most common modality at present is still project support. Some donors are piloting use of new assistance modalities, and have met with many difficulties, necessitating more careful preparation of conditions for applying the new modalities. The application of new aid modalities still depends on the policies and strategies of donors themselves, and among these, some donors still require use of projects, while others have policies requiring use of program or budget support. The section below discusses some findings and lessons learnt about different approaches of external assistance used in recent years.

5.1 Project support

Project support is currently a common form of ODA delivery in Viet Nam. The project modality has been considered by both donors and the MoH as necessary to mitigate fiduciary risk and to ensure achievement of development objectives. Clear delineation of responsibility in the project management structure is considered an advantage for both the Government and donors. Extensive experience applying the project modality of external assistance has improved local capacity in project management. Existing government legislation on ODA project management is very comprehensive, clear and specific.

However, there are a number of limitations in respect of stand-alone projects in the health sector. Implementing a large number of different projects with different reporting and accounting requirements is a heavy burden with high transactions costs. Local ownership can be undermined when projects have a high level of donor control over design and implementation. At times there are overlaps between different projects. The isolated project management and budget disbursement systems (through PMUs) reduce the opportunity to improve planning, management, monitoring, and state budget funding. Salary allowances and training have been used as incentives, however they have not yet provided sufficient motivation for government staff to implement project management effectively [23, 31].

5.2 Programme-based approaches (PBA)

The move towards programme-based approaches in the health sector has been facilitated by the fact that some key donors (e.g. EC, ADB, Lux Development, the Netherlands and Sweden) are very keen to adopt the programme-based approach in their development strategies. Many of these donors have been heavily influenced by country strategies and pressure from headquarters (e.g., for the EC, a certain amount of its funding has to be channelled through the programme-based approach). Some of these key donors are preparing a "sector development programme", that will share some of the common purposes of "health sector development", which can in turn serve as a basis for donor coordination and harmonization.

The foundation for implementing a programme based approach includes strong government ownership, leadership and partnership with donors. These are exhibited by clearly agreed policy frameworks based on shared priorities and preferably common programme expenditure frameworks and harmonized implementation mechanisms [31]. For the health sector, the existence of a sector master plan, national health strategy, and clear financial management functions are facilitating conditions for applying program based approaches. In order to strengthen coordination and dialogue, the HPG was formed and has become the main forum for health sector policy dialogue and exchange of information in the health sector. The HPG has agreed with the MoH to implement the JAHRs, which are considered as a joint voice of the stakeholders within the sector on priority issues and solutions. The next step will be to incorporate these priorities and solutions into the sector planning and budgeting process. The European Commission (EC) has taken the initiative in developing a programme based approach at the provincial level, and encouraged dialogue through development of a coherent sector strategy, budget framework and capacity building plan.

National tuberculosis programme support

National target programmes are considered one channel for receipt of external assistance from donors [31]. Support for the National TB Control Programme has been ongoing for more than ten years, with two major donors being the Netherlands and the Global Fund.[13] While the Government focuses its budget on "hardware" such as procurement of medicines and equipment, the donors provide "software" support including capacity building and development of new initiatives such as the public private partnership. Of the total budget of USD 48 million, the Global Fund contributed 36%, the Netherlands 26% and government funds almost 40%, accounting for the largest share.

Funding is channelled through government systems and donors comply with national target programmes in the implementation of activities. An advantage of the alignment is that the system for implementation is strong from the national level through to the provincial, district and commune level.[14] The key problems emerging from the implementation process were:

[13] This is an example of program support, providing support based on national target programs of the Government. In some documents (Ministry of Planning and Investment), this is called targeted budget support. However, it is still questionable whether this should be considered budget support. In reality, support to the Tuberculosis program was implemented like a project, with a separate management unit, although the donor (e.g. the Netherlands), was determined to shift to budget support fully utilizing Government systems.

[14] At the national level, the National Hospital of Tuberculosis and Respiratory Diseases is managing the National Tuberculosis Control Program. At the provincial level, the provincial hospitals or centers

- There are no formal procedures to apply to donors regarding use of their assistance funds Donors were asked to introduce different norms from those of the Government, and to submit additional reports for their own funds. The approval procedures still follow the project approval process.[15]
- National target programme staff preferred to use the donors' norms as these incorporated greater incentives for implementation.
- Extra reporting was required for each donor, not according to donor requirements, but rather due to Vietnamese Government requirements. This created a heavier burden on government staff.
- Impact on the government system was limited to the TB control programme.

The programme-based support approach adopted in the TB control programme is similar to that for the Education for All Action Plan, using the national target programme in the education sector as a vehicle for implementation. Unlike the National TB Control Programme, target-based budget support in the education sector was completely aligned with government systems. There were no separate requirements in terms of reporting, auditing or supervision. Problems arising from this alignment were that donors were not satisfied with the reporting and delays in disbursement were caused as a result of such disagreements [23].

Programme-based support for provincial health systems

Over the past two years, the EC has conducted several studies in three provinces (Bac Giang, Bac Ninh and Ha Nam) to assess the conditions for implementing pilot provincial health support programmes. The studies revealed that a number of challenges would have to be met in order for a programme-based approach to be implemented at the province level:

- The planning process still focused too much on inputs (e.g. number of patient beds). The annual budget increased incrementally, but was not based on sectoral priorities. A switch from input-based to result-based planning is necessary.
- At the provincial level, while 5-year plans exist in the health sector, with objectives and targets, annual planning is not entirely linked to the 5-year plans.
- Cooperation between different provincial line departments (Department of Health, Department of Finance, Department of Planning and Investment, etc.) is still weak, which slowed the process of negotiating budget support for priority health objectives.

The EC is planning to provide support for pilot provinces to develop sector strategies in line with the national strategy and linked with the provincial MTEF. A synthesis of the findings and lessons learnt in implementing the programme-based approach needs to be made.

for Tuberculosis and Respiratory Diseases are the main counterparts for service provision, supervision of activities of the lower levels, developing standard targets and referral system. At the district level, the Tuberculosis control teams at the district hospital or preventive medicine centers treat TB patients. TB patients are monitored and receive drugs at the commune health stations.

[15] When the Netherlands expressed the desire to provide budget support, many impediments and a lack of detailed guidelines were revealed.

Seeking consensus in the implementation of the programme-based approach

There is a lack of consensus with regards to financial mechanisms and approval procedures for the application of the programme-based approach. It is claimed that Decree 131 is the key document to guide implementation of different support approaches, but it does not give details of the financial mechanism and approval procedures for budget support. Lessons learnt from other ministries on adoption of the programme-based approach need to be extensively disseminated, e.g. the World Bank's Development Programme Loan for Higher Education, under the Ministry of Education and Training, and the Comprehensive Capacity Building Programme on ODA Management (CCBP), implemented by the Ministry of Planning and Investment.

5.3 Selection of aid modality

Like other sectors, there has not been a formalized process for modality selection in the health sector. There is an on-going exchange of ideas between the MoH and donors through the HPG on assistance modalities for the health sector in the coming years. The Department of Planning and Finance is a key player in discussions with donors on the approach and proposals for projects/programmes. The perspective of the MoH and donors is to have a flexible mechanism for selection of assistance modalities in order to satisfy the management requirements of the Government, policies of the donors, and to use donor funds effectively to satisfy the objectives set out.

6. Priority issues

The discussions above indicate that the Vietnamese health sector is encountering multiple challenges in attracting and productively utilizing external assistance, some of the most challenging priorities include:

1) The absence of a policy framework linking different sub-sectors and problems of the sector, for example to manage and supervise human resources, at the same time linking the roles and functions of the MoH and the health system with other players such as the private sector, occupational associations and other relevant ministries. The MTEF for the health sector is still only in the trial stages, and has not yet become a formal document for donors to align with.
2) Inadequate coordination to increase aid effectiveness and to avoid duplication and fragmentation.
3) Inconsistencies and lack of harmonization between Government and donor procedures, guidelines and regulations.
4) Absence of conditions to adopt new support approaches, and lack of evidence on the effectiveness of various aid modalities to inform dialogue between the MoH and donors, as well as among donors.

Chapter VI. Household direct out-of-pocket health expenditure

Household direct out-of-pocket health expenditure is an important indicator for assessing equity in a health system. In Viet Nam, household out-of-pocket health expenditure as a proportion of society's total health expenditure is high, ranging from 60% to 70%. This chapter examines the current situation and expected trends in household out-of-pocket health expenditure in the near future to create a basis for making recommendations on how to gradually decrease this inequitable form of health expenditure.

1. Relevant concepts

Household health expenditure is the total spending of a household on all of its health-related needs, including preventive, promotive and curative care. Household health expenditures can include pre-payment before an illness (e.g. to purchase health insurance) or direct out-of-pocket health expenditures when using health services (e.g. paying hospital user fees).

Direct out-of-pocket payment for health care refers to the expenditures households make directly when they use services, primarily purchase of drugs, payment of hospital user fees, diagnostic service fees and other indirect expenses related to seeking medical care at state or private facilities (including self-medication). These direct expenditures often create a financial burden for patients and are among the causes of impoverishment and inequity in health care. In order to reach the goal of equity in health care, it is necessary to increase state budget health expenditures, expand pre-paid expenditures (health insurance) and reduce to a minimum direct out-of-pocket health spending by households.

Catastrophic health expenditures are direct household out-of-pocket health expenditures (usually calculated over a year) that exceed household ability-to-pay based on some standard threshold (for example, health spending accounting for 40% or more of total non-food household expenditures). Household ability-to-pay is measured as the amount of income remaining to the household after paying for food costs.

2. An overview of policies affecting household out-of-pocket health expenditure

Prior to the "Renovation", the Government provided free health care to the population. Therefore household out-of-pocket health spending was very low.

In 1989, the Government issued Decision No. 45-HDBT, on collection of partial user fees, which was subsequently updated and revised by the 1994 Decree No. 95-CP and the 1995 Decree No. 33-CP. These policies had the positive effect of increasing revenues of hospitals and hospital budgets, but they also forced the people to pay part of service costs, increasing household out-of-pocket spending for health services.

Since 2002, the implementation of a policy of financial autonomy in public hospitals according to the 2002 Decree No. 10-CP and the 2006 Decree No. 43-CP, and the policy of social mobilization which advocated for mobilizing non-budgetary financial resources, has led many hospitals to diversify the forms of health services they provide, facilitating

opportunities for patients to obtain better health care. However, as a result the people often have to spend more from their own pockets on health care services.

In addition to policies related to partial user fee collection, the Government has also adopted policies supporting health care costs for the poor and other vulnerable groups, including Prime Ministerial Decision No. 139/2002/QD-TTg on curative care for the poor and Government Decree No. 36/2005/ND-CP on free healthcare for children under age six. The Government also has policies to subsidize health care costs for other social policy beneficiaries including the elderly aged 85 and older, the disabled, the elderly without family support… These policies have contributed considerably to reducing household out-of-pocket health expenditure.

Politburo Resolution No. 46, dated 23 February 2005, has laid out an important orientation to ensure equity in health care for the general population: "to renovate and refine health financing policies with a view towards a rapid increase in the proportion of the public expenditure share (state budget, health insurance), and gradual declines in the form of direct out-of-pocket health spending of patients."

3. The situation of household out-of-pocket health expenditure

3.1 Household out-of-pocket health expenditure share

Household out-of-pocket health expenditure accounts for a large proportion of the total health expenditure. According to the MoH National Health Accounts data [12], 2004 - 2006, the figures were 63.9%, 65.8% and 62.8% respectively in 2004, 2005, and 2006 (Table 7). Based on the Minister of Health's May 2008 presentation to the National Assembly on social mobilization in health care, the state budget currently only covers around 30% of total health expenditures, while another 60% is expended by the people, mostly for user fees and self-medication, with the remaining 10% being contributed from agencies and the business community. According to the World Health Organization (WHO), this is a very high share of health expenditures coming from household out-of-pocket spending, leading to inequity in health care.

However, according to World Bank calculations, in 2005, Viet Nam spent some 5% of GDP on health care with household out-of-pocket spending accounting for as much as 70% of total health expenditures of the entire society, reaching even higher in 2004 at 73% [37].

Table 7: Household out-of-pocket health spending, 2000 - 2006 (VND billion)

Year	2000	2001	2002	2003	2004	2005	2006
Total health expenditure	23,289	26,869	27,508	32,017	39,511	49,577	62,685
Household health expenditure	14,611	15,689	15,576	17,645	25,251	31,988	38,107
Percentage	*62.74*	*58.40*	*56.62*	*55.11*	*63.91*	*64.52*	*60.79*

Source: National Health Accounts, MoH, 2008 [12]

According to data from the National Health Accounts for 2001–2006, household out-of-pocket health expenditure as a percentage of the society's total health expenditure has been declining, although this change is very small and fluctuates over the years. While the percentage in 2000 was 62.7%, in the years 2001, 2002 and 2003, this percentage declined to 58.4%, 56.6% and 55.1% respectively, although in 2004 and 2005 it increased again to 63.9% and 64.5%, declining again in 2006 to 60.8%. Despite the minor fluctuations of out-of-pocket spending over the years, the above figures provide an overall picture of generally limited support from public financial resources, accounting for only 23.4% to 31.8% of the society's total health expenditure.

3.2 Structure of household out-of-pocket health expenditure

In 2006, on a per capita basis, direct household health expenditure was VND 452,000 (USD 27) [12]. Household out-of-pocket spending on health care in Viet Nam accounts for a large share of total health expenditure. As indicated by the National Health Survey in 2002, as much as 70% of household out-of-pocket payments are spent on inpatient and outpatient treatment (both in public and private facilities) with the remaining 30% being spent on self-medication and procurement of health-related materials [38]. For inpatients, user fees account for only 60% while the remaining 40% includes other indirect costs (lodging, meals, transportation and gifts to health workers) and purchases of additional drugs and health services outside the treatment facility. The share of such indirect costs increases the higher the level of facility used [38]. In contrast to inpatient spending, about 84% of outpatient spending of households is to purchase drugs and health services, with indirect costs accounting for only 16%.

3.3 Effects of out-of-pocket health expenditure on households

Health expenditures, particularly out-of-pocket payments, are generally different from spending on other goods and services, since they are unwanted expenditures made in response to often unexpected and unpredictable negative health events, which have an entirely negative effect on household welfare, cutting into resources that could be used to purchase other goods and services. Out-of-pocket household health expenditures can result in inequity in health care in a variety of ways.

Direct out-of-pocket payment of user fees can limit access and utilization of services not only for poor households but also for the not so poor. Generally, expenditure on inpatient care from household out-of-pocket resources is quite high. The richest living standard quintile spends 2.5 times more than the poorest quintile, suggesting a greater use of medical services by the better off. Results of analysis of the Viet Nam National Health Survey 2001-2002 found that if a poor person is hospitalized without government support, on average for each inpatient episode they will have to spend the equivalent of 17 months of household non-

food expenditures [39]. In the case that a poor patient is covered by health insurance, their out-of-pocket health expenditures decline considerably, however because they have to pay for other expenditure items not covered by health insurance including some drugs, materials, IVs, health expenditures still cause a considerable burden for the household. Thus, when it comes to illness, if the out-of-pocket resources are the only resort, some households may not use health services because they simply cannot afford them. If they do use medical services, many will have to sell their property or means of livelihood to pay for the hospital costs and this may set them on the road to poverty.

In respect of outpatient care, although one-time costs may not be high, the accumulation of costs over multiple treatment visits in a year will create no less a burden than for inpatient care. Patients covered by the health insurance fund or entitled to exemptions or reductions in medical care fees, can be expected to pay an acceptable amount, 7% - 25% of the monthly non-food expenditure for a family member. However, in the event that a poor person doesn't have health insurance and thus has to pay entirely out of his own pocket for health services, the costs can soar up to 75% of the monthly non-food per capita expenditure of a household. That is obviously an extremely heavy burden for poor households, especially in the case of chronic illnesses that require prolonged treatment and multiple uses of outpatient services [40].

Direct out-of-pocket health expenditures are an important cause of impoverishment. For the poor, medium-income groups and even for the better off, just one inpatient stay may lead to high medical expenditures, which can easily lead to debts and poverty. A 2003 research study indicated that 10.45% of Vietnamese households were affected by catastrophic health expenditures- the highest of all 59 countries included in the study [41]. Although the share of households suffering catastrophic health expenditures has seen a clear decline from 1992 to 2006, this share is still at a high level compared to other countries [42] (Table 8).

Table 8: Percentage of households facing catastrophic health expenditures (1995~2000)

Country	Percentage of households	Year
Viet Nam	10.45	1997
Cambodia	5.02	1999
Ukraine	3.87	1996
Republic of Korea	1.73	1999
Bangladesh	1.21	1995/96
Thailand	0.80	1998
Philippines	0.78	1997
Slovenia	0.06	1997
UK	0.04	1999/2000

Source: K. Xu et al. [41]

In general, spending on inpatient treatment is a heavy burden for the people. A survey on health expenditure in 30 hospitals indicates that when compared to the average monthly non-food expenditure across the entire country, the expenditure on an inpatient treatment episode of acute pneumonia for a child under 5 years of age was some 6.5 times higher, in the case of appendicitis 11 times higher, and in the case of a stroke 22 times higher, almost equivalent to the non-food expenditure of an average person for two years [43].

One common strategy employed by households to deal with the health expenditure burden is to borrow money or sell assets. According to the Viet Nam National Health Survey, around one-third of the total number of inpatients had to borrow money to pay for their health care needs, of them, about 10% had to part with their assets and 3.3% had to rely both on loans and sales of assets. Many more poor people are obliged to borrow money to pay for inpatient care than those from the medium and high-income groups. Nearly two thirds of the poor had to borrow money and sell properties to pay for health care. Even a large number of medium-income people without health insurance had to resort to debt and sales of assets. Clearly, health expenditure is a significant burden not only for the poor but also for households with medium income.

The aforementioned negative impacts of household out-of-pocket health expenditures lead to limited ability to access health care of a portion of the population and is a main cause of increased health status disparities between population groups.

3.4 Factors influencing out-of-pocket health expenditure

As discussed above, out-of-pocket health expenditures are already high and may continue to rise. In order to reduce out-of-pocket health expenditures of households, it is necessary to analyse the major contributory factors. Household out-of-pocket health expenditures are influenced by many factors, which can be categorized into policy factors, health service delivery factors and household factors.

Policy factors

In general, many policies can be used to reduce out-of-pocket spending. First, increasing the state budget share for health care can help reduce the need for expenditures from other funding sources including household out-of-pocket spending. Management policies and solutions that increase cost-effectiveness, reduce abuses of health services, encourage appropriate use of services at the correct referral level can all help to reduce out-of-pocket health spending.

The amount of state budget being allocated to health services is increasing slowly while household and other social spending on health care is rising rapidly, leading to a reduction in the state budget share of hospital funding resources. MoH statistics show that user fees accounted for an increasing share of hospital financing sources during the period 2001 – 2005 [44]. During those five years, the proportions were 27.1%, 27.9%, 34.5%, 33.9% and 33.5%, respectively. The state budget share, while still accounting for almost 50% of curative care spending (47.3% on average over the five years, 2001 – 2005), has seen a downward trend from 55.2% in 2001 to 42.6% in 2005. Thus, revenues from user fees are becoming the main source of income for curative care facilities. Despite efforts to increase public health financing (from state budget, external assistance and health insurance), household out-of-pocket health expenditure as a proportion of health expenditure of the whole society remains high and negatively affects equity in health care.

Health service delivery factors

The delivery of health services has a direct impact on patients. If the qualifications and skills of health workers are improved, physical infrastructure and equipment are upgraded, the quality of drugs and diagnostic techniques are assured, these will all contribute to improving the quality of treatment and reducing health care costs by reducing the duration

of treatment. Appropriate management solutions and financial mechanisms that encourage rational use of health services will also help reduce health expenditures.

On the other hand, some other factors in this category can directly increase household out-of-pocket health spending, including overuse of laboratory tests and diagnostic imaging by some physicians, especially in the context of increased reliance on the market mechanism in health care, financial autonomy and social mobilization to install expensive diagnostic equipment for revenue generation.

Household factors

From the perspective of the people, even if the policy and health service delivery factors remain as they are, the people can still actively reduce their direct health expenditures through actively preventing illness, seeking care early when they suffer from health problems, limiting self-medication and finding out more information about their diagnosis and treatment in order to choose the most appropriate health care services. It is vital that the people raise their awareness about health insurance and participate more actively, reducing the risk of high out-of-pocket expenditures for themselves and others in their community.

4. Priority Issues

The above analysis has indicated that household out-of-pocket health expenditure in Viet Nam accounts for a very high share of total health expenditure of society, which could lead to inequity in health care. This situation arises from many causes related to shortcomings in health financing policies, which points to certain problems that could be considered as high priorities, including:

1) Soaring household out-of-pocket spending as a result of increasing user fees in public hospitals.
2) Ineffective health care seeking behaviour and use of health services by the people.
3) Health-related social protection system falling short of need.

Chapter VII. Social mobilization of financial resources for health

Social mobilization is a key policy on the agenda of the Party and Government, aiming to mobilize resources and the potential of the entire society for the purposes of protection and care of the people's health. Social mobilization covers a broad range of issues, but this chapter will focus on analyzing and assessing the current situation, as well as the advantages and disadvantages of implementing social mobilization of financial resources for health. On the basis of this analysis, recommendations will be made for improving efficiency and equity in mobilizing the society's financial resources for health. Issues concerning various concepts and perspectives on "social mobilization" will also be analyzed to provide a common foundation for evaluating related policies.

1. The concept of "Social mobilization"

For the past 10 years, "social mobilization" has become a major orientation and an important solution, especially in reforms that have taken place in the sectors of health care, education and culture in Viet Nam. According to Government Decree No. 73/1999/ND-CP, dated 19 August 1999, "Social mobilization in the areas of education, health care, culture and sports is the promotion and facilitation of the extensive involvement of the people and entire society in the development of these fields in order to steadily improve the level of benefit from education, health, culture and sports in both the physical and mental development of the people".

Government Resolution No. 05/2005/NQ-CP, dated 18 April 2005 clearly states that social mobilization has two major aims: first, to bring into play the intellectual and physical potential of the people and involve the entire society in developing education, health care, culture and sports, and second, to create conditions for the entire society, especially policy beneficiary target groups and the poor, to enjoy the increasing benefits from achievements in education, health care, culture and sports.

Thus, the core contents of the social mobilization policy, are to mobilize the human, physical and financial resource potential of the entire society, through reforming the management mechanisms and diversifying the modes of operation and sources of investment funds in order to create conditions for the whole society to benefit from improved outcomes.

2. Overview of the policy of social mobilization for health

In 1996, the VIIIth Party Congress asserted that "all social policy issues will be addressed through the principle of social mobilization. While the Government retains a key role, the people, business community, social organizations, individuals and international organizations should be encouraged to work together to solve social issues" [45]. While this is the first time the term 'social mobilization' was specifically mentioned in a Party document, as early as 1986, the VIth Party Congress committed itself to the credo of "the Government and the people working together" and made it clear that health care should be the responsibility and also the immediate concern of each and every citizen. This was followed by policies such as "the development of health activities with the resources of the Government and the people" (1991) [46] and "the diversification of forms of health care provision, in which the public sector has the leading role" (1993) [20].

To provide guidance for the implementation of the social mobilization policy, the Government has issued many important documents [47-51]. According to Government Resolution No. 05/2005/NQ-CP, social mobilization for health covers the following major areas.

1) *Continue to invest more government resources in health*, including ensuring financial resources for public health, provision of basic health care for policy beneficiary target groups, the poor and children under 6 years of age. Give priority to investments for the preventive health system, the grassroots health care network, especially in remote, isolated and disadvantaged areas, children's hospitals, paediatric departments and specialist clinical areas that are less likely to attract investment. Implement projects to train doctors and pharmacists at the university level to work in the Northern Uplands, the Central Region, Central Highlands and Mekong Delta. Give priority to investment in development of pharmaceutical materials resources and domestic production of drugs.

2) *Strengthen activities for the care and protection of the people's health*. Urge every community member to play a role in the care and protection of their own health, that of their family and their community. Encourage individuals and organizations, both local and international, to participate in charity activities, to provide support in terms of medical equipment and curative care.

3) *Accelerate the pace of development and improvement in the quality of health insurance*. Strengthen and expand health insurance with a view to diversifying forms of health insurance to meets people's health care needs. Vigorously promote community-based health insurance based mainly on contributions from the insured, with support from the Government and other funding sources. Encourage voluntary forms of health insurance.[16] Increase the number of health facilities registered for health insurance reimbursement of their services. Gradually allow health insured patients to choose the service provider they prefer. The Government stipulates the health insurance reimbursement mechanism, while giving preferences to target groups, children under 6 years of age, support for the poor, ethnic minority groups and people living in disadvantaged areas.

4) *Pursue reform of the hospital user fee system* based on accurate and comprehensive calculations of direct service costs. Gradually switch from providing recurrent budgets to service providers towards providing direct subsidies to users in the form of health insurance.

5) *Encourage the opening of private hospitals, clinics and family doctors.*

6) *Mobilize contributions from communities in society* for the development of public services, to gradually replace the role of state budget subsidies (Decree No. 43/2006/ND-CP).

The above discussion reveals that social mobilization in health is a multi-faceted and complex policy requiring major changes in the administration system. However, this chapter of the review will merely focus on the topic of mobilizing financial resources for health care – an important yet sensitive part of the social mobilization policy that requires careful guidance if the targets of equity and efficiency in health financing are to be satisfactorily achieved.

[16] The policy on developing voluntary health insurance has since changed.

3. An overview of social mobilization of financial resources for health

The recent application of the social mobilization policy in health care indicates that the mobilization of financing for health has been implemented through a variety of forms as outlined below:

- Policy on partial user fee collection (applicable since 1989)
- Policy on health insurance (applicable since 1992)
- Mobilizing resources for development of public health services
- Development of the private health sector.

Evaluations and analysis of the partial user fee collection and health insurance policies have already been covered in previous chapters. This chapter will undertake an in-depth analysis of the two remaining forms of social mobilization, namely the mobilization of resources for investment in state health facilities and development of the private health sector.

3.1 Mobilizing resources for development of state health services

In order to implement the social mobilization policy, a project called "Promotion of social mobilization for the protection, care and improvement of people's health" was approved by a MoH Decision dated 21 June 2005 and recommended a series of solutions including "mobilizing resources for development of the state health care system". Specifically, this solution calls for "encouragement of health services, sanatoria and rehabilitation centres to mobilize non-state financial resources, engage in business collaborations and joint-ventures with businesses and individuals to develop infrastructure, upgrade equipment and provide health services in line with the approved plans" [52].

The mobilization of resources for investment in state health services is currently being undertaken in two main forms:

- Joint ventures and business collaborations for the upgrade of medical equipment in public hospitals.
- Development of "elective" services[17] in public hospitals.

Joint ventures and business collaborations for the upgrade of medical equipment in public hospitals

Positive effects have resulted from joint ventures and business collaborations in public hospitals in terms of addressing urgent needs for upgrading medical equipment, especially high tech equipment, serving in a timely manner the health care needs of the people in a context of a shortage of state budget funds for procurement of equipment. Results of a study have shown that in almost all hospitals, the number of items of medical equipment valued at more than VND 10 million is now considerably higher than before the financial autonomization policy was introduced. However, the extent and form of investment vary considerably between hospitals. Hospitals with a high level of financial autonomy often rely on joint ventures and business collaborations in which the investor installs the equipment at

[17] Elective services in this context refer to services for which patients pay additional fees in return for better quality services, for example, shorter waiting time, better quality room, higher tech equipment…

the hospital and the two sides share profits or Build Operate Transfer (BOT) [18] arrangements to obtain new and high tech equipment [53].

To date, according to a government report [6], public hospitals have succeeded in raising about VND 3 trillion for investment in high technologies. Of these funds more than VND 500 billion was raised by hospitals under the MoH, almost VND 1 trillion was mobilized and borrowed from special funds[19] in Ho Chi Minh City, more than VND 100 billion was mobilized for investment in facilities in Hanoi, VND 50 billion was raised in Quang Ninh province, etc.

One issue of concern here, however, is that most of the investments are made by private entities, with resources used to purchase equipment for profit motives, which leads to undesirable outcomes, such as over-servicing, which increases costs to patients. Access to and use of non-profit loans from development banks or government bonds or loans from other non-profit institutions to overcome the shortage of funds remains very limited.

Another aspect of the problem relates to questions about the criteria used when procuring expensive high-tech equipment, standards for when and for whom the equipment should be used, and whether it is used effectively.[20] These issues require further assessment in order to issues regulations aimed at efficient implementation of social mobilization in the health sector, while ensuring equity in health care for the people.

The current low level of investment in public hospitals [54], coupled with the increasing number of privately funded joint ventures and business collaborations in public hospitals, without a system in place for the strict control of prescribing use of high-tech equipment, may result in an increase in the proportion of hospital fees paid out-of-pocket by households. The 2007 Hospital Report covering 731 hospitals conducted by the MoH Department of Therapy (now called Medical Services Administration) indicates that the main source of hospital revenue is from user fees, accounting for 59.4% of all revenues and representing an increase of 26.5% compared with 2006 [55]. An increased proportion of hospital fees paid out-of-pocket by patients will lead to limitations in access to health services by the poor and near-poor.

Another issue of concern comes from findings of an assessment of medical equipment in a sample of provincial general hospitals, which indicated that about 20% of medical equipment was not used to full capacity [56]. This implies that effectiveness in the use of funding through social mobilization is not high as reflected in the uncoordinated investment in equipment, sometimes exceeding actual demand, or lack of coordination in training

[18] The investor builds and operates the facility (or piece of equipment) for a certain period of time and on expiration of the investment period, transfers, without refund, the facility (or piece of equipment) to a public service facility.

[19] "Special funds" lend capital for which the state budget pays the interest (the investor only pays back the principle).

[20] Statistics from Binh Dinh General Hospital indicate that revenues from high-tech services in 2007 were VND 15.8 billion of which: 50.2% came from health insurance (including health insurance for the poor), 46.5% from user fees, 3.2% from health care for children under 6 years of age. The structure of expenditures from these revenues were as follows: expenditure on chemicals, supplies, stationary, electricity, water; labour; management; maintenance and depreciation of fixed assets amounted to 45.7%. The remainder was a before-tax profit of about 54.3%. Payment of entreprise profit tax was 28%. Total profits after taxes were VND 6.2 billion (39%), which were allocated as follows: 40% contributed to the provincial general hospital fund and the remaining 60% of profits divided amongst people contributing capital.

between the equipment operators and clinical practitioners (resulting in an even greater need to overuse diagnostic equipment to compensate for losses).

In addition, joint ventures or business collaborations for investment in medical equipment in public hospitals, under conditions of a lack of MoH regulations on technical standards for laboratories, could result in overuse of testing in many health facilities with the goals of recovering investment capital, and ultimately could impose an unnecessary financial burden on people using health services. This implies the necessity for the formulation and enforcement of a control system for prescribing and using high technology equipment to ensure quality of care, along with cost-effectiveness and equity in health.

The establishment of joint ventures and business collaborations are only really viable in central and provincial hospitals, because they offer secondary and tertiary level care and have a large number of patients. District health care and preventive health services, on the other hand, are facing huge challenges in implementing social mobilization in order to attract private investment, joint ventures and business collaborations.[21]

Another concern is the inadequacy of existing guidelines on reforming operations of state health facilities, as well as the organization of "elective" services, joint ventures and business collaborations in public hospitals. Reports from some health facilities indicate that the lack of concrete guidelines creates confusion for public hospitals when implementing joint ventures or business collaborations for use of medical equipment. Some of the confusion is related to the extent and scope of their financial autonomy and right to enter joint ventures or business collaborations related to equipment (types of equipment as well as profit share allowed). Almost all localities have faced impediments in implementing autonomy due to the lack of specific guidelines in the appraisal of land value contributed in joint ventures. The joint venture partner is only allowed to provide equipment, however the land and premises still belong to the Government. It is a challenge to come up with a formula to calculate how profits should be shared [53].

As the report of the National Assembly Standing Committee [5] indicated, public hospitals are in dire need of regulatory provisions on the use of public properties and land as shares in joint-ventures and business collaborations and for the development of "elective" service treatment facilities, in order to avoid the ambiguous division between private and public assets.

Many believe that the Government should invest using a more uniform approach to modernizing public hospitals through use of state budget and other legitimate resources. At the same time, there is a need for policy to strongly promote the development of private hospitals, to overcome the mixing up of public and private assets. This is a problem that should continue to be evaluated in greater depth and comprehensiveness.

Development of "elective" health services in public hospitals

Changes in hospital investment can be seen very clearly at larger hospitals. Many hospitals have plans to build and expand, but with a strong focus on wards for providing "elective" health services, i.e. where the facility can charge additional fees for preferential or priority services. The area that tends to receive the most investment is in diagnostic imaging

[21] Some district hospitals did set up lab testing equipment but had to close down after 1-2 months of operation due to low usage rates and losses, causing investors to withdraw their investments.

equipment such as CT scanners, colour ultrasound, digital X- ray, and endoscopic equipment, etc. primarily to serve patients electing to pay more to use these services.

Once the financial autonomy policy began implementation, most hospitals focused their attention on development of these "elective" services because they consider these to be revenue generators. Some hospitals have separate wards for "elective" services, while others integrate them into the regular treatment facilities.

The "elective" health services approach has developed primarily in larger hospitals, such as provincial and district hospitals where the population density is higher and people are better off. Forms of "elective" health services vary across hospitals, from "special patient rooms" and ""elective" surgery" to "after-hours examinations", etc. With regard to user fees for "elective" services, a survey conducted by the Health Strategy and Policy Institute in 14 provincial and district hospitals revealed that there are usually two different user fee schedules, one for normal services and one for "elective" services. Fees for "elective" services vary substantially across hospitals[22]. This reflects the highly diversified forms of "elective" health service delivery in public hospitals in the absence of specific provisions for more uniform implementation.

There is currently no distinction between public and private assets in "elective" health service facilities. Physical facilities and some furnishings, such as beds and closets, are still owned by the hospital. The juxtaposition of images of patients being treated in spacious, fully-furnished rooms in the "elective" care wards with images of two to three patients sharing one bed in the same public hospital have sometimes led to public outrage related to equity in health care. This is also why in some places there is as yet no consensus about the implementation of "elective" service provision and joint ventures or business collaborations in public hospitals.

In short, the social mobilization of funds for investment in health facilities through joint ventures, business collaborations to upgrade equipment and the development of "elective" health care services in public hospitals has yielded some positive benefits. However, it has also created many concerns about equity and efficiency. The Prime Minister has recently requested relevant Ministries to report on the performance of implementation of the social mobilization policy to date and develop a "Project on social mobilization for specific public services and continue to reform the operations of public service units" for review by the Party and Government by year end [11].

3.2 The development of private health services

The promotion of private medical and pharmaceutical services is stipulated in ordinances, and resolutions of the National Assembly [57, 58]. The legislation has created the legal basis for the establishment of nearly 70 private hospitals, almost 30,000 private clinics, 21,600 private pharmacies and distributors, and 450 traditional medicine production facilities manufacturing more than 2,000 herbal products. The private health care sector has taken care of a large proportion of outpatients, relieving the overcrowding in public facilities and providing more convenient conditions for the public in need of health care. Some private

[22] The charges for special patient beds in Tu Du hospital range from VND 300,000-500,000/day; In Tien Giang they range from VND 30,000-80,000/day; In Cai Lay hospital the range is from VND 50,000-100,000/day.

hospitals have invested in advanced technologies, which allows patients to seek treatment in Viet Nam, rather than spending large amounts of money to seek health care overseas.

However, the performance of the private health sector, both in terms of quantity and quality, has yet to realize its full potential. Most private facilities only offer easy-to-deliver services and lucrative tests and clinical imaging services. Most private hospitals are small in size and are mainly located in large cities, with low bed occupancy rates[23]. According to the 2007 hospital inventory report of 731 hospitals, conducted by the MoH Department of Therapy, bed occupancy rates in private hospitals were 67.8% in 2006 and 74.7% in 2007; while average bed occupancy rates across all levels of public hospitals were 118.1% in 2006 and 122.4% in 2007 [55]. The number of inpatient visits treated in private hospitals accounted for a relatively small share of total inpatients in all levels of public hospitals (only 1.9% in 2006 and 2.2% in 2007).

Information from some private facilities indicates that regulatory provisions on the establishment and operation of private health services are considered appropriate. Current difficulties facing them are mainly related to the high tax rate[24], lack of convenient location for the development of private hospitals or hardship undertaking the administrative procedures involved in the construction of private hospitals.

The current manpower shortages in both public and private hospitals are a major barrier to the realization of social mobilization in health care. The need for health human resources for private services increased immediately after the ratification of the Ordinance on private medical and pharmaceutical practice in 1994, however projections of demand for human resources and the facilitation and encouragement of health human resource training to satisfy the need for human resources for the private sector remain limited. To date, to recruit staff, private facilities still rely largely on public health services. Almost 60% of doctors in private services are concurrently working in public hospitals, while in some public hospitals at the central level and in large cities, a doctor may examine 60 – 80 patients a day on average, making it difficult to ensure adequate quality of care.

Public administration in the private sector is generally weak. Most private services are not registered with the appropriate organizations to facilitate management of professional standards. Collection of information on the private sector and the management and supervision of quality of care in private health facilities are also facing multiples obstacles.

3.3 Challenges in social mobilization of financial resources for health

As discussed above, the challenges in social mobilization for public health can be identified as follows:

1) Awareness of the meaning of social mobilization in the health sector, and mobilization of financial resources for health care in particular, are not yet uniformly understood. The social mobilization policy covers a variety of aspects, including health promotion, development of health insurance, “elective” health care services, joint ventures and business collaborations, hospital financial autonomy, development of the private health sector, user fees, etc. As long as there are financial difficulties, the social mobilization of resources will be necessary, but in many places, the main

[23] In Hanoi, there are nine private hospitals, with about 20-60 beds, and low bed occupancy rates; Information from Health Policy Options; Vietnam Health Report, 2006, JAHR 2007

[24] Some private hospitals established in the Business Law pay taxes at a rate of 28%

interest has only been to raise capital that increases revenues and yields profits, without distinguishing between equitable and inequitable funding sources.

2) The health system has not been very successful in mobilizing financial resources from not-for-profit lending institutions, but has mobilized capital mostly from profit-driven private investors, which may lead to undesirable results.

3) The joint venture and business collaboration mechanisms for development of public hospitals and "elective" health service activities are not sufficiently clear. There is a need for a comprehensive and reliable health information system covering private investment in health care, joint ventures and business collaborations between public hospitals and private investors and "elective" health services in public hospitals.

4) Overuse of health services and technology in health facilities (both public and private) has yet to be controlled or limited. Such behaviour may be motivated by the attitude of those hospitals and health services to exhaust all revenue potential when undertaking joint ventures or business collaborations to invest in medical equipment or when mobilizing loans from profit-motivated lenders.

5) The development of the private sector suffers from many impediments due to the lack of preferential policies for taxes and land for construction.

6) The social mobilization of financial resources for the development of public hospitals may have undesirable social consequences, which should be comprehensively assessed in order to refine policies, including:

Differential benefits to service users: Investment from private funding sources and operation of "elective" health care services has mostly served the needs of high-income people able to access these services. In localities with better-off social and economic conditions, mobilizing financial resources is easy, while in almost all disadvantaged regions, especially the mountainous, remote and isolated areas, mobilization of financial resources of society is near impossible.

Impact on hospitals and their staff: Social mobilization of resources to develop "elective" health services and to upgrade medical equipment, which is linked with cost recovery and profit motives (when hospital staff are shareholders), has contributed to easing the budget shortage and supplementing incomes for the staff in large hospitals. However, this can also lead to disparities in income between health workers at different levels of care, clinical specializations and locations.[25] The movement of highly qualified medical staff from upland to lowland areas, from rural to urban areas, from lower to higher level facilities, and from preventive to curative care, has badly affected the health system, particularly the public sector. Furthermore, allowing health facilities to take from health service revenues to supplement resources for salary increases may result in the overuse of diagnostic and treatment technology to exploit all revenue potential, creating a financial burden on patients and the health insurance fund.[26]

[25] At present, hospital pediatrics departments are facing difficulties. Part of the reason is related to financial autonomy in hospitals, the policy on providing free health care services for children under 6 years old, and gaps in health workforce training.

[26] One district preventive medicine centre was able to earn VND 100 million a year through implementation of social mobilization activities, of which VND 40 million was used to supplement salary and VND 10 million for taxes. As too much emphasis has been given to social mobilization and

Regarding the health care system: The development of "elective" health care services and joint ventures or business collaborations with the private sector to upgrade equipment in public hospitals may lead to some ambiguity about whether services are public or private in terms of use of human resources and physical facility ownership, which will ultimately weaken public hospitals, diminishing the integration of the hierarchy of care and breaking up the coherence of the delivery system. This trend will undoubtedly promote the "fee-for-service" approach and increase out-of-pocket payments from patients – the major cause of increased inequity in access to health services.

3.4 Priority issues

Among the aforementioned challenges, the most critical have been identified so appropriate solutions can be found, including:

1) The unsuccessful mobilization of financial resources from not-for-profit lending institutions for the health system rather than profit-driven private investors, which has led to undesirable results.
2) The lack of regulatory systems in administering joint ventures and business collaborations for development of public hospitals; controlling and overcoming over-servicing of health services and high technology in health facilities (both public and private).
3) Impediments to development of the private health sector preventing it from realizing its full potential. Challenges to service quality management and monitoring of the private sector.
4) The need for further evaluation to refine policies to resolve the multi-faceted impacts of some forms of social mobilization for development of public hospitals, including joint ventures or business collaboration to upgrade medical equipment and development of "elective" health care services.

reducing expenditures, preventive health workers have cut down on outbreak control field trips, from which they can only get VND 150,000 per diem a day.

Chapter VIII. Implementation of financial autonomy in state health facilities

One of the guiding policies of the Government and Party in renovating the management mechanism to accord with the socialist-oriented market economy is the step-by-step reform of the public financing system in order to promote ownership, effective use of the state budget and to harness the potential of public services to deliver quality care. This policy is reflected in Government Decree 10/2002/ND-CP and Decree 43/2006/ND-CP on transferring authority and accountability over performance, organization of staff and finances to public service institutions in general, and to state health facilities in particular.

This Chapter aims to give an overview of the current process of implementing financial autonomy in the Vietnamese health sector, especially in curative care services, and identifying priority issues in order to recommend solutions to increase the effective use of resources and limit any adverse effects during the implementation of this important reform policy, in 2009 and subsequent years.

1. Concept of financial autonomy

The “autonomization” process, including financial autonomy, has taken place in many countries around the world as part of the trend of public administration reform in the early 1980s. While the concept has gradually taken shape, a definitive consensus has yet to be reached. According to the World Bank, autonomization and corporatization are reforms that give public service providers more autonomy and rely on market or "market-like" incentives, to improve performance. Both autonomization and corporatization can change decision-making powers, residual claimants and market exposure. These reforms also create more indirect accountability arrangements that give managers more freedom in their day-to-day operations. Accountability in relation to loss-making services and other social functions are also made more explicit, and resources are often readily available to ensure continuous delivery [59].

In Viet Nam, the concept of autonomization in the health sector has not been very clearly defined. Nevertheless, the autonomization process, is ongoing under the general guidance of Government Decree 43/2006/ND-CP which delegates authority and accountability for operations, organization, staffing and financing to public service facilities. Financial autonomy is defined more clearly and categorized into three types: 1) self-financing institutions (those able to finance their entire operating costs); 2) partially self-financing institutions (with the rest subsidized by the Government); and 3) institutions fully subsidized by the state budget (revenue covering less than 10% of total expenditure).

2. Overview of financial autonomy policies

In line with the policy of transition from a centrally planned economy to a socialist-oriented market economy, since 1989 the health financing system has seen considerable changes with the introduction of a series of policies to mobilize different resources for health care. In implementing the policy to strengthen decentralization of management, including decentralization of revenue earning public services, on 16 January 2002, the Government issued Decree No. 10/2002/ND-CP, empowering public services with autonomy in their financing and human resource arrangements for the purpose of unifying management of

revenues, reducing expenditures, assuring recovery of operating costs, reducing staff and increasing income (through payment of "additional salary" from surplus revenues) for workers, based on performance and fulfilment of obligations to the state coffers. To provide guidance for the implementation of this Decree, on 21 March 2002, the Ministry of Finance issued Circular 25/2002/TT-BTC, specifying the financial systems universally applicable to revenue earning public services. As for the health sector in particular, in February 2004, the MoH, Ministry of Finance and Ministry of Home Affairs issued Joint Circular 13/2004/TTLT-BYT-BTC-BNV, providing for specifics on the adoption of the autonomy system on financing, workforce and salaries for revenue earning public health services such as hospitals, institutes with patient beds, centres, training facilities, research institutes, and preventive health services [60].

For public administration agencies and science and technology organizations, the Government issued Decree No. 130/2005/ND-CP regulating authority and accountability for the use of government employees and administrative management expenses and Decree No. 115/2005/ND-CP allowing science and technology organizations to switch their operating modality to one of two modes: self-financing science and technology organizations or science and technology businesses. To date, most state-run public administration agencies have adopted the autonomy mechanism under Decree 130/2005/ND-CP, while no science and technology organizations have applied for financial autonomy under Decree 115/2005/ND-CP.

In the process of implementation, shortcomings in Decree 10 arose, because units were only granted autonomy in finances, but not in staffing and organization. To overcome the shortcomings of Decree 10, on 25 April 2006, the Government issued Decree No. 43/2006/ND-CP, expanding the scope of autonomy and accountability in operations, organization, human resources and financing in all public services. Subsequently, the Ministry of Finance issued Circular 71/2006/TT-BTC to guide implementation of Decree 43, and the MoH and Ministry of Home Affairs issued Joint Circular 02/2008/TTLT-BYT-BNV providing guidance on implementation of certain aspects of Decree 43/2006/ND-CP for state health facilities. In the spirit of Decree 43 and its implementing Circulars, autonomized institutions are allowed to recruit, appoint, transfer and promote government employees (with the exception of "high level" doctors), and to establish, dissolve and re-organize departments, wards and other affiliated units, based on plans or proposals approved by relevant authorities.

With regards to financial autonomy, public institutions are given full power over revenues and expenditures, and encouraged to transform into businesses or non-public institutions. They are also allowed autonomy in setting up development funds, welfare funds, bonus funds, and reserve funds to stabilize income for their workers. They are also allowed to use assets as share capital in joint ventures and business collaborations with foreign and local individuals and organizations in infrastructure construction and procurement of equipment for service delivery purposes in line with their functions and responsibilities as defined by the law. Thus, Decree 43 has provided a generous legal framework for revenue earning public services to fully exploit the autonomy and accountability for their own development and to increase incomes for their employees.

The policy to "Convert public institutions operating under the subsidized and bureaucratically managed public services to autonomous units providing not-for-profit public services without excessive subsidies (in short this is called the "service provision modality")" is also stated in the Government Resolution No. 05/2005/NQ-CP, dated 18 April 2005. MoH

Circular 15/2007/TT-BYT, dated 12 December 2007, provides guidance on implementation of autonomy and accountability related to use of assets in joint ventures, business collaborations or through capital contributions to procure equipment to provide services in state health facilities.

Decentralization and transfer of financial autonomy to health service providers is expected to serve as a lever to strengthen effectiveness of activities, save on expenses, increase revenues from service activities for health facilities and at the same time increase availability of health services to meet the health care needs of the people. However, if the granting of autonomy is not accompanied by improved management capacity, strengthened accountability, transparency and relevant monitoring and oversight, it is more likely to result in the raising of barriers to accessing health services by the poor and near-poor. Experience of decentralization in the health sector in other Asian countries such as China, Indonesia and the Philippines show that the health care system may have to suffer some relatively serious consequences from autonomization that lacks accountability if the management capacity and supervisory systems are not strong enough. Therefore, a sensible approach should be taken in balancing between efforts at increasing revenues and achieving social goals in health care.

3. Implementation of financial autonomy policy

3.1 Directing implementation

Leadership role of relevant agencies

Taking the lead role in the implementation of the financial autonomy policy in state health facilities, the MoH, in cooperation with the Ministry of Finance and the Ministry of Home Affairs, has issued various guiding Circulars and Decisions, reviewed proposals and approved internal expenditure regulations applicable to institutions under the Ministry. Provincial Health Departments also play a key role in setting and assigning performance targets to implementing institutions, as well as giving guidance, monitoring and supervision as to how the policy should be implemented in their own locality. The Provincial Health Departments are also responsible for reviewing proposals and approving internal expenditure regulations of divisions under their jurisdiction, while the local Departments of Finance work in an advisory and consultative role. Budget estimates of the health sector are approved by provincial People's Councils and People's Committees. Training and dissemination of this policy is also a local concern. Nevertheless, in practice, there are a number of obstacles to the effective communication of regulatory documents, limiting awareness of financial autonomy among employees in most state health facilities [53].

The MoH and Provincial Health Departments play the key role in monitoring and oversight of activities, from implementation progress to the process of implementing all aspects of autonomy in the operations of their affiliated divisions. The VSS, in the role of fund manager and payer of health services, also takes an active part in supervision of service providers, both in terms of medical care and finance, by means of auditing. Other relevant local agencies also undertake annual recurrent inspections, inventory and monitoring activities, though mostly on the financial management side only. However, in practice the effectiveness of inspections and supervision remains minimal due to human resource and physical constraints and the absence of a clearly defined monitoring system.

Financial autonomy in the health sector has taken place in two phases:

Financial autonomy under Decree 10/2002/ND-CP (2002 – 2006) was adopted in a conservative fashion. According to MoH reports, by the end of December 2005, 676 health facilities have been authorized with partial financial autonomy, 10 of these under the MoH, 24 under other Ministries and 623 under local management. Some 18 provinces had introduced the system in more than half of their local health facilities, 14 provinces in less than half of their health services, some provinces only piloting a few services and 6 provinces not having even started, including Quang Ngai, Binh Dinh, Dac Nong, Bac Kan, Cao Bang and Dong Thap [61]. All in all, progress in implementing Decree 10 in the health sector was slower than in other sectors, consisting primarily of pilot implementations in health facilities situated in large, heavily populated cities, with high living standards and in facilities with relatively good physical facilities.

Financial autonomy under Decree 43/2006/ND-CP (2006 – present) has been adopted on a much larger scale and has become almost mandatory for all state health facilities. As estimated by the MoH, to date, almost 100% of health facilities at the district level and above have adopted financial autonomy under Decree 43 [62]. Some district health facilities have not yet applied financial autonomy due to limited revenue and insufficient physical, equipment and human resources but are also stepping up their financial autonomy proposals for approval by relevant authorities.

Extent of financial autonomy

Generally speaking, the level of financial autonomy of state health facilities varies substantially across types of facilities, across levels of care and across regions. Facilities in large cities and populous areas with high living standards generally have a higher level of autonomy. The extent of autonomy depends almost entirely on the financial health and existing physical conditions of the entities themselves. It also depends heavily on the management capacity of the institution's leadership. Where the manager is more self-motivated, the level of autonomy is likely to be higher and vice versa. Observations reveal that autonomy in central and provincial/municipal hospitals is much stronger than in district hospitals. The difference is seen not only between fully self-financed hospitals and partially self-financed hospitals or between those adopting autonomy earlier or later but also between entities with the same level of autonomy or duration of applying autonomy. Moreover, the differences can be seen even more clearly in specific aspects for which the facilities have been granted autonomy, including financial management, equipment investment, development of "elective" services, mobilization of or contributions to joint ventures and business collaborations, etc.[53] However, the evaluation of the extent of autonomy at present is only based on qualitative findings and not on specific criteria.

3.2 Some initial achievements

The implementation of financial autonomy in health has witnessed some encouraging achievements, as outlined below:

(1) *Increased power and accountability of managers*. Most agree that once autonomy has been implemented, managers of relevant institutions are more dynamic, enterprising and accountable for corporate performance, with a view to increasing both hospital revenues and incomes for employees.

(2) *Enhanced organizational structures and better use of existing human resources*. The institutions involved have paid attention to restructuring to ensure fewer surplus workers,

greater efficiency, improved quality of recruitment and appointment of key personnel, especially managers. Meanwhile, they also emphasize the importance of training staff and applying new technologies. Management training is beginning to be more focused. However, autonomy in management and use of human resources has thus far been limited to the internal reassignment of staff, rather than to the recruitment and dismissal of staff, due to restrictions in other existing regulatory documents that have yet to be amended. Furthermore, in many upland, remote and isolated areas, human resource management faces many challenges, due to a serious shortage of clinical personnel in these regions.

(3) *Substantial increase of financial revenue*. Reports indicate that revenues of most institutions have increased substantially since the introduction of financial autonomy, especially in the case of curative care (hospitals). Besides the revenues from the state budget, health insurance and user fees as regulated, these institutions have taken initiatives to establish price lists of auxiliary services to create supplementary revenues for their recurrent budgets. Results from one study indicate that 8 out of 12 hospitals had increased the pace of revenue growth after autonomization. However, it should be noted that those hospitals with a high degree of autonomy also tended to have higher revenues to begin with, while the trend is not so clear in district hospitals (with 50% increasing and 50% decreasing revenues) [53]. The structure of revenues has also changed with variation across hospitals. Revenues from user fees, health insurance and "elective" services has increased strongly in central and provincial hospitals, while state budget allocations have declined and only account for one fifth of hospital revenues. However, at the district level, state budget still accounts for a high share (50%) of revenues, health insurance is increasing, but user fee revenues are declining and revenue from "elective" services is limited. Diagnostic testing and clinical imaging services have contributed substantially to rising revenues in most hospitals. This is an issue that requires reconsidering in the context of hospitals maximizing revenues. In the drive to maximize revenues, overuse of diagnostic tests, imaging and drugs is hard to avoid. However, there is a lack of evidence-based assessments about the degree of abuse as well as of analyses and evaluations on the cost-effective use of resources in health care.

(4) *More active control over use of revenues*. Because these institutions are given powers to use recurrent state budget, which is stable over a three-year period) along with other revenues, they are able to regulate their expenditure more rationally and effectively. These institutions have cut costs by eliminating irrational expenditures and by allocating a fixed expenditure budget to separate departments (e.g. telephones, electricity, water, meetings, travel, etc.). Thanks to these cost-cutting measures, the share spent on administrative costs has tended to decline (e.g. at the Obstetrics Hospital, these costs declined to 13.8% after autonomization, and in Tu Du Hospital they were cut by 13%). Expenditure on equipment procurement and maintenance has tended to increase in most hospitals (in the Obstetrics Hospital, it increased 117.8%, while in Quang Ninh Hospital, it went up by 14%). The share spent on staff remuneration, especially "additional salary" for staff (paid out of revenue surplus in autonomous units), has tended to increase in institutions with large revenues, especially in central hospitals or those in big cities, while in district facilities and the preventive health system, the increase was not substantial [63, 64].

(5) *Strengthened funding mobilization for the upgrade of facilities and equipment*. To date, public hospitals have mobilized about VND 3,000 billion to invest in high technologies [6]. With these supplementary resources, the institutions have more leeway in expansion, new construction of departments and wards and procurement of expensive equipment like CT scanners, MRI systems and other clinical imaging equipment for delivery of "elective"

services. Central institutions and those located in large provinces and cities tend to invest more than district hospitals or hospitals in upland, remote and disadvantaged areas. Despite the requirement that the use of hospital revenues for upgrades of equipment must be approved by the supervising authority in advance, there is a danger that hospitals will tend to focus on highly profitable medical services and technologies and move away from less profitable services, which, in the end, will affect the patients' interests. Thus, through the social mobilization and autonomization policies, health service facilities have succeeded in attracting a sizable amount of funds to upgrade facilities and equipment despite limited state budget resources. However, the lack of specific legislation offering guidance for the management and use of private investment in public services has raised concerns about equity and the quality of health services, since such investments will undoubtedly target high income generation and profitable services paid for directly out of patients' pockets [65].

(6) *Increased benefits for employees*. Since the inception of financial autonomy, hospital staff incomes have increased dramatically. Deliberations over payment of additional salaries have tended to focus more on performance and staff capacity. Evidence shows that the additional salary varies significantly between institutions, as the additional salary coefficient in central and municipal areas is often much higher than in rural, mountainous and remote areas. For example, in large income-generating hospitals such as Tu Du, Cho Ray, Bach Mai, and the Central Ophthalmology Hospital, the added salary coefficient is about 1.5 - 2.5 times the base salary, while many other hospitals are facing huge difficulties in generating additional revenue due to physical capital, human and geographical constraints. Moreover, given the current level of user fees and health insurance reimbursements, it is already difficult enough for them to cover the operating costs of the facility without having to try to set aside a modest portion of the revenue to pay additional salaries for their employees. According to reports from Ha Tay Provincial Health Department, the province has 21 institutions implementing partial financial autonomy since 2007. After one year of implementation, the increased salary coefficient for staff ranged from 0.01 - 0.2 in 19 hospitals, while only the Ha Tay General Hospital and Ba Vi Hospital achieved higher additional salary coefficients of 0.46 and 0.55 respectively [66]. On the other hand, some hospitals have managed to provide a salary approximately 4 – 5 times the base salary, despite the fact that Decree 43 specifies that the maximum additional salary coefficient must not exceed three times the annual basic payroll of the unit, which is an issue that needs further review. In light of the current situation, with striking differences in terms of income and working conditions, it is likely that there may well be increasing migration of qualified doctors from rural to urban and upland to lowland areas as well as from the public to the private sectors.

(7) *Increased competitiveness between service providers*. The implementation of financial autonomization has resulted in competition between public health services, and with the private sector, in terms of service quality, price and customer service. Hospitals need to make more of an effort to improve performance and attract patients, especially those with higher purchasing power. Autonomization also promotes renewal of financial management thinking, operation methods and customer service culture, hopefully improving satisfaction among patients and their families. On the other hand, this runs the risk of breaking up the consistency and uniformity of service delivery, such as the disintegration of the hierarchy of care (from primary to tertiary levels) and escaping from the necessary controls of state administration, if the necessary administrative instruments are not in place.

3.3 Difficulties and challenges

To date, there have been no comprehensive evaluations of the implementation of financial autonomy and the overall impact of the policy on the health system. However, initial survey and study results of hospital financial autonomy have pointed out some potential limitations and undesirable impacts from the implementation of this policy.

Firstly, autonomization has been applied uniformly without sufficient consideration being given to feasibility, local conditions or implementation capacity of the institutions being autonomized. At the same time guidelines and specific regulations for implementation, monitoring and inspection, as well as other necessary supporting policies, are lagging behind. This has made things more difficult for the hospitals and adversely affected the professional and personal lives of health workers in most district hospitals in rural, upland and disadvantaged areas.

Secondly, the financial autonomy policy in state health facilities has been implemented despite the existence of an '*inconsistent regulatory system*', as related legislation are overlapping and conflicting and cause serious impediments to the financial autonomization process. The provisions of Decree 43 and its implementing Circulars are themselves not entirely appropriate for the unique nature of the health sector and the potential implications on equity in health [67] (since health services, unlike normal services, are more strongly affected by asymmetric information between providers and customers, low elasticity of demand, sensitive nature of health care in society and extreme difficulties in determining cost-effectiveness, etc.). To be specific, the current policy of partial user fee payments and health insurance reimbursements set inappropriate levels, that are insufficient to cover the costs of providing health care services. Provisions on general public service salary payments under Government Decree No. 03/2003/ND-CP do not take into account the uniqueness of the health sector. The referral system and hierarchy of care levels are inappropriate. Stipulations on salary levels, establishment of various funds and human resources management are creating hurdles in the implementation of the autonomization policy.

Thirdly, the tendency to increase investment in facilities, equipment, and expansion of "elective" services for profit can result in the risk of service providers becoming solely "profit-driven" and the commercialization of the health system in the absence of relevant regulatory systems for monitoring and inspection, leading to:

- *Use of funds not for the development of a health system for the public but rather to meet the needs of those who can pay.* This situation may result in hospitals trying to pass difficult, low profit cases to higher levels and retain the easily treatable and higher profit cases. The lack of attention paid to technical guidance and backstopping from higher to lower levels may cause a breakdown in the hierarchy of care levels, overloading the higher levels and weakening the grassroots health care facilities.
- *Adverse impact on equity in health care.* Patients will become targets for revenue generation, overuse of diagnostic tests and expensive technologies, and discrimination against patients not making out-of-pocket payments, leading to limited access to health services, especially for the poor, the near-poor, those without health insurance and vulnerable groups.
- *The huge gap in income and working conditions* between central and large municipal hospitals and hospitals in poorer, remote provinces, district hospitals and preventive health services will likely result in the migration of the workforce from lower to

higher levels, and from rural to urban areas, causing an additionally severe dearth of health professionals in the grassroots levels.

- *The fragmentation of the health system* into independent units lacking coordination and cooperation creates a risk of losing the comprehensiveness and systematic nature of service delivery, as well as breaking up the current technical hierarchy of care and escaping from the necessary controls of public administration.

Fourthly, the capacity of hospital management is not yet responsive enough due to lack of understanding and knowledge about autonomization and inadequate health economics, health finance and hospital management skills, all in the context of a weak information and monitoring system, leading to considerable confusion in implementation nationwide. Continuing low levels of openness, transparency and accountability in implementation of autonomization lead to a risk of leakages, waste and inefficiency in using hospital resources.

4. Priority Issues

Based on the above discussion, the following can be identified as priority issues to address:

1) Continued difficulties in implementing the autonomization policy due to the lack of guiding legislation and conflicts with other related policies (e.g. the user fee policy).
2) The mechanism for supervising the process of implementing autonomization needs to be more comprehensive, consistent and efficient in order to limit the negative effects of the process of implementing autonomization.
3) The health economics management and hospital management capacity, openness, transparency and accountability of the hospital leadership is not yet adequate for the requirements of the new mechanism.
4) The positive and negative effects of autonomization for the health system, especially evaluation of the impact on the people, particularly people using health services, has not yet been adequately assessed to form a basis for adjusting related policies.

Chapter IX. Hospital service payment mechanism

The mechanism by which hospitals are paid for their services significantly affects health service delivery and use. This Chapter presents an overview of financing channels and the corresponding reimbursement methods applied to hospital services. This is followed by an analysis of hospital payment mechanisms along with achievements and limitations that need to be addressed in relation to the mechanism for paying for hospital services in Viet Nam. From this analysis, recommendations are made regarding reforms needed to create a more appropriate hospital payment system.

1. Overview of hospital financing policies

Hospital service financing is directly affected by policies on state budget allocation, collection of partial user fees, financial autonomy of revenue-generating public services and health insurance.

State budget allocation for public hospitals in Viet Nam is undertaken mostly according to the traditional method of input-based funding. Under this method, funding of public hospitals is allocated based on the resources required for the operation of the health facility (patient beds, staff size, equipment and other overhead costs).

Prior to the enactment of the Revised Budget Law in 2002, the state budget was allocated to public hospitals in accordance with various general norms applicable to different socio-economic areas. Since the introduction of the Revised Budget Law (especially since the implementation of financial autonomy and accountability at local levels), the budget allocation to provincial and district hospitals is determined primarily by local authorities based on the level of priority given to health care by individual authorities and according to the financial resources available in the locality.

One can see a clear increase in the recurrent expenditure norms for health care in 2006 (norms specified in Decision 151) compared with 2003 (norms specified in Decision 139, see Table 9). However, it is worth noting that the health care budget expenditure norms specified in Decisions 139 (2003) and 151 (2006) are only recommendations. In addition, these norms cover expenditures on both curative and preventive care. In practice, state budget expenditure on hospital operations varies substantially between localities. According to 2005 statistics from the MoH Planning and Finance Department, almost all hospitals received a budget allocation in the range from VND 14 to 24 million per bed per year. Large cities like HCMC and Hanoi had even higher budget allocations per bed.

Table 9: State budget norms for health care under Decision 139/2003/QD-TTg and Decision 151/2006/QD-TTg

Zone	Norm 139/2003/QD-TTg (VND/person/year)	Norm 151/2006/QD-TTg (VND/person/year)	Ratio of 2006 to 2003 norms
Urban	32,180	58,680	1.8
Lowland	35,400	79,280	2.2
Upland, ethnic and remote areas	44,780	101,100	2.3
High mountains and islands	48,050	140,700	2.9

There is currently neither a formal database nor an official method of allocating hospital budgets. This explains the difference in budget allocations for hospitals and the high level of dependence on local budget funding for hospitals.

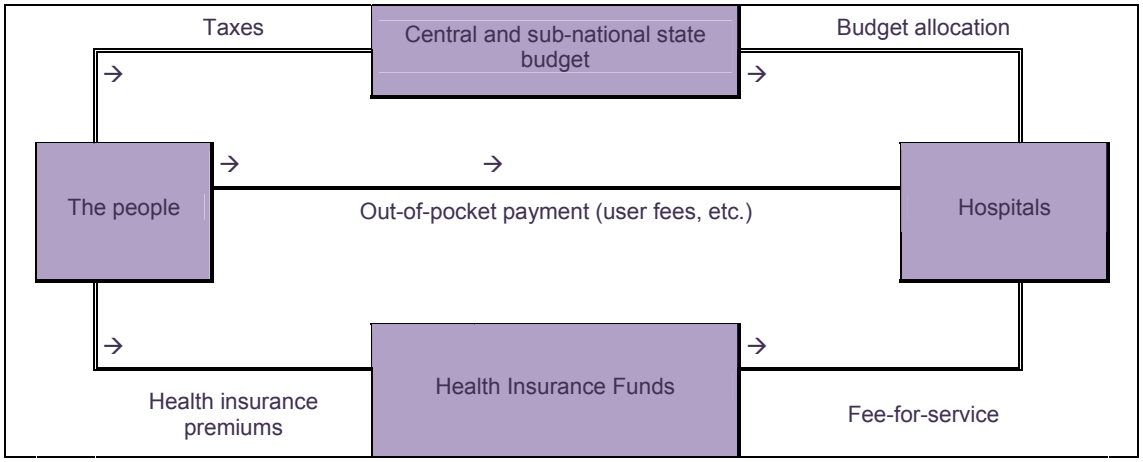
Public hospitals operated almost entirely on state budget funding for a long period until the late 1980s, when they were allowed to collect user fees covering part of their costs (called partial user fees). Revenue from user fees covers an increasingly important share of total hospital revenues. Nevertheless, the user fee schedule developed for basic services in 1995 under Circular 14/1995/TTLB-BYT-BTC-BLDTBXH has never been updated since that time.

Since 2002, some hospitals have begun to undertake financial autonomy in line with Decree 10/2002/ND-CP, and since 2007, most health services registered to transfer to autonomous operations under Decree 43/2006/ND-CP. Revenue from partial user fee collection is retained entirely by the health services to cover costs of service delivery. Institutions are authorized to use this financial resource at their discretion, as specified in Government Decree 43/2006/ND-CP, dated 25 April 2006. Starting in 2006, the system of "three year fixed budgets" with strong encouragement of efficiency has gradually been applied in public hospitals.

2. Sources and methods of hospital service payment

Hospitals receive reimbursement of their costs through different payment channels, with different payment mechanisms. To date, however, there have been few research studies and systematic assessments of hospital financing methods in Viet Nam. Figure 16 describes the payment channels and hospital financing methods used. Hospital services are being reimbursed from two pooled sources (the state budget and health insurance) with the remainder coming from out-of-pocket payment by service users. The latter channel, direct out-of-pocket payments from users, is being increasingly mobilized by hospitals.

Figure 16: Financing channels and hospital service payment mechanisms



The state budget (primarily from tax revenues) accounts for 35% of total hospital inpatient expenditures [12], and increases to 42% [64] if outpatient expenditures are also included. This budget funding is used to finance part of hospital expenditures (mostly human resource costs and part of operating costs) by means of budget allocation. Before 2007, the state budget was usually allocated to public hospitals on an annual basis, proportionate to the

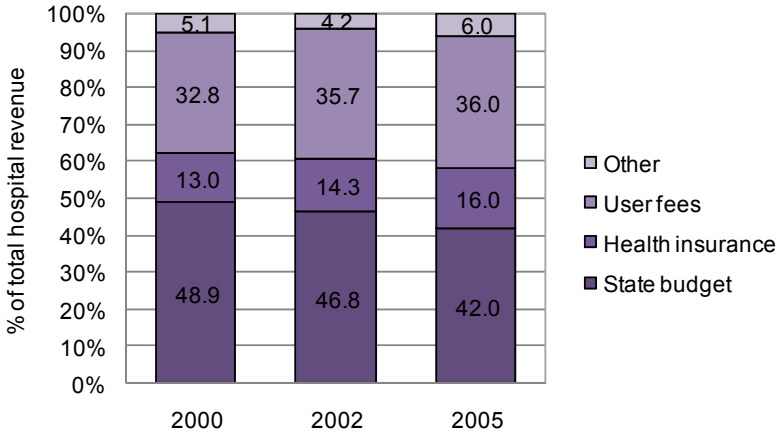
number of patient beds or staff size, etc. Since 2007, the traditional budget allocation method has been transformed into a new method of stable budget allocation over three-year periods. This can be considered as a major step forward in the change to fixed-budget allocation, while reducing regulations on inflexible norms applied to hospital spending.

The share of hospital revenues from **health insurance reimbursements** has seen a moderate increase, from 13% in 2003 to 16% in 2005. However, while health insurance in general covers about 40% of the population, in terms of financing (in hospital finance) it only covers about 16% of total costs. This reflects limitations in health insurance premiums and benefit packages for health insurance members.

Health insurance reimburses some hospital costs (mostly for pharmaceuticals, IV fluids and consumables) through the fee-for-service payment mechanism using the same fee schedule stipulated in the partial user fee regulations. Due to pressure from budget shortfalls, health insurance reimbursement to provincial and district hospitals involves a cap (total spending allowed in relation to the number of insured registered for health services in that hospital). This, in fact, is like a fixed budget allocation that is often used in other countries. However, in the past this cap was not applied to higher level hospitals, especially central hospitals, which has led these hospitals to attempt to maximize their revenues from health insurance. Their health insurance reimbursement comes from the health insurance fund allocation to first-level care hospitals when they refer patients to higher level hospitals, leading to a high share of these resources being taken away from lower level hospitals.

Out-of-pocket payments by service users, also determined through the fee-for-service modality, account for a sizable and increasing proportion of the total revenue of hospitals (from 32.8% in 2002 to 36% in 2005, see Figure 17). In the foreseeable future, this increase is expected to be even higher as hospitals are encouraged to generate additional revenues in order to remain financially autonomous.

Figure 17: Structure of hospital financing sources, 2000~2005



Source: Hospital inventories 2000 [68], 2003 [63] and public hospital budgeting, Health Policy Unit, 2005 [69].

3. Shortcomings of current hospital service payment mechanism

3.1 Inappropriate changes in the composition of hospital revenue

The composition of hospital funding in Viet Nam indicates that the proportion of income from user fees (including health insurance and out-of-pocket user fee payments) out of total hospital revenues has been increasing gradually. This is a direct result of policies aiming to reduce the financial reliance on the state budget and increase the financial autonomy of hospitals through income sources other than the state budget.

Out-of-pocket service payments are the root cause of health expenditure burdens on households. This is exacerbated by the situation in which hospitals are being encouraged to increase revenues for financial autonomy purposes while cost and service quality control systems are inadequate. Many households are facing excessively high health care expenditures. These are the early signs of the adverse effects that reliance on the out-of-pocket payment method can have on equity in health care.

3.2 Service fee schedule no longer rational

The legislated service fee schedule [70, 71] allows for collection of only part of the total cost of providing services, and primarily covers the costs of drugs, consumables and materials used for diagnostics. Direct subsidies for public hospitals can only cover a proportion of operating costs, labour costs and depreciation of equipment and buildings. Thus, revenue from partial user fee collection and state subsidies falls short of what is required to finance operations and improve service quality. Under this system, the state budget subsidy for use of hospital services is the same, irrespective of whether the patient has a high or low income, which in effect leads to the state subsidies accruing to the better off more than the poor, the opposite of what is desired to achieve equity objectives.

3.3 The user fee schedule lacks incentives appropriate for use of technically appropriate care

The user fee schedule is set up so that the level of the fee for the same service rises with the level of facility in the hierarchy (primary, secondary tertiary) including for services that are more appropriately provided at a lower level. The motivation for setting up user fees in this way was to encourage patients to use grassroots level health services where the services are cheaper, thus contributing to relieving the overcrowding at higher levels of care.

However, from the perspective of incentives in the provider system, when a lower-level health facility is only permitted to recover costs at a lower rate than higher level facilities, it is highly unlikely that the lower-level health services is going to be sufficiently motivated to improve either performance or service quality. From a policy point of view, if the strategic target is to promote the development of lower level hospitals, then these hospitals should receive priority attention through appropriate financial incentives. Experience from China reveals a serious deterioration in the capacity of the lower-level hospitals and health service system as a direct consequence of irrational service financing policies.

3.4 Many drawbacks in input-based state budget funding

Most public hospitals are still receiving their state budget allocations based on input requirement budgeting norms (patient beds, staff size, etc.) [72]. However, input-based budget financing aims to control expenditure without aligning budgets to performance and/or output targets. Completion of tasks according to plan is always accompanied with full

disbursement of the allocated budget, without any incentives to ensure that the resources are used effectively.

In reality, the number of inpatient beds is not a good indicator of the need for resources, as it does not reflect the actual productivity and performance of the hospitals. Public hospitals may attempt to attract more state budget funding by increasing patient beds, unreasonably encouraging more patients to use hospital services, increasing inpatient admissions, lengthening the duration of treatment to achieve higher bed occupancy rates, etc. This may well be one of the reasons for the persistent overloading in higher level hospitals, where bed occupancies often exceed 130% - 150%.

3.5 Fee-for-service provider payment mechanism

Fee-for-service is the main mechanism for payment of hospital services in Viet Nam currently applied to both health insurance and out-of-pocket funding. The fee schedule is determined by relevant state agencies, based on which, the local authorities (in charge of hospital management in their locality) specify the precise fee level for each service, taking into account the technical capacity of the hospital and the ability to pay of the local community.

The fee-for-service mechanism has the advantage of motivating the productivity of hospital service providers, and therefore the capacity utilization of the health system. However, the inherent incentives in this mechanism to over-provide services and escalate costs are major limitations.

Evidence from many countries around the world indicates that, on balance, fee-for-service reimbursement promotes over-servicing (abuse of services) for profit motives. Service abuse may occur due to requests of service users (mostly the better-off, for use of high technology services, or “elective” services), or through the overprescribing practices of service providers. The problem of provider-induced demand is usually more serious, especially when services are paid for by a third party (usually the health insurance agency). In addition, health care is a special type of service, for which clients usually lack sufficient understanding to determine which services are most appropriate for them. The request to use services (especially diagnostic testing) primarily depends on the provider.

Under the financial autonomy and social mobilization mechanisms (especially for procurement of testing equipment), the trend towards over-servicing may increase as hospitals want to increase revenues. Over-servicing is now widespread, in both public and private health facilities.

Another limitation attributed to fee-for-service reimbursement is the oversupply or abuse of treatment services. Such abuses primarily focus on services with official user fees set at a level higher than cost or for services for which official user fees have not yet been set, especially high tech services. The overuse and overprovision of services may satisfy those users who believe that more services and more expensive services means better quality (and better customer service by providers). In fact, this is a waste of resources and sometimes these unnecessary services can also result in complications and adverse effects on users’ health as well as increasing their expenditures.

Fee-for-service payments can also result in a situation where the hospitals try to attract more patients, even those with mild illnesses (that could be treated at lower levels),

and prolong the duration of treatments, etc. in order to maximize revenue. This is also seen as one of the most important reasons for the current overcrowding in higher-level hospitals.

As a result, the fee-for-service payment method has actually limited the performance of the health system. Due to overcrowding, higher-level hospitals have to use resources to provide health care for mild cases that could easily be treated at lower levels (e.g. normal delivery, child pneumonia, etc.), which therefore drains the resources needed for more severe, life-threatening conditions, and research and development of use of modern health technologies in Viet Nam. At the same time, many district hospitals are operating at under capacity, which also leads to a waste of resources invested in this level of the system.

From the service users' perspective, health expenditures sharply increase as a result of multiple use tests, use of expensive drugs, irrational drug combinations, and prolonged inpatient periods, etc.

Therefore, transferring from the fee-for-service payment mechanism to a new mechanism (such as package prices by disease or disease group such as the DRG system) is very necessary in order to increase the performance of the service delivery system and to mitigate the health-related financial burdens for the service users.

4. Priority issues

From the policy-making perspective, the pressure on resources to meet increasing needs in terms of both quantity and quality of health services is a problem affecting most countries. When resource requirements for hospitals increase and the costs of service delivery escalate, efficient and optimum use of available resources is vital to the development and success of the entire system. Reform of hospital operations in Viet Nam towards autonomy, as specified in Decree 43 (2006), is a move intended to motivate hospitals to mobilize and use resources in order to ease the pressure on the state budget. The above-mentioned targets all require a transformation from the existing input-based funding system to a new financing modality for more effective use of hospital resources.

Lessons learned from the reform of other public services, such as power and water utilities, indicate that minimizing waste of existing resources is the most feasible and effective strategy for the sustainable development of the service delivery system.

The MoH has made considerable efforts to reform hospital financing methods to improve efficiency. With regard to the state budget, in the proposal for reform of health care operations and financing submitted to the Prime Minister, the MoH recommends more studies on budget allocation to public hospitals, based on performance (quantity and quality of services) instead of the current patient bed-based allocation. With donor support, a number of studies are currently underway as part of efforts to change from the fee-for-service system to a case-based package price system and eventually to a diagnosis-related groups (DRG) system. It is expected that the case-based package price payment method will be piloted with some diseases in the immediate future and rolled out over time if positive results are achieved.

From the analysis above, we can determine the most pressing issues requiring priority resolution in order to build and implement a reasonable hospital payment mechanism, these include:

1) The method of determining user fees is irrational and does not yet include full costing of services provided.

2) The fee-for service payment mechanism does not provide incentives for efficient use of resources.
3) The lack of a uniform mechanism to supervise and manage the quality of care and reduce over-servicing, especially when transferring to a payment mechanism that encourages cost saving.

Chapter X. Financial support for health care of the poor and social welfare target groups

The move away from financing health service providers towards financing service users constitutes an important part of the health financing reform policy, and health system reform in general, in the direction of equity, efficiency and development. In light of this orientation, in the past few years, a number of policies have been adopted to provide financial support to different groups of the population, including the poor, the elderly over 85 years of age, and children under 6. This Chapter offers an analysis of the policy agenda and updates the situation on financial support for the poor and social welfare target groups[27] in order to make recommendations to improve the effectiveness of support and promote the orientation towards providing financial support for health to service users.

1. Orientation from financing service providers to financing service-users

Government Resolution No. 05/2005/NQ-CP, dated 18 April 2005, on promoting social mobilization in education, health care, culture and sports underlines the need to "steadily shift from provision of recurrent financing to health providers to direct state financing for beneficiaries of health services in the form of health insurance". This policy reflects a fundamental shift in the way financial resources are allocated to health care in Viet Nam.

First, this policy can help low income groups to avoid financial risks when it comes to health expenditures. Since 1989, with the introduction of the partial user fee policy, fee waivers and reduction for the poor and social welfare target groups have been stipulated [73, 74]. Recently, these subsidy policies have been amended, revised and expanded to cover many different target groups such as the poor, children under 6, elderly people aged 85 years and older, the near-poor, those who have contributed meritorious service to the nation, the handicapped, orphan children and so on.

Second, government subsidies for target groups in health care have primarily been implemented through support to purchase health insurance, which has contributed significantly to widening health insurance coverage in recent years. In addition, in some regions, the poor also receive subsidies to cover the costs of medical transport and meals during inpatient treatment.

Third, the policy contributes to reducing the financial burden on health facilities (who formerly had to provide free services to target groups without reimbursement), reduced hassles in paperwork when seeking exemptions or reductions, and improved financial transparency between health service providers, patients and the health insurance agency.

However, the success of shifting from financing service providers to allocating government subsidies to eligible service-users requires certain pre-conditions:

First, health services must have adequate technical capacity to fulfil their functions and health insurance coverage must be relatively broad. For this policy to be effective, the

[27] Social welfare target groups referred to in this review include the poor (as defined in Decision 139), people aged 85 years and older, children under age 6, people with meritorious contributions to the nation and the near-poor.

unique settings of different areas and facilities need to be taken into consideration. If direct state budget funding to health facilities in poor, isolated and remote areas is reduced, and these facilities are not yet able to generate their own revenues, they will face great difficulties in maintaining activities.

Second, the Government must allocate sufficient resources to support social welfare target groups. The number of people entitled to financial assistance for health care is currently 27 million people, if we also include the near poor (eligible for a 50% subsidy in their health insurance premiums), the number reaches 41 million people, and the Government will have to spend about VND 6.6 trillion a year to support this high proportion of the population (see Table 10).

Table 10: Target groups eligible for the subsidy and estimates of state budget expenditures to purchase health insurance for these groups, 2008

Target group eligible for subsidy	Mode of payment	Number of benefi-ciaries (million)	Current premium value (VND)	Premium paid by benefi-ciary (VND)	Support from state budget (VND)	Total support from state budget (VND billion)	Total expenditure on health insurance (VND billion)
Existing							
The poor – target of Decision 139	Health insurance	17.0	194,000	0	194,000	3,298	3,298
Children under age 6	Direct reimbursement	8.5	194,000	0	194,000	1,649	1,649
Elderly aged 85 and older	Health insurance and direct reimbursement	0.19	194,000	0	194,000	77.6	77.6
People contributing meritorious service to the nation	Health insurance	1.1	194,000	0	194,000	213.4	213.4
Subtotal		**27.0**				**5,238**	**5,238**
Planned							
The near-poor (Government subsidy of 50% of premium)	Health insurance	14.0*	194,000*	97,000 (50%)	97,000 (50%)	1,358	2,716
Total		**41.0**				**6,596**	**7,954**

* According to the Household Living Standards Survey 2006, out of the 14 million near-poor people, about 7 million have health insurance cards, including 2 million with health insurance for the poor, 2.4 million with compulsory insurance and 2.5 million with voluntary health insurance cards. Therefore, the figure - 14 million near-poor people expected to take part in the health insurance scheme - is simply an estimate to envisage the maximum state budget subsidies that would be required [75].

Source: Various legislation and reports, 2006- 2008 [76-78]

2. Implementation of policies providing financial assistance for health care to the poor and social welfare target groups

2.1 Policy on health care for the poor

Outcomes

On 15 October 2002, the Government issued Decision No. 139/2002/QD-TTg on health care for the poor, stipulating coverage to include all of the poor with living standards below the poverty threshold, ethnic minority populations living in disadvantaged upland provinces, as defined in Decision No. 168/2001/QD-TTg and Decision No. 186/2001/QD-TTg, and residents of extremely disadvantaged communes, in accordance with Decision No. 135/1998/QD-TTg. Stable funding for these health care subsidies comes from the state budget. Provincial People's Committees could establish a Health Care Fund for the Poor to either purchase health insurance cards for the poor or finance direct reimbursement of services used by eligible beneficiaries. The Fund is also allowed to pay part of the user fees in cases where individuals meet unexpected difficulties due to severe illness requiring expensive treatment when seeking care at public hospitals.

Decree No. 63/2005/ND-CP on health insurance regulations allowed for all of the poor to be covered by compulsory health insurance paid for by the state budget, and for their medical transport costs during referrals to be covered by health insurance. In recent years, some poor people have received subsidies for meals, lodging and medical transport during inpatient treatment through donor projects.[28]

Since Decision 139/2002/QD-TTG was issued till the present, the allocation of state budget to health care funds for the poor has increased continuously as the regulations on the health insurance premiums have increased and the number of beneficiaries have also increased. Initially, the premiums were VND 50,000 per person per year (in 2002), increasing to VND 60,000 (in 2005), and VND 80,000 (in 2007) [79]. At the beginning of 2008, the premium was set at VND 130,000, then increased to the present figure of 3% of the minimum salary[29] (about VND 194,000 per person per year). A new poverty threshold was issued [80], increasing the number of beneficiaries of the Health Care Fund for the Poor from 13 million in 2002 to 17 million in 2006.

When it first came into effect, the policy allowed two modes of payment for services provided to eligible beneficiaries: procurement of health insurance cards for the poor or direct reimbursement. This resulted in only a limited number of poor people being issued with health insurance cards, only about 3.7 million in 2003. Later, however, the Government decided to require that all target groups be covered by the compulsory health insurance scheme [81], resulting in a substantial increase in health insurance coverage to almost 15.2 million in 2006.

[28] For example, the project to support healthcare for the poor in the Central Highlands funded through ADB loans and with support from the Swedish Government.

[29] Decision 117/2008/QD-TTg dated 27/08/2008 stipulated that the contribution for health insurance for the poor, near poor, elderly aged 85 and older should be 3% of the minimum salary (equivalent to VND 194,000 per person per year).

Table 11: Number of beneficiaries and proportion in the entire population (both health insurance and direct reimbursement), 2003-2006

Year	2003	2004	2005	2006
Number and proportion of beneficiaries in the entire population	14,367,167 17.5%	13,831,330 16.8%	14,341.851 17.3%	17,012.385 20.1%
Number of health insurance card holders (people)	3.7 million	3.9 million	4.8 million	15.2 million
State budget allocated to the Fund (VND)	522 billion	717 billion	784 billion	1,020 billion

Source: VSS [82] and local reports on implementation of Decision 139/2002/QD-TTg submitted to the MoH [77]

On 25 January 2008, the Prime Minister issued Directive No. 04/2008/CT-TTg on strengthening leadership in implementing poverty reduction programmes, which put the MoH in charge of revising policies on health care for the poor, specifically recommending to increase the health insurance card validity period to two years or more, and continuing to cover households during the first two years after escaping from poverty. Once again, this new policy will expand the coverage of Health Insurance for the Poor and, therefore, require even more state budget subsidies for the poor and social welfare target groups.

Regarding use of health services by targeted beneficiaries, a synthesis of data from a sample of 33 provinces and cities indicates that from 2004 to 2006, there was an increase in the average use of inpatient and outpatient services per beneficiary (see Table 12), although the level of use is still somewhat below the national average.

Table 12: Health service utilization by beneficiaries in 2004 and 2006

	Average per capita outpatient visits		Average per capita inpatient visits	
Year	Beneficiaries of Decision 139 (both hospitals and health centres)	National average (hospitals only)	Beneficiaries of Decision 139 (both hospitals and health centres)	National average (hospitals only)
2004	0.76	0.68	0.06	0.09
2006	0.88	0.84	0.07	0.086

Source: Data on health care delivery for the poor in reports submitted to the MoH by provincial Health Departments on the implementation of Decision 139 (33 provinces) [77]; national average provided by Planning and Finance Department, MoH.

In addition to support for the poor nationwide, in accordance with the health insurance provisions outlined above, with support from donors (e.g. Swedish Sida), in some locations (Central Highland provinces), the poor are also provided with subsidies for transportation from home to hospitals, meals during inpatient treatment and assistance to cover expensive services (exceeding health insurance coverage limits).

In remote and isolated areas, as the inhabitants are unable to access health services easily, the local health sector has organized outreach service delivery, which has helped to detect, diagnose and treat many health problems directly in the community.

Besides the poor, the Government has recently reached out to the near-poor. On 27 August 2008, the Prime Minister issued Decision No. 117/2008/QD-TTg, stating that the Government will subsidize at least 50% of health insurance premiums for the near-poor (those with maximum average per capita incomes equivalent to 130% of the poverty line). The total health insurance premium payment for the near-poor is equivalent to 3% of the general minimum salary. On 24 September 2008, the MoH and Ministry of Finance issued Joint Circular No. 10/2008/TTLT-BYT-BTC guiding implementation of the policy on health insurance to members of near-poor households.

Challenges and shortcomings

In some areas, the process of identifying beneficiaries, and printing and distributing cards remains slow, with many mistakes, including incorrect spelling of names, and delays in printing and distributing cards to the beneficiaries who have been identified [83], or in some cases, village heads simply forgetting to hand out cards to the villagers [84]. The most common problem has been delayed delivery of cards as too many cards were misprinted and it often took several months for the information on the cards to be revised and reprinted [77].

Some health services have been unable to meet the needs of users, including the poor, especially in remote and disadvantaged areas. Many commune health stations are not yet permitted to receive reimbursements for health services they provide. Service quality generally remains low due to deficiencies in infrastructure, equipment, human resources and lack of funds to cover recurrent expenditures.

Limited awareness among some of the poor prevents them from fully understanding their rights and responsibilities, or knowing how to properly use the health insurance cards while IEC activities about these issues remain inadequate.

With a limited budget the Government has only been able to subsidize direct health expenditures (pharmaceuticals, blood products, IV fluids, consumables, etc.), while indirect costs (40% - 50% of total health care expenditures) are still not covered by financial assistance (except in the case of some provinces who benefit from donors' projects).

More emphasis needs to be placed on monitoring and evaluation of the effectiveness and impact of policies.

2.2 Policy on health care for children under six years old

Outcomes

The 1991 Law on Protection, Care and Education for Children states that children under 6 are entitled to primary health care and curative care free of charge at state health facilities. The policy was further elaborated in Decree No. 95/CP, dated 27 August 1994, on partial collection of user fees, Joint Circular of the Ministries of Health, Finance, Labour-War Invalids-Social Affairs and the Government Pricing Committee No. 14/TTLB, dated 30 September 1995, and MoH official document No. 306/YT-KHTC, dated 14 January 2005. Free health care for children under 6 was finally rolled out when the Government enacted Decree No. 36/2005/ND-CP, on 17 March 2005, specifying details for the implementation of the Law on Protection, Care and Education of Children and implementing guidelines from the Ministries of Finance and Health.

In recent years, the budget norms for health care of children under 6 have increased gradually: from VND 75,000/child in 2005 to VND 108,000/child in 2007 and VND

130,000/child as of early 2008. The policy on free health care for children under 6 has helped several million children gain access to free curative care, including treatment for many serious illnesses which could otherwise have cost their families as much as VND 40 - 50 million [6].

Challenges and shortcomings

When the policy on free health care for children under 6 was widely announced in 2005, many provincial hospitals experienced an overcrowding of paediatric patients [76]. This phenomenon occurred for two reasons: inadequate equipment at lower level facilities forcing patients to flock to the provincial hospitals and fraudulent use of health cards.

The exemptions granted to children (with payments to facilities covered by this policy) are limited to care of common conditions, with no guidance on implementing the policy for preventive interventions, or expensive surgical interventions that should be subsidized such as treatment of congenital abnormalities.

The current funding support for health care of children under 6 is implemented through direct reimbursement of facilities for care provided to children, and has not yet adopted the health insurance mechanism to increase management efficiency and increase health insurance coverage, while better ensuring the rights of beneficiary children. The mechanism for allocating funds by locality has caused impediments in the reimbursement of health care costs of children when they are referred to different levels of care.

Policy dissemination and communication have been inadequate. Some health workers are unaware of procedures for reimbursement or pharmaceuticals allowed to be prescribed, which have affected quality of treatment. In addition, payment procedures are still heavily administrative which has increased the workload of health workers.

2.3 Policy on health care for the elderly

Outcomes

The Ordinance on the Elderly, issued on 28 April 2000, clearly states that the elderly seeking health services should be given priority and allows for the establishment of the Health Care for the Elderly Fund. In 2002, Decree No. 30/2002/ND-CP specified that senior citizens of 100 years or more are to be provided with free health insurance. In 2003, Decree No. 120/2003/ND-CP, dated 20 October 2003, lowered the minimum age for elderly people entitled to free health insurance to 90. Finally, Prime Ministerial Decision 67/2007/ND-CP, dated 13 April 2007 redefined the age for elderly people eligible for subsidy to 85 and above. With such provisions, the number of elderly people eligible for subsidies will be in excess of 400,000.[30]

In order to ensure satisfactory implementation of the Ordinance on the Elderly, the MoH issued Circular No. 02/2004/TT-BYT, dated 20 January 2004, providing guidance on delivery of health services for the elderly and specifying that the elderly are entitled to health maintenance and primary health care at the commune level and priority at higher levels of care.

[30] According to the Household Living Standards Survey in 2006, the total number of people aged 85 and older was about 470,000. However, the policy discussed above does not include elderly pensioners or old people on social security, which would reduce the estimated number of people aged 85 years and older entitled to support under Decision 117/2008/QD-TTg to about 400,000 people.

Between 2004 and 2006, while the number of elderly people aged 90 years and older only increased from 175,000 to 189,000, the percentage of old-aged health insurance card holders (of any type) increased from 27.3% in 2004 to 63% in 2006. This is clear evidence of considerable improvement in the implementation of the policy on health care for the elderly.

Table 13: Percentage of the elderly (aged 90 and over) covered by health insurance, 2004

	Compulsory health insurance (pensioners)	Health insurance for the poor	Health insurance for social welfare benefi-ciaries	Voluntary health insurance	Any health insurance	No health insurance	Total
2004	1.3%	7.6%	14.3%	4.0%	27.3%	72.7%	100%
2006 (% and number of elderly people in each group)		33.2%	22.5	7.3%	63%	37.1%	100%
		62,804	42,515	13,822	119,141	70,250	189,391

Source: VHLSS 2004 [85], VHLSS 2006 [78]

Challenges and shortcomings

Many elderly people hardly ever use their health insurance cards. Findings from a study conducted in three provinces show that the number of elderly people who consider that they have poor health increases clearly with age [86]. Yet, a large number of elderly people have never used their health cards. The study reveals that the main reason for elderly people not visiting health services (even among the insured) is limited mobility, even for the short trip from home to the commune health stations (only 36% of the elderly aged 85 years and older are mobile enough to move around within the neighbourhood). Sometimes, old people cannot go to the hospital simply because they cannot afford the cost of transportation or because they feel uncomfortable bothering their children to take them.

The enforcement of the Ordinance on the Elderly and the funding of health care cards for the elderly is uneven across provinces. Many localities have been slow to implement the policy, leading to unnecessary hardship for the elderly.[31]

Health care for the elderly entails certain special aspects that differ from other population groups, therefore, subsidizing access to health services for the elderly requires specific attention to make sure that they receive the intended benefits. In the years to come, when the state budget share for health care is augmented, the age limit for entitlement to benefits should be lowered to increase coverage of support for the elderly. Policies on community-based outreach services to enhance accessibility to the elderly also need to be considered.

[31] The main cause is the loose inter-ministerial cooperation at the grassroots level. On paper, the provincial Labor-War Invalids-Social Affairs Department is the regulatory authority responsible for the elderly, but it does not have a network at the grassroots level; thus they encountered difficulty in counting elderly people.

2.4 Other assistance policies

In addition to the target groups above, every year, the Government also earmarks a portion of the budget to purchase health insurance cards for about 1.1 million people who have contributed meritorious service to the nation, in accordance with the Ordinance on Citizens with Meritorious Contributions to the Revolution. Health expenditures incurred by this group are covered by the health insurance fund.

At the same time that the policy on partial collection of user fees was introduced, groups such as the disabled, orphans, homeless people, people with mental health problems, epilepsy and leprosy, etc. were also exempted from payment of such user fees. To date, assistance for health care for these groups (except those subject to other later policies) has been maintained, mostly with funding from the state budget.

In addition to health support policies, the Party and Government have also issued many other policies to strengthen grassroots health care capacity and to improve convenience of access to services for the aforementioned target groups in line with Central Party Secretariat Directive No. 06-CT/TW, dated 22 January 2002, on strengthening the grassroots health care network, MoH Decision No. 370/2002/QD-BYT, dated 7 February 2002, introducing the "National benchmarks for the commune health system, 2001–2010", and 2005 Politburo Resolution No. 46 on "protection, care and promotion of people's health in the new situation". The Government Plan of Action for implementing Resolution 46 also highlights the need to strengthen and develop the grassroots health care network in terms of infrastructure, equipment and human resources.

3. Priority Issues

1) The implementation of the above policies in practice has faced many difficulties. As mentioned above, access and utilization of health services of target beneficiaries of Decision 139/2002/QD-TTg still suffer from many shortcomings, such as slow identification of beneficiaries, errors in printing and distributing health insurance cards, inadequate knowledge of how to use the card after it has come into the beneficiaries hands, etc. Assistance for health care of children under age 6 still applies a direct reimbursement mechanism.

   Some health financing mechanisms affect quality of care for the insured such as the user fee policy, low premium contributions for health insurance of the poor and the elderly, inadequate funds allocated to the recurrent budget of commune health stations, hospital autonomy… For the near poor, analysis indicates a policy of voluntary health insurance for them, up till now, is inappropriate. Besides this, supervision of implementation of assistance policies for the poor and other policy beneficiaries has been limited.

2) Ability to access and utilize quality health services of social policy beneficiaries faces many impediments. The quality of health care at the grassroots level is limited, reducing their trust in these services, leading to bypassing of lower level facilities and overcrowding in higher level hospitals.

Chapter XI. Conclusions

1. Financing for Viet Nam's health sector consists of the following principal sources: the state budget (including external assistance), health insurance, household out-of-pocket payments and other socially mobilized resources. With the aim of realizing the goal of an equitable, efficient and developed health system, Viet Nam considers the state budget and health insurance as the two most important financial resources for health care. Total per capita health expenditure in Viet Nam is approximately USD 45 a person per year, an average amount compared with other countries in the region. The structure of health financing in Viet Nam in the past few years has experienced some changes for the better with higher proportions of public expenditure, increased state budget funding for health, broader coverage of health insurance and reduced private expenditures. Out of total health expenditure, however, private spending (out-of-pocket payments) still accounts for almost 70%, a relatively high level compared with other countries in the world, and this has substantial implications for the target of equity in health care in Viet Nam.

2. Striving for equity in health care, over the past few years, the Government has increased the **state budget for health** substantially. The average annual increase of state budget spending for health was 22% between 2002 and 2006. Besides growth in recurrent expenditures, the Government has issued many decisions to increase investments in health care facilities, including investments in district hospitals, regional hospitals, commune health stations, and district preventive medicine centres. Besides tax-based state budget funding, the Government has also relied on treasury bonds to mobilize resources to invest in health care. This is a visible demonstration of the serious concern the Government has about health care for the people, the result of which has been a large boost in investment for health care. In principle, the state budget allocation for health care gives priority to the poor and to poor and disadvantaged areas. A proportion of the state subsidies for health care are being diverted to the form of direct support to beneficiaries, through the Health Care Fund for the Poor, support for purchase of health insurance cards for the near-poor, free health care for children under six and support in service delivery to social welfare target groups and ethnic minority populations, to increase the effectiveness of state support by making sure that the targeted service-users receive the intended benefits. The Government has also stressed the need to strengthen and upgrade the grassroots health care network, develop primary health care, implement national target health programmes and bring quality health care closer to the people.

Nevertheless, state budget funding for health care still suffers from shortcomings. While state budget spending on health care has increased in absolute terms, the share of state budget expenditures on health, as a percentage of GDP or as a share of total state budget expenditures, has not increased by much. The share of state budget expenditures on health out of total state budget expenditures in 2007 is estimated at about 7.1%[32], a far cry from the target of 10%. Per capita state budget spending on health care remains low compared to many other countries in the region. The proportion of public spending in the total health expenditure has increased but is still low (30%). Some localities have not been able to ensure that their total budget for health care attains the level approved by the National Assembly. Spending on preventive health from the state budget overall

[32] According to informal estimates from the Ministry of Finance.

reached 27.7% (in 2005), but this proportion was larger at the national level (38.5%) than at the local level (21%) where almost 80% of the local budget was spent on curative care. The methods of allocating state budget to curative and preventive care is currently facing many shortcomings as they are still primarily based on inputs (number of patient beds, size of medical staff) rather than on performance.

3. **Health insurance** is currently one of the most important health financing resources in Viet Nam. Viet Nam is striving to achieve universal health insurance coverage. Social health insurance coverage has been on the rise in the past few years. The number of health insurance members has surged since 2005, mostly owing to the Government policy of purchasing health insurance cards for the poor. In 2007, approximately 36.5 million people were covered by health insurance, accounting for about 42% of the population. Among the insured, 41% are covered by health insurance for the poor, and 28% by voluntary health insurance. The package of services covered by health insurance has been expanded and updated on a regular basis. Many new medical services and technologies are provided to people with health insurance. The organization of the health insurance system is also being strengthened and refined. The National Assembly has ratified the Health Insurance Law in November 2008, which serves as the legal basis for achieving universal health insurance in Viet Nam.

   However, on its road to universal health insurance coverage, there are still many challenges ahead. Health insurance coverage remains low and with poor sustainability, especially with regards to farmers and the low-income groups. Premium contributions are low compared with the actual costs of health services, restricting the service package for health insurance members. The widely used fee-for-service payment mechanism has adversely affected access to health services by low-income groups. Adverse selection remains a major problem in the voluntary health insurance scheme. Health insurance fund expenditures substantially exceed revenues. The health insurance system lacks specialized skills for its operation.

4. In the past decade, **external assistance** for health care has never ceased to grow and overall accounts for about 8% of the state budget for health. External support in the form of loans has tended to increase and to date accounts for about 40% of the total external financial resources for health care. In 2007, the MoH was managing a portfolio of 61 ODA supported projects, with commitments totalling VND 10.313 billion. A large number of INGOs were committed to supporting the health sector in a vast array of domains in 2007. External assistance plays a vital role to the operations of the health sector and contributes to the upgrade of infrastructure, procurement of medical equipment, staff training and human resource development, strengthening of management capacity, technical cooperation in prevention and control of diseases and more generally for health care of the people.

   The MoH and development partners in the health sector have been very active and resolute in seeking solutions to improve aid effectiveness, including the implementation of the Paris Declaration and Hanoi Core Statement on aid effectiveness. Policy dialogue between the MoH and donors has been maintained and improved through multiple channels, including regular workshops with donors (HPG), JAHRs, evaluation of the use of external assistance in the health sector and the potential of applying the sector-wide approach in health.

In addition to these optimistic results, aid management is still encountering challenges. Donors are not really clear about the development strategy of the health sector in Viet Nam. Coordination between external assistance funds and the state budget and among the donors also needs improvement. The shift towards adopting new approaches to external assistance (programme-based assistance, sector-wide assistance, budget support) has faced many impediments and lacks clear guidelines. Many regulations between the Government and donors on aid management lack consistency. The management and operation of some PMUs have encountered limitations. The disbursement rate for external assistance projects remains low.

5. **Household out-of-pocket payments** for health care in Viet Nam are estimated to account for from 60% - 70% of total health expenditures of the nation. This is a very high proportion that needs to be reduced (the World Health Organization recommends that it should be less than 50%). Most out-of-pocket payments are for self-medication, health service fees at private facilities and expenditures incurred when seeking health care at state health facilities. For inpatient treatment, user fees only account for 60% of the total cost to households, while other indirect costs (meals, transportation and others) account for the remaining 40%. The higher the level of facility, the higher the indirect portion of expenditures. With regards to outpatient care, almost 84% of the expenditures are on pharmaceuticals and medical services, while indirect costs only account for 16%. Quite clearly, increased reliance on outpatient treatment and use of services at lower level health care facilities should help reduce indirect costs in health care.

   The fact that many of the contributors to the high proportion of household out-of-pocket payments still exist is worthy of concern. These include, for example: the widespread reliance on self-medication without a prescription; prevalent and unnecessary bypassing of lower level facilities; the fee-for-service provider payment mechanism; determination of user fees not based on accurate estimates of costs; health insurance coverage of only part of the population, facility attempts to maximize all revenue resulting in abuse of services and technology when financing autonomy is employed in hospitals, etc.

6. **Mobilization of financial resources for health care from society**, in line with the policy of social mobilization, is a major orientation of health sector reforms. In implementing this policy, state health facilities have managed to pool together considerable resources for investment through joint ventures and business collaborations in the purchase of medical equipment, development of “elective” services and wards, etc.. In this way, the equipment and technological capacity of public hospitals has been upgraded, increasing quality of care and raising income for the health staff. However, these modes of social mobilization have mainly been employed in urban areas where living standards are higher. There is a tendency for these investments to be for profit. The overutilization of services receiving socially mobilized investments need to be scrutinized and put under stricter oversight to ensure equity in health care for the people.

   Due to the social mobilization policy the private health sector is also growing rapidly. To date, there are over 70 hospitals, about 30,000 clinics, 21,600 drug stores and dealers, 450 traditional medicine manufacturing facilities. A majority of private health facilities, however, remain small-scale and fragmented, located largely in large cities, specialized in providing simple services, diagnostic tests and imaging that are quick to recoup costs. Challenges related to the development of private health care at present are mostly attributed to high taxes, shortage of convenient locations for facility development, and

health human resource constraints. Information collection as well as quality control and supervision of private health care services remain weak.

7. State-owned service providers in the health sector have adopted **financial autonomy** in accordance with Government Decree 43/2006/ND-CP and achieved impressive outcomes. The authority and accountability of facility managers has clearly improved. Financial revenues of facilities have increased substantially helping to resolve obstacles stemming from limited state budget resources. Quality of care and performance has also considerably enhanced while staff incomes have grown.

   However, the introduction of financial autonomy has not been entirely smooth. Some related mechanisms and policies are inconsistent with promotion of greater autonomy. The outdated user fee policy has exposed shortcomings but the policy has not yet been revised. The economic management and hospital administration capacity of the hospital leadership are inadequate, while openness, transparency and accountability remain limited. The fee-for-service payment mechanism tends to induce overuse of technology and services to maximize profits, creating financial burdens on patients and wasteful use of resources. Without effective management in facilities with "elective" services, there is a serious possibility of the mixing of public and private interests in use of human resources and physical facilities.

   At this time, available evaluations and reviews on the autonomy system focus mainly on the institutional level, for specific hospitals (management, hospital revenue, staff income, etc.), while evaluations on the effect of the approach on the entire health system, community and health service users, especially the poor, are not yet available.

8. **Regarding hospital service payment mechanisms**, currently the most commonly used method of user fee collection employed in Viet Nam is still the fee-for-service payment. This has been used since the user fee policy was brought into effect (1994), with fees collected for each individual service used by the patient. Both out-of-pocket payments and health insurance reimbursements apply this method.

   In the past few years, with so many reforms in health policy (social mobilization, financial autonomy, and so on), the fee-for-service payment mechanism has begun to expose its many drawbacks. Health care is a special type of service characterized by its compulsory nature (sick people have to go to the hospital) and service users with inadequate understanding and information to decide what services are most suitable for their condition. Thus, abuse of health services (diagnostic tests, pharmaceuticals, treatment duration, etc.) are quite common at both public and private health facilities. One of the major causes of this situation is the fee-for-service payment mechanism. The more services the patients use, the more providers can earn. Many higher level hospitals are eager to accept patients with even mild illnesses just for the extra income generated, often causing their own facilities to be overloaded.

   Viet Nam is in the process of considering a switch from the fee-for-service payment mechanism to case-based package payments and eventually the DRG payment method. Currently, with support from some donors, the MoH is planning to pilot the case-based package payment method for some common services (normal delivery, C-section, appendicitis, pneumonia, etc.) in selected hospitals. After the pilot period, the MoH will consider rolling out use of this new modality to other conditions and other hospitals. With the case-based package payment method in use, service abuse should be

significantly curtailed as hospitals will have to provide effective and cost-efficient treatment to reduce expenses while maintaining quality of care.

9. **Financial assistance for health care of the poor and social welfare target groups**. In the process of reform and development of the health sector in a socialist-oriented market economy, many health financing policies may have implications on access to services by the poor and other low-income groups. To ensure equity in health, the Government has given priority to providing financial assistance to make sure that the poor, low-income and other underprivileged groups are guaranteed access to health services. In support of the poor and ethnic minority groups, the Government continues to increase the state budget allocation to buy health insurance cards for the poor (under Decision 139/2002/QD-TTg). In 2007, the premium contributed from the state budget was VND80,000, which increased to VND130,000 in 2008 and has now reached the level of 3% of minimum salary (equivalent to VND194,000 per person per year). The number of beneficiaries also increased dramatically when the Government revised the poverty line (the poor now account for about 20% of the population). In addition to the poor, the Prime Minister recently decided to subsidize at least 50% of the health insurance premium, now set at 3% of the minimum salary. The policy of free health care for children under six continues to be implemented. In recent years, the state budget allocation to the health care fund for children has risen, from VND75,000 per child in 2005 to VND108,000 per child in 2007 and VND130,000 per child in 2008. In addition, the elderly, handicapped, orphan children, homeless people, mentally ill, epileptic, leprosy, TB patients and others also continue to receive free health care services.

   Challenges in the process of providing assistance to the poor and other social welfare beneficiaries include mistakes and delays in identifying target beneficiaries; inadequate health services in some locations (especially the upland, isolated and remote areas); quality of care falling short of health care needs of the community; meagre government assistance to cover the substantial indirect costs of seeking care; and scant monitoring and evaluation of policy implications.

Chapter XII. Recommendations

This Chapter presents recommendations of the JAHR 2008, intended to support the planning tasks of the MoH for 2009 and subsequent years and also to serve as the basis for selection of the focal points for cooperation and dialogue between the Vietnamese health sector and international development partners. The recommendations consist of the major solutions to priority problems of health financing in the next few years.

1. State budget for health

Increase state budget for health to meet health-related needs of the public

1. The Government needs to continue increasing state budget spending on health. The increase in state budget health expenditure needs to outpace the average increase in general state budget spending in order to reach a 10% share of total state budget spending each year. Minimum spending norms need to be established for basic domains of the health sector. A monitoring system can be put in place to guarantee that the directive of increasing the health budget is effectively undertaken at both the national and local levels.
2. Funding sources consisting of external assistance (ODA, NGO), government bonds, bank loans and other legal financial resources should continue to be prioritized in the drive to achieve a breakthrough in investing in and improving quality of health services at all levels.

Reform allocation, management and use of state budget for health care

3. Reform the mechanism for allocating state budget for health services with priority on poor people, poor and disadvantaged regions, grassroots health care and preventive health. Prioritize use of state budget funding to implement basic health policies, especially those targeting the poor, the near-poor, children under age 6 and other social welfare beneficiaries.
4. Gradually reform the way the state budget is channelled to health services from the current input-based method (patient beds, staffing) to a results-based method linked to assigned tasks, quantity and quality of performance, with a monitoring mechanism that assesses performance of the assigned tasks.
5. Reform the mechanism for allocating preventive health funding, based on assigned tasks and performance on these tasks. Develop a roadmap and monitoring mechanism to increase expenditures on preventive health, so total state budget expenditure on this sub-sector reaches at least 30% by 2010, in particular at the local level.
6. Strengthen the reporting system on state budget expenditures for health in order to have accurate information to inform health financial planning. Establish a reporting system across the levels of the health system on state budget expenditures on health. Research the option of applying the MTEF in the health sector. Undertake a study on effectiveness in use of state budget for health, especially for certain focal sub-sectors.
7. Develop and implement a rational remuneration policy to encourage health workers to work in the grassroots level and in disadvantaged areas.

2. Health insurance

Adjust policies to expand sustainable coverage of health insurance

8. To reach complete coverage of the formal sector workforce, it is necessary to ensure compliance in making contributions to health insurance through regulatory mechanisms such as assigning clear responsibility over the right to monitor, inspect and impose penalties on people who do not participate in health insurance.
9. Health insurance policies need to be revised to include health insurance for dependents of workers according to the Health Insurance Law. This will increase both the number of health insurance members and revenues from premium payments from employees and employers (instead of using the state budget to purchase health insurance for dependents of workers).
10. To safeguard the sustainability and ability to balance the health insurance fund, adjustments need to be made to align health insurance schemes with fundamental health insurance concepts including financial risk sharing within the community of people participating in health insurance during times of illness. Distinguish clearly between the health insurance policies and social protection policies. It is necessary to have a policy on management of the voluntary commercial health insurance schemes operated for profit through revising and supplementing guiding circulars on implementation of the 2000 Insurance Business Law, which stipulates mechanisms for the monitoring and management of commercial health insurance schemes.

Solutions to address the imbalance of the health insurance fund

11. Study and review the list of health services, pharmaceuticals and consumables included in the package covered by health insurance; formulate the basic health service benefit package based on principles of cost-effectiveness and suitable with the ability to balance the health insurance fund; formulate the health insurance premium levels in line with the health care package and fund balance.
12. Health insurance should gradually apply a case-based (diagnosis specific) package payment mechanism to replace the fee-for-service mechanism currently used. Put an end to the unrestricted reimbursements for services at higher level health facilities through deduction from the health insurance budget of lower level facilities to pay for referral care by revising the multi-level reimbursement regulations in Joint Circular No. 21/2005/TTLT-BYT-BTC.
13. Control adverse selection in health insurance through use of appropriate technical measures. The VSS agency needs to effectively educate and communicate to the public so they can gain a correct understanding about health insurance, contributing to reducing adverse selection.
14. Revise and amend the decrees guiding implementation of the Law on Insurance Business, to complete the legal basis to implement voluntary commercial health insurance schemes, in accordance with the principle that commercial health insurance is not a replacement for social health insurance and that social health insurance target groups may only purchase commercial health insurance once they have duly paid their social health insurance premiums.

Strengthen management capacity of the health insurance system

15. Strong and consistent leadership by the Party and at different levels of government is imperative to ensure the development of health insurance as one of the local political commitments and as an integral part of the local socio-economic and health care development plan. Close cooperation between relevant agencies and organizations (e.g. administrative units in the Ministries of Planning & Investment, Finance, Labour – War Invalids – Social Affairs, etc.) and support from mass organizations and society are also vital to the development of the health insurance system.

16. The health insurance system must be organized along professional specializations, not as a set of extra tasks assigned to someone also managing pension and unemployment funds. The health insurance system needs to uniformly adopt the single-fund approach, yet allow for increasing decentralization to empower provincial level health insurance authorities. There is a need to create a central reserve fund that assures the ability to share risks across the entire system, yet finds a means to avoid the situation of health insurance funds in poor provinces subsidizing richer provinces where health care costs per insured patient tend to be higher.

17. Establish dedicated agencies serving health insurance work, e.g. committee advising on the health insurance package and on the health insurance drug list. Employees in the health insurance system need basic health insurance management training, relevant to their roles and the mandates of their positions. Health insurance management needs to be systematically computerized and integrated with hospital patient management and health insurance expenditure management software programs, in order to gradually modernize the health insurance management system.

3. External aid

18. Although GDP per capita in Viet Nam is improving, it remains low. The need for investment in health is still very high. It is proposed that the donor community continue to prioritize assistance to health in Viet Nam in the upcoming years.

19. The MoH should formulate a consistent development plan for the health sector, elaborating upon strategies and areas of priority essential for the future development of the sector, especially in five-year plans (2011 – 2015). This plan should give an overall picture of how much funding is needed for the entire sector, including from the state budget, external assistance, resources from social mobilization, along with an estimate of the funding shortfall, to serve as a basis for mobilizing external assistance and other supplementary funding sources and effectively coordinate health financing resources. Donors should focus their assistance on the strategies, plans and priorities of the Vietnamese health sector.

20. Upgrade the information system on external assistance to health to ensure comprehensive, precise, up-to-date information and to inform health planning at the central and local levels

21. The MoH and its development partners should work together to implement the “Hanoi Core Statement” and Accra Agenda for Action (AAA) to increase aid effectiveness; develop together a joint agreement to strengthen effectiveness of external assistance in the health sector.

22. The MoH and its development partners should continue to implement the JAHR. Donors should commit to continue financial assistance for the JAHR under the coordination of the Planning and Finance Department of the MoH.

23. Strengthen the activities of the HPG in an effective manner through reforming the working mechanism, revising the TOR of the HPG and strengthening further the participation of relevant parties (Departments/ Administrative Units/ General Departments, institutions affiliated with the MoH, other relevant Ministries, policy beneficiaries, etc.). Consolidate the Secretariat and working sub-groups through defining clear and specific roles, tasks and mechanisms for operation.

24. Study to understand better the advantages and disadvantages and the conditions necessary to implement new aid modalities (sector support, programme support, budget support), and on that basis identify concrete conditions, specific health sub-sectors and preparatory steps necessary to apply these new approaches.

4. Reduce household out-of-pocket health expenditures

25. Develop forms of pre-payment for all groups in society, especially in the form of health insurance. Continued state budget funding is required to support procurement of health insurance for the poor, near-poor and other social welfare target groups. The health insurance premiums for the poor and near-poor need to be raised to keep up with rising service costs. Health insurance reimbursement should be adjusted to increase the coverage limits for the poor and near-poor. Relevant local agencies should be encouraged to direct more resources to support the poor and near-poor with non-health expenses like transportation, meals, etc.

26. Formulate clinical standards on prescribing use of laboratory tests, diagnostic imaging, especially for costly tests and tests related to joint venture and business collaboration investments in equipment; standardize and calibrate laboratory equipment to ensure that test results are valid and can be relied on at different health service providers.

27. Reform hospital management, improve quality and efficiency of patient service, promote rational use of diagnostic tests, pharmaceuticals, and consumables, restrict misconduct and informal payments.

28. Encourage use of appropriate levels of care and medical technology, according to the referral system and use lower levels of care in a rational manner to reduce related costs of health care, especially indirect costs. Limit self-medication and over-the-counter sales of prescription drugs.

5. Mobilize financial resources in society for health care

29. The MoH should collaborate with relevant Ministries and local authorities to continue to mobilize and effectively use investment capital to develop public health facilities using loan funds from Development banks, government bonds and other legal sources of capital to invest in developing health facilities, especially grassroots, district and provincial levels.

30. Develop a transparent financial system with detailed provisions on the use of public assets (e.g. land, infrastructure, human resources, brand names, etc.) as shares in joint ventures and business collaborations, and on the mobilization of other non-public

funds for health care. At the same time a control mechanism is needed to supervise use of medical services of joint ventures and business collaborations in order to ensure quality of care goes along with economic efficiency and assures equity in health care

31. In the immediate future, promote development of the private health care system (especially private hospitals, foreign invested hospitals, etc.) as the focus of the policy on social mobilization of resources for health care, in order to replace private investment in "elective" services, semi-public services, joint venture and business operations in public hospitals.
32. Undertake an assessment of the non-state budget sources of investment financing in health, forms of joint venture and business collaborations with private investors, and "elective" services in public hospitals to assess the implications of the current partial privatization of public hospitals and recommend solutions to control the situation.

6. Financial autonomization

33. Supplement and refine policies associated with financial autonomy, including: (i) prompt adjustment of the user fee policy; (ii) effective implementation of policies supporting the poor, near-poor and social welfare target groups; and (iii) adjustments in relevant regulations on setting up development funds, additional salary coefficients, joint ventures and business collaborations, payment of business income tax, etc.
34. Strengthen openness, transparency and accountability of health facility financing; promote democracy in oversight of operations; Organize training to improve capacity for hospital management, especially management under the autonomous hospital mechanism.
35. Strengthen the monitoring and inspecting role of supervising authorities over financially autonomous institutions to restrict the trend of chasing after profits. Strengthen supervision of the implementation of basic tasks of public hospitals at the higher levels, especially technical mentoring of lower level facilities, rotation of staff to support lower levels.
36. Implement research studies and evaluations on the impact (both positive and negative) of financial autonomy in public hospitals on both the health system and service users themselves, especially the poor and the near-poor.

7. Hospital service payment mechanism

37. Reform the method for allocating state budget to hospitals based on the number of patient beds or staff size towards allocation based on assigned tasks, workload and performance, and subject to a performance monitoring system.
38. Gradually develop standard care pathways for common illnesses to form the basis of standardizing health care, limiting overprovision of health services at health facilities and in order to implement a pilot to transform from the fee-for-service payment mechanism to a case-based package payment system or eventually to a diagnostic-related group system (DRG). First of all, implement a pilot covering a few common conditions, with clear diagnostic criteria and treatment protocols.

8. Financial support for the poor and other social welfare target groups

39. The Government needs to maintain state budget priorities for effective implementation of policies assisting the poor, children under age six and social welfare target groups, and ensuring health care equity in the context of the market economy, increasing share of investment from socially mobilized funds and financial autonomy in health facilities. Resolve shortcomings in management and implementation of the health care fund for the poor. Provide free health care for children under age 6 in the form of purchasing health insurance cards. Effectively implement the policy to subsidize at least 50% of the health insurance premium for the near poor. Strengthen IEC on the rights and responsibilities of the poor when using health services
40. Local authorities need to be committed to mobilizing resources to support indirect expenses (meals, lodging, transportation, etc.) to lessen the financial burden for the poor who have to seek health services far from their homes. Donors can play a supportive role in the process of creating and undertaking pro-poor health-related policies in Viet Nam.
41. The MoH should establish a liaison office (situated in the Planning & Finance Department) responsible for regular monitoring and reporting on the delivery of assistance for the poor and other beneficiaries of social welfare policies.

Annex 1. Recommendations from 2007 and outcomes

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
1. Health system organization and management		
Amend and refine basic health policies	▪ Draft Law on Examination and Treatment, Law on Health Insurance and some other legal documents to be submitted to the Government and National Assembly for review and public referendum. ▪	▪ The MoH is in the process of reviewing the Law on Health Care for the People in preparation for the formulation of the Law on Examination and Treatment. ▪ The Health Insurance Law was passed by the 4th session of the XIIth National Assembly in November 2008 and becomes effective starting 1 July 2009. ▪ National Assembly Resolution No. 11/2007/NQ-QH12, dated 21 Nov. 2007 on the law- and ordinance-making agenda of the 12th National Assembly for 2007–2011and 2008 approved the schedule for law making including the Law on Examination and Treatment, the Population Ordinance and the Food Safety Ordinance. On stand-by are the Law on the Disabled and the Tobacco Control Law.
Continue to reform and increase effectiveness of public administration in the MoH; define the role and mandates of the MoH in a decentralized health care system and strengthen policy analysis capacity	▪ Undertake a study to analyze the state administration functions and mandates of the MoH in line with the need to renovate public administration, implement public administrative reforms, decentralize and integrate internationally. ▪ Draft plans and solutions. ▪ Draft materials to institutionalize recommended adjustments.	▪ Decree 188/2007 ND-CP dated 27 Dec. 2007 outlines the functions, mandates, jurisdiction and organization of the MoH. ▪ Minister of Health Decision 19/2008/QD-BYT dated 30 May 2008 specifies the operating procedures of the MoH; the Minister of Health issued Decision 16/2008/QD-BYT, dated 22 Apr. 2008, defining the role, mandates, jurisdiction and organization of the Medical Services Administration. The MoH is now further reviewing the proposed functions and mandates of other units under its jurisdiction for ratification and is in the process of submitting to the Prime Minister for approval of 77 ministerial agencies. ▪ Five MoH agencies having obtained the VN ISO standards 9001: 2000 (the Cabinet, Organization and Management Department, Drug Administration of Vietnam, Food Safety Administration and HIV/AIDS Administration) and are now applying 70 operating procedures to improve effectiveness of public administration in health.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
Health management information system	▪ Formulate and set in motion a plan to establish a health information system for 2008 -2010. ▪ Improve and integrate the application of information technology in hospital and patient management, under the overall management of the MoH.	▪ A plan for developing the health management information system has been devised while the hospital management system and software, including the second phase of patient records management, is currently under development. ▪ The Medical Services Administration is drafting a proposal for a telemedicine project as an initial step in the formulation of a proposal on applying information technology in hospital management. ▪ Prime Ministerial Decision 43/2008/QD-TTg dated 24 March 2008 was issued in approval of the plan to use information technology in the public administration sector in 2008, including assistance to develop an information management system for preventive medicine.
Regulation of public and private medical/ pharmaceutical practice	▪ Establish mechanisms and requirements for medical practice registration in close connection with quality control. ▪ Establish a quality assurance system to monitor quality of care for both the public and private sectors. ▪ Establish the Medical Council. ▪ Attract private health facilities to join local civil society organizations related to the health sector	▪ The establishment of the Medical Council is being proposed in the draft Law on Examination and Treatment. Requirements for registration of medical practice will also be elaborated in the Law and its implementing decrees. ▪ The draft Law on Examination and Treatment, when ratified, will provide a legal basis for the development of regulations on quality assurance and improvement, including rules on practice registration.
Consolidate the organization of the health system at district and commune levels	▪ Develop a strategy to improve cooperation between the District Health Office, Preventive Health Centres and hospitals in the management and leadership of the preventive and curative care network in the communes.	▪ Government Decree 14/2008/ND-CP was issued, superseding Decree 172 on the organization of the local health system. ▪ Joint Circular 03/2008/TTLT-BYT-BNV of the MoH and Ministry of Home Affairs dated 25 Apr. 2008 defines the role, mandates, jurisdiction and organization of Provincial Health Departments, and district health offices affiliated to the Provincial and District People's Committees.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
Improve aid coordination, cooperation and effectiveness	▪ JAHR 2007 and JAHR 2008 are implemented and are working to strengthen donor performance (regarding coordination, consistency, support modalities, etc.).	▪ Donors have worked more closely with each other and the MoH in providing external assistance. The partners have also asked the MoH to maintain its coordinating role for health-related aid. ▪ Donors and the MoH are drafting a statement of intent to implement the Hanoi Core Statement in the health sector, expected to be completed in December 2008.
2. Health human resources		
Health human resources development strategies and plans	▪ Compile a status report on health human resources. ▪ Devise and approve a strategic plan.	▪ The MoH Science and Training Department is working on the master plan for health human resources training and development network. ▪ The MoH (Science and Training Department) is currently preparing the "Health human resources sector development programme" focused on human resources development and management.
Strengthen the health workforce at the commune level, especially in remote areas	▪ Reform staff remuneration packages, including salaries, allowances and other fringe benefits, such as housing, transportation and further training for health workers stationed in remote and isolated areas.	▪ The Prime Minister approved the proposed plan on: "Health human resources on-the-job training for disadvantaged and upland areas in the North, Central, Mekong Delta and Central Highlands" on 14 November 2007. ▪ MoH Circular 06/2008/TT-BYT dated May 26 2008 gives guidance on the recruitment of students to upgrade their medical or pharmaceutical training at the university or junior college levels.
Strengthen regulations associated with workplace conditions	▪ Approve regulations requiring health workers to spending 2 – 3 years at a community-based job before being allowed to work in private practice or to pursue further training.	▪ The Planning & Finance Department has developed a proposal for "Renewal of the financing and salary system in the health sector" which also specifies the obligations of medical doctors. ▪ The Organization & Manpower Department is drafting a proposal on the obligations of health workers.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
Financing mechanisms	▪ Approve plans and regulatory documents to increase the training budget and diversify training approaches for the purpose of increasing revenues for training institutions. ▪ Channel donor support to the upgrade of facilities at training institutions.	▪ Resolution 18/2008/NQ-QH12 on social mobilization in the health sector has been issued, calling for a faster growth in the state budget allocation for health than in the overall state budget. ▪ The MoH management is working closely with the Science and Training Department to develop the Project "Health human resources sector development programme", which includes infrastructure investment for medical schools.
Quality assurance	▪ Ratify the Law on Examination and Treatment, with provisions regarding standardized issuance and extension of practitioner certification to ensure health service quality. ▪ Establish a roadmap, with budget funding, for the audit of training quality by the Ministry of Education and Training. ▪ Ensure more medical colleges go through the training quality audit. ▪ Approve procedure on refresher training. ▪ Approve and implement work plan for refresher training.	▪ The role and mandates of the Medical Council (under the Law on Examination and Treatment) are under consideration, with the likely potential that the Council will be tasked with accrediting medical training institutions. ▪ ▪ ▪ The Minister of Health issued Circular 07/2008/TT-BYT on 28 May 2008 providing guidelines on continuous medical training for health workers.
Intensive training	▪ Identify needs, training facilities and resources to develop an intensive training plan. ▪ Assist the health sector in upgrading staff capacity on applying medical high technologies. ▪ Formulate an agenda and launch training courses on public administration in health care at different levels and in hospital management.	▪ The Minister of Health issued Decision 1816/2008/QD-BYT on the rotation of specialists from upper level hospitals to support lower level hospitals to improve quality of care. ▪ A handful of universities have started a graduate level course on hospital management (Hanoi School of Public Health, Thang Long University, etc.).

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
3. Health financing		
Health care resource mobilization	▪ Increase the share of the state budget expenditures on health care in the total national health expenditure. ▪ Reduce the share of out-of-pocket spending in the total national health expenditure. ▪ Increase health insurance coverage across the entire population, especially in respect of compulsory health insurance in the formal sector workforce. ▪ Conduct study and evaluated pilot of the programme-based support approach.	▪ National Assembly Resolution 18/2008/NQ-QH12 was ratified calling for growth in the state budget expenditure on health to be faster than the growth in the overall state budget expenditures. ▪ The MoH has stipulated that Provincial Health Departments must install 2 – 3 officers to be dedicated to health insurance management. ▪ The Health Insurance Law was passed providing a stronger legal basis to gain compliance with health insurance coverage in the formal sector. ▪ A few donors are working with the MoH and other relevant ministries to promote programme-based or budgetary support in the Vietnamese health sector.
Sharing of health financial resources	▪ Improve household financial protection against catastrophic medical expenditures, particularly for poor and near-poor households. ▪ Revise the draft Health Insurance Law to ensure support for the poor and near-poor.	▪ Prime Ministerial Decision 289/QD-TTg dated 18 March 2008 issued assistance policies for ethnic groups, social welfare targeted households, poor and near-poor households and fishermen and states that at least 50% of the health insurance premium should be subsidized by the state budget for members of near-poor households buying voluntary health insurance, starting from 2008. ▪ The Health Insurance Law was passed by the National Assembly ensuring continued support to the poor and near-poor.
Manage and utilize health financial resources	▪ Study and introduce new financing and budgeting modalities for health services. ▪ Modify user fee levels based on a full accounting of hospital service costs. ▪ Ensure effective drug price control and safe and rational use of drugs.	▪ A draft Government Decree on the user fee policy (including specifics of amendments and revisions to Decision 139/2002/QD-TTg on health care for the poor) has been written. ▪ Piloting of new financing modalities is being planned in specific hospitals (as part of an AusAID supported project) ▪ Drug price control and safe and rational use of drug management measures are being exercised and further adjusted where applicable.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
4. Health service delivery		
Preventive medicine	▪ Develop policies to motivate preventive health workers to serve in disadvantaged areas. ▪ Invest in equipment for preventive medicine at the grassroots level. ▪ Provide training and refresher training for the preventive health workforce.	▪ The Project "Renewal of the financing and salary system in the health sector" currently being drafted addresses problems with the current salary policy and recurrent expenditures in the preventive health system. ▪ Decision 1402/QD-TTg in approving the project for development of district Preventive Health Centres for 2007 – 2010 targets both capital investment and training of staff, with preference being given to disadvantaged areas.
	▪ Emphasize and motivate the 'social mobilization' movement in health care: involving the government authorities at different levels and the community in health care activities, while mobilizing resources from localities and organizations. ▪ Develop national strategies in prevention of non-communicable diseases, with an initial focus on hypertension and diabetes. ▪ Strengthen education, awareness raising and behavioural change among the community.	▪ National Assembly Resolution No. 18 on social mobilization provided additional guidance for implementing this policy. ▪ Prime Ministerial Decision 77/2002/QD-TTg, dated 17 June 2002 approves the Programme for the prevention of non-communicable diseases, 2002 – 2010. The MoH is implementing the Programme for prevention of non-communicable diseases, and the national target programme for cancer prevention has also been adopted by the Government. ▪ Pilot activities are on the ground regarding hypertension and diabetes. ▪ Decision 16/2007/QD-BYT approves the national action plan on IEC for HIV/AIDS control and behavioural change by 2010. ▪ Decision 3526/2004/QD-BYT approves the Health Education action plan by 2010.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
Commune health and primary health care	▪ Come to a new consensus on regulations regarding responsibility and authority of commune level curative care to lay a legal foundation for health workers providing curative care (making a specific distinction between health centres with and without doctors).	▪ Decree 14/2008/ND-CP and Circular 03/2008/TTLT-BYT-BNV have been issued laying out clearly the functions and responsibilities of different levels and organizations of the local health system.
	▪ Set up a coordinating system between the district hospitals, health offices and preventive health centres to monitor and provide clinical support for commune health care	▪ The district health management approach is changing in line with Decree 14 and Circular 03. ▪ Decision 1816 has defined the responsibilities of upper level personnel being seconded on rotation to lower levels for clinical and curative care support.
	▪ Strengthen equipment facilities in health centres, with preference being given to remote areas and sub-standard centres, especially equipment for preventive health care.	▪ Decision 950/QD-TTg on building commune health stations in disadvantaged areas, 2008-2010 calls for increased investment in this important level of primary health care.
	▪ Cooperate with higher level health services to provide continued outpatient treatment after discharge.	▪ Piloting has been underway in some provinces on selected diseases (diabetes, TB).
	▪ Strengthen resources and ensure effective implementation of Project 225: “upgrade of district hospitals”.	▪ Prime Minister Decision 47/2008/QD-TTg dated 2 Apr. 2008 approves the Project for construction, renovation, and upgrading of district and inter-district general hospitals from funds raised from Treasury bonds and other legitimate funding for 2008 – 2010.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
Curative care	▪ Develop management capacity building for health and hospital managers; maintain hospital autonomy in line with Decree 43.	▪ The MoH has organized a few training courses on upgrading management capacity for management staff of central and provincial hospitals in 2008. ▪ Some universities have started hospital management training (at graduate and post-graduate levels). ▪ Ministry of Finance – Ministry of Information and Communication Joint Circular No. 43/2008/TTLT-BTC-BTTTT, dated 26 May 2008 provides guidelines on the management and utilization of expenditures on information technology used in governmental agencies which should help to push ahead with computerization of management of health care facilities..
	▪ Increase access for the poor, ethnic groups and other vulnerable groups to quality health services.	▪ Prime Ministerial Decision 950/2007/QD-TTg on development of commune health stations in disadvantaged areas for 2008 – 2010 provides for investments to improve quality of commune health stations. ▪ Decision 289/2008/QD-TTg issues specific support policies for ethnic groups, social welfare targeted households, poor, near-poor and fishermen households. ▪ The Projects “Health care support for Northern Upland provinces” (NUP) and “Health care for the poor in the Northern Uplands and Central Highlands” (HEMA) have been approved and set in motion. The MoH is in negotiation with World Bank and ADB on some support for health projects in other regions.
	▪ Set up and strengthen a medical waste processing system.	▪ Minister of Health Decision 43/2007/QD-BYT dated 30 Nov. 2007, specifies regulations on medical waste management (superseding previous regulations dating back to 1999). ▪ Official dispatch 5069/VPCP-VX offers guidance on adoption of the regulations on medical waste management.
	▪ Revise level-based lists of available medical techniques to respond to actual sector development and society’s needs.	▪ The Minister of Health has requested that the Curative Care Department reviews the lists of medical techniques available at different levels of care.

Recommendations from JAHR 2007		
Key issues	**Expected outcome**	**Outcome by end of 2008**
	▪ Set service costs so as to encourage use of services at lower levels. ▪ Improve inpatient quality while shortening treatment length. ▪ Research, develop and pilot treatment using care pathways for some basic disease groups.	▪ The proposal on "renewal of financing and salary system in the health sector" has recommended a few related policies. ▪ The Minister of Health issued Directive CT 06/2007 on raising quality of care and taking steps to relieve overloading. ▪ An AusAID supported project is piloting care pathways for four diseases in four hospitals.
Strengthen drug price control	▪ Reinforce drug supply, management and use in hospitals. ▪ Develop plans to strengthen education on safe and rational use of drugs for both providers and service-users.	▪ MoH Decision 24/2008/QD-BYT, dated 11 July 2008 specifies the proper organization and operation of hospital pharmacies. ▪ The television programme on Channel 02 give extensive coverage and guidance for safe and rational use of drugs.

Annex 2: Summary of key challenges and solutions

State budget		
Priority issues	**Solutions/Activities**	**Expected outcome**
State budget allocation for health care is not yet meeting the health care needs of the public	▪ The increase in state budget health expenditure needs to outpace the average increase in general state budget spending; ▪ Propose and lobby for state budget expenditure on health that reaches 10% of total state budget expenditure; ▪ Minimum spending norms need to be established for basic domains of the health sector; ▪ Establish a monitoring system for the implementation of the policy calling for a "the rate of increase in state budget expenditure on health care to be higher than the average rate of increase of overall state budget expenditure"; ▪ Funding sources consisting of external assistance (ODA, NGO), government bonds, bank loans and other legal financial resources should continue to be prioritized in the drive to achieve a breakthrough in investing in and improving quality of health services at all levels. ▪ Reform the mechanism for allocating preventive health funding, based on assigned tasks and performance on these tasks; ▪ Develop a roadmap and monitoring mechanism to increase expenditures on preventive health, so total state budget expenditure on this sub-sector reaches at least 30% by 2010, in particular at the local level.	▪ A higher rate of state budget spending on health care than inflation rate; ▪ A higher rate of state budget allocation for health care than the average state funding increase rate; ▪ Relevant norms developed along with implementation of monitoring system; ▪ An established monitoring system for state budget allocation for health care; ▪ Increased share of resources used for health care from ODA, NGO, government bonds, bank loans. ▪ An improved state budget allocation system for preventive health; ▪ State budget funding for preventive health accounting for at least 30% of total state budget spending on health care.

State budget		
Priority issues	**Solutions/Activities**	**Expected outcome**
Low effectiveness in utilization of state budget	▪ Reform the mechanism for allocating state budget for health services with priority on poor people, poor and disadvantaged regions, grassroots health care and preventive health.; ▪ Prioritize use of state budget funding to implement basic health policies, especially those targeting the poor, the near-poor, children under age 6 and other social welfare beneficiaries; ▪ Gradually reform the way the state budget is channelled to health services from the current input-based method (patient beds, staffing) to a results-based method linked to assigned tasks, quantity and quality of performance, with a monitoring mechanism that assesses performance of the assigned tasks; ▪ strengthen the reporting system on state budget health expenditures to accurately inform health financing planning; ▪ explore alternatives to adopt the medium term expenditure framework; ▪ initiate an array of studies on efficiency of state budget utilization, especially with regards to core domains in the health sector.	▪ A higher share of state budget allocation for health services in poor and disadvantaged areas, community-based health and preventive health; ▪ An increase in the proportion of state budget allocated for the implementation of health support policies for the poor, near-poor, children under 6 and other target groups; ▪ Regulations issued on responsibility- and performance – based state budget allocation; ▪ Regulations issued on state budget health expenditure reporting by health facilities; ▪ Studies conducted on efficiency of state budget utilization in core health sub-sectors.
Irrational incentive structure for health workers, especially at the grassroots levels, insufficient to entice health personnel to work in grassroots health services, particularly in isolated and poor regions	▪ Develop and implement a rational remuneration policy to encourage health workers to work in the grassroots level and in disadvantaged areas.	▪ A better remuneration package for health workers in areas in need of attracting more staff; ▪ Remuneration packages for health workers based on staff capacity and performance.

Health insurance		
Priority issues	**Solutions/Activities**	**Expected outcome**
Impediments to achieving universal coverage	▪ To reach complete coverage of the formal sector workforce, it is necessary to ensure compliance in making contributions to health insurance through regulatory mechanisms such as assigning clear responsibility over the right to monitor, inspect and impose penalties on people who do not participate in health insurance.	▪ The Health Insurance Law is approved by the National Assembly. ▪ Supervisory authority and penalty mechanisms regarding health insurance are clarified in legal documents. ▪ Health insurance compliance in the salary earning sector achieves at least 80% by 2010.
Imbalance of the health insurance fund	▪ Study and review the list of health services, pharmaceuticals and consumables included in the package covered by health insurance, formulate the benefit package based on cost-effectiveness and set suitable premium levels to balance the health insurance fund. ▪ Health insurance should gradually apply a case-based (diagnosis specific) package payment mechanism to replace the fee-for-service mechanism currently used. Put an end to the unrestricted reimbursements for services at higher level health facilities through deduction from the health insurance budget of lower level facilities to pay for referral care by revising the multi-level reimbursement regulations in Joint Circular No. 21/2005/TTLT-BYT-BTC.	▪ The list of drugs, health services and consumables under health insurance coverage is reviewed by the MoH and reformulated. ▪ Health insurance premiums are adjusted to match service costs. ▪ Pilot studies conducted on case-based package payments or the DRG system
	▪ Control adverse selection in health insurance through use of appropriate technical measures. The VSS agency needs to effectively educate and communicate to the public so they can gain a correct understanding about health insurance, contributing to reducing adverse selection ▪ Revise and amend the decrees guiding implementation of the Law on Insurance Business, to complete the legal basis to implement voluntary commercial health insurance schemes, in accordance with the principle that commercial health insurance is not a replacement for social health insurance and that social health insurance target groups may only purchase commercial health insurance once they have duly paid their social health insurance premiums.	▪ Situation of adverse selection lessened. ▪ The implementing Decree of the Insurance Business Law 2000 is revised.

Health insurance		
Priority issues	**Solutions/Activities**	**Expected outcome**
Organization management and capacity of the health insurance system falling short of requirements	▪ Strong and consistent leadership by the Party and at different levels of government is imperative to ensure the development of health insurance as one of the local political commitments and as an integral part of the local socio-economic and health care development plan. Close cooperation between relevant agencies and organizations (e.g. administrative units in the Ministries of Planning & Investment, Finance, Labour – War Invalids – Social Affairs, etc.) and support from mass organizations and society are also vital to the development of the health insurance system. ▪ The health insurance system must be organized along professional specializations, not as a set of extra tasks assigned to someone also managing pension and unemployment funds. ▪ The health insurance system needs to uniformly adopt the single-fund approach, yet allow for increasing decentralization to empower provincial level health insurance authorities. There is a need to create a central reserve fund that assures the ability to share risks across the entire system, yet finds a means to avoid the situation of health insurance funds in poor provinces subsidizing richer provinces where health care costs per insured patient tend to be higher. ▪ Establish dedicated agencies serving health insurance work, e.g. committee advising on the health insurance package and on the health insurance drug list. ▪ Employees in the health insurance system need basic health insurance management training, relevant to their roles and the mandates of their positions. ▪ Health insurance management needs to be systematically computerized and integrated with hospital patient management and health insurance expenditure management software programs, in order to gradually modernize the health insurance management system.	▪ Government and Prime Ministerial directives requiring that the localities consider health insurance as one of their important political responsibilities. ▪ An implementing Decree ensuring the professionalization in the organization of health insurance is issued. ▪ Regulations on the single-fund model and reserve fund are issued. ▪ Dedicated health insurance specific agencies are established. ▪ The number of health insurance personnel who receive training on health insurance management increases; ▪ The proportion of hospitals using computerized health insurance management programs is increased.' ▪ Regulations on cooperation between the health sector and VSS are issued.

External aid		
Priority issues	**Solutions/Activities**	**Expected outcome**
Absence of an aid coordination and management system in harmony with the sector master plan	▪ The MoH should formulate a consistent development plan for the health sector, elaborating upon strategies and areas of priority essential for the future development of the sector, especially in five-year plans (2011 – 2015). This plan should give an overall picture of how much funding is needed for the entire sector, including from the state budget, external assistance, resources from social mobilization, along with an estimate of the funding shortfall, to serve as a basis for mobilizing external assistance and other supplementary funding sources and effectively coordinate health financing resources. Donors should focus their assistance on the strategies, plans and priorities of the Vietnamese health sector. ▪ The MoH and its development partners should work together to implement the "Hanoi Core Statement" and Accra Agenda for Action (AAA) to increase aid effectiveness; develop together a joint agreement to strengthen effectiveness of external assistance in the health sector. ▪ The MoH and its development partners should continue to implement the JAHR. Donors should commit to continue financial assistance for the JAHR under the coordination of the Planning and Finance Department of the MoH.	▪ Aid utilization plan in the health sector is issued in the short run (2009 – 2010) and for 2011 – 2015, in harmony with the sector master plan for 2011 – 2015. ▪ Statement of intent between the Government and donors in implementing the Hanoi Core Statement in the health sector is completed. ▪ JAHR reviews are implemented annually.
Aid coordination and management are falling short of requirements, resulting in duplication, fragmentation and low aid effectiveness	▪ Strengthen the activities of the HPG in an effective manner through reforming the working mechanism, revising the TOR of the HPG and strengthening further the participation of relevant parties (Departments/ Administrative Units/ General Departments, institutions affiliated with the MoH, other relevant Ministries, policy beneficiaries, etc.). Consolidate the Secretariat and working sub-groups through defining clear and specific roles, tasks and mechanisms for operation.	▪ The HPG Terms of Reference are revised to clarify the role and mandates of the secretariat and working groups. ▪ The HPG agenda for 2008 – 2010 to include priorities as recommended in JAHR.

External aid		
Priority issues	**Solutions/Activities**	**Expected outcome**
Lack pre-conditions for implementation of new aid modalities, lack of evidence on effectiveness of new modalities in Viet Nam	▪ Study to understand better the advantages and disadvantages and the conditions necessary to implement new aid modalities (sector support, programme support, budget support), and on that basis identify concrete conditions, specific health sub-sectors and preparatory steps necessary to apply these new approaches.	▪ Studies on aid approaches are conducted and specific recommendations for the preparations needed for the adoption of new modalities are formulated.
Lack of consistency and uniformity between Government and donor procedures, guidelines and regulations; remaining limitations in aid absorption capacity	▪ Upgrade the information system on external assistance to health to ensure comprehensive, precise, up-to-date information and to inform health planning at the central and local levels ▪ Collaborate with the Ministry of Planning & Investment and the Ministry of Finance to simplify administrative procedures and regulations on project management, especially project plan approval and adjustment procedures; come to a consensus with donors on uniform and appropriate cost norms.	▪ Implementing guidelines from the Ministries of Planning & Investment and Finance on simplifying project management procedures are issued. ▪ An implementation and outcome matrix, with effective indicators and data collection instruments, is devised and used. ▪ A MoH website on external aid in health care is developed and regularly updated. ▪ Relevant cost norms are unanimously adopted.

Household out-of-pocket health expenditures		
Priority issues	**Solutions/Activities**	**Expected outcome**
Excessive household spending on health care	▪ Formulate clinical standards on prescribing use of laboratory tests, diagnostic imaging, especially for costly tests and tests related to joint venture and business collaboration investments in equipment; ▪ Standardize and calibrate laboratory equipment to ensure that test results are valid and can be relied on at different health service providers. ▪ Reform hospital management, improve quality and efficiency of patient service, promote rational use of diagnostic tests, pharmaceuticals, and consumables, restrict misconduct and informal payments.	▪ Several standard pathways established. ▪ Clinical standards established regarding prescribing tests and clinical imaging; ▪ Standardization and calibration of laboratory equipment is applied. ▪ The main drug list (drugs covered by health insurance) is reviewed.
Inefficient health seeking and utilization behaviour of households	▪ Encourage use of appropriate levels of care and medical technology, according to the referral system and use lower levels of care in a rational manner to reduce related costs of health care, especially indirect costs. ▪ Limit self-medication and over-the- counter sales of prescription drugs.	▪ Number of patients receiving health services at the right level of care is increased. ▪ Regulations on prescription drug sales are more tightly exercised. ▪ Self-treatment is reduced.
Inadequate health-related social protection	▪ Develop forms of pre-payment for all groups in society, especially in the form of health insurance. ▪ Continued state budget funding is required to support procurement of health insurance for the poor, near-poor and other social welfare target groups. ▪ The health insurance premiums for the poor and near-poor need to be raised to keep up with rising service costs. ▪ Health insurance reimbursement should be adjusted to increase the coverage limits for the poor and near-poor. Relevant local agencies should be encouraged to direct more resources to support the poor and near-poor with non-health expenses like transportation, meals, etc.	▪ Health insurance coverage is increased. ▪ State budget subsidy to purchase health insurance at 100% for the poor and 50% for the near-poor is guaranteed. ▪ Premium contributions for health insurance cards for the poor and near-poor are increased ▪ More reasonable health insurance package and reimbursement ceilings for the poor. ▪ State budget and donor support funding for indirect costs incurred by the poor and near-poor are Increased.

Mobilization of social resources for health care		
Priority issues	**Solutions/Activities**	**Expected outcome**
Failure of the health system to mobilize sizeable 'not-for-profit' social resources	▪ The MoH should collaborate with relevant Ministries and local authorities to continue to mobilize and effectively use investment capital to develop public health facilities using loan funds from Development banks, government bonds and other legal sources of capital to invest in developing health facilities, especially grassroots, district and provincial levels.	▪ The composition of investment funds for districts, communes, preventive health and some specialist hospitals reflects a high proportion of loans from development banks and government bonds.
Lack of clarity in joint ventures and business operations operating in public hospitals	▪ Develop a transparent financial system with detailed provisions on the use of public assets (e.g. land, infrastructure, human resources, brand names, etc.) as shares in joint ventures and business collaborations, and on the mobilization of other non-public funds for health care. ▪ At the same time a control mechanism is needed to supervise use of medical services of joint ventures and business collaborations in order to ensure quality of care goes along with economic efficiency and assures equity in health care	▪ Circular No. 15/2007/TT-BYT on joint ventures and business collaborations in public health facilities is amended. ▪ Regulations on control of utilization of high technology equipment are created.
Many of the effects of social mobilization of resources for health care are not clearly understood, causing difficulties in formulation of relevant policies.	▪ Undertake an assessment of the non-state budget sources of investment financing in health, forms of joint venture and business collaborations with private investors, and "elective" services in public hospitals to assess the implications of the current partial privatization of public hospitals and recommend solutions to control the situation.	▪ Report evaluating and predicting impact of partial privatization in public hospitals is implemented.
The private health sector has been slow to develop and remains fragmented; safety and quality control are weak; a data reporting system for monitoring and evaluation purposes is non-existent.	▪ In the immediate future, promote development of the private health care system (especially private hospitals, foreign invested hospitals, etc.) as the focus of the policy on social mobilization of resources for health care, in order to replace private investment in "elective" services, semi-public services, joint venture and business operations in public hospitals. ▪ Regulations requiring private health services to report on clinical operations in order to ensure service safety and quality are needed.	▪ Regulations licensing and operations of private health services are revised and issued. ▪ Private health services, especially private hospitals, are increased in number. ▪ An information system for management of private health services is developed and formalized.

Financing autonomy in public health services		
Priority issues	**Solutions/Activities**	**Expected outcome**
Inconsistent ongoing process of autonomization due to the lack of specific regulations and implementing guidelines	▪ Supplement and refine policies associated with financial autonomy, including: (i) prompt adjustment of the user fee policy; (ii) effective implementation of policies supporting the poor, near-poor and social welfare target groups; and (iii) adjustments in relevant regulations on setting up development funds, additional salary coefficients, joint ventures and business collaborations, payment of business income tax, etc.	▪ Revised policy on user fees, health insurance, management and use of human resources in public health services. ▪ Supplementary guiding documents related to implementing provisions of Decree 43 on development funds, additional salary coefficient, joint ventures and business collaborations are issued. ▪ Other new guidelines for implementation of financing autonomy are issued. ▪ Guidelines on implementation of autonomy for different types of institutions.
The monitoring system to minimize adverse effects from autonomy lacks comprehensiveness, consistency and effectiveness	▪ Strengthen openness, transparency and accountability of health facility financing; promote democracy in oversight of operations; Organize training to improve capacity for hospital management, especially management under the autonomous hospital mechanism. ▪ Strengthen the monitoring and inspecting role of supervising authorities over financially autonomous institutions to restrict the trend of chasing after profits. Strengthen supervision of the implementation of basic tasks of public hospitals at the higher levels, especially technical mentoring of lower level facilities, rotation of staff to support lower levels. ▪ Implement research studies and evaluations on the impact (both positive and negative) of financial autonomy in public hospitals on both the health system and service users themselves, especially the poor and the near-poor.	▪ A set of indicators for monitoring finance and medical inputs and outcomes are established. ▪ Monitoring, audit and inspection reports of the MoH and other stakeholders. ▪ Plans and monitoring reports on autonomy of health services, monitoring reports on line leadership of upper level health services. ▪ Regular evaluation reports on impacts of autonomy on health services.

Hospital service payment mechanisms		
Priority issues	**Solutions/Activities**	**Expected outcome**
The current method for setting user fees is irrational, and does not include all the costs of delivered services	▪ Provide leadership and guidelines for computing hospital expenditures in a systematic manner. ▪ Formulate a rational and transparent user fee schedule for medical services and technologies	▪ A MoH guideline on the development of a database and renovation of hospital service financing modes is introduced. ▪ A database on costs and fees (service charges) is developed and continuously updated.
Hospital financing modalities lack incentives to improve efficiency of the resources used.	▪ Reform the method for allocating state budget to hospitals based on the number of patient beds or staff size towards allocation based on assigned tasks, workload and performance, and subject to a performance monitoring system. ▪ Implement a pilot to transform from the fee-for-service payment mechanism to a case-based package payment system or eventually to a diagnostic-related group system (DRG). First of all, implement a pilot covering a few common conditions, with clear diagnostic criteria and treatment protocols.	▪ A new modality of state budget allocation for health services is introduced over time. ▪ The case-based package payment method is applied for some basic disease-related groups and then expanded to include outpatient treatment.
Absence of a strong, uniform service quality monitoring and control system	▪ Gradually develop standard care pathways for common illnesses to form the basis of standardizing health care, limiting overprovision of health services at health facilities.	▪ Care pathways are applied to inpatient disease groups of the highest prevalence, then expanded to many other groups, including outpatient treatment.

Financial support for the poor and other social welfare target groups		
Priority issues	**Solutions/Activities**	**Expected outcome**
Financial assistance policies for health care of the poor and other social welfare target groups still have limitations.	▪ The Government needs to maintain state budget priorities for effective implementation of policies assisting the poor, children under age six and social welfare target groups, and ensuring health care equity in the context of the market economy, increasing share of investment from socially mobilized funds and financial autonomy in health facilities. ▪ Provide free health care for children under age 6 in the form of purchasing health insurance cards. ▪ Effectively implement the policy to subsidize at least 50% of the health insurance premium for the near poor. ▪ Strengthen IEC on the rights and responsibilities of the poor when using health services ▪ The MoH should establish a liaison office (situated in the Planning & Finance Department) responsible for regular monitoring and reporting on the delivery of assistance for the poor and other beneficiaries of social welfare policies.	▪ The actual health insurance coverage of the poor, children under 6, elderly people of 85 years and above and other target groups is closely monitored. ▪ Health financing for children under 6 is changed to health insurance. ▪ Health financial assistance policies for the near-poor are implemented and monitored. ▪ Specific agencies are tasked with monitoring and reporting on support for the poor and other social welfare target groups.
Access to and use of quality health services by social welfare target groups remains a challenge	▪ Local authorities need to be committed to mobilizing resources to support indirect expenses (meals, lodging, transportation, etc.) to lessen the financial burden for the poor who have to seek health services far from their homes. ▪ Donors can play a supportive role in the process of creating and undertaking pro-poor health-related policies in Viet Nam.	▪ Provinces reporting the mobilization of funds to implement additional subsidies for meals, lodging and transportation for the poor increase in number. ▪ Donor support funds for the poor are monitored and increase over time.

Annex 3: Monitoring indicators

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
	Health status and determinants							
1	Infant mortality rate (IMR) / 1000 live births	26	21.0	18.1	17.8	16.0	16.0	Annual Survey of population change and family planning (GSO)
	Under 5 mortality rate (U5MR) / 1000 live births	35	32.8	28.5	27.5	26.0	25.9	Health Statistics Yearbook
2	Maternal mortality rate (MMR) (per 100,000 live births)	91	85	85	80	75	75	Health Statistics Yearbook
3	Percentage of underweight newborns (%)	7	6.5	5.8	5.1	5.3	5.3	Health Statistics Yearbook
	Malnutrition rate for children under age 5 (low weight for age) (%)	30.1	28.4	26.6	25.2	23.4	21.2	Annual survey of the National Institute of Nutrition
	Malnutrition rate for children under age 5 (low height for age) (%)	33.0	32.0	30.7	29.6	31.9	33.9	Annual survey of the National Institute of Nutrition
	Malnutrition rate for female children under age 5 (low weight for age) (%)			26.5	25.4			National Institute of Nutrition
4	Pregnant women found to be infected with HIV	-	-	-	-	-	479	HIV/AIDS Administration
	People living with HIV/AIDS	54,311	68,630	81,982	94,040	104,763	121,734	Estimates based on Health Statistics Yearbook
	Women living with HIV	-	-	-	4029	5440	6030	HIV/AIDS Administration

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
	HIV prevalence rate per 100,000 population	74.6	94.1	110.2	125.3	138.5	143.0	Health Statistics Yearbook
	HIV incidence rate per 100,000 population	19.8	21.0	17.3	16.5	14.8	27.0	Estimates based on Health Statistics Yearbook
	AIDS-related mortality rate per 100,000 population	1.7	2.1	2.3	2.0	2.1	4.0	Estimates based on Health Statistics Yearbook
5	Newly detected TB patients per 100,000 population	120.3	114.5	120.9	115.5	116.8	115.5	Estimates based on Health Statistics Yearbook
	AFB+ TB incidence rate per 100,000 population	71.2	69.3	71.2	66.9	67.0	63.9	Estimates based on Health Statistics Yearbook
6	Malaria prevalence per 100,000 population	232.7	203.5	156.8	119.4	108.9	83.3	Health Statistics Yearbook
	Malaria mortality rate per 100,000 population	0.06	0.06	0.03	0.02	0.05	0.02	Health Statistics Yearbook
7	Dengue fever prevalence rate per 100,000 population	39.8	61.5	95.9	68.8	81.4	118.79	Health Statistics Yearbook
	Dengue fever mortality rate per 100,000 population	0.06	0.09	0.14	0.00	0.06	0.10	Health Statistics Yearbook
8	Food poisoning cases reported to the Food Safety Administration	218	238	145	144	165	248	Food Hygiene and Safety Administration
	Deaths from food poisoning reported to Food Safety Administration	71	37	41	53	57	55	Food Hygiene and Safety Administration
9	Traffic accident death rate per 100,000 population	-	-	-	19.9	21.2	21.7	Preventive Medicine Administration

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
	Male traffic accident death rate per 100,000 population	-	-	-	30.8	32.8	35.7	Preventive Medicine Administration
	Female traffic accident death rate per 100,000 population	-	-	-	8.6	9.0	8.7	Preventive Medicine Administration
	Injury rate from road accidents (rate per 100,000 population)	37.4	25.8	18.5	14.1	13.2	12.1	Estimates based on Health Statistics Yearbook
10	Cancer prevalence rate (hospital estimates) per 100,000 population	58.3	64.1	62.9	138.3	124.6	120.4	Estimates based on Health Statistics Yearbook
	Organization and management of the health care system							
11	Percentage of state health facilities granted autonomy under Decrees 43 and 10 (%)	-	-	-	46.2	-	88.0	Planning & Finance Department, MoH
	Percentage of central state health services granted autonomy under Decrees 43 and 10 (%)	-	-	-	41.4	-	100.0	Planning & Finance Department, MoH
	Percentage of local state health services granted autonomy under Decrees 43 and 10 (%)	-	-	-	46.4	-	87.5	Planning & Finance Department, MoH
12	Percentage of hospitals using hospital management software (% estimates)	-	-	-	-	-	52.7	Medical Services Administration
13	Licensed private health services							Data not available
	Health human resources							
14	Number of doctors per 10 000 population (including central, sub-national levels and other sectors)	5.65	5.88	5.88	6.03	6.23	6.77	Estimates based on Health Statistics Yearbook

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
	Proportion of doctors who are female (including central, sub-national levels and other sectors) (%)	-	-	-	34.2	33.9	32.9	Estimates based on Health Statistics Yearbook
	Number of pharmacists per 10 000 population (including central, sub-national levels and other sectors)	0.76	0.77	0.78	1.28	1.27	1.48	Estimates based on Health Statistics Yearbook
	Proportion of pharmacists who are female (including central, sub-national levels and other sectors) (%)	-	-	-	59.0	59.2	51.1	Estimates based on Health Statistics Yearbook
15	Proportion of commune health stations with doctors (%)	61.5	65.4	67.8	69.4	65.1	67.38	Health Statistics Yearbook
16	Number of health workers with university training per 10 000 people (including central, sub-national levels and other sectors)	7.3	7.7	7.7	8.5	8.8	-	Estimates based on Health Statistics Yearbook
	Proportion of district health workers with university training in the Northwest (typical of disadvantaged areas) (%)	22.8	19.8	16.5	15.4	15.6	18.1	Estimates based on Health Statistics Yearbook
	Proportion of district health workers with university training in the Southeast (typical of better-off areas) (%)	30.5	29.4	30.0	30.6	29.6	27.9	Estimates based on Health Statistics Yearbook
17	Ratio of health workers to population in disadvantaged areas							Data not yet available
	Health financing							
18	Total health expenditure as a share of GDP (%)	5.13	5.22	5.52	5.91	6.44	-	National Health Accounts, 2000 - 2006
19	State budget spending on health care as a share of total health expenditure (%)	25.60	27.25	23.14	21.74	28.77	-	National Health Accounts, 2000

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
20	Gross public expenditure on health care (net state budget, user fees and other service fees collected by public health services, health insurance, aid/loans) as a share of total state budget (%)	7.71	7.66	7.85	8.59	9.77	-	National Health Accounts, 2000
	Net state budget spending on health care (direct state budget funding and not including user fees and other service fees collected by public health services) as a share of total state budget (%)	4.8	4.8	4.3	4.2	5.7	-	National Health Accounts, 2000
	Public health expenditure (net state budget, health insurance, aid/loans) as a share of total state budget [WHO] (%)	5.4	5.3	4.6	4.6	6.2	-	National Health Accounts, 2000 - 2006
21	Health insurance coverage as a percentage of total population	16.5	20.3	21.1	28.1	43.8	42.0	Health Statistics Yearbook
22	Health insurance coverage for the poor as a percentage of total population (%)	-	-	-	4.9	15.3	15.5	Estimates based on Health Statistics Yearbook
23	Health insurance coverage for the near-poor as a percentage of the entire near-poor population	-	-	-	-	-	-	Data not yet available
24	Preventive health expenditure as a share of total health expenditure (%)	15.4	15.0	14.0	13.8	-	-	National Health Accounts, 2000
	Public preventive health expenditure as a share of total public health expenditure (%)	31	29.8	30.8	27.7	-	-	National Health Accounts, 2000
	Health service delivery							
25	Annual hospital outpatient visits per 1000 population	67.2	68.8	68.4	73.8	84.3	126.6	Estimates based on Health Statistics Yearbook
26	Annual hospital inpatient stays per 1000 population	86.2	88.4	91.1	88.9	86.7	109.1	Estimates based on Health Statistics Yearbook

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
27	Overall bed occupancy rate (%)	95.8	92.1	91.8	89.7	103.1	116.1	Health Statistics Yearbook
	Bed occupancy rate at central facilities (%)	102.2	99.22	105.2	109.4	132.2	134.2	Health Statistics Yearbook
	Bed occupancy rate at sub-national levels (province, district) (%)	95.0	76.5	89.5	86.7	99.13	117.9	Health Statistics Yearbook
28	Average number of inpatient treatment days	6.7	6.7	6.5	6.6	7.8	7.2	Health Statistics Yearbook
	Average inpatient treatment days (central level)	10.4	10.0	10.5	10.6	11.6	11.0	Estimates based on Health Statistics Yearbook
	Average inpatient treatment days (sub-national levels)	6.2	6.2	6.0	6.1	7.3	6.9	Estimates based on Health Statistics Yearbook
29	Proportion of health facilities processing hazardous solid medical wastes (estimates) (%)	-	-	-	-	30	-	Medical Services Administration
	Proportion of hospitals meeting the requirements for processing and incinerating hazardous solid medical wastes (%)	-	-	-	-	73.3	-	Medical Services Administration
30	Proportion of women giving birth who had at least three antenatal checks (%)	78.1	83.0	87.9	84.3	84.5	86.2	Annual Review, 2002 – 2004, Reproductive Health Department, MoH; Health Statistics Yearbook, 2005 - 2006
	Proportion of pregnant women delivering at a health facility (%)	76	80	89	84.6	90.6	-	Annual Review, 2002 – 2004, Reproductive Health Department, MoH; Health Statistics Yearbook, 2005

Proposed indicators		2002	2003	2004	2005	2006	2007	Source
	Proportion of deliveries assisted by health workers (%)	86	95	94.7	93.4	92.7	94.3	Annual Review, 2002 – 2004, Reproductive Health Department, MoH; Health Statistics Yearbook, 2005
31	Proportion of children under age 1 who were fully immunized (%)	89.7	97.1	96.5	96.5	95.7	81.8	Health Statistics Yearbook
32	Proportion of commune health stations meeting national benchmarks (%)	-	-	-	-	38.5	50.5	Health Statistics Yearbook

References

1. Braveman P, Gruskin S. Defining Equity in Health. J Epidemiol Community Health. 2003;57:254 - 8.
2. WHO. Strategic Plan for Strengthening Health Systems in the WHO Western Pacific Region. March. Manila; 2008.
3. WHO. The World Health Report 2000. Health Systems: Improving Performance. Geneva; 2000.
4. Quyết định của Bộ trưởng Bộ Y tế số 370/2002/QĐ-BYT ngày 07/02/2002 về việc ban hành "Chuẩn quốc gia về y tế xã giai đoạn 2001-2010" 2002.
5. Báo cáo của Uỷ ban Thường vụ Quốc hội số 118/BC-UBTVQH12 ngày 13/5/2008 về "Kết quả giám sát thực hiện chính sách pháp luật về xã hội hóa công tác chăm sóc sức khỏe nhân dân". 2008.
6. Báo cáo của Chính phủ số 65/BC-CP ngày 05/05/2008 về "Tình hình thực hiện chính sách, pháp luật về công tác xã hội hoá chăm sóc sức khoẻ nhân dân" (Báo cáo do Bộ trưởng Bộ Y tế Nguyễn Quốc Triệu thừa ủy quyền của Thủ tướng Chính phủ trình bày tại kỳ họp thứ 3, Quốc hội khóa XII) 2008.
7. Vụ Kế hoạch-Tài chính (Bộ Y tế). Niên giám thống kê y tế 2007. Hà Nội; 2008.
8. Quyết định của Thủ tướng Chính phủ số 117/2008/QĐ-TTg, ngày 27/8/2008, về điều chỉnh mức đóng bảo hiểm y tế đối với các đối tượng thuộc diện chính sách xã hội 2008.
9. Nghị định của Chính phủ số 105/2008/NĐ-CP, ngày 16/9/2008, Quy định mức trợ cấp, phụ cấp ưu đãi đối với người có công với cách mạng. 2008.
10. Bộ Y tế. Báo cáo của Lãnh đạo Bộ Y tế trong buổi làm việc với Phó thủ tướng Nguyễn Thiện Nhân, ngày 9/09/2008 tại Bộ Y tế.; 2008.
11. Thông báo của Văn phòng Chính phủ số 246/TB-VPCP ngày 08/09/2008, về kết luận của Phó Thủ tướng Nguyễn Sinh Hùng về Đề án Xã hội hóa một số loại hình dịch vụ công cộng và tiếp tục đổi mới cơ chế hoạt động của đơn vị sự nghiệp công. 2008.
12. Bộ Y tế. Tài khoản y tế quốc gia thực hiện ở Việt Nam thời kỳ 2000-2006. Hà Nội: NXB Thống kê; 2008.
13. WHO. Statistical Information System (WHOSIS) (http://www.who.int/whosis/en/). 2008.
14. BHXH Việt Nam. Số liệu ước tính từ thu chi BHXH 2007; 2007.
15. WHO. Strategy on Health care financing for the countries of the Western Pacific and South – East Asia Regions (2006 – 2010). Manila; 2005.
16. Government of Viet Nam, World Bank. Viet Nam: Managing public expenditures for growth and poverty reduction. Review of public expenditure, procurement, and financial accountability, 2004. Hanoi: Finance Publishing House; 2005.
17. Viện Chiến lược và Chính sách y tế. Đánh giá triển khai thực hiện Chương trình mục tiêu y tế quốc gia giai đoạn 2001-2005 và định hướng đến 2010 và tầm nhìn 2020; 2008.
18. Thông tư liên tịch của Bộ Y tế- Bộ Tài chính số 10/2008/TTLT-BYT-BTC ngày 24/09/2008 hướng dẫn thực hiện BHYT cho người thuộc hộ gia đình cận nghèo.; 2008.
19. Uyen V. Commercial Health Insurance, presentation at Health insurance workshop on 9 May. 2007.
20. Đảng Cộng sản Việt Nam. Văn kiện Hội nghị lần thứ bảy Ban Chấp hành Trung ương khoá X, tr. 126, 128. Hà Nội: NXB Chính trị quốc gia; 2008.
21. BHXH Việt Nam. Số liệu báo cáo quyết toán 2006 của BHXH Việt Nam; 2006.
22. Nghị định của Chính phủ số 131/2006/NĐ-CP ngày 09/11/2006 ban hành quy chế quản lý và sử dụng nguồn hỗ trợ phát triển chính thức. 2006.

23. Bộ Kế hoạch và Đầu tư. Các phương thức cung cấp nguồn vốn ODA và tăng cường hiệu quả viện trợ, Các sáng kiến đã, đang và sẽ triển khai tại Việt Nam theo Phương thức Hỗ trợ Chương trình và Hỗ trợ Ngân sách, Việt Nam, tháng 9; 2007.
24. Vụ Kế hoạch-Tài chính (Bộ Y tế). Số liệu ước tính về tổng số viện trợ trong lĩnh vực y tế năm 2007. 2008.
25. Vụ Kế hoạch-Tài chính (Bộ Y tế). Báo cáo quản lý ODA.
26. Bộ Kế hoạch và Đầu tư. Cơ sở dữ liệu DAD (Development Assistance Data), http://dad.mpi.gov.vn/dad/. 2008.
27. Bộ Y tế. Một số bài học kinh nghiệm qua triển khai các dự án tài trợ liên quan đến chăm sóc sức khỏe ban đầu; 2005.
28. Cục Phòng chống HIV/AIDS Việt Nam. Số liệu 2007-2008 về viện trợ từ PEPFAR; 2008.
29. Cục Phòng chống HIV/AIDS Việt Nam. Báo cáo năm 2007-2008 2008.
30. NGO Resource Center. NGO Resource Center Annual Report 2007 tại http://www.ngocentre.org.vn/files/docs/NGO_RC_Annual_report_2007_final.pdf 2007.
31. Bijlmakers L, và cộng sự. Khả năng áp dụng mô hình viện trợ theo ngành/chương trình trong trong ngành y tế ở Việt Nam; 2006.
32. Tổ chức Y tế Thế giới. Đánh giá nhanh hệ thống y tế Việt Nam; 2006.
33. Quyết định của Thủ tướng Chính phủ số 48/2008/QĐ-TTg ngày 03/04/2008 ban hành hướng dẫn chung lập báo cáo nghiên cứu khả thi dự án sử dụng vốn hỗ trợ phát triển chính thức của nhóm 5 ngân hàng (Ngân hàng phát triển Châu Á, Cơ quan phát triển Pháp, Ngân hàng hợp tác quốc tế Nhật bản, Ngân hàng tái thiết Đức, Ngân hàng Thế giới.). 2008.
34. Quyết định của Bộ Kế hoạch và Đầu tư số 1248/2007/QĐ-BKH ngày 30/10/2007 ban hành Khung theo dõi và đánh giá các chương trình, dự án ODA thời kỳ 2006-2010.; 2007.
35. Hội LQ. Định hướng sử dụng ODA; 2007.
36. Bộ Kế hoạch và Đầu tư. Số liệu về tổng nợ quy đổi của Việt Nam hiện nay 2007.
37. World Bank. Health Financing and Delivery in Viet Nam: The Short- and Medium-Term Policy Agenda; 2008.
38. Bộ Y tế, Tổng cục Thống kê. Báo cáo kết quả Điều tra Y tế Quốc gia 2001-2002. Hà Nội: NXB Y học; 2003.
39. Bộ Y tế. Báo cáo Y tế Việt Nam 2006: Công bằng, hiệu quả, phát triển trong tình hình mới. Hà Nội: NXB Y học; 2007.
40. Liệu DH, Ân NQ, Long NH, và cộng sự. Tài chính y tế từ góc độ hộ gia đình và người sử dụng dịch vụ y tế. Hà Nội: NXB Y học; 2006.
41. Ke Xu, et al. Household catastrophic health expenditure: a multicountry analysis. Lancet. 2003;362(9378):111-7.
42. Wagstaff A. Measuring Financial Protection in Health. World Bank Policy Research Working Paper 4554, March. 2008.
43. Liệu DH, Long NH, Bales S, và cộng sự. Nghiên cứu chi phí điều trị một số nhóm bệnh tại bệnh viện đa khoa tuyến tỉnh. Hà Nội: NXB Y học; 2005.
44. Vụ Kế hoạch-Tài chính (Bộ Y tế). Cơ cấu chi ngân sách khám chữa bệnh tại các bệnh viện công ở nước ta hiện nay: Thực trạng, thách thức và giải pháp; 2007.
45. Đảng Cộng sản Việt Nam. Văn kiện Đại hội đại biểu toàn quốc lần thứ VIII, tr. 114. Hà Nội: NXB. Chính trị quốc gia; 1996.
46. Đảng Cộng sản Việt Nam. Văn kiện Đại hội đại biểu toàn quốc lần thứ VII. Hà Nội: Nhà xuất bản Sự thật; 1991.
47. Nghị quyết của Chính phủ số 90/CP, ngày 21/08/1997 về phương hướng và chủ trương xã hội hóa các hoạt động giáo dục, y tế, văn hóa, thể dục thể thao. 1997.
48. Nghị định của Chính phủ số 73/1999/NĐ-CP ngày 19/08/1999 về chính sách khuyến khích xã hội hóa với các hoạt động trong lĩnh vực giáo dục, y tế, văn hóa, thể dục thể thao. 1999.

49. Nghị quyết của Chính phủ số 05/2005/NQ-CP, ngày 18/04/2005, "Về đẩy mạnh xã hội hoá các hoạt động giáo dục, y tế, văn hoá và thể dục thể thao". 2005.
50. Nghị định của Chính phủ số 10/2002/NĐ-CP ngày 16/01/2002 về chế độ tài chính áp dụng cho đơn vị sự nghiệp có thu. 2002.
51. Nghị định của Chính phủ số 43/2006/NĐ-CP, ngày 25/04/2006, về việc quy định quyền tự chủ cho các đơn vị sự nghiệp công lập. 2006.
52. Quyết định của Bộ Y tế số 2194/QĐ-BYT ngày 21/6/2005 về phê duyệt đề án phát triển xã hội hóa bảo vệ, chăm sóc và nâng cao sức khỏe nhân dân. 2005.
53. Viện Chiến lược và Chính sách y tế. Đánh giá tác động của việc thực hiện tự chủ tài chính bệnh viện đối với cung ứng và chi trả dịch vụ y tế. 2008.
54. Vụ Điều trị (Bộ Y tế). Báo cáo kiểm tra bệnh viện. 2007.
55. Vụ Điều trị (Bộ Y tế). Báo cáo tổng kết công tác khám chữa bệnh năm 2007 và định hướng kế hoạch hoạt động năm 2008. 2008.
56. Chương trình hợp tác y tế Việt Nam-Thụy Điển, Đại học Y Hà Nội. Đánh giá đầu tư công nghệ bệnh viện: kiểm kê và đánh giá thực trạng đầu tư trang thiết bị chẩn đoán tại bệnh viện đa khoa tuyến tỉnh. Hà Nội; 2006.
57. Pháp lệnh của Uỷ ban thường vụ Quốc hội Số 07/2003/PL-UBTVQH11 ngày 25/02/2003 về hành nghề y, dược tư nhân. 2003.
58. Nghị quyết của Quốc hội khoá XII, kỳ họp thứ 3, số 18/2008/NQ-QH12 ngày 03/06/2008 về đẩy mạnh thực hiện chính sách, pháp luật xã hội hoá để nâng cao chất lượng chăm sóc sức khoẻ nhân dân. 2008.
59. Preker AS, Harding A. Innovations in Health Service Delivery: The corporatization of public hospitals. Washington, D.C.: World Bank; 2003.
60. Thông tư liên tịch của Bộ Tài chính- Bộ Y tế- Bộ Nội vụ số 13/2004/TTLT-BTC-BYT-BNV, ngày 27/02/2004, Hướng dẫn chế độ quản lý tài chính đối với các đơn vị sự nghiệp có thu hoạt động trong lĩnh vực y tế công lập. 2004.
61. Vụ Kế hoạch-Tài chính (Bộ Y tế). Báo cáo ảnh hưởng của Nghị định số 10/2002/NĐ-CP ngày 16/01/2002 của Chính phủ về chế độ tài chính áp dụng cho các đơn vị sự nghiệp có thu đến lĩnh vực tài chính y tế và điều kiện thực hiện, tháng 5. 2005.
62. Vụ Kế hoạch-Tài chính (Bộ Y tế). Số liệu về thực hiện Nghị định 43/2006/NĐ-CP về tự chủ tài chính; 2008.
63. Vụ Điều trị (Bộ Y tế). Số liệu điều tra kiểm tra bệnh viện năm 2003. 2004.
64. Vụ Điều trị (Bộ Y tế). Số liệu điều tra kiểm tra bệnh viện năm 2005; 2006.
65. Bộ Y tế. Nghiên cứu hệ thống bệnh viện. Nhóm sáng kiến chung về y tế (JHPI); 2007.
66. Sở Y tế tỉnh Hà Tây. Báo cáo tình hình thực hiện Nghị định 43 Tỉnh Hà Tây; 2007.
67. Bộ Y tế, Nhóm đối tác y tế. Báo cáo chung tổng quan ngành y tế năm 2007. Hà Nội; 2008.
68. Vụ Điều trị (Bộ Y tế). Số liệu điều tra kiểm tra bệnh viện năm 2000. 2001.
69. Liệu DH, và cộng sự. Ngân sách chi thường xuyên Bệnh viện đa khoa tỉnh và Bệnh viện huyện, tháng 12: Đơn vị Chính sách- Chương trình Hợp tác Y tế Việt Nam- Thụy Điển; 2006.
70. Thông tư Liên bộ Y tế-Tài chính-Lao động TBXH-Ban vật giá Chính phủ số 14/TTLB ngày 30/09/1995 Hướng dẫn thực hiện việc thu một phần viện phí. 1995.
71. Thông tư liên tịch của Bộ Y tế-Bộ Tài chính-Bộ Lao động, Thương binh và Xã hội số 03/2006/TTLT-BYT-BTC-BLĐTB&XH ngày 26/01/2006 bổ sung Thông tư liên bộ số 14/TTLB ngày 30/09/1995 của Liên bộ Y tế- Bộ Tài chính- Lao động Thương binh và Xã hội- Ban Vật giá Chính phủ hướng dẫn thực hiện việc thu một phần viện phí. 2006.
72. Brumby J, Robinson M. Does Performance Budgeting Work? An Analytical Review of the Empirical Literature, IMF Working Paper, WP/05/210 (November): IMF; 2005.
73. Quyết định của Hội đồng Bộ trưởng số 45-HĐBT ngày 24/04/1989 về việc thu một phần viện phí. 1989.
74. Nghị định của Chính phủ số 95-CP ngày 27/08/1994 về việc thu một phần viện phí. 1994.

75. Bộ Tài Chính. Báo cáo trình bày của Bộ Tài chính. Tham luận về Chính sách tài chính hướng tới mục tiêu chăm sóc, bảo vệ và nâng cao sức khỏe nhân dân: Tài liệu hội thảo tài chính y tế do Ban Khoa giáo Trung ương tổ chức 29/09/2006; 2006.
76. Cương ĐV, Vân PH, và Cộng sự. Báo cáo công tác quản lý các hoạt động KCB cho trẻ em dưới 6 tuổi tại ba tỉnh Ninh Binh, Đà Nẵng, Tiền Giang. Trình bày tại Hội thảo quản lý các dịch vụ y tế công tư trong KCB cho trẻ em. Đà Nẵng 1/6/2006. 2006.
77. Hương ĐB, và cộng sự. Kết quả từ một điều tra tuyến tỉnh về thực hiện Quyết định 139 về khám chữa bệnh cho người nghèo. Đơn vị Chính sách cho Bộ Y tế; 2006.
78. Tổng cục Thống kê. Khảo sát mức sống dân cư 2006 (cơ sở dữ liệu). 2007.
79. Công văn của Bộ Tài chính số 9090/BTC-HCSN ngày 10/7/2007 về mệnh giá thẻ BHYT đối với người nghèo. 2007.
80. Quyết định của Thủ tướng Chính phủ số 170/2005/QĐ-TTg ngày 08/07/2005 về việc ban hành chuẩn nghèo áp dụng cho giai đoạn 2006-2010. 2005.
81. Nghị định của Chính phủ số 63/2005/NĐ-CP ngày 16/05/2005 Ban hành Điều lệ Bảo hiểm y tế. 2005.
82. BHXH Việt Nam. Số liệu của BHXH về BHYT. 2007.
83. Vụ Kế hoạch-Tài chính (Bộ Y tế). Đánh giá tác động của việc thực hiện Quyết định 139 về khám, chữa bệnh cho người nghèo: Báo cáo tổng hợp: Chương trình hợp tác y tế Việt Nam-Thụy Điển; 2008.
84. Viện Chiến lược và Chính sách y tế. Đánh giá tác động quỹ khám chữa bệnh 139 lên các hộ gia đình nghèo tại Bắc Giang và Hải Dương. Hà Nội; 2005.
85. Tông cục Thống kê. Khảo sát mức sống dân cư 2004 (cơ sở dữ liệu). 2005.
86. Lương DH, và cộng sự. Đánh giá tình hình chăm sóc sức khỏe người cao tuổi ở Việt Nam. Viện Chiến lược và Chính sách Y tế và Chương trình Hợp tác Y tế Việt Nam-Thụy Điển. 2006.