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HEALTH CARE FINANCING FOR THE POOR IN VIETNAM

Paper No. 2004-8

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CURRENCY EQUIVALENTS

Currency Unit = Dong

Exchange rate as of March 15, 2003: US$1 = VND 15,432

ACKNOWLEDGMENTS

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### PUBLIC HEALTH CARE SYSTEM IN VIETNAM

<table>
<thead>
<tr>
<th>Administration Authorities</th>
<th>Health Authorities</th>
<th>Main Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Government</td>
<td>Ministry of Health</td>
<td>- Departments in the MOH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- National medicine/pharmacy training colleges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Central hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Central research/professional institutions</td>
</tr>
<tr>
<td></td>
<td>Provincial People's Committee</td>
<td>- Central pharmaceutical companies/factories</td>
</tr>
<tr>
<td></td>
<td>Provincial Health Bureau</td>
<td>- Provincial health offices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provincial hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provincial preventive health centers</td>
</tr>
<tr>
<td></td>
<td>District People's Committee</td>
<td>- Provincial pharmaceutical companies/factories</td>
</tr>
<tr>
<td></td>
<td>District Health Centre</td>
<td>- District health Centre offices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- District hospital/polyclinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- District preventive health teams</td>
</tr>
<tr>
<td></td>
<td>Commune People's Committee</td>
<td>- Public pharmacies</td>
</tr>
<tr>
<td></td>
<td>Communal Health Centre</td>
<td>- Communal health centers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Drug outlets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Village health workers</td>
</tr>
</tbody>
</table>

**Source:** Ministry of Health of Vietnam, 2000

### MAIN HEALTH INDICATORS FOR VIETNAM

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (in millions)</td>
<td>78.5</td>
</tr>
<tr>
<td>Population growth rate (percent)</td>
<td>1.4</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>36.7</td>
</tr>
<tr>
<td>Mortality rate for children under five (per 1,000 live births)</td>
<td>42</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>95</td>
</tr>
<tr>
<td>Birth weight &lt; 2500g (percent)</td>
<td>7.3</td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td>67.8</td>
</tr>
<tr>
<td>- Male</td>
<td>65</td>
</tr>
<tr>
<td>- Female</td>
<td>70</td>
</tr>
<tr>
<td>Number of doctors per 10,000 inhabitants</td>
<td>5.13</td>
</tr>
<tr>
<td>Number of pharmacists per 10,000 inhabitants</td>
<td>0.76</td>
</tr>
</tbody>
</table>

**Source:** Ministry of Health of Vietnam, 2000
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1. **BACKGROUND**

For most of its modern history, Vietnam relied on a public system of health service delivery and financing to provide its population with the basic health services required to prevent diseases and treat illnesses. State expenditures have kept an array of state facilities operating to serve anyone who needs care. This system has produced remarkable improvements in overall health status for a country with such a low per capita income as Vietnam. The system, however, is undergoing radical change. At about the same time that the country adopted market-oriented economic reforms, it also liberalized the private practice of public health service providers. By the late 1990s, private payments to public providers had become the dominant source of financing the health system.

As it now stands, government-owned and administered health care providers still deliver most of the care in Vietnam. State subsidies keep these providers available to the community. But increasing portions of their operating budgets come from revenues they earn from fee-for-service payments. To a lesser extent, providers get reimbursed for care provided to patients from a social health insurance fund financed by mandatory contributions from enrolled civil servants and private sector employees. Fee-for-service rates charged by public providers are regulated. Health insurance coverage is limited in terms of the number of people covered and the level of financing.

Four sources of health care financing combine to cover the cost of care in Vietnam. They are state subsidies, patient payments, health insurance payments and foreign aid; in 2000, they accounted for 51.75%, 15.69%, 15.1% and 6.49%, respectively (Ministry of Health 2000). The relative importance of each financing source, however, varies among the different categories of care:

- State subsidies, with some additions from patient payments, finance most of the cost of providing basic care at community levels. Services include immunizations, family planning, malaria control, Acute Respiratory Infection (ARI) treatment and first contact treatment for common illnesses.

- Patient payments finance most of the cost of drugs and outpatient clinic care. There is a minimum state subsidy for consumption of drugs for certain categories of patients and an allowance for providers serving in public outpatient clinics. Health insurance does not cover outpatient services.

- Patient payments and health insurance payments finance most inpatient care. State subsidies cover most of the fixed costs of public hospitals, such as salaries, utilities and overhead.

- Foreign aid is a temporary resource; it is part of the Government’s long-term policy aimed at improving economic and social access to health care services.

In 2000, according to the National Health Account study (Ministry of Health 2003), total health expenditures, which include public and household resources, was estimated at VND 22,910 billion or VND 291,847 per capita. This is equivalent to about 20 USD or about 5.2% of GDP; public health spending accounted for about 7.5 USD. Expenditures for preventive care represented a small percentage compared to curative --16.2% versus 71.8%, respectively. Among different levels of service delivery, commune health stations, which are most accessed by the poor, received about 10% of the total state budget allocated for health. On a per capita basis, public health spending varied considerably among the provinces.
For more than 10 years, hospitals in Vietnam have been authorized to collect fees for services and drugs provided to patients. The introduction of user fees improved health care performance by raising revenues. But these fees prevent many poor people from utilizing health services. User fees, together with other non-fee-related costs, are often cited as the main reason why the poor have lower rates of utilization of hospital services (Dhalgren 2000).

In principle, the poor are exempt from paying hospital fees (stated in article 3 of Decree No. 95/CP). According to Inter-ministerial Circular No. 20/TTLB, they are eligible for a poor book or poor health insurance card. But, in fact, these actions are ineffective because hospital funds are limited. It is estimated about 18 million people live near the poverty level; they do not have enough money to pay for services, but they are not poor enough to be exempt (Hung et al. 2000). Sometimes exempt patients receive care of a lesser quality compared to that received by paying patients. On October 15, 2002, the Prime Minister issued decision No. 139, which created a Health Care Fund for the Poor in each province to pay for the health care expenses of the poor.

According to the official fee policy, 70% of fee revenue is to be used by the facility to purchase items that will improve the quality of service. The remaining 30% may be used to provide bonuses to health workers (Dong et al. 2002). Because the salary of health workers is low, the bonuses that come from 30% of revenues are very important. It is not equitable for patients to be responsible for the salary deficiencies of health staff. The lack of appropriate incentives for health staff contributes to inefficiency in government health service. As a result, health staff over prescribe; they work a fraction of their contracted hours, open private clinics and there are problems with informal fees.

Beginning in 2003, according to government Decree 03 issued on January 15, 2003, hospitals are allowed to use 35% of their revenues from hospital fees to increase the salaries of their staff. This new policy, together with Decree 10/CP, which gives hospitals autonomy on the number of staff they can have and their salaries, merits discussion.

A promising method of revenue generation is the introduction of health insurance. A national system using health insurance cards was introduced in 1993. This risk pooling method has mobilized revenues, protected people from catastrophic losses, ensured fiscal sustainability and made people feel secure. However, before decision 139 went into effect, health insurance reached a small segment of the population, such as students; the poor were still not enrolled. Several initiatives targeted the poor; they included health care cards for the poor, direct exemption of the poor at health facilities, hospitals for the poor, and a health care fund for the poor. However, there are still obstacles that need to be overcome, such as the “leakage of funds” and “moral hazard.”

Data and analysis cited in the Vietnam Health Sector Review indicate that the relative percentage of poor people using different categories of health services varies considerably in comparison with the percentage of the poor in the general population. For example, poor households use more services from commune health centers and fewer services of public hospitals. The mix of users by income class varies by category or level of care.

What explains variations in the accessibility of the poor within a system that is struggling to maintain its open character? Is it geographical distribution? Variations in cost of care? Differences in state subsidies across provider categories? Differences in insurance coverage?
2. **Policy Implications of the Study**

Based on the analyses of these factors, this study should generate policy options in such areas as:

- Should hospitals in poor areas receive higher subsidies and should community level care in rich areas receive less? Will performance-based budgeting help improve access by the poor?

- Will a socialized fee policy adversely affect access and quality of care received by the poor?

- What are effective measures to finance the health care costs of the poor?

- How can incentives for performance be balanced with possible second-degree price discrimination practices?

- How can the program protect member interests against what might effectively be a government-owned cartel of hospital care providers? How can social insurance promote competition among public providers?

3. **Objectives**

The overall objective of this study is to examine the equity and efficiency of existing health care financing policies, especially targeting the poor in Vietnam, to analyze their implementation and to offer recommendations for making health care financing polices more equitable and efficient.

The specific objectives are:

1. To examine the allocation of state subsidies by type of care and by type of provider.

2. To analyze the impact of user fees on the poor.

3. To assess the implementation of policies on health care financing for the poor, including decision 139 on Health Care for the Poor Fund.

4. To analyze the use of revenues for staff salary supplements and its relationship to quality of care.

5. To analyze existing policies on social health insurance and their implementation.

6. To provide recommendations for making health care more affordable for the poor in Vietnam.

4. **Methodology**

The study examines available information from primary and secondary sources to address the research questions. The information sources include:


- Results from Hospital Inventory Survey 2001

- Results from Mediconsult data 2002

- Results from an exit survey conducted in 2002

5. RESULTS

THE ALLOCATION OF STATE SUBSIDIES

The first step in any financial strategy is to mobilize different types of resources. The second step is to allocate available resources, according to the need for health services.

There are four financial resources for health care, including government subsidies, patient payments, insurance payments and foreign aid. But only government subsidies, which play the predominant role, can be reallocated from rich to poor regions (Hung et al. 2000).

In Vietnam, the public health budget contains four fiscal levels: central and three levels of local governments (see the flowchart of resource allocation in Annex 1). The Ministry of Finance (MoF), the Ministry of Planning and Investment (MPI) and the Ministry of Health (MoH) (of which the MoH has little role) decide the overall level of recurrent spending on health, based on projected growth rates of total revenue and total recurrent expenditures.

The norms for budget allocations are based on the number of hospital beds belonging to a ministry or province for curative expenditures or on the population of the province for preventive expenditures. These amounts are supposed to cover salaries for a centrally determined number of health workers in the provinces, fees and drug exemptions for the poor and other recurrent expenses. The allocation norms vary across five geographic regions, presumably to capture variations in the cost of health services by region. In addition, Hanoi and Ho Chi Minh City enjoy a norm that exceeds those of other cities by 50 percent because they have regional and national functions as well.

In the annual budget allocation document sent to the provinces, an aggregate recurrent budget is provided, not its composition across sectors. Thus, the provinces allocate the budget to each sector, including health, based on norms established by the Ministry of Finance. For a poor province, a minimum budget has to be allocated to health. The provinces can add to these funds on health out of their own revenues, although this generally happens only in the better-off provinces.

In addition to the budgeted amounts for health, the provinces receive funds from the various national health programs, such as the Expanded Program of Immunizations, the National Tuberculosis Program, etc. Starting with fiscal year 2000, a new method of allocating funds was introduced; provinces receive block grants for all targets of the national health program and they have discretion in allocating funds across the different programs.

Districts receive most of their support from the provinces, although they may have their own revenue sources. Provinces (Provincial People’s Committee) have almost complete discretion in the resources they pass on to district health services. There may be a reason for greater variation in per capita resources at the district level than that existing at the provincial level.

Commune health centers either receive funds from the Commune People’s Committee or the District Health Center. They supplement their budgets through the sale of drugs.

How effective and equitable is the allocation of resources within the health sector in terms of service? Do existing

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1 Provinces are provided with two minimum amounts for spending on education, science and technology and a maximum for administration. Except for these, no sectoral breakdowns are provided.
2 A province can retain revenue that it collects in excess of its assigned target. It can choose to spend this retained revenue in any way it wishes, including health. Likewise, provinces have to reduce spending on health if their revenue performance falls short of the assigned target.
Table 1: Functional Composition of Public Expenditures on Health by Financing Source (1991–2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>ALL PUBLIC SPENDING (INCLUDING USER FEES AND HEALTH INSURANCE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Curative</td>
</tr>
<tr>
<td>1991</td>
<td>70.55</td>
</tr>
<tr>
<td>1992</td>
<td>70.12</td>
</tr>
<tr>
<td>1993</td>
<td>73.85</td>
</tr>
<tr>
<td>1994</td>
<td>65.59</td>
</tr>
<tr>
<td>1995</td>
<td>66.22</td>
</tr>
<tr>
<td>1996</td>
<td>65.82</td>
</tr>
<tr>
<td>1997</td>
<td>67.86</td>
</tr>
<tr>
<td>1998</td>
<td>69.72</td>
</tr>
<tr>
<td>1999</td>
<td>68.10</td>
</tr>
<tr>
<td>2000</td>
<td>71.80</td>
</tr>
</tbody>
</table>


allocation norms target the poor? How equitable is the allocation of expenditures among provinces; do funds allocated through state budgets offset or reinforce inequity in private spending? What factors are associated with the allocation of public expenditures among the provinces?

FUNCTIONAL COMPOSITION OF PUBLIC HEALTH EXPENDITURES

In Vietnam, as shown in Table 1, during 1991-2000, curative care took up a disproportionate share of public spending on health (65.6%-73.8%). In contrast, preventive interventions, such as communicable disease-control programs, account for a small share (11.3-19.4%). The same is true for total expenditures of the provincial health sector during the period 1999-2001 (Figure 1).

As demonstrated in Vietnam, preventive programs are extremely cost-effective and easy to access by the poor. However, the bulk of public spending on health goes into curative services, especially at the secondary and tertiary levels. Relatively few resources are allocated to preventive care and primary health programs. With such a distribution, the health system may not be efficient and equitable.

ECONOMIC COMPOSITION OF PUBLIC HEALTH EXPENDITURES

As shown in Table 2, recurrent expenditures have increased over time (from 16.6% in 1992 to 47% in 2000). Of recurrent expenditures, the budget spent on salaries and wages has also increased, while the budget spent on goods and services has decreased.

Figure 1: Functional composition of total expenditures of provincial health sector during the period 1999-2001

Source: Mediconsult 2002

3 Goods and services include drugs, consumables, water, electricity.
Table 2: Distribution of Public Health Spending by Source and Economic Type, 1991–2000

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Recurrent Expenditures as % of Total Expenditures</th>
<th>As % of Total Recurrent Expenditures</th>
<th>Capital Expenditures as % of Total Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salaries and Wages</td>
<td>Goods and Services</td>
<td>Subsidies and Transfers</td>
</tr>
<tr>
<td></td>
<td>22.67</td>
<td>71.29</td>
<td>5.89</td>
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<tr>
<td>1991</td>
<td>71.70</td>
<td>16.34</td>
<td>76.79</td>
</tr>
<tr>
<td>1992</td>
<td>76.22</td>
<td>27.45</td>
<td>69.57</td>
</tr>
<tr>
<td>1993</td>
<td>77.99</td>
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<td>62.32</td>
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<td>1994</td>
<td>76.21</td>
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<td>1997</td>
<td>79.08</td>
<td>29.38</td>
<td>59.38</td>
</tr>
<tr>
<td>1998</td>
<td>60.80</td>
<td>39.90</td>
<td>55.60</td>
</tr>
<tr>
<td>1999</td>
<td>67.80</td>
<td>47.00</td>
<td>47.80</td>
</tr>
<tr>
<td>2000</td>
<td>71.70</td>
<td>22.67</td>
<td>71.29</td>
</tr>
</tbody>
</table>


However, in contrast, the percentage of capital expenditures, which has increased, made up 32.2 percent of total public spending on health in 2000, according to National Health Account 1998-2001 and 29.4 percent according to Mediconsult 2002. These expenditures meant less money for recurrent expenditure and exemptions for the poor from paying hospital fees. In 1998, the amount spent on subsidies and transfers to the poor because of fee exemptions or free health cards constituted only four percent of the state recurrent health budget and three percent of recurrent public spending on health4 (World Bank et al. 2001). Commune health centers, which were accessed most by the poor, received a small share of the recurrent state health budget. A similar pattern emerges from data put out by the National Health Account 1998-2001; in 2000, commune health stations received about 10% of total state budgets allocated for health (MOH 2003).

**COMPOSITION OF PUBLIC HEALTH EXPENDITURES BY TYPE OF PROVIDERS**

Unfortunately, budgetary data in Vietnam are not organized by service levels. So it is difficult to know how much of the central and provincial state budget is devoted to primary, secondary and tertiary care. A rough decomposition of budgetary health spending into spending by levels appears in Table 1.3. This decomposition is not perfect and is only indicative (World Bank et al. 2001).
Table 3: Recurrent Health Sector Expenditures 1991–1998*

<table>
<thead>
<tr>
<th>PROGRAM CATEGORY</th>
<th>ESTIMATED ACTUAL EXPENDITURES (IN MILLIONS OF VND)</th>
<th>BUDGET (PLANNED) (IN MILLIONS OF VND)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Administration</td>
<td>2,730</td>
<td>3,450</td>
</tr>
<tr>
<td>and Management</td>
<td>(0.40)</td>
<td>(0.43)</td>
</tr>
<tr>
<td>Commune Health Centers</td>
<td>50,000</td>
<td>50,000</td>
</tr>
<tr>
<td>Inter-Communal Polyclinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Health</td>
<td>86,100</td>
<td>46,100</td>
</tr>
<tr>
<td>Centers</td>
<td>(12.57)</td>
<td>(5.71)</td>
</tr>
<tr>
<td>ALL HOSPITALS</td>
<td>546,000</td>
<td>690,000</td>
</tr>
<tr>
<td>District Hospitals</td>
<td></td>
<td>128,900</td>
</tr>
<tr>
<td>Provincial Hospitals**</td>
<td>324,300</td>
<td>324,300</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including central)***</td>
<td>92,800</td>
<td>117,300</td>
</tr>
<tr>
<td>TOTAL</td>
<td>684,830</td>
<td>804,492</td>
</tr>
</tbody>
</table>

Source: Vietnam, Growing Healthy (World Bank et al. 2001)

* Includes state budget (central and provincial) expenditures only. Does not include ODA sources.

** Includes both general and specialty hospitals.

*** Includes teaching hospitals, specialty hospitals and hospitals for special populations. Numbers in parentheses are percentages of the total.

**Provincial Distribution**

Besides the annual amounts spent on health out of the central state budget, the provinces can add to that from their own revenues. As a result, these may be disparities in government health expenditures per capita across provinces. Better-off provinces are able to spend more on health than poorer provinces.

The equity-related issues that need to be addressed here are:

- How is per capita public spending on health in a province related to its GDP per capita?
- Does public spending on health compensate for or reinforce provincial disparities in private health spending?

In 1998, per capita public health spending on health varied from a low of VND 20,000 in Nghe An to a high of VND 313,000 in Da Nang. The vast majority of provinces spent VND 25,000-50,000 (World Bank et al. 2001). In 2000, according to Mediconitor 2002, per capita public health spending still varied among provinces. Most provincial public health expenditure levels ranged between VND 24,000 and VND 50,000 per capita. The high levels of public health spending in
Figure 2: Per Capita Public Health Spending And Per Capita Provincial Domestic Product, 2000

Source: Mediconsult 2002

Ho Chi Minh City (VND244,000) and Hanoi (VND 217,000) might reflect the fact that these provinces are also partly responsible for providing public health services in surrounding provinces.

In 1998, public health spending per capita in a province was related to provincial domestic product per capita. The positive association between government health expenditures and provincial GDP per capita reflects that a portion of government health expenditures in a province are financed by provincial governments out of their own revenue sources. This allows local governments in better-off provinces to spend more on health than those in poorer provinces (World Bank et al. 2001).

However, in 2000, as presented in Figure 2, the association between per capita public health expenditures and provincial GDP per capita was not strong (correlation coefficient =0.23). This indicates the disparities among provinces have narrowed.

This positive sign (the decrease of disparities in health spending across provinces) is further illustrated by the relationship between public and private (household) spending on health. As shown in the Lorenz distributions of user fees collected in provinces and total public spending on health in 2000 (Figure 3), the better-off provinces collected more revenues from user fees. But they received less from the state budget and provincial resources even though compensation was incomplete. This trend is different from the findings in 1998 (World Bank et al. 2001) that provinces with higher levels of private spending on health per capita also had higher levels of government spending on health per capita.

The 2000 study shows that public spending on health is one of the tools for reducing inequities inherent in private health care spending. This should be explored further.

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5 The figure was drawn using Mediconsult 2002 data. The differences in methodology may be one of the reasons explaining the variation.

6 The Lorenz curves were drawn using Mediconsult 2002 data.
Figure 3: Lorenz Distribution of User Fees Collected in Provinces and Total Public Spending on Health in 2000

Lorenz distribution of user fees collected in provinces in 2000

Lorenz distribution of total state budget and provincial budgets spent on health in 2000

Source: Mediconsult 2002

Figure 4: Per Capita Allocation of Public Health Budget in 2000

Source: Mediconsult 2002
Table 3: Estimated Coefficient for Econometric Model

<table>
<thead>
<tr>
<th>DEPENDENT VARIABLES</th>
<th>COEFFICIENT</th>
<th>SE</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Log per capita allocation of public health budget</td>
<td>0.32</td>
<td>0.14</td>
<td>0.02</td>
</tr>
<tr>
<td>Explanatory variable</td>
<td>0.55</td>
<td>0.20</td>
<td>0.01</td>
</tr>
<tr>
<td>- Norm categorization (omitted plains/coastal):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mountainous/remote</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Regional effects (omitted Red River Delta):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Highland</td>
<td>0.03</td>
<td>0.14</td>
<td>0.97</td>
</tr>
<tr>
<td>Central North Middle</td>
<td>0.10</td>
<td>0.15</td>
<td>0.67</td>
</tr>
<tr>
<td>Middle Coast Region</td>
<td>0.26</td>
<td>0.10</td>
<td>0.00</td>
</tr>
<tr>
<td>Central Highland</td>
<td>-0.05</td>
<td>0.18</td>
<td>0.73</td>
</tr>
<tr>
<td>South-East Region</td>
<td>0.25</td>
<td>0.13</td>
<td>0.10</td>
</tr>
<tr>
<td>Mekong River Delta</td>
<td>0.11</td>
<td>0.11</td>
<td>0.50</td>
</tr>
<tr>
<td>- General health needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Log infant mortality rate</td>
<td>0.09</td>
<td>0.11</td>
<td>0.61</td>
</tr>
<tr>
<td>- Fiscal capacity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Log health revenues</td>
<td>0.11</td>
<td>0.04</td>
<td>0.00</td>
</tr>
<tr>
<td>- Social needs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Log number of poor households in the province</td>
<td>0.03</td>
<td>0.06</td>
<td>0.50</td>
</tr>
<tr>
<td>Constant</td>
<td>9.9</td>
<td>0.76</td>
<td>0.00</td>
</tr>
</tbody>
</table>

N: 61 Prob>:F 0.00 R²: 0.60

What factors are associated with the allocation of public expenditures among provinces?

In 2000, total budget allocations on health per capita varied from a low of VND 76,173 in the Red River Delta Region to a high of VND 121,800 in the Southeast region. The North Highland and Central Highland provinces, classified as mountainous, have a high per capita allocation (Figure 4).

The state budget is allocated based on geographic norms as well as health needs. This policy could be one reason for the differences in allocations across regions. In fact, an earlier analysis found that provincial allocation of public health funding favors remote mountainous provinces and those with greater health needs (Fritzen 1999).

However, in practice, other factors hold sway, such as the socio-demographic condition of the province (e.g., population, per capita GDP) social needs (e.g., number of poor households) and fiscal capacity (e.g., revenues).

To further examine factors associated with the allocation of public health budgets, we looked at an econometric model, using Mediconsult data 2002. The hypothesis is that a province’s per capita allocation is influenced by:

- Norm categorization: Provinces in the North Highlands and Central Highlands are classified as mountainous, Hanoi and Ho Chi Minh City as urban and the rest as Plain/Costal.
- Regional effect: 7 geographic regions
- General health needs: Infant mortality
- Fiscal capacity: Health revenues
- Social need: Number of poor households in the province.
The estimated coefficients appear in Table 3. These figures prove the significant positive association between per capita allocation of public health budgets and norm categorization. As compared to the plains /coastal region, the mountainous/remote provinces received a greater allocation per capita. Hanoi and Ho Chi Minh City received more funds which might be one explanation these provinces had a greater fiscal capacity. The coefficients on health needs (infant mortality as proxy) and social needs (represented by the number of poor households in the province) were also positive; the differences were not significant.

However, a disparity shows up in a review of coefficients on health revenues. The better-off provinces received more (10 percent higher in provincial revenues associated with 1.1 percent higher allocation to that province) after controlling for norm categorization, region, health needs.

In brief, the econometric model, which accounts for 60 percent of the variations in per capita health allocation ($R^2=0.60$), suggests that government subsidies for health have been relatively well-targeted on areas with greater health needs. This result is similar to findings in a 1995 study by Fritzen.

6. POLICIES ON USER FEES AND THE IMPACT OF USER FEES ON THE POOR

THE POLICY

In April 1989, the partial hospital fee policy was introduced following Decision No. 45/HDBT dated 24/4/1989 by the Ministers' Council. It allows public health facilities to collect partial hospital fees. Hospital fees include charges for hospital bed use, nursing, drugs, blood, tests, X-ray films, and technical services. Five years after implementation, Decree No. 95/CP was issued on August 27th 1994, regulating the partial hospital fee policy. Key issues of that decree are as follows:

Groups targeted to pay user fees are:

- Those without health insurance cards who are not eligible for partial reduction of hospital fees.
- Sick persons who own health insurance cards but who want to have services based on demand.

Those who are privileged to receive fee exemption are:

- Disabled people, orphans and old people who are helpless;
- Children under six years of age;
- Patients with schizophrenia/hecophrenia, epilepsy, leprosy, lung tuberculosis with BK+
- Sick persons in mountain communes operated by the Committee of Ethnicity and Mountainous Affairs;
- People reclaiming virgin soil and developing new economic zones within the first three years of their arrival;
- Sick persons who are poverty stricken.

Health facilities providing services to those holding health insurance cards are partially reimbursed by health insurance agencies. Social policy beneficiaries who a receive monthly allowance are subsidized by the Government’s Labor - Invalids - Social Affairs agencies that purchase health insurance cards for them.

To implement the partial hospital fee policy, the Ministry of Health, Ministry of Labor -Invalids and Social Affairs,
Table 4: Health Care Service Use in Vietnam by Expenditure Quintile

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>POOREST</th>
<th>SECOND</th>
<th>THIRD</th>
<th>FOURTH</th>
<th>RICHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita health service contact (Excluding drug vendors)</td>
<td>2.4</td>
<td>3.2</td>
<td>3.8</td>
<td>3.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Inpatient Admission rate/1000 person/year</td>
<td>33.9</td>
<td>43.5</td>
<td>49.3</td>
<td>61.9</td>
<td>63.3</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>10.3</td>
<td>10.9</td>
<td>13.9</td>
<td>14.6</td>
<td>18.8</td>
</tr>
</tbody>
</table>

Source: Dunlop 1999

Ministry of Finance and State Pricing Committee promulgated the Interministerial Circular No. 20/TTLB, dated November 23, 1994, which guides the implementation of Decree No. 95/CP.

In 1995, the Ministry of Health issued user fee schedules for each type of consultation and each type of diagnostic test and procedure performed in clinics and hospitals. For inpatient services, there is an additional daily bed charge. User fees indicated in the schedule vary by hospital level (i.e., first-class hospital, second-class hospital, fourth-class hospital and polyclinic, etc.). In addition, the schedule specifies a range of charges, not a single fixed charge for each type of service. For example, a full medical examination for issuing an employment eligibility certificate to an individual costs VND 25-50,000 at a Class I hospital, VND 25-40,000 at a Class II hospital, and VND 18-35,000 at a Class III hospital.

Most fees must be paid in advance by noninsured patients and those who are ineligible for fee exemptions. For the most part, patients are responsible for purchasing their own drugs from a private pharmacy or a pharmacy on the premises of the public facility.

Because the price schedule issued by the government indicates a range of fees that can be charged, hospitals have some discretion in user fees, especially for technical services and laboratory tests. Central hospitals normally apply the ceiling price indicated in the price schedule; lower-level hospitals charge the floor price. There are also differences in fees across regions. In the South, user fees tend to be higher for comparable services than in the North.

**IMPACT OF USER FEES ON THE POOR**

The user fee policy has brought about some improvements in the quality of health care services. During 1990-1995, user fees increased revenues in the state health budget from 5-7% to 15.69% in 2000 (Ministry of Health 2000). User fees helped reduce subsidies and contributed to an increase in the income of the medical staff (Dong et al. 2002). However, utilization studies indicate a decline in utilization of health services, especially by the poor, since user fees were introduced (Tipping 2000).

User fees have a significant impact on the equity of health benefit usage (i.e., on the proportion of public subsidies allocated to different income groups). The higher the user fees are, the lower the rate of utilization of health care services by the poor and the fewer state subsidies they receive for health care.

While the poor are often less healthy and suffer from the greatest number of diseases due to poor nutrition and/or the environment, they are also less likely to seek health care. As shown in Table 4, the more affluent seek health care services 45 percent more frequently than the poorest group. If contacts with drug vendors are excluded, this difference is even greater. The most affluent seek care nearly twice as often as the poorest (4.6 times as compared to 2.4 times per person per year, respectively) (Dunlop 1999).
Table 5: Distribution of health services contacts expenditure quintiles, 1998

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>POOREST</th>
<th>SECOND</th>
<th>THIRD</th>
<th>FOURTH</th>
<th>RICHEST</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals</td>
<td>3.15</td>
<td>3.75</td>
<td>4.63</td>
<td>7.22</td>
<td>9.55</td>
<td>5.84</td>
</tr>
<tr>
<td>Commune health center</td>
<td>7.39</td>
<td>6.84</td>
<td>6.91</td>
<td>5.62</td>
<td>1.72</td>
<td>5.56</td>
</tr>
<tr>
<td>Other public providers</td>
<td>2.05</td>
<td>1.79</td>
<td>2.13</td>
<td>3.14</td>
<td>2.89</td>
<td>2.42</td>
</tr>
<tr>
<td>All public providers</td>
<td>12.59</td>
<td>12.38</td>
<td>13.67</td>
<td>15.98</td>
<td>14.16</td>
<td>13.82</td>
</tr>
<tr>
<td>Private clinics, doctors</td>
<td>14.93</td>
<td>14.46</td>
<td>17.38</td>
<td>16.00</td>
<td>21.38</td>
<td>17.02</td>
</tr>
<tr>
<td>Drug vendors</td>
<td>69.29</td>
<td>69.68</td>
<td>66.56</td>
<td>64.81</td>
<td>59.37</td>
<td>65.66</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>3.19</td>
<td>3.38</td>
<td>2.39</td>
<td>3.21</td>
<td>5.10</td>
<td>3.48</td>
</tr>
<tr>
<td>Other providers</td>
<td>0.00</td>
<td>0.09</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>


Some poor people do not visit clinics or hospitals. They delay their visit to health facilities which leads to severe complications. Some poor patients silently leave the hospital before they are scheduled to do so because they do not have enough money to pay for treatment. Based on an investigation, a large percentage of households with some sick members couldn't afford user fees: 45.6% in Tien Giang and 42% in Dong Thap (Hien 1999).

A similar finding was revealed in a 1999 poll of provincial, district and commune key leaders in representative provinces by the Central Committee on Science and Education. Approximately 83.3% of respondents said some poor people in their locality did not dare to contact health facilities. The breakdown is as follows: 66.5% of the respondents said that the poor within their locality did not dare to contact health facilities at the provincial level, 52.4% at the central level, and 21.1% at the district level. Furthermore, 39.6% of respondents said they knew of cases where poor people died because they did not dare to contact a health facility. On the other hand, the rest (60.4%) denied the statement. Roughly, 71% of respondents said some poor people had some money, but after contacting a health facility they realized user fees were too high and they reluctantly came home without receiving treatment. Among those who made this complaint, 61.7% went to health facilities at the provincial level and 42.3% at the central level (Dong et al. 2002). These figures indicate that a considerable segment of the population suffered from the negative effects of user fees.
The poor also use providers of lesser quality than the non-poor. They don’t have the financial capacity to seek care at higher levels of health care (e.g. hospitals). Data from the Vietnam Living Standard Survey 1998 (Table 5), showed there is a correlation between income and the number of health service contacts. Among the bottom 20 percent of the population, hospital visits constitute 3.2 percent of total service contacts. This share increases to 9.6 percent for the top 20 percent of the population.

This is clearly observed in the Lorenz curves for hospital contacts shown in Figure 5.

Drug vendors were the most popular provider among the poor. Drug vendors obviate the need for two separate health visits, one to a physician and the second to purchase the drugs the physician prescribed. Drug vendors saved the poor time and money. A sentinel survey conducted in 28 rural communes during 2000-2001 also found that the poor relied on drug vendors when they got sick. The poorest people had the highest proportion
Figure 7: Reason for Non-Use of Hospitals by the Poorest Quintile

Source: Dung et al. 2002

of those who bought drugs on a self-medicating basis; however, the percentage was not as high as it was in 1998 (Dung et al. 2002) (Figure 6). The tendency to self-medicate may be because of obstacles posed by user fees; there were other difficulties, such as physical accessibility and health insurance coverage. The poor may consider self-medication as the least expensive form of treatment, especially compared to hospitals.9

The study also shows that lack of money is the third reason why the poor used hospitals following “light sick” and “far-away reasons” (5.9% compared to 0.5% among the richest) in Figure 7. However, the severity of illness and of physical proximity to hospitals varied from person to person. The poor tend to consider their illnesses less serious and they hesitate if the hospital is far away. The poor cannot afford hospital as well as transportation costs.

Several qualitative studies support this view. Many poor people live with chronic diseases because health care entails not only the payment of an official fee to providers but also indirect costs. They can’t afford to seek treatment (World Bank 1999a). A person living in a remote area of Vietnam put it this way: “I can’t go to the hospital because it is too expensive. I have to borrow money just to go to the health station… If we became severely ill, we would have to stay at home to die. We can’t afford to go to the hospital.” (Tipping et al. 1994).

Not only are the poor less healthy, they seek care less frequently from health care providers. But they also spend a considerable part of their income on health care. Based on a study by Segall, 493 households reported having a sick person during the study period, 6% of them spent at least one-half of their household income on health care (Segall et al. 2000). For a person from the poorest quintile, a single contact with a public hospital consumed as much as 22 percent of his or her annual non-food expenditures (Table 6).

9 The expenses for health are not only the direct official fee paid to health care providers. Indirect costs may be higher than formal user fees which include payments to those who accompany the patient, food, accommodations, travelling, “under-the-table”… (Dong et al 2002)
Table 6: Fees, relative cost of selected health services in Vietnam 1998

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Poorest</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Richest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita expenditure (1000 VND)</td>
<td>1,219</td>
<td>1,767</td>
<td>2,251</td>
<td>3,073</td>
<td>6,259</td>
</tr>
<tr>
<td>Share of non-food expenditure per contact at public hospital (%)</td>
<td>22</td>
<td>21.8</td>
<td>17.6</td>
<td>12.2</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Sources: Dunlop. 1999

Table 7: Average expenses/episode by Expenditure Quintile
(Unit:1000 VND)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Poorest</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Richest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Means</td>
<td>80.6</td>
<td>107.2</td>
<td>108.6</td>
<td>109.4</td>
<td>89.1</td>
</tr>
<tr>
<td>SD</td>
<td>306.5</td>
<td>494.2</td>
<td>378.9</td>
<td>309.5</td>
<td>305.9</td>
</tr>
<tr>
<td>Share of annual income per capita (%)</td>
<td>11.9</td>
<td>7.9</td>
<td>5.0</td>
<td>2.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Sources: Dung et al. 2002

Table 8: Strategies That the Poor Use To Cope with Unaffordable Health Expenses
(Unit: %)

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Poorest</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
<th>Richest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrict expenses</td>
<td>24.4</td>
<td>18.7</td>
<td>25.3</td>
<td>17.8</td>
<td>13.8</td>
</tr>
<tr>
<td>Stop using care</td>
<td>26.4</td>
<td>18.9</td>
<td>15.1</td>
<td>22.6</td>
<td>17.0</td>
</tr>
<tr>
<td>Deeper in debt</td>
<td>31.8</td>
<td>28.3</td>
<td>22.5</td>
<td>12.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Not influenced</td>
<td>11.3</td>
<td>18.0</td>
<td>23.1</td>
<td>23.4</td>
<td>24.3</td>
</tr>
<tr>
<td>Continue selling properties</td>
<td>20.7</td>
<td>27.6</td>
<td>27.6</td>
<td>19.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Other</td>
<td>10.5</td>
<td>21.1</td>
<td>31.6</td>
<td>26.3</td>
<td>10.5</td>
</tr>
</tbody>
</table>

Sources: Dung et al. 2002

One episode of illness cost 12% of annual income for a person from the poorest quintile, compared to 1.6% for a person from the richest quintile. When they use health services, the risk of falling into poverty was clearly greater for the poor (Table 7) (Dung et al. 2002).

The strategies that the poor use to cope with unaffordable health expenses by income quintile appear in Table 8. The proportion of patients who stop treatment before they recover was highest among the poorest quintile.

Many households had to cut back on essential expenses, including money spent on food and education or they failed to contact a hospital because they thought they couldn’t afford to pay for hospital services. Some families were driven into poverty because of disease and hospital fees (Dung et al. 2002).

Morbidity, illness and user fees are among major causes for driving the poor or near poor deeper into poverty. The implementation of the user fee policy has reduced access to health care services, causing not only inequities in health care but also a negative impact by making the poor poorer and pushing low-income groups into poverty.
The "Medical poverty trap" has been the subject of many studies in Vietnam. One by Wagstaff (Wagstaff 2001) shows that out-of-pocket expenditures on health care account for a 4% increase in poverty. This means about three million people slide into poverty because of large health care expenditures, for example, they take out high-interest loans or sell cattle to pay user fees. A survey conducted in 88 Northern communes revealed that 50% of poor households interviewed sold rice, assets or took out loans to pay for health services. Another sociological investigation found that 36% of the poor borrowed money at high interest rates to pay for user fees compared to 4.5% for the rich. Many households borrowed money but could not repay it until after the harvest.

According to the report "Vietnam attacking poverty," the main reason households fall into poverty is illness, particularly when seriously ill patients seek medical services from hospitals at the district or a higher level. When a family member was sick, poor families had to borrow money, sell off assets or reduce their already limited food budgets.

The positive as well as the negative effects of user fees came out in interviews with representatives of the Provincial and Municipal Communication and Information Agency, provincial Health Bureaus; boards of directors of central, provincial and municipal hospitals, Insurance Agencies, Finance, Labor-Invalids-Social Affairs Departments, Investment and Planning Departments, Women's Union, Farmers' Associations (Dong et al. 2002):

- **User fees provide an important financial source to hospitals:**
  - + Yes: 50 persons (64%); of whom 100% were from the health sector; 60% from other sectors; 40% from the health insurance sector; and only 25% from People's Committees and Communication and Information Agencies.
  - + No: no one
  - + No response: 38 persons (36%).

- **User fees contribute to an increase in income for hospital staff:**
  - + Yes: 67 persons (86%); of whom: 100% were from the health sector; 80% from other sectors and health insurance sector; 75% from People's Committees and Communication and Information Agencies.
  - + No: No one
  - + No response: 11 persons (14%).

- **User fees place the burden of payments on the sick:**
  - + Yes: 53 persons (68%); of whom 100% were from the health insurance sector; 80% from other sectors and 75% from People's Committees and Communication and Information Agencies; only 34.6% were from the health sector.
  - + No: No one.
  - + No response: 25 persons (32%).

- **User fees undermine the poor's access to health services:**
  - + Agreement was found in all groups (100% from People's Committees and Communication and Information Agencies and health insurance sector; 92% from the health sector and 80% from other sectors). The total number of respondents who agreed was 71 (91%).
  - + No: No one.
  - + No response: 7 persons (9%).

---

• User fees deepen poverty among low-income groups:
  ✓ + Yes: 100% from People's Committees and Communication and Information Agencies and the health insurance sector; 69% from the health sector and only 60% from other sectors. A total of 60 respondents agreed (77%).
  ✓ + No: No one.
  ✓ + No response: 18 persons (13%).

• User fees increase access to high quality health services:
  ✓ + Yes: 53 persons (68%) of whom 92% were from the health sector (highest); 80% from other sectors; 50% from People's Committees and Communication and Information Agencies; the lowest were from the health insurance sector: 20%.
  ✓ + No: No one.
  ✓ + No response: 25 persons (32%).

• User fees improve equity in health care:
  ✓ + Yes: only 18 persons (23%); the proportion of respondents was fairly similar among all groups.
  ✓ + No: 51 persons (65%)
  ✓ + No response: 9 persons (12%).

• User fees are not a financial resource that can meet all criteria of an efficient equity-oriented health care system:
  ✓ + Yes: 64 persons (82%); 100% from People's Committees and Communication and Information Agencies; proportion of respondents in the other three groups: 70-80%.
  ✓ + No: 14 persons (18%)

• User fees constitute a temporary short-term option:
  ✓ + Yes: 68 persons (87%); the proportion of respondents was quite similar among different groups.
  ✓ + No: 10 persons (13%).

Here are some concrete comments provided by the interviewees:

Dr. Truong Van Viet: Director of Cho Ray Hospital- Ho Chi Minh City:
“Cho Ray hospital had the greatest revenue from user fees in 2000, VND200 billion. It was estimated that the revenue in 2001 would be greater... Charging user fees means that we reduce the share that hospitals have to spend on providing services to patients. (The perception is) our policies then are pro-rich, rather than in favor of economically poor groups and those who rendered meritorious service to the country.”

Dr. Pham Viet Thanh: Deputy Director of Tu Du Hospital- Ho Chi Minh City:
“Charging user fees (have) improved quality of care and upgraded medical equipment. Yet some negative effects have also arisen relative to the poor. Poor people have a greater disease burden and no access to high-tech health services. Some hospitals still charge user fees (to) economically-disadvantaged people. Some health facilities collect user fees every two days and for those incurring serious diseases, they have to pay once every day. Otherwise, they receive no drugs. In some other hospitals, patients are forced to pay a deposit (for admission or surgery).” However, existing policies are market-oriented,” they further polarize the rich and the poor.

Dr. Luu Tri Dung: Long An General Hospital- Long An Province:
“User fees can help solve some problems, but they surely cannot be the best and sustainable solution.”

Mr. Cai Phuc Thang: Ho Chi Minh Municipal Communication and Information Agency:
“User fees will be gradually eliminated with the development of
universal health insurance schemes; we can only talk about whether user fees should be continued or not whenever universal health insurance is expanded to cover the whole population."

In summary, partial user fees have made a significant contribution to increasing the revenue of public hospitals. However, it has also led to substantial inequities in health care. Unaffordable official as well as unofficial fees (the latter may be much higher) had a major role in driving low-income people into a "poverty trap" and creating a cycle of poverty and morbidity. As stated by Prof. Goran Dahlgren, the magnitude of the medical poverty trap in Vietnam is not yet fully known. However, there's no doubt that high user fees, together with an uncontrolled and growing pharmaceutical market, have become a major threat that is driving Vietnamese households into poverty (Dahlgren 2002).

**Effectiveness of Policies on Health Care Financing for the Poor**
*(including a description of decision 139 on Health Care for the Poor Fund)*

In recognition of the problems associated with payment burdens by the poor, there have been several policies and initiatives to make health care more equitable, including:

- **Providing health insurance cards for the poor**
  
  Circular No. 05/TTLT, which provides health insurance cards to the poor, went into effect on January 29 1999.  It was implemented in most provinces in Vietnam. By 2000, the poor received 1,367,523 cards; they represented 30% of eligible beneficiaries. That is encouraging. However, implementation did not go so well because of a shortage of funds and difficulties in identifying the poor who need financial support.

- **Providing cards and medical record books for the poor**

  In 1995 Hanoi started to deliver T8 Cards to its poor residents. A T8 card pays actual expenditures, but it is not health insurance. The principle behind the T8 card is that healthy people help sick people and slightly-sick people help seriously-sick people. In effect, a T8 card functions as a medical card for the poor.

  Meanwhile, medical record books are delivered to poor people in Ho Chi Minh City and other provinces like Thanh Hoa and Nghe An. Book owners can get free medicine from health facilities.

- **Free hospitals for the poor**

  In Ho Chi Minh City, An Binh, Cu Chi and Can Gio, hospitals provide free care to the poor. However, these hospitals cannot be expanded; poor people do not live in one place but are scattered to different parts of the country. Most poor people live in mountainous remote areas where travel is difficult. If a free hospital is located in a central city, most poor people can't afford to get there. In addition, it is impossible to build and maintain a hospital system for the poor on a national basis because of lack of financing.

- **Exemption and reduction of user fees for the poor at health facilities**

  As in other countries, there is a formal mechanism in Vietnam for exempting certain classes of people from user fees; they include the poor, handicapped, war veterans, orphans, and individuals suffering from certain ailments, such as tuberculosis and leprosy. In addition, children are supposed to receive services free of charge through vertical programs funded directly by the central government or aid agencies.

---

13 The Social Security Fund awards a poor health care card, valued at VND 30,000/each, to all hungry and 30% poor households.
As shown in Table 9, this kind of support has benefited many patients.

About 18 million people living near poverty do not have enough money to afford health care, but they are not poor enough for an exemption (Hung et al. 2000). Problems exist with exemptions. A study by Ensor and San in 1996 found no correlation between fee exemptions and household income and no correlation between the number of fee exemptions and the general level of affluence of the commune. VLSS data from 1993 and 1998 in Table 3.2 shows the percent of users from different economic backgrounds who were exempt from user fees and drug charges at public hospitals and commune health centers in 1993 and 1998.

Table 10 reveals that the overall rate of fee exemptions at both public hospitals and commune health centers has declined since 1993. While 57 percent of users were exempt from user fees at hospitals in 1993, only 42 percent were exempt in 1998. Likewise, the exemption rate at commune health centers declined from 91 percent to 82 percent over the same period. The decline occurred across all income groups.

Table 11 shows data reported by nine hospitals on the percentage of fee exemptions they offered during the period 1993-97. The data show large inter-hospital variations in fee exemptions. In some hospitals, such as Bach Mai, Viet Tiep, Dong Da and Son Tra, fee exemptions and reductions were offered to just 2-5 percent of patients. But in other hospitals, such as Khanh Hoa and Da Nang, fee exemptions were more liberal. It is unlikely that these large variations reflect socio-economic differences in the

### Table 9: Exemption And Reduction Of User Fees For The Poor At Health Facilities 1998-2000

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving exemptions</td>
<td>3,130,545</td>
<td>3,117,153</td>
<td>3,223,887</td>
</tr>
<tr>
<td>and reduced fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% to total patients</td>
<td>38.5%</td>
<td>40.9%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Amount of money</td>
<td>104,394</td>
<td>107,306</td>
<td>125,893</td>
</tr>
<tr>
<td>exempted in (VND million)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% to state budget for</td>
<td>7.04%</td>
<td>6.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>curative care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Inventory 2000 (MOH 2002)

### Table 10: Percent Of Users Who Reported Paying Nothing For a Visit To a Government Health Facility, 1993 And 1998

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>POOREST</th>
<th>SECOND</th>
<th>THIRD</th>
<th>FOURTH</th>
<th>RICHEST</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% paying no fees</td>
<td>60</td>
<td>57</td>
<td>57</td>
<td>55</td>
<td>58</td>
<td>57</td>
</tr>
<tr>
<td>% paying nothing for drugs</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Commune Health Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% paying no fees</td>
<td>94</td>
<td>90</td>
<td>98</td>
<td>90</td>
<td>77</td>
<td>91</td>
</tr>
<tr>
<td>% paying nothing for drugs</td>
<td>13</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

1998

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>POOREST</th>
<th>SECOND</th>
<th>THIRD</th>
<th>FOURTH</th>
<th>RICHEST</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% paying no fees</td>
<td>50</td>
<td>42</td>
<td>42</td>
<td>41</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td>% paying nothing for drugs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Commune Health Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% paying no fees</td>
<td>90</td>
<td>83</td>
<td>78</td>
<td>79</td>
<td>75</td>
<td>82</td>
</tr>
<tr>
<td>% paying nothing for drugs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Vietnam Growing Healthy, World Bank et al. 2001
clientele of the various hospitals. More likely, the data suggest that different hospitals apply fee exemptions inconsistently.

Table 11: Percentage of Fee Exemptions and Reductions in Selected Hospitals, 1993–97

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bach Mai</td>
<td>-</td>
<td>4.0</td>
<td>4.0</td>
<td>4.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Cho Ray</td>
<td>24.5</td>
<td>21.7</td>
<td>27.4</td>
<td>24.2</td>
<td>25.3</td>
</tr>
<tr>
<td>Thai</td>
<td>40.3</td>
<td>30.7</td>
<td>22.5</td>
<td>27.8</td>
<td>16.3</td>
</tr>
<tr>
<td>Nguyen</td>
<td>28.0</td>
<td>28.5</td>
<td>29.9</td>
<td>28.1</td>
<td>29.8</td>
</tr>
<tr>
<td>Da Nang</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>38.9</td>
<td>30.2</td>
</tr>
<tr>
<td>Khanh Hoa</td>
<td>2.9</td>
<td>2.1</td>
<td>2.0</td>
<td>2.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Viet Tien</td>
<td>13.4</td>
<td>14.4</td>
<td>10.8</td>
<td>12.8</td>
<td>14.6</td>
</tr>
<tr>
<td>Dong Da</td>
<td>2.9</td>
<td>2.8</td>
<td>4.3</td>
<td>6.9</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Source: Vietnam Growing Healthy (World Bank et al. 2001)

• Residents of the poorest communes as defined by decision 135/1998
• Ethnic people living in the Central Highland (Dac Lac, Gia lari, Kontum, Lam Dong-decision 168/2001) and six Northern Mountains (Cao Bang, Bac Can, Lao Cai, Ha Giang, Son La, Lai Chau decision 186/2001).

The selection process of beneficiaries involves identifying eligible beneficiaries in villages, hamlets and communes. At the district level, lists of those eligible are consolidated, then sent to the provinces for final selection.

The Fund Management Board, headed by the Chairman of the Provincial People’s Committee (the permanent vice-head is Director of the Provincial Health Bureau), decides on the sources and uses of the HCFP. The fund is managed separately from the provincial government’s general funds; the Provincial Health Bureau handles the accounting.

The HCFP encourages initiatives by the Vietnam Government and is expected to have the following positive effect on health financing:

• Provide funds for a health program targeting the poor:

The HCFP will overcome a funding problem encountered in the implementation of other policies.

In 2003, the estimated number of eligible beneficiaries in Vietnam is 15 million;¹³ the approximate per capita cost is VND 70,000. Total annual expenditures for the HCFP are about VND 850 billion or about USD70 million. This fund accounts for about 4.6% of total health care expenditures (from both public and private sources) and about 14% of public spending. This fund has a specific purpose and

¹⁴ According to decision 1143/2000/QD-LDTBXH by the Ministry of Labor, War Invalids and Social Affairs (MOLISA): the poor are defined as individuals with monthly incomes less than VND 80,000 (in mountainous and island rural areas), less than VND 100,000 (in rural plains) and less than VND 150,000 (in urban areas).

¹³ Estimation by the MOLISA
will not lead to a reduction in current public expenditures for health.

- *Reduce the financial burden on the poor and prevent them from the “medical poverty trap.”*

Having a health insurance card offers the poor some security; the expectation is that they won’t experience a delay when they visit health facilities when they get sick.

- *Change health-seeking behavior of the poor and increase appropriate use of health services.*

This can have a positive effect on increasing use of health care by the poor. The expectation is the poor will choose public providers as their primary source of care, thereby reducing self-treatment and the use of drug vendors.

- *Introduce new sources of payment to public hospitals.*

This additional source of funds for hospitals comes from the state budget. It will also reduce hospitals’ financial deficits that have accrued as a result of direct fee exemptions/reductions. Furthermore, once the poor have the HCFP, public health facilities can consider raising user fees to generate revenues which cover or exceed their costs.

- *Create incentives to buy voluntary health insurance cards*

In Vietnam, the percentage of those enrolled in voluntary health insurance schemes is quite low. Once fee-for-service rates in the public sector cover costs in full, non-poor people who are uninsured will have to consider buying voluntary health insurance.

However, there are some outstanding issues regarding the implementation of the HCFP, namely:

- *Eligible beneficiaries identification:*

The criteria for eligible beneficiaries are quite clear. In practice, however, other factors can influence the identification process. For example, having a personal relationship with decision makers may lead to deceptive practices.

- *Contribution of Government and communities*

The HCFP is financed 75% by Government and 25% by communities. The latter contribution may not be sustainable by some disadvantaged communities.

- *Problems with health insurance card*

If the HCFP buys health insurance cards for the poor, but the poor can’t use them at commune health stations, then the cards are invalid. Furthermore, copayments under the current health insurance scheme create a financial burden for the poor.

In summary, although some problems have yet to be worked out, decision 139 has been a powerful and effective tool for health sector reform.

**The Use of Revenues as Supplements to Staff Salaries**

Personnel are one of the most important components of the health care system. The quality of health services is synonymous with the morale and motivation of health workers. In Vietnam, the morale of public health staff is low because health staff, like all civil servants, have low salaries. The average monthly salaries of health staff have remained unchanged in real terms since 1994. In 1998, the average monthly salary of a government health worker was US$29. Low salaries and wages cause public health staff to seek additional sources of income which reduces their time, attention, and dedication to their work. Incentives to health staff are very important to the equity and efficiency of the provision of health care.
One way to reward health staff comes from the collection of user fees; user fees are considered revenue for the Government. According to Inter-ministerial Circular No. 11/TTLB, dated June 29, 1995, which guides the implementation of Decree No.33/CP and amendment Item 1, Article 6, in Decree No. 95/CP on the partial hospital fee policy, the revenue from hospital user fees should be utilized as follows:

- 30% of this revenue should be used for bonuses to health workers, based on their performance and their responsiveness to patients. 2% - 2.5% of this share should be set aside for the host agency (MoH, provincial Health Bureau, the host Ministry/sector) to establish a fund offering incentives to institutions and individuals for their achievements and to support hospitals where the possibility of charging user fees is limited. Hospitals are not permitted to use any of the user fees for capital projects.

- 70% of this revenue should remain with the health facility that generates this income. The revenue could buy drugs, blood, solutions, chemicals, X-ray films, and other medical material as well as equipment and tools for the provision of services.

The policy allows hospitals to use part of the 30% user fees collected for bonuses. But, in practice, it doesn’t always work that way. Surveys show that most hospitals have used 25-28 percent of the revenue collected from user fees to increase the income of all health workers in the hospital instead of rewarding only those who "have properly acquitted themselves in their professional work and have shown their commitment and responsiveness to patients." Each hospital worker receives an additional amount of 50,000 to 200,000 VND/month. Some hospitals argue that setting aside money from user fee revenues to pay health workers is necessary to encourage them to work better (Dong et al. 2002). However, it is inequitable to compensate low-paid workers with payments from user fees, thus making patients responsible for making up deficiencies in staff salaries.

This practice facilitates the "legalization" of different types of "overtime," "voluntarily paid health services," or "semi-public services" provided in many public hospitals; these services are those that only the more affluent can afford. Such practices cry out for reform. It is important to preserve the intent of public hospitals and not allow them to become commercialized. Otherwise, there may be negative consequences (Dong et al. 2002).

Moreover, there have been other problems associated with the management and utilization of the revenue from user fees and fee exemptions for different groups of patients. Providers often give priority to the easiest-to-reach patients first (well-off people) and ignore the hard-to-reach (often the poor).

In Vietnam, despite legal documents which regulate medical ethics, health staff have an incentive to discriminate against the poor and favor those who are better off.
According to a recent survey on health care utilization of the poor in 10 provinces across Vietnam, the poor often have longer waiting times: 8.3% of the poor who used outpatient services reported that they had to wait up to four hours compared to 7% of paying patients and 1.8% of those with health insurance (Figures 8 and 9) (Thuy et al. 2002).

The study did not report a problem of discrimination against the poor in daily examinations or care provided by health staff. But some poor people complained about the quality of drugs they received. They felt that domestic drugs were of less quality than imported drugs. Imported drugs are usually expensive and unaffordable by the poor because imported drugs are not covered by the insurance ceiling.

Regarding patient satisfaction with doctor’s responsiveness, the poor said that they received little instruction in the use of drugs, instruction in taking care of themselves and applying disease prevention measures. In response to these complaints, the doctors said, “The poor have low levels of education and it is difficult for them to understand even if I explain or instruct” and “It is a waste (of) time to explain to the poor…” (Thuy et al. 2002).

Recently, the use of revenues from hospital fees went into effect following the Decree 03 of Vietnam Government (dated January 15, 2003). This policy allows hospitals to use 35% of revenue from hospital fees to increase the salaries of their health staffs; the rest is for buying drugs, blood, solutions, chemicals, consumables, etc. This policy is even more inequitable. The supplemental fund for improving hospital performance has dropped (only 65% of revenues from hospital fees) and health staffs in each hospital are responsible for their own salary increases. In comparison, the Government finances the salaries of other government staff. Some health staff complain that their income has dropped; they are unhappy about this and need to find a way to survive.\footnote{This idea came from a personal conversation with some doctors.}

Another policy which is relevant to health staff salaries is Decree 10/CP. According to the decree, hospitals can be self-governed and the number of health staff and their salaries will be decided by hospital boards of directors. So far, there have not been any autonomous hospitals set up. But stakeholders and the public have discussed the equity aspect of this policy, to wit: Will this hospital be accessible to the poor? Will the salaries of health staff be high and stable? If the salaries of health staff are not high, will they be responsive to patients?
Table 12: Coverage of Different Schemes From 1997-2002

<table>
<thead>
<tr>
<th>Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole country</td>
<td>9,758,015</td>
<td>10,231,879</td>
<td>10,399,264</td>
<td>12,505,460</td>
<td>13,034,278</td>
</tr>
<tr>
<td>Coverage rate</td>
<td>12.7%</td>
<td>13.4%</td>
<td>13.4%</td>
<td>15.8%</td>
<td>16.5%</td>
</tr>
<tr>
<td>to total population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory</td>
<td>6,069,039</td>
<td>6,354,821</td>
<td>6,469,322</td>
<td>6,976,120</td>
<td>6,976,634</td>
</tr>
<tr>
<td>Voluntary</td>
<td>3,688,706</td>
<td>3,384,092</td>
<td>3,088,905</td>
<td>4,041,757</td>
<td>4,392,625</td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>492,966</td>
<td>841,037</td>
<td>1,487,583</td>
<td>1,665,019</td>
</tr>
</tbody>
</table>

Source: Health insurance statistical yearbook

HEALTH INSURANCE

CURRENT SITUATION

Vietnam Health Insurance, which is now called Vietnam Social Security, administers the following three schemes: Compulsory, Voluntary and for the Poor (Annex 2).

The number of insured people enrolled in all three schemes is 13,034,278. They account for 16.5% of the total population (Table 12). Most of the insured population are people working in state-owned sectors (considered better-off groups) or they belong to meritorious protected groups (Table 13). The number of the poor who obtained FHIC (Poor Health Insurance Card) increased from 492,266 in 1999 to 1,665,019 in 2002. The growth rate was more than 300% in three years. However, when compared to the roughly 12-14 million people who were entitled to the program, based on new criteria set by MOLISA in 2002, this rate of growth is not so large. The new program is in accordance with decision 139. It is premature to assess what impact decision 139 will have on these figures.
### Table 13: Covered Groups in Compulsory Scheme

<table>
<thead>
<tr>
<th>GROUP</th>
<th>1998 Number of insured</th>
<th>Percentage of total insured</th>
<th>1999 Number of insured</th>
<th>Percentage of total insured</th>
<th>2000 Number of insured</th>
<th>Percentage of total insured</th>
<th>2001 Number of insured</th>
<th>Percentage of total insured</th>
<th>2002 Number of insured</th>
<th>Percentage of total insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servants</td>
<td>-</td>
<td>-</td>
<td>1,457,867</td>
<td>22.9</td>
<td>1,492,170</td>
<td>23.0</td>
<td>1,568,347</td>
<td>22.5</td>
<td>1,598,673</td>
<td>22.9</td>
</tr>
<tr>
<td>State enterprises</td>
<td>-</td>
<td>-</td>
<td>1,612,226</td>
<td>25.3</td>
<td>1,617,798</td>
<td>25.0</td>
<td>1,707,955</td>
<td>24.4</td>
<td>1,660,593</td>
<td>24.6</td>
</tr>
<tr>
<td>Private enterprises</td>
<td>-</td>
<td>-</td>
<td>121,044</td>
<td>1.9</td>
<td>148,700</td>
<td>2.3</td>
<td>262,721</td>
<td>3.7</td>
<td>271,989</td>
<td>4.0</td>
</tr>
<tr>
<td>Foreign joint ventures</td>
<td>-</td>
<td>-</td>
<td>256,973</td>
<td>4.04</td>
<td>304,220</td>
<td>4.7</td>
<td>443,490</td>
<td>6.3</td>
<td>450,411</td>
<td>6.4</td>
</tr>
<tr>
<td>Pensioners and disabled</td>
<td>-</td>
<td>-</td>
<td>1,607,077</td>
<td>25.2</td>
<td>1,583,032</td>
<td>24.4</td>
<td>1,597,340</td>
<td>22.9</td>
<td>1,596,153</td>
<td>22.8</td>
</tr>
<tr>
<td>Social protected groups</td>
<td>-</td>
<td>-</td>
<td>1,182,481</td>
<td>18.6</td>
<td>1,152,820</td>
<td>17.8</td>
<td>1,142,228</td>
<td>16.3</td>
<td>1,126,751</td>
<td>16.6</td>
</tr>
<tr>
<td>Voted members of people's council</td>
<td>-</td>
<td>-</td>
<td>49,256</td>
<td>0.7</td>
<td>57,395</td>
<td>0.08</td>
<td>80,250</td>
<td>0.54</td>
<td>77,832</td>
<td>0.11</td>
</tr>
<tr>
<td>Administrators or local level</td>
<td>-</td>
<td>-</td>
<td>68,077</td>
<td>1.07</td>
<td>113,187</td>
<td>1.7</td>
<td>144,558</td>
<td>0.2</td>
<td>151,866</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Health insurance statistical yearbook, 2002

In general, most insured people belong to better-off groups; they live in urban areas where the infrastructure and health care conditions are much better than rural or mountainous areas. The total number of insured enrolled in the compulsory scheme accounted for 8-10%. Most of them are concentrated in mega-cities.

With the new decision 139, about 15 million poor people, who met the poverty specifications of MOLISA, will be enrolled in the health insurance scheme or protected by the government. But what about the near poor, the self-employed, farmers, craftsmen? Without a supportive program, this group is vulnerable to disaster. If they get sick, health care costs are always 6.65 times higher than their average income or 17.73 times when compared to actual costs recorded in patient records (Report on Health Care Financing for the Poor in 10 Provinces – Hanoi Medical University, 2002).

For a comprehensive view of the current health insurance system, it is best to review financing, benefits, and the provision of health care services.

**FINANCIAL ASPECTS**

Before 1998, the fund was managed by the provinces, not by the Central Headquarters Office as it is now. During this period, two-thirds of the provinces experienced a loss, especially in Haiphong where the deficiency was about 5 Billion VND by 1998. Since the fund was centrally managed, in accordance with Decree 58 CP, the deficit was controlled and stopped. The surplus increased and represented about 10-20% of total medical funds. However, the poor scheme faced a major financial challenge; the premium was only 30,000VND, but the unit cost was roughly double that.
Table 14: Financial Situation By Health Insurance Schemes in Billions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expenditure</td>
<td>Expenditure</td>
<td>Expenditure</td>
<td>Expenditure</td>
</tr>
<tr>
<td>Whole country</td>
<td>669</td>
<td>522</td>
<td>760.5</td>
<td>587.1</td>
</tr>
<tr>
<td>Compulsory</td>
<td>683</td>
<td>77.5</td>
<td>943.8</td>
<td>1,152.3</td>
</tr>
<tr>
<td>Voluntary</td>
<td>-</td>
<td>-</td>
<td>797.577</td>
<td>850</td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>-</td>
<td>54.431</td>
<td>974.400</td>
</tr>
</tbody>
</table>


Table 15: Utilization Rate of Health Care Services by Schemes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory</td>
<td>0.171</td>
<td>2.089</td>
<td>0.155</td>
<td>1.934</td>
<td>0.16</td>
<td>2.015</td>
<td>0.176</td>
<td>2.118</td>
<td>0.175</td>
<td>2.281</td>
</tr>
<tr>
<td>Voluntary</td>
<td>0.101</td>
<td>0.428</td>
<td>0.078</td>
<td>0.319</td>
<td>0.072</td>
<td>0.288</td>
<td>0.049</td>
<td>0.13</td>
<td>0.053</td>
<td>0.208</td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>-</td>
<td>0.036</td>
<td>0.415</td>
<td>0.047</td>
<td>0.547</td>
<td>0.046</td>
<td>0.526</td>
<td>0.054</td>
<td>0.736</td>
</tr>
<tr>
<td>Whole country</td>
<td>-</td>
<td>1.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Note: IDP=inpatient; ODP=outpatient

BENEFIT ASPECTS

In principle, benefits provided to the poor and the compulsory scheme are essentially the same. They are entitled to inpatient, outpatient and emergency care. The poor, pensioners and meritorious groups do not have to satisfy a copayment. Voluntary health insurance applied mostly to students and school children who received primary health care at school. Therefore, they were not entitled to outpatient care but were eligible for inpatient care. The school health program is supported by the fund (35% of total collected revenues) which the health insurance agency transfers back to the schools.

However, in reality, implementation of health insurance reveals and exposes some differences among insured groups.

UTILIZATION OF HEALTH CARE SERVICES

As previously discussed, the utilization rate of health care services is different from one group to another for insured and non-insured groups. For example, in 2002, for both inpatient and outpatient care, members of the compulsory scheme had utilization rates about three times higher than members of the poor scheme: inpatient 0.175 versus 0.54; outpatient 2.28 versus 0.73. The reason is most of the poor are self-employed farmers living mostly in rural areas where the health care network is not as good as that in urban areas. A Hospital Survey in 2000 confirmed this tendency: the number of visits/1000 residents in Region 7, where Hanoi and Ho Chi Minh City are located, were three to four times higher than the northern mountainous areas or highlands in the middle of the country: 1,150 versus 358.5 and 489.5 (Ministry of Health 2002). In urban areas, the number of health care facilities is large when you consider the public system and the private sector. Most of the private practitioners are concentrated in urban areas, not in rural or mountainous areas. According to the Vietnam Living Standards Survey in 1997-1998, 70% of private clinics were located in urban areas. However, 80% of the population lived in these areas. Therefore the ratio of private practitioners/population in urban areas was nine times higher than those in rural areas.

The utilization rate is also affected by financing. Table 16 indicates that prepayment and health insurance
Table 17: Utilization rate by scheme in 2000

<table>
<thead>
<tr>
<th></th>
<th>Hanoi Compulsory</th>
<th>Hanoi Voluntary</th>
<th>Poor</th>
<th>Hai phong Compulsory</th>
<th>Hai phong Voluntary</th>
<th>Poor</th>
<th>Dong nai Compulsory</th>
<th>Dong nai Voluntary</th>
<th>Poor</th>
<th>Quang nam Compulsory</th>
<th>Quang nam Voluntary</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central level</td>
<td>15.7</td>
<td>1.8</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>1.2</td>
<td>2.1</td>
<td>0.2</td>
<td>0.9</td>
<td>1.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Provincial level</td>
<td>37.4</td>
<td>61.7</td>
<td>5.1</td>
<td>17.8</td>
<td>8.2</td>
<td>15.1</td>
<td>39.6</td>
<td>48.3</td>
<td>18.4</td>
<td>29.8</td>
<td>7.3</td>
<td>39.4</td>
</tr>
<tr>
<td>District level</td>
<td>46.9</td>
<td>36.4</td>
<td>94.7</td>
<td>82.1</td>
<td>91.7</td>
<td>84.8</td>
<td>59.2</td>
<td>49.5</td>
<td>81.4</td>
<td>69.3</td>
<td>91.6</td>
<td>60.2</td>
</tr>
<tr>
<td><strong>Inpatient admission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central level</td>
<td>27.7</td>
<td>14.4</td>
<td>17.0</td>
<td>1.0</td>
<td>0.2</td>
<td>0.8</td>
<td>7.2</td>
<td>11.0</td>
<td>0.5</td>
<td>9.2</td>
<td>3.2</td>
<td>4.4</td>
</tr>
<tr>
<td>Provincial level</td>
<td>51.6</td>
<td>51.8</td>
<td>22.9</td>
<td>46.4</td>
<td>42.1</td>
<td>37.9</td>
<td>68.1</td>
<td>77.7</td>
<td>65.1</td>
<td>26.7</td>
<td>35.9</td>
<td>22.1</td>
</tr>
<tr>
<td>District level</td>
<td>20.7</td>
<td>33.8</td>
<td>60.1</td>
<td>52.5</td>
<td>57.7</td>
<td>61.2</td>
<td>24.7</td>
<td>11.3</td>
<td>34.4</td>
<td>64.0</td>
<td>60.9</td>
<td>73.5</td>
</tr>
</tbody>
</table>

Contribute greatly to utilization. If we compare the poor holding FHIC and the poor without FHIC, FHIC increased utilization two times for outpatient care and inpatient care (0.912 versus 0.59 and 0.058 versus 0.031). When we look at the utilization rate of people holding FHIC and people holding poor book, the FHIC financing approach is two times higher for inpatient and outpatient care. The poor with FHIC do not compare to the compulsory scheme. The compulsory scheme has a utilization rate roughly two times higher. Some people may think that the compulsory scheme is made up of older people who need more medical care. Students, as a group, have few needs. But the survey on health care for the poor indicated that most of the poor obtaining free health care cards were elderly people with a high frequency of illness or those who had already been sick; this survey was conducted in 10 provinces by Vietnam Health Insurance (VHI) in 2000 and complied with circular 05/BLDTBMXH dated 29/1/1999. Therefore, the comparison is important.

The poor holding free health care cards had limited access to high levels of care. In 2000, outpatient visits by the poor were less than 1% in all provinces, inpatient was less than 5%, except in Hanoi where it was 17% (Table 17).

The poor holding health insurance cards tended to delay their visits to health facilities until they got severely ill. According to a survey in 2002, 34.4% of the poor with health insurance cards were in serious condition when entering the hospital (Survey Report of Health Care for the Poor in 10 Provinces, 2002). The reasons for the delayed visits could be:

Table 16: Utilization Rates Based on Financing

<table>
<thead>
<tr>
<th>Scheme Health Care</th>
<th>Compulsory Scheme</th>
<th>Poor Scheme</th>
<th>Verifying Book of Poor</th>
<th>User Fees (the Poor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>1.8</td>
<td>0.912</td>
<td>0.590</td>
<td>0.590</td>
</tr>
<tr>
<td>Inpatient</td>
<td>0.12</td>
<td>0.058</td>
<td>0.032</td>
<td>0.031</td>
</tr>
</tbody>
</table>

Source: Survey Report of Health Care for the Poor in 10 Provinces, 2002

Living far away from health care providers; high cost of utilization (formal and informal costs); poor understanding and lack of knowledge about their own health status.

**Benefit package:**

In principle, the benefit package is the same for compulsory group and the poor group, but in fact there is a little difference between those two schemes in terms of total expenditure. At district level, the amount spent on the poor is even higher than that of the compulsory scheme. But at
Table 18: Difference by total expenditure by groups and by level for inpatient care

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>1999</th>
<th></th>
<th>2000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory</td>
<td>Voluntary</td>
<td>Poor</td>
<td>Compulsory</td>
</tr>
<tr>
<td>Central</td>
<td>671</td>
<td>399</td>
<td>493</td>
<td>778</td>
</tr>
<tr>
<td>Provincial</td>
<td>356</td>
<td>347</td>
<td>362</td>
<td>387</td>
</tr>
<tr>
<td>District</td>
<td>164</td>
<td>118</td>
<td>190</td>
<td>147</td>
</tr>
</tbody>
</table>


Table 19: Average length of stay by insurance schemes

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>1999</th>
<th></th>
<th>2000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory</td>
<td>Voluntary</td>
<td>Poor</td>
<td>Compulsory</td>
</tr>
<tr>
<td>Central</td>
<td>14.2</td>
<td>10.8</td>
<td>8.7</td>
<td>13.4</td>
</tr>
<tr>
<td>Provincial</td>
<td>10.6</td>
<td>8.9</td>
<td>10.6</td>
<td>9.9</td>
</tr>
<tr>
<td>District</td>
<td>7.9</td>
<td>7.1</td>
<td>5.4</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Source: Survey report of health care for the poor in 10 provinces, 2002

central level the total amount spent on the poor was about 73% in 1999 and 61% in 2002.

For the poor holding health insurance cards, their additional payment to health care providers ranged 9,807 VND to 63,141 VND. For other financing approaches like “poor book,” the poor have to pay from 65,484 to 368,81 VND or up to 100% of the medical costs at the provincial level (Report on health care for the poor in 10 provinces 2002).

At the central level, doctors probably used more brand name drugs (not all brand name drugs are reimbursed by VHI) instead of generic drugs and prescribed more services, especially high-tech services. Not all high tech services are reimbursed by VHI. Therefore, at the central level, the percentage covered by VHI is always lower compared to other levels of government.

Quality of care

The average length of stay of the poor was often short when compared with other groups. The difference happened clearly at central level 3.4 days (10 versus 13.4 days). At the provincial and district levels, the difference was not as great (Table 19). This is not logical. As previously discussed, the poor often go to the hospital only when they are severely ill.

Health care network

Vietnam health insurance (now called Vietnam Social Security) signed contracts with all public health care facilities from the district level up to the central level, including specialty hospitals to provide health care services to its enrollees. As previously discussed, the barriers to the poor are not only financial but also physical. To make it more convenient for enrollees to access health care providers, Vietnam Health Insurance–Ministry of Health asked communal health centers to provide health care services to insured people at the commune level. This new approach is being implemented in 40 provinces. However, at the communal level, there are public health care providers and private practitioners; private practitioners in rural areas are few in number. Hanoi and HCM City account for 69% of the total registered private health care facilities nationally. Getting private practitioners to provide care for insured patients could be an alternative to promote competition among public and private health care providers.

Affordability: Members of the compulsory scheme have to contribute 3%
of their salaries or wages; 2% of that comes from the employer and 1% from the employee. The better-off groups have to contribute one-third. The poorer groups (self-employed, farmers) have to pay the entire contribution, even though their income is much lower compared to the compulsory scheme. That is illogical. A study (York University –1996) on affordability of the farmer who wants to join the voluntary scheme concluded that the maximum amount Vietnamese farmers could contribute was 30,000 VND per/person. This study was done in 1996, but it is still valid. Evidence for that study came from the voluntary health insurance scheme in Gialam (1998) district and Soc Son (2001) District – Hanoi. In the two programs, Hanoi people’s committee provided support, equaling one-third of the premium. In Gialam, support was 15,000 VND/50,000 VND; in Soc Son they also contributed one-third of the premium. Neither program was successful. Both experienced adverse selection. In Gialam district, there were 5000 enrollees out of a population of 95,000. In 2001 in Soc Son, the health insurance office carried out a marketing campaign but only 25% of the population enrolled; most of them were elderly people who were sick. Adverse selection happened again. These two programs prove that farmers and people in the informal sector cannot afford premiums, which exceed 30,000-40,000 VND. The Hanoi Health insurance agency has shifted from an individual to a family based program. But it is too early to see the results.

7. MAIN REMARKS AND RECOMMENDATIONS

RESOURCES ALLOCATION

Although resources have targeted those provinces where the need for health care is greatest, the norm for allocating health care in Vietnam is based on inputs, such as the number of hospital beds for curative expenditures and the population for preventive expenditures. There is an imbalance in funding curative and preventive services as well as an imbalance among different levels of service delivery, which prevents the poor from using health services. That norm may also encourage the false reporting of beds; this makes the regional imbalance worse and it is also inefficient and discourages prompt services to patients.

To make health care more accessible and affordable for the poor in Vietnam, here are some recommendations:

- Decentralization has positive aspects. But it may aggravate disparities in the allocation of resources. It is up to the central government to mitigate this effect by redistributing resources and topping funding for poorer local governments.

- The allocation should target pro-poor health interventions; resources should target diseases affecting the poor, including communicable diseases.

- The allocation should target pro-poor health services: more resources should flow to preventive and primary health care services to benefit more of the poor than the rich.

- Allocations should target poor areas: they need to be pro-poor, based on population or a per capita for rich and poor alike. However, the poor who need more services should receive a higher subsidy.

- The allocation should target poor households and communities: Resources flow directly to low-income communities and households. Hospitals in poor areas have a much higher percentage of non-paying patients. They must be funded so they can provide services at the same level as hospitals in better-off areas.

- Poor people are typically less informed than the rich. The poor should have information about cost effective health interventions, ways to change their behavior, prices and resources. The poor should have ways to compare providers on the basis of price and quality.
• Finally, needs-based budgeting may contradict performance-based budgeting. Poor areas may not perform as well as other areas and may be more costly to reach. The trade-off between efficiency and equity is often a delicate issue. This can be addressed in part by allocating funds to users based on need and to providers based on their performance.

**USER FEE POLICY**

The cost of using health services affects whether people use them and their frequency of use. Reducing the cost of health care to the poor has an impact on their health and the impact that poverty has on their health.

Medical expenses are not recognized as a major poverty trap. Patients have to pay regardless of whether they have to sell off capital goods to settle their hospital bills. In any health care system with fairly high user fees, it is critical to analyze the effects user fees have on access and the consequences they have on the family budget.

Hospital fees are a temporary solution during a transition.

Over the long and short-term user fee policies need to be reformed and equitable.

*Long-term orientation for user fee policy*

To gradually reduce out-of-pocket payments for health services, particularly user fees, so that the revenue from user fees can be replaced by other sources for the purpose of efficiency and equity. The extent to which user fees may be reduced should be considered in connection with an increase in the Government’s budget for health and different types of health insurance schemes.

Public expenditures on health should be gradually increased in absolute terms and as a share of GDP and the total Government budget. At the same time, different solutions for gradually improving different types of pre-paid schemes need to occur to gradually achieve universal health insurance. In accordance with the socio-economic strategy for Vietnam adopted by the 9th Party Congress, they include the expansion of existing compulsory health insurance schemes, the development of voluntary social health insurance schemes as well as different types of community-based health insurance schemes for e.g. farmers and people working in the informal sector in urban areas.

Distributing health facilities all over the country; expanding the health care system and enhancing the quality of care and securing more convenient access to health care services are also in order.

*Short-term activities*

In the short-term a mandate should be exercised to adjust the user fee policy, according to resolution of the 9th Party Congress: "... Implement social equity in health care, adjust the user fee policy, subsidy and health insurance for the poor, develop universal coverage of health insurance..." To realize this important goal, it is impossible to separate the user fee policy from the subsidy policy for the poor. Other relevant social policies, such as Government financing for health; development of the basic health care system; adjustment of hospital regulations; incentives for health staff also deserve attention. Policy-related adjustments to be made include: identifying the purpose of charging user fees as a management tool instead of a way to increase revenue, criteria and methodology to define target groups to benefit from waiving user fees or reducing them; new methods of charging, managing and using the revenue from user fees.

Positive ways of financing health care for the poor should be continued. Furthermore, decision 139 on Health Care for the
Poor Fund should be implemented across the board.

THE HEALTH CARE FOR THE POOR FUND (DECISION 139)

We affirm that decision 139, a progressive policy in health care financing for the poor in Vietnam, should be implemented across the board. To do that, we recommend the following:

- MOH should provide technical guidance to the organization and operation of the HCFP.
- MOLISA should guide the beneficiary identification process and supervise it.
- The benefits covered under the HCFP should be designed based on consultations with all stakeholders.
- All beneficiaries need to be well informed about the HCFP.
- The quality of services provided under the HCFP program should be assured.
- All public providers who participate in this program should be trained in its implementation.
- Expand health insurance coverage to all commune health stations.
- The HCFP should receive a sustainable commitment from Authorities over time.
- There should be a target for different periods of implementation (e.g. 5 years, 10 years...).
- The HCFP should be evaluated for its impact and refined if necessary.

INCENTIVE MECHANISM FOR HEALTH STAFF

The Government should think about increasing salaries for workers in the health sector; formulating better payment mechanisms in parallel with reforming hospital management and enhancing medical ethics.

Incentives are very important. There are several ways to offer them to health staff: financial (such as bonuses and fee schedules) and non-financial (such as technical assistance for quality improvement, reducing administrative requirements...)

Incentives can apply to individual physicians, medical groups, independent practice associations, hospitals, physician-hospital organizations, and health plans.

Organizational leaders can select among several types of performance measures, including performance benchmarks and comparative data from other provider groups.

An incentive model should include a way of monitoring provider performance. The People's Committees play an important role in monitoring the quantity and quality of care, especially at the commune and district levels and also at the provincial level.

Autonomous hospital policy also needs careful review before implementation.

HEALTH INSURANCE

The current health insurance system has achieved most of its goals. However, for purposes of equity, the following aspects need to be addressed:

- Reduce the gap between different insured groups regarding utilization, total expenditures, health services delivery
- Improve equity in terms of contribution
- Improve budget allocations and reimbursement policies
- Improve legal framework to promote the private sector but under control of the health sector
The solutions could be:

- Improve the health care network: sign contract not only with public health care providers but also private practitioners, especially at the grassroots level.

- Adjust legal framework so that more general practitioners may enter the market freely and risk pooling may be expanded. The MoH should organize a licensing system and keep requirements about working at least 5 years in the public or standard private health care facilities.

- Apply DRG (diagnostic related group) to pay health care providers: We have seen the difference in prices for the same services charged by health care providers at the district or provincial level and for the same condition. Applying DRG would solve this problem. We do not have to control average length of stay, drug component, and lab tests. However, to develop a DRG system is complicated and takes time to customize. It would be better to start with DRGs for simple and complicated surgeries. Insured patients may be more satisfied with DRGs if the system of reimbursement is more equitable across the country. Health care providers may also be happier if they are paid the same for the work they do. The DRG system may be meaningful to the poor in this way; health care providers should not be concerned whether the insured patient is rich or poor; treatment should be based on diagnosis.

- Apply an accreditation system to standardize quality of care and form the basis for reimbursement. Progress has been made since the introduction of a central health insurance system in 1998. Benefits and payment procedures were standardized. This was for the insurer, not for suppliers. In general, public hospitals are classified into three levels: district, provincial and central. There is no system to control quality assurance at hospitals. Insurer (VHI) pays the same price to health care providers although the infrastructure and competence of staff may vary from one hospital to another. An accreditation system would assure the quality of care provided and help classify hospitals according to an appropriate benchmark. The poor will also benefit from such a system if their length of stay is comparable to those who are not poor.

- Applying a reimbursement weight to health care providers may solve the problem of equalization in providing inpatient and outpatient health care services.

- Expanding the prepayment scheme with state subsidies to get people near the poverty line to join the scheme. It is more appropriate to offer them a prepayment scheme with different benefits relevant to their contribution, for example, a plan that covers catastrophic illnesses and subsidizes 50% of the premium.
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ANNEX 1: STATE BUDGET ALLOCATION FLOWCHART

ALLOCATION OF RESOURCES - HOSPITALS

- Central
  - Ministry of Finance
  - Ministry of Health
  - Central Health Institutions (Hospitals)

- Province
  - Provincial Peoples' Committee (Department of Finance)
  - Province Health Bureau
  - Hospitals

- District
  - District Peoples' Committee (Department of Finance)
  - District Health Center (Hospital)

- Commune
  - Commune Peoples' Committee (Finance Board)
  - Commune Health Station

ALLOCATION OF RESOURCES - VERTICAL PROGRAMS

- Central
  - Ministry of Finance
  - Ministry of Health
  - Central Health Institutions (e.g. Malaria, TB)

- Province
  - Provincial Peoples' Committee (Department of Finance)
  - Province Health Bureau
  - Preventive Center

- District
  - District Peoples' Committee (Department of Finance)
  - District Health Center (Preventive Center)

- Commune
  - Commune Peoples' Committee (Finance Board)
  - Management Board (for vertical programs)
  - Commune Health Worker

Source: Ministry of Finance, 2003
ANNEX 2: STATE BUDGET ALLOCATION NORMS

Annex Table 1: Budget Transfer Norms for Health (VND/Person/Year) 1996

<table>
<thead>
<tr>
<th>GEOGRAPHIC ZONE</th>
<th>PREVENTIVE CARE</th>
<th>CURATIVE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cities</td>
<td>5,200</td>
<td>14,500</td>
</tr>
<tr>
<td>Plains</td>
<td>3,800</td>
<td>11,000</td>
</tr>
<tr>
<td>Midlands</td>
<td>3,800</td>
<td>11,000</td>
</tr>
<tr>
<td>Deep lying, low mountains</td>
<td>4,800</td>
<td>13,800</td>
</tr>
<tr>
<td>High mountains</td>
<td>6,000</td>
<td>17,600</td>
</tr>
</tbody>
</table>


Annex Table 2: Budget Allocation Norms For Local Health Expenditures (In Millions of VND/Hospital Bed/Year) 1998

<table>
<thead>
<tr>
<th>GEOGRAPHIC ZONE</th>
<th>PROVINCE AND CITY LEVEL</th>
<th>DISTRICT LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanoi</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Ho Chi Minh City</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Other cities</td>
<td>13-16</td>
<td>8-11</td>
</tr>
<tr>
<td>Delta</td>
<td>10-13</td>
<td>6-9</td>
</tr>
<tr>
<td>Midlands</td>
<td>11-14</td>
<td>7-10</td>
</tr>
<tr>
<td>Deep lying and low mountainous areas</td>
<td>12-15</td>
<td>8-11</td>
</tr>
<tr>
<td>High mountainous areas, islands</td>
<td>14-17</td>
<td>7-10</td>
</tr>
</tbody>
</table>

ANNEX 3: EVOLUTION OF HEALTH INSURANCE AND HEALTH SCHEMES

EVOLUTION OF HEALTH INSURANCE IN VIETNAM

Before 1989, Vietnam was considered one of the poorest countries in the world. But in most of its modern history until the economic crisis of the 80's, the government of Vietnam provided free health care for everybody in the country. The health sector was unable to meet the people's demand for services and to protect vulnerable groups. To reduce dependency on the government's budget, Vietnam introduced reforms. Reforms also included the introduction of health insurance schemes. Health care providers could charge users of health care services a separate and additional fee and private practitioners were able to operate private clinics.

From 1989-1992, the Health sector piloted health insurance schemes in three provinces (Hai phong, Quang Tri and Vinh Phu). This three-year piloting program resulted in Decree 299/HDBT (ministerial council). For the first time ever, Vietnam had a legal framework for a national health insurance policy with three objectives:

- Generating additional resources to supplement the government budget for health care to assist public health facilities improve their quality of care;
- Reducing the financial burden on insured patients with serious diseases who needed high technology as part of their treatment;
- Achieving social equity in health care and its distribution.

With Decree 299/HDBT, Vietnam Health Insurance comes under the Ministry of Health. Provincial Health Insurance Offices come under the Provincial People's Committee. The central office offered technical and professional guidance. The provinces managed the financial aspects.

From 1998-2002: Decree 299/HDBT was in place for five years and there was pressure to change. The result was Decree 58/1998/NDCP, which has the following features:

- The system was unified and managed vertically and nationally
- Funds were managed centrally and independently of the government budget but protected by the government.
- Benefits were standardized nationally.
- Cost sharing (copayments) was introduced for the first time
- Benefits for high-tech services, such as MRI, doppler ultrasound, coronary angiography, cerebral angiography, endoscopic surgery were expanded in 2002

This new decree brought about an imbalanced situation in some health insurance plans.

During this period, a scheme for the poor came into being. The government of Vietnam initially intended to cover four million of the poorest people. However, only about 800,000 poor people received a Free Health Care Card.

In 2001, new criteria for the poor were introduced which made about 12-14 million poor people in Vietnam eligible for the Free Health Care Card Program. Nevertheless, by the end of 2002, only 1.6 million poor people had obtained FHC. The chief constraint to the expansion of the program was the shortage of resources; about 10 provinces in Vietnam were in good shape financially.

In December 2002, the government allocated about 600 billion VND for this program for the poor. Vietnam has done
the right thing in setting up a social safety net. The 139 decision should help the poor when they get sick and should also contribute to the growth of the national economy. Local authorities (provincial people's committee) will set up a medical fund for the poor with a minimum of 70,000 VND. This fund will either buy health insurance based on a premium of 50,000 VND for all eligible people. Or they can reimburse health care providers directly based on the actual cost of care. The remaining fund is to support hospital fees for those who meet with unexpected difficulties because they have ailments requiring high cost treatment at state-run hospitals; it's also for the poor and the homeless. This fund will come from the following sources: 75% from the state budget and 25% from each locality. Local budgets or contributions from domestic or international organizations or individuals may supplement the fund.

The poor who have a health insurance card are entitled to essentially the same benefits as those who are insured under the compulsory scheme.

From 2003: Merging of Social Security and Health Insurance

HEALTH INSURANCE SCHEMES

Compulsory Health Insurance applies to:

1) Vietnamese employees working in:
   a) State enterprises, including those who work in the armed forces.
   b) Business units that belong to State, Governmental Administrative Organizations, Party Organizations and Socio-Political organizations;
   c) Enterprises with foreign investment, industrial processing zones; foreign and international organizations except those stipulated otherwise in International Treaties that the Socialist Republic of Vietnam has entered;
   d) Non-State Business Units, enterprises with 10 employees or more.

2) Civil servants working in Administrative Organizations; people who work in the Party Offices, Socio-Political Organizations, cadres at the commune and ward level who receive monthly allowances based on Decree 09/1998/ND-CP dated 23 January 1998 by the Government; those working in people-nominated agencies at the Central and grassroots levels

3) Pensioners, incapacitated people who enjoy a monthly allowance.

4) Meritorious people stipulated in the Vietnamese laws.

5) Special groups who receive social protection allowance through the social security system.

6) Agent Orange Victims and their children.

Voluntary health insurance scheme:

The voluntary health insurance scheme aims at carrying out social policy in health care. It is not for commercial purposes; corporate law does not apply. Voluntary Health Insurance applies to everyone, including foreigners who come to Vietnam to do business, study or travel.

Current enrollment in the voluntary scheme:

- School health insurance for school children and students
- Dependents
- Farmers, veterans, members of some social associations

CONTRIBUTIONS

Compulsory health insurance

For compulsory health insurance, the following principal applies:
• Employers contribute 2%

• Employees contribute 1%
  ✓ For those with a monthly salary, the contribution rate is 3% of basic salary plus regional, job-title and service-seniority allowances which are determined in the labor contracts; employers pay 2% and employees pay 1%
  ✓ For those working at the commune level and receiving monthly position allowance, the contribution rate is 3% of monthly position allowance and other allowances; the employers pay 2% and employees pay 1% of the allowance.
  ✓ For standing members of the People's Council at any level, if they are neither payroll members nor social security beneficiaries, the contribution rate is 3% of minimum salary paid by the People's Councils.
  ✓ Pensioners and the incapacitated who enjoy a monthly allowance: contribution is 3% of their pension or monthly allowance paid by the Social Security Office.
  ✓ Meritorious people: contribution is 3% of the minimum salary paid by MOLISA.
  ✓ Agent Orange Victims and their Agent-Orange-affected children: contribution is 3% of the minimum salary and paid by MOLISA.

**Voluntary health insurance**

The Vietnam Social Security (previously Ministry of Health) and the Ministry of Finance determine the contribution rate and benefits of voluntary health insurance for each scheme, based on the proposed program developed by the provincial social security office.

For students and school children, the rate of contribution ranges from 15,000 to 45,000 VND.

For farmers, veterans, members of some social associations like the women’s union, the contribution ranges from 60,000 to 100,000 VND. It varies by province. But the lessons learned from the pilot program are as follows:

**HEALTH INSURANCE BENEFITS PACKAGE**

Compulsory insured persons are entitled to:

• Outpatient and inpatient treatment as stipulated in Degree 58/CP (inpatient and outpatient care, emergency, pharmaceutical benefits within the drug list promulgated by MoH).

• To choose one health provider, which is most convenient to register.

80% of the charge is paid by the Health Insurance (HI) fund, the remaining 20% of the charge is paid by the insured to the health care provider. During the year, if the total copayment by the insured person reaches six times the minimum salary, the Health Insurance Office pays for all other covered health insurance charges incurred for the rest of that year.

Co-payments do not apply to:


• Health insurance card holders residing in 1,715 disadvantaged remote mountainous communes identified by the Ethnic and Mountainous Committee.

• The poor with free health insurance cards stipulated in the Inter-Ministerial Circular 05/TTLT dated 29/1/1999 by MOLISA, MoH, MoF.

• Pensioners, the Social Security-approved incapacitated people.

• The insured whose total copayment amount has reached six times the minimum salary.
- Health insurance members who go for a health consultation in an enterprise health unit.
- Voluntary health insurance scheme members such as farmers, students.

**Partly-covered cases by health insurance:**

- Those who choose specific physician, bedrooms, and medical services.
- Those who choose health care providers who do not sign an official contract with health insurance agencies
- Those who cross the referral line.

In all the above mentioned cases, insured patients have to pay the health provider first, then keep all papers (prescription, receipt of drug procured, discharge paper, hospital fees and other documents related to payment procedure as stipulated by the Ministry of Finance). VSS will partly reimburse them as stipulated in provision 2, clause II, Part C of this Circular.

Insured patients will not be reimbursed by VSS in the following cases:

- Leprosy treatment
- Specific drugs (listed by the MoH) funded by the Government for special treatments such as: TB, malaria, schizophrenia and epilepsy
- Family planning services including: contraceptive pills, IUD, menstrual regulation, abortion, male and female sterilization and other contraceptive methods, early pregnancy tests, pregnancy management from the 3rd child up.
- Prevention, laboratory tests, diagnosis and treatment of HIV/AIDS, gonorrhea and syphilis.
- Vaccination, nursing, convalescence services, regular health checkups, sterilization treatment.
- Orthopedics, cosmetic surgery, glasses, hearing aids; artificial limbs, dentures, artificial lenses, artificial eyes, joints and heart valves.
- Rehabilitation beyond the list stipulated by the MoH.
- Congenital diseases and deformities.
- Occupational diseases and accidents, traffic accidents, accidents caused by war or natural disasters.
- Suicide, self-inflicted injury, drug addiction, violation of laws

**Voluntary scheme**

- For students: inpatient care, emergency, pharmaceutical benefits within the drug list promulgated by MoH.
- For farmers and social associations: as compulsory scheme, no copayment
- For free health care card scheme: As compulsory scheme, copayment does not apply to this group

**FUND UTILIZATION**

The health insurance fund is managed nationally. It is autonomous and protected by the Government. Total compulsory scheme contributions are allocated as follows:

- 91.5% for sickness fund, of which 5% is for reserves

  - ✓ If the actual health care expenditure is lower than allocated, then the remainder will be transferred to the reserve fund.
  - ✓ If the actual health care expenditure exceeds the allocated amount, then the deficit will be provided from the reserve fund.
• The reserve fund can be used to buy state bonds and deposited into bank accounts for interest. VSS can use other methods to maintain and develop the fund. The reserve fund should be managed in such a way that it is available when needed.
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