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Health Care Reforms in Vietnam
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Introduction

- Vietnam known for its “pragmatism”
  - Not evident in health care!
- The government is unwilling or incapable of adopting meaningful reforms, despite
  - Repeated attempts
  - Massive increase in government expenditures
- I will argue that
  - The government is trapped in a line of thinking that does not address the root cause of the problem
  - The problem will not be addressed until it reconfigures provider incentives

Introduction

- In my view, the key shortcomings of the Vietnamese reforms are:
  1. Encouraging public hospitals to raise revenues through user charges.
  2. Expanding operational autonomy for providers.
  3. Trying to overcome the ill-effects of user charges (1st) and provider autonomy (2nd) through expanded social insurance.
- The 1st offers providers the motive to raise revenues while the 2nd provides the means to it.
  - Expansion of social insurance will further increase expenditures due to expanded income opportunities for providers.

History of Reforms

- In the 1980s, Vietnam had an impressive health care system by standards of the developing world.
  - Low expenditures
  - Superior outcomes (measured by infant mortality)
- The goal of *Doi moi* reforms launched in 1986 was "socialist-oriented market economy“
  - In reality, there was little socialist orientation!
- Subsidy for hospitals were cut, forcing them to look for new sources of revenues
- Reforms have undergone three phases since late 1980s

  1st. hospitals allowed to collect charges to compensate for reduction in public subsidies.

  2nd. health insurance expanded to maintain access to health care.

  3rd. health care system decentralized

1st Phase: Imposition and expansion of User Charges

- User charges at public hospitals became official policy in 1989
  - User charges' share of hospitals' total revenue rose from 9 % in 1994 to 30 % in 1998
- User charges paid largely out of pocket
- To control costs (and hence what users paid), price caps for drugs and services below costs were imposed
  - Encouraged prescription of non-covered drugs and services
- Combination of (1) controlled prices and (2) encouragement of user charges led providers to concentrate on getting around the former and focusing on the latter
- Total health expenditures (THE) increased from 4.9 % in 1999 to 5.9 % in 2005.
  - OOP spending on health increased to 71 % of total health spending in 1993.

2nd Phase: expansion of User Charges

- To improve affordability in the face of rising OOP, government expanded insurance
  - Compulsory Social Health Insurance (SHI) launched in 1992 for public sector workers and in private firms employing 10 or more workers. Dependents excluded.
  - Voluntary Health Insurance also launched in 1992.
  - Compulsory scheme expanded to all formal sector workers in 2005
    - In reality only 1/5th of private firms comply.
    - SHI also covers retirees, the disabled and “meritorious” people
- Greatest expansion of insurance began in 2008 when the poor were brought under SHI
  - Central and provincial governments pay (50: 25) the poor's premium

Population (86.2 million) covered by Health Insurance, 2010

	Million	%
Low income	15	**30**
Workers	8.3	**16**
Children under six years old,	7.5	**15**
Students	11	**22**
Voluntary (excluding students)	2.3	**5**
State budget beneficiaries	6.3	**13**
Total covered	50.4	**58**

- Majority of the population now covered by SHI
  - Government Target is 100% by 2014: achievable
- Premium 4.5 % of basic salary (3 % employer, 1.5 % employee). (Will rise to 6 %) 3% for children and students
- The Government is the largest source of insurance revenues:
  - 2/3rd come from govt budget (premium for the poor, retirees, and contributions for state workers.)

3rd Phase: Decentralization

- Decentralization began in the 1990s. Became official policy in 2004
  - The law gave financial autonomy to lower levels of government and health care providers
- Decentralization expanded greatly in 2006
  - Allowed providers to generate and retain revenues from users
  - Encouraged providers to attract private investment and engage in joint ventures on profit-sharing basis. ("energetically mobilize financial resources from society").
    - Providers prescribe diagnosis and drugs that generate profits for them.
- The share of state health facilities granted autonomy increased from 46 % in 2005 to 88 % in 2007.
  - National govt accounts for 37 % of THE, provincial govt 45 %, and local government 16 %

Health Care Expenditures and Outcomes

- THE in Vietnam rose from 5 % of GDP in 2000 to 7 % in 2007
  - More than Hong Kong!
- OOP still large, despite expansion of SHI and govt expenditure
  - 61 % of THE in 2006 compared to 63 % in 2000.
- Health status of population good by international standards
  - But it was good even before the reforms began.
  - Improvements slowed down after reforms began

Conclusions and Lessons

- Health status stagnant (though still relatively good)
- Total Health expenditures and the government's share of it rising.
  - OOP still very large: 60 % of THE.
- Key Questions
  - Why are health care expenditures rising?
  - Why is OOP still large despite massive expansion of insurance?
- The answer **cannot** be the provision system
  - Vietnam's system of public provision associated with low expenditures (e.g. UK, Hong Kong, Singapore, Thailand)
- The answer can be partially found in the financing system
  - Insurance associated with high expenditures. But SHI forms only a small share of THE
  - OOP, which is the main form of financing, is theoretically associated with low expenditures (though rarely in reality)

Conclusions and Lessons

- The answer in all likelihood lies in the payment system
- Providers in Vietnam are paid on Fee for Service (FFS) basis
- FFS offers health care providers the means to increase the volume and intensity of services and medication with the largest profit margin.
  - Especially when providers have invested in the facilities and their income is directly tied to
- In contrast FFS, capped payment systems offer providers incentives to reduce expenditures
- Compulsory health insurance addresses adverse selection problems
  - But leads to rising expenditures if the payment system is FSS.
- Insurance needs to be accompanied by capped payment if both access and cost containment are objectives

Conclusions and Lessons

- Co-existence of OOP, FSS, and insurance is a bad combination
  - Compromises access
  - Promotes inequality
  - Raises expenditure