Integrating the Poor into Universal Health Coverage in Vietnam

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All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the nuts and bolts protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

CHSs  commune health stations
DOLISA  Provincial Department of Labor, Invalids and Social Affairs
MOF  Ministry of Finance
MOH  Ministry of Health
MOLISA  Ministry of Labor, Invalids and Social Affairs
OOP  out-of-pocket
SHI  Social Health Insurance
THE  total health expenditures
VSS  Vietnam Social Security
Executive Summary

By 2011, 97 percent of the poor in Vietnam had been enrolled in Social Health Insurance (SHI). High rates of enrolment into SHI have not translated into effective coverage for the poor, however. The fragmentation of funding across different groups has serious negative implications for risk pooling and equity. The poor are subsidizing the rich, and poorer provinces are subsidizing richer provinces. Out-of-pocket (OOP) payments are high and persistent, resulting in limited financial protection for the poor. Meanwhile, government subsidies for health are not sufficiently reaching the poor. Hospital subsidies, in particular, tend to favor the rich, exacerbating existing inequalities.

This case study is aimed at providing a descriptive assessment of the key features of Vietnam’s SHI, focusing on the impediments to integrating the poor into universal coverage. The trajectory of SHI in Vietnam is similar to that of many other countries in the East Asia and Pacific region. The poor were covered under a separate Health Care Fund for the Poor to begin with. The 2009 Law on Health Insurance merged all of the different programs into one. Health insurance premiums for the poor were fully subsidized by the government and enrolment became mandatory, resulting in almost complete enrolment of the poor by 2011. Vietnam has combined elements of contributory social health insurance with substantial levels of tax financing to provide coverage for the poor and informal sector.

In principle, Vietnam now has a single-payer insurance system, with a single pool and unified benefits package. In practice, the capitation-based resource allocation mechanism for primary care has exacerbated already high levels of fragmentation of revenues and risk pools. Capitation rates are determined on the basis of historic and province- and group-specific utilization rates. Poorer groups and provinces tend to face greater barriers to access, have lower utilization rates and, consequently, lower capitation rates. Because the poor tend to have lower capitation rates, health facilities are more likely to underprovide to this group, perpetuating the cycle of lower utilization and capitation rates.

This fragmentation of risk pools combined with high OOP payments, and weak cost containment more generally have been detrimental to equity in access and financial protection for the poor. The increase in enrolment rates has not been accompanied by any significant reduction in rates of catastrophic spending or OOP-related impoverishment among the poor. Fee-for-service payment, hospital autonomy, and resource allocation and payment methods have created strong incentives for providers to oversupply services, making it difficult to contain costs and stem the growth of OOP payments. The wide prevalence of balance billing, although not permitted, and of informal payments, further contributes to this.

Public hospital subsidies fail to reach the poor because a disproportionately large share is allocated to secondary and tertiary hospitals that the poor have limited access to. The expansion of insurance coverage and increased use of public hospitals by the poor has led to a slight improvement in the distribution of public subsidies. Nevertheless, the fact that the distribution of nonhospital services—largely commune health stations—is pro-poor, while that of hospital services is pro-rich, suggests that the poor have limited access to hospital services. The poor face significant financial barriers in accessing hospital services because of the high OOP costs.
1. Introduction

The goal of integrating the poor into the universal health coverage program in Vietnam remains unattainable despite the fact that by 2011, nearly 100 percent of the poor had been enrolled into Social Health Insurance (SHI). Since 2009, insurance premiums for the poor have been fully subsidized by the government, and enrolment of the poor has been mandatory. Vietnam has combined elements of contributory social health insurance with substantial levels of tax financing to provide coverage for the poor and the informal sector.

High rates of enrolment into SHI have not translated into effective coverage for the poor, however. The fragmentation of funding across different groups has had serious negative implications for risk pooling and equity. The poor are subsidizing the rich, and poorer provinces are subsidizing richer provinces. Out-of-pocket (OOP) payments are high and persistent, resulting in limited financial protection for the poor. Meanwhile, government subsidies for health are not sufficiently reaching the poor. Hospital subsidies, in particular, tend to favor the rich, exacerbating existing inequalities.

This case study is aimed at providing a descriptive assessment of the key features of Vietnam’s SHI, focusing on the impediments to integrating the poor into universal coverage. The case study finds that capitation-based payments under SHI have exacerbated already high levels of fragmentation in pooling and revenues. Meanwhile, a combination of hospital autonomy, revenue-enhancing efforts, balance billing, and weak governance has led to high and persistent out-of-pocket payments. The case study also shows that there are several features of Vietnam’s SHI that could be considered best practice. Vietnam has not been able to reap their potential benefits because of flaws in the design or implementation of those features.

The case study is structured as follows. Section 2 describes the institutional structure and system characteristics of Vietnam’s SHI. Section 3 addresses the main topic of the case study—the impediments to integrating the poor. Section 4 concludes by addressing the pending agenda.

2. Institutional Architecture and System Characteristics of Vietnam’s SHI

Vietnam’s SHI\(^2\) was formally established in 1992 and covered civil servants and formal sector workers. Over the last 20 years, SHI has increased coverage to more than 64 percent of the general population (Figure 1).

\(^2\) Although Vietnam had a separate program for the poor prior to 2009, this was merged with the national SHI program under the law passed in 2009, as described below. Currently, there is no separate Health Care Program for the Poor in Vietnam. The organization and management arrangements for the compulsory insurance program for the poor are the same as for other types of compulsory insurance (SHI).
The Evolution of Social Health Insurance in Vietnam

Collapse of the centrally planned economy and the privatization of the health sector. Prior to the late 1980s, Vietnam had a socialist-style health care system that provided universal coverage. In the late 1980s and early 1990s, the reform process known as Doi Moi\(^3\) led to a series of policy shifts in the health care system. Central among these reforms were the liberalization of the health care and pharmaceuticals markets, the introduction of official user fees at public health facilities and, more important, the inception of health insurance. By the early 1990s, OOP payments accounted for over 70 percent of total health financing, with significant negative impacts on financial protection and equity in health care. In short, economic liberalization and the consequent privatization of the health sector had significantly eroded coverage, as was the case in many former centrally planned economies around the world.

The first mandatory scheme. To address the growth in OOP payments and associated problems of financial barriers to access, the government piloted a series of voluntary noncommercial health insurance schemes between 1989 and 1992. In 1992, Decree No. 299 was passed introducing a mandatory scheme for civil servants, formal sector workers, pensioners, and people receiving social assistance. This nationwide scheme covered all of the eligible population by 1993. Supervised by the Provincial Health Departments, it had a multiple fund structure with a health insurance reserve fund in each province, and a national reserve fund. In 1998, Decree No. 58 unified all of the health insurance funds into a national health insurance fund, and enlarged the scheme to include a few other groups such as meritorious people and dependents of military officers.

Health insurance for the poor. Throughout the 1990s, the government issued several policies aimed at providing coverage for the poor. In 1994, Decree No. 95 introduced a fee exemption policy for the poor. This was not accompanied by any explicit subsidy to facilities to implement the policy, however. In 1999, a government circular required facilities to use budget funds to

\(^3\) “Doi Moi” refers to the economic reforms initiated in Vietnam in 1986 with the goal of creating a “socialist-oriented market economy.”
enroll at least 30 percent of the poor in compulsory health insurance. The most critical policy change came in 2002, when Decision 139 led to the introduction of the Health Care Fund for the Poor (including ethnic minorities). Under this policy, either the poor could be enrolled in health insurance or providers could be reimbursed for providing free health services to the poor. The latter option led to administrative difficulties, and in some cases adverse selection, since providers included the very sick among the poor. In 2005, Decree No. 63 led to the direct exemption policy being abandoned. Instead, the decree required that all of the poor be enrolled in compulsory health insurance, with the government fully subsidizing the premium.

The Law on Health Insurance. In 2009, the Law on Health Insurance was passed. It stated the following among its goals: “The State pays or assists payments of health insurance premiums for people who provided meritorious services to the revolution and socially protected groups.” The law stipulates that all children under six years of age, the elderly, the poor, and the near-poor will be compulsorily enrolled. Under the law, the government is responsible for fully subsidizing the health insurance premium for children under six, the elderly, and the poor, and for partially subsidizing premiums for the near-poor and students. The law also provides a roadmap for universal coverage with the enrolment of other groups. The recent Master Plan for Universal Health Insurance (Ministry of Health 2012) has set a target of 80 percent coverage by 2020.

Institutional Architecture

The Ministry of Health (MOH) is in charge of SHI policy formulation and monitoring and evaluation, while Vietnam Social Security (VSS) is responsible for managing the SHI fund and implementing the program by issuing health insurance cards and purchasing services for its members. Institutionally, VSS is a ministerial-level government agency that reports to both the MOH and the prime minister. In addition, several other government agencies are involved in SHI. The Ministry of Labor, Invalids and Social Affairs (MOLISA) is responsible for the identification of the poor; local governments (and their Provincial Department of Labor, Invalids and Social Affairs [DOLISA]) are responsible for the identification process and for producing the final list of the poor in the provinces. The Ministry of Finance (MOF) and provincial departments of finance are responsible for the allocation and transfer of money to VSS.

MOH reports on the basis of specific criteria to the National Assembly. These are mostly process indicators and some outcome indicators. Other indicators that are important for assessing equity and efficiency are not used for reporting. It is not compulsory to report on OOP payments for health care to the National Assembly, for instance.

Financing and Delivery of Services under Vietnam’s SHI

Sources of financing

Total health expenditures were 6.9 percent of gross domestic product in 2010, or US$85 per capita. Households account for the largest share of total health expenditures—50.5 percent in 2009—although this declined from 67.1 percent in 2005 (Figure 2).
The expansion of SHI in Vietnam has been financed largely through tax subsidies to cover insurance premiums for the poor and other vulnerable groups. As Figure 3 shows, as SHI expanded rapidly during 2006–10, the government share of SHI revenues rose from 29 percent to almost 50 percent. Government health spending increased at a faster rate than economic growth from 2006 to 2010. By comparison, income elasticity of government health spending was only about 0.5, which indicates that there was a clear upward shift in government health spending after 2006. This includes government subsidies to cover the premium costs of enrolling the poor and other vulnerable groups, and partial subsidies to cover the premium costs of enrolling the near-poor. Contributions from employers, employees, and individuals have declined as a share of total revenues. Vietnam, like other countries in the region has recognized that expanding coverage based on contributory mechanisms alone is not feasible in a context where a large share of the population is still poor, in the informal sector, or both.
Figure 4 illustrates the financing flows in Vietnam. Government supply-side subsidies are channeled through MOH or Provincial Health Bureaus, while demand-side subsidies are channeled through VSS. In theory, they are pooled at the facility level. However, as discussed in the remainder of this case study, there is significant fragmentation of pooling. The different sources of funding also weaken purchasing capacity in the system, as discussed below.

**Figure 4 National Health System Financing Flows**
**Delivery of services**

Vietnam has a mixed delivery system, with the public sector dominant in the provision of hospital care services, and the private sector dominant among smaller ambulatory care providers and the sale of pharmaceuticals. The public sector delivery system consists of central and specialized hospitals, provincial and district hospitals, and commune health stations (CHSs) and village health workers. Private providers of primary care consist of drug vendors, general practitioners, private pharmacies, and nursing homes. The private hospital sector is relatively underdeveloped. The number of private hospital beds accounts for only 4 percent of the total beds. In 2010, public sector hospitals and CHSs accounted for nearly half of all health expenditures. Private health care providers accounted for 12 percent and drug stores for 17 percent of total health expenditures.

All public providers were automatically approved to participate in SHI prior to November 2011, while private providers needed certification and permission. In recent years, no provider has lost the right to participate. From November 15, 2011, onward all public and private providers were required to obtain certification and permission to practice medicine.

**Resource allocation and provider payment mechanisms**

The allocation of supply-side subsidies is largely based on historical norms. The MOH allocates subsidies to tertiary hospitals and specialized hospitals, and the Provincial Governments allocate subsidies to provincial, district, and commune-level health services through the Provincial Health Bureaus. Both types of budget subsidies are allocated based on historic spending norms and bed numbers, with the exception of preventive care subsidies, which are capitation based.

VSS manages SHI revenues, and purchases services for the insured using a combination of payment methods. SHI premiums from employers (4.5 percent of the minimum salary) and demand-side subsidies from the government for the poor, near-poor, and other vulnerable groups (4.5 percent of the basic minimum salary) are managed by VSS. Provincial Social Security offices handle payments at the provincial level.

Capitation-based mechanisms are used for outpatient and inpatient care provided at CHS and district hospitals. Nearly 60 percent of all district hospitals have switched to capitation, to date. Extending capitation to all district hospitals is a key policy priority. SHI members must enroll either at a CHS or district hospital. The district hospitals are contracted by VSS. The capitation funds cover all costs incurred by the capitated district hospital and CHS, as well as referral costs at secondary and tertiary hospitals for members registered at the district hospital.

SHI members are divided into six specific groups, with a group-specific capitation rate calculated for each group for each of the 63 provinces using the following formula:

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4 The six groups are (a) civil servants and formal sector workers; (b) pensioners, meritorious people, beneficiaries of social security/protection allowances, and veterans; (c) the poor and near-poor; (d) children under six years of age; (e) school children and students; and (f) all remaining members including voluntary members.
\[ R_{ij} = \frac{\text{Exp}_{ij}}{N_{ij}} \times K \]

- \( R_{ij} \) is the capitation rate for group \( i \) in province \( j \).
- \( \text{Exp}_{ij} \) is the total health expenditure of group \( i \) in province \( j \) for the previous year.
- \( N_{ij} \) is the total number of group \( i \) in province \( j \) for the previous year.
- \( K \) is the annual adjustment coefficient to account for fluctuations in medical care costs, inflation, and changes in other related factors in the subsequent year.

The capitation fund is limited to 90 percent of the revenues collected from registered members. When there is a surplus in the capitation fund in any one year, district hospitals can use up to 20 percent at the hospital and return the remainder to the health care fund. When there is a deficit, the provincial social security office will reimburse at least 60 percent of the deficit or pass it on to VSS.

Fee-for-service is the payment method used for all secondary and tertiary hospitals and certain high-cost services that are excluded from capitation payment.

Expenditure caps are in place to control costs. For district hospitals with capitation-based payment, the capitation fund must not exceed 90 percent of the health care fund of the district hospital. The health care fund of the district hospital is 90 percent of the premium revenues collected from members registered at the district hospital; the remaining 10 percent goes into a reserve fund. For secondary and tertiary hospitals with fee-for-service remuneration, the cap is based on historical expenditures adjusted for inflation.\(^5\) In addition, there is a cap per episode on the maximum benefit that the SHI fund will cover, defined as 40 months of the minimum monthly salary (approximately US$35 in 2010) for high-tech and high-cost services.

**Impact on provider behavior**

Vietnam has taken critical steps to achieve and sustain universal coverage by introducing a closed-ended provider payment in the form of capitation. Few countries have achieved universal coverage and sustained it without moving away from or strictly controlling fee-for-service provider payment systems. Thus, the introduction of a capitation-based payment system for district hospital services is a step in the right direction.

The problem is that the design and implementation arrangements of the capitation system make it difficult to reap the potential benefits of capitation. Not only does it exacerbate the fragmentation and inequities in the system (as discussed in Section 2), it also weakens the district-level health system. The capitation system places district hospitals entirely at risk for the costs of referrals to the provincial level. Referral costs at secondary and tertiary hospitals for those registered at the district hospital are deducted from the capitation package of that district hospital. District hospitals therefore have few incentives to refer patients and carry out their gatekeeping functions effectively. Meanwhile, secondary and tertiary hospitals that are paid on a fee-for-service basis have little incentive to control costs, since the risk is borne by the district hospital.

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\(^5\) Cap for inpatient expenditures = average expenditure per admission last year \( \times 1.1 \times \) number of admission per month. Cap for outpatient specialist care = average expenditure per outpatient visit last year \( \times 1.1 \times \) number of visits per month.
The resource allocation mechanisms under SHI combined with the hospital autonomy policy have led to providers engaging in revenue-enhancing practices. Supply-side subsidies account for less than 30 percent of total hospital revenues (La Forgia 2012). The majority of central and provincial hospitals derive 70 to 90 percent of their revenues from sales of services reimbursed by SHI, from patients, or both. This creates strong incentives to generate demand by creating new services lines, investing in new medical equipment, and providing more intensive procedures. The Hospital Autonomy policy (Decree No. 43) allows hospitals to define service mix and mobilize resources. This has created an explicit link between hospital revenues and staff incomes and reinforced incentives to engage in revenue-enhancing practices.

Three examples of revenue-enhancing practices by staff are well known (La Forgia 2012). First, most hospitals operate profit-sharing schemes among staff, in accordance with Decree No. 43 regulations. These include the payment of performance-related bonus payments well in excess of the government salaries paid to staff. Second, the practice of “social mobilization” is used in most central and provincial hospitals whereby staff pool money to make the investment. Since revenues from the use of the equipment contribute to the profit-sharing schemes, staff face strong incentives to perform as many procedures as possible using the equipment. For instance, one provincial hospital possesses seven ultrasounds, each producing an average of 107 tests per day. Third, anecdotal evidence points to providers deriving benefits from the procurement of drugs, even though hospitals are not permitted to charge a margin on drug sales. Drug prices in Vietnam are higher than international reference prices (WHO 2012b), and prescription rates appear to be high (La Forgia 2012). Spending on drugs accounted for 70 percent of all VSS spending.

In short, hospital autonomy combined with the lack of effective control of fee-for-service mechanisms encourages hospitals to increase high-cost services. Balance billing, although not permitted, remains widespread. The payment system does not promote cost containment, and has put in place a set of perverse incentives that undermine efficient delivery of services, and contributes to rising out-of-pocket payments.

Targeting and Enrolment of Beneficiaries

The national system for identifying the poor managed by MOLISA and provincial DOLISAs is used to identify the poor under SHI, as well. The process for identifying poor households, which is conducted annually, involves reviewing preliminary lists of poor households using a nationally defined scoring table. This is conducted by a steering committing consisting of the village leader and representatives of social organizations. An economic survey is carried out of the households on the preliminary lists. Next, the poor households are discussed and voted on at a hamlet representatives’ meeting. The lists are then submitted to the District Internal Affairs and Labour Agency, DOLISA and, finally, MOLISA. There are no targets regarding the number of poor who must be covered in a particular year. “Poor” status must be recertified annually. However, there is a grace period of three years to ensure that the household successfully escapes from poverty before it is removed from this group.

Enrolment is mandatory and automatic for the poor under the SHI law. Every year, all households that are identified as poor are issued a health insurance card. The health insurance
card is sent by VSS to DOLISA and then to the district commune government, which distributes the cards to the poor households.

There are reports of fraud associated with identifying and issuing health insurance cards for target groups, but limited options exist for preventing this. In 2011, there were reports of abuse by health workers producing fake profiles of insurers. VSS cannot carry out inspections or take action against suspected fraud. The Law of Inspection only allows public agencies like ministries and the Provincial Health Bureau to carry out inspections, and not VSS. All departments of the People’s Committee are also allowed to do inspections. However, these organizations lack the resources to carry out inspections or to take action against fraudulent practices in SHI.

Management of the Benefits Package

In principle, all SHI members are entitled to the same benefits package. In reality, there are large inequalities in services provided to the poor compared to the nonpoor, as discussed in Section 3.

The SHI benefits package (Table 1) includes a broad range of services from ambulatory care to rehabilitation and advanced diagnostic and curative services. MOH established the package and plays a prominent role in revising the package, although VSS and service providers are also involved in the latter.

Table 1 SHI Benefits Package

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Details of Coverage</th>
<th>Copayment Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services</td>
<td>Birth delivery.</td>
<td>- 5% for pensioners, the poor, and members who receive a social protection allowance. 20% for all remaining groups if referred;</td>
</tr>
<tr>
<td></td>
<td>Emergency services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other inpatient hospitals services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital components (hotel services, nursing care, disposables, tests)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Physician service components</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pharmaceutical, MRI.</td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Public health services, excluding immunization if covered by National Targeted Program.</td>
<td>No copayment is charged for services provided at commune health stations (only outpatient), including child delivery services. In other levels, same to above.</td>
</tr>
<tr>
<td></td>
<td>Outpatient primary care contacts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient specialist contacts.</td>
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</tr>
<tr>
<td></td>
<td>Pharmaceuticals for outpatient services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical laboratory tests for outpatient services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic imaging for outpatient services – basic + MRI, CT Scan, etc.</td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>Dental care – basic.</td>
<td>- 5% for pensioners, the poor, and members who receive a social protection allowance. 20% for all remaining groups.</td>
</tr>
<tr>
<td></td>
<td>Mental health/behavior.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dialysis or transplants.</td>
<td></td>
</tr>
</tbody>
</table>

Note: The copayment ceiling is defined as 40 months of the minimum monthly salary for high-tech and high-cost services.

The definition of the benefits package is not based on cost-effectiveness, affordability, or any technical criteria. In recent years, the benefits package has been expanded to meet the
requirements of suppliers who have invested in advanced technology. The benefits package has also been expanded to keep pace with a fast-growing pharmaceutical market. SHI fund deficits during 2006–09 (caused by benefits package expansion and cancelation of copayment) did not lead to any revision of the benefits package based on cost-effectiveness criteria. Instead, it resulted in the reintroduction of copayments, this time without any ceiling. To date, there has never been an effort to estimate the actual cost of the benefits package.

Charging significantly higher copayment rates for self-referrals is the primary means of utilization management under SHI. For insured patients who bypass lower-level referral facilities, the copayments are 30 percent at district hospitals, 50 percent at provincial hospitals, and 70 percent at central and tertiary hospitals. In practice, this has proven to be an ineffective means of utilization management, because the higher copayment rates do not deter users from self-referring to the provincial level. Overcrowding at the provincial and tertiary levels is one of the major constraints to making insurance coverage effective.

The Information Environment under SHI

The information environment under SHI is weak, with little strategic or systematic use made of what data are collected. Data are collected manually and transferred from Provincial Social Security offices to VSS on a quarterly basis. These include data on utilization by beneficiary and provider, and payments and accounting information. Information on expenditures and utilization are not made publicly available by VSS and are difficult to access even for other government agencies. The MOH also collects data on infrastructure, and processes measures of quality such as infection rates, readmission rates, and health outcomes. However, these data are not used in a systematic manner to assess SHI and provider performance. Instead, simple administrative and financial data are used for making budget adjustments from year to year. There are no real incentives for providers to focus on improving health outcomes, with the possible exception of the vertical National Health Targeted Programs.

The National Assembly Committee for Social Affairs is responsible for supervision of health insurance and health care issues. This committee conducts annual supervision visits to provinces and requires reports from the MOH and VSS. In recent years, the Committee has focused its supervision on the implementation of the SHI law, population coverage, and access to and quality of health care.

3. Impediments to the Integration of the Poor Into Universal Coverage

Vietnam has been successful in enrolling almost all of the poor into SHI, but this has not translated into effective coverage of the poor. This section provides three explanations why the goal of integrating the poor into universal coverage remains unattainable.

Fragmentation of Pooling Undermines Equity

In principle, Vietnam’s SHI program involves a single payer and a single pool with a unified benefits package. The Law on Health Insurance in 2008 was an important step on the path to universal coverage for Vietnam. It integrated the existing health insurance program with the program for the poor, thus bringing together all groups into one program. This put Vietnam
ahead of several other countries in the region such as China and Indonesia, whose SHI schemes involve multiple payers.

In practice, Vietnam’s SHI program is characterized by a high degree of fragmentation of pooling and revenues, which is exacerbated by the capitation-based payment mechanism. The genesis of this fragmented system can be traced back to the early stages of SHI development, when the different SHI groups (the poor, pensioners, the formal sector, etc.) had separate sources of financing. Despite the Law on Health Insurance and the decision to integrate the different groups of insured into one program, there continues to be an unwillingness to pool revenues across insured groups. The capitation-based payment system that evolved in this context sets capitation rates differently for the different groups of insured in each province (as described in Section 1), and exacerbates the fragmentation of pooling and revenues.

The high degree of fragmentation of pooling and revenues has three implications for pooling and equity.

First, it leads to limited pooling of risks between the rich and poor. The capitation rates are based on historic expenditures and utilization patterns, which are driven largely by financial and geographic barriers to access faced by the different groups, and already high levels of fragmentation in pooling and revenues. They do not reflect the actual need for health care because the groupings do not reflect homogenous health risks within any particular group (Tran Van Tien et al. 2011). Groups such as the poor and near-poor tend to have lower expenditures compared to other groups. They face greater barriers to access and therefore have lower utilization relative to need. Figure 5 shows average capitation rates by region for the six groups. In 2010–11, the annual premium for subsidized members was about VND 380,000, or 4.5 percent of the minimum salary, denoted by the red line in Figure 5. It is clear that school children and students as well as the poor receive a capitation rate that is significantly below the contribution rate. In effect, the poor are subsidizing better-off groups such as formal sector workers and pensioners.

Second, it leads to limited pooling of risks and revenues across provinces. The size of the capitation fund varies by the composition of the enrollees by type of group, geographic barriers to accessing services, and the technical capacity of hospitals to deliver services. Provinces with a larger share of poor or minority groups that have lower utilization rates and poor-quality hospitals tend to have lower per capita expenditures than better-off provinces. Since the surplus of one province can be used to pay for the deficits of another, poorer provinces end up subsidizing richer provinces.

Third, it results in underprovision of services to the poor and other vulnerable groups. Given large differences in the capitation rates, provinces actually maintain subpools for each of the six groups and transfer the subpool ceilings to district hospitals (Tran Van Tien et al. 2011). District hospitals then limit services to within the available budget for each group. For instance, health facilities with a relatively large share of people receiving subsidies for the poor are more likely to underprovide services due to the relatively lower value of the capitation rate for that group. Combined with existing inequalities in utilization and expenditures (discussed below), this pattern of underproviding for the poor worsens the fragmentation of pooling.
Thus, the benefits package is uniform across membership groups only in principle. In reality, large variations in capitation rates across membership groups and across provinces implicitly allow for differences in how much of the benefits package members can really access and what types of services they have access to.

**Figure 5 Average Capitation Rates (VND) by Region, 2011**

![Figure 5](image)


*Note:* Red line shows the annual premium for subsidized members of VND 380,000 (4.5 percent of the minimum salary).

**Out-of-pocket Payments are High and Persistent**

Coverage in terms of enrolment has not led to lower OOP payments and improved financial protection (Figure 1). For the poor, who have limited disposable income, savings, or assets, OOP payments are potentially impoverishing. Figure 6 shows that the share of households experiencing catastrophic OOP payments (over 40 percent of the monthly budget) in the poorest two quintiles has changed little over time. The same is true of the probability of OOP-related impoverishment for the poorest quintile, although not for the second-poorest quintile (Hoang et al. 2012).
Figure 6 Share of Poor Households Experiencing Catastrophic Impact and Impoverishment among the Poor

Source: Hoang et al. 2012

Note: Catastrophic impact is defined as OOP payments exceeding 40 percent of monthly household expenditures. Impoverishment is defined as the likelihood of a household’s monthly expenditures falling below the poverty line once OOP payments are included.

The persistence of high OOP payments is clearly an impediment to integrating the poor into universal coverage, because it means that entitlements are linked to ability to pay under SHI. It raises questions about SHI’s ability to provide financial protection, a key goal of universal coverage. Empirical evaluations carried out during the course of SHI’s evolution have produced mixed results with regard to the impact of insurance on utilization and OOP payments. Some studies (Wagstaff 2007) found that free health care for the poor had a positive impact on utilization but no significant impact on OOP payments, while others (Bales et al. 2007; Wagstaff 2009) found that the same program reduced OOP payments significantly but had no impact on utilization. There are no evaluations yet of the post-2008 expansion of SHI coverage.

The inability to control OOP payments is linked to the broader issues of cost containment and poor governance under SHI. As described in Section 2, fee-for-service payment, hospitals’ heavy reliance on own income, and hospital autonomy have combined to create strong incentives for hospitals, particularly secondary and tertiary hospitals, to oversupply services. VSS is a passive purchaser of services and has no effective volume or price controls. Revenue-enhancing practices by providers drive up costs, and therefore OOP payments. VSS reimburses according to the fee schedule, while household OOP payments pick up the rest. In addition, while balance billing is not allowed under SHI, there is anecdotal evidence that hospitals may be charging patients for “better quality” technical services, pharmaceuticals, and supplies that are not part of the official price list and package. Finally, informal payments to individual doctors and nurses are reported to be quite common at higher-level hospitals (Tran Tuan et al. 2011).

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6 For instance, under a recent World Bank project that financed a health insurance package of services, the difference between the cost of the package and what health insurance actually financed was attributed to balance billing for extras such as more up-to-date surgical thread and pharmaceuticals that are not included in the VSS lists (Hurt 2012).
Public Subsidies do not Reach the Poor

Public subsidies for health, in the form of direct supply-side subsidies to health facilities or demand-side subsidies through insurance mechanisms, have a potentially redistributionary role to play in any health system. They are instruments for broader poverty alleviation and redistribution policy when redistribution through other mechanisms is impeded by information and administrative constraints (Besley and Coate 1991). However, the extent to which public health subsidies contribute to redistribution depends on the distribution of their benefits.

While the distribution of public subsidies for hospital services remains prorich, a recent benefit incidence analysis indicates that it became less prorich during 2006–10 (Figure 7). The distribution of nonhospital subsidies has been propoor throughout. A negative concentration index indicates the distribution is propoor and vice versa. Income inequality, as measured by the Gini coefficient, changed little during this period, and if anything, increased slightly in 2010 (Figure 7). Given this, it can be argued that public subsidies for health are redistributionary because nonhospital subsidies are propoor, and hospital subsidies have become less prorich. Both direct supply-side subsidies to health facilities and demand-side subsidies through SHI were included in the analysis. Interestingly, including the demand-side subsidies improved the distribution of the hospital subsidies compared with supply-side subsidies alone (Figure 8).

**Figure 7 Concentration Indexes for Total Health Subsidies, 2006–10**

![Figure 7 Concentration Indexes for Total Health Subsidies, 2006–10](image)

*Source: Tran Thi Mai Oanh and Bales et al. 2012.*
Public hospital subsidies fail to reach the poor because a disproportionately large share is allocated to secondary and tertiary hospitals, which the poor have limited access to. The expansion of insurance coverage and increased use of public hospitals by the poor has led to a slight improvement in the distribution of public subsidies in favor of the poor. Nevertheless, the fact that the distribution of nonhospital services—largely CHS—is propoor, while that of hospital services is prorich, suggests that access by the poor is a key underlying factor. Interviews with patients and staff suggest that people have little confidence in the quality of lower-level facilities (La Forgia 2012). CHSs, which are the first point of contact in the health system for much of the rural population, are poorly resourced and consequently viewed as poor quality. District hospitals provide a broader range of services than CHS but are still perceived as being of worse quality than higher-level facilities. Bypassing the lower level involves a significantly higher copayment, which imposes financial barriers to access. Again, this is to the detriment of the poor, because it means that access to services is linked to ability to pay. The Annex provides more details about the primary care system and referral mechanisms.

The underresourcing and lack of confidence in lower-level facilities is also linked to the resource allocation and payment methods described in Section 2. A joint report by the Ministry of Health, World Bank, and Health Strategy and Policy Institute (2011) found that higher-level hospitals have been taking staff from lower-level facilities. Physicians are moving from less profitable lower-level facilities to more profitable higher-level facilities that use high-tech equipment. VSS rules, which restrict the volume and doses for drugs that are reimbursed at lower-level facilities, also contribute to the perception that lower-level facilities provide worse-quality services. For instance, while tertiary hospitals can prescribe 100 percent of the SHI drug list, district hospitals can dispense only 69 percent and CHSs only 33 percent. CHS-based prescriptions cannot exceed VND 10,000 per visit with doses of a maximum of three days, while central hospitals are reimbursed up to VND 50,000 per visit and are permitted to prescribe doses up to seven days (La Forgia 2012).
This case study has highlighted that, while there are several features of Vietnam’s SHI system that are considered good practice based on international experience, Vietnam has failed to reap the potential benefits of these because of design or implementation flaws. This is particularly so with regard to efforts to integrate the poor into SHI. Table 2 provides a summary of the potential good practices that have been stymied by design and implementation flaws.

### Table 2 Potential Good Practices in Vietnam’s SHI and Challenges to Implementation

<table>
<thead>
<tr>
<th>Potential Good Practice</th>
<th>Challenge in Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam has integrated its program for the poor into the national social health insurance program and premiums for the poor fully subsidized with general revenues.</td>
<td>• It has been difficult to achieve cross-subsidization, so the poor still have lower-resourced pool.</td>
</tr>
<tr>
<td>Vietnam’s insurance system has a single payer.</td>
<td>• The purchasing function remains weak and the potential strategic power has not been exploited.</td>
</tr>
<tr>
<td></td>
<td>• A significant share of funding still comes through supply-side subsidies, fragmenting the purchasing function.</td>
</tr>
<tr>
<td>Vietnam is moving away from fee-for-service payment in its insurance system and introducing closed-ended payment through capitation and other caps.</td>
<td>• The capitation payment system helps with cost control for VSS. It does not bring most of the potential benefits and incentives.</td>
</tr>
<tr>
<td></td>
<td>• Most risk transferred to district hospitals.</td>
</tr>
<tr>
<td></td>
<td>• Fragmentation of pools translated to fragmentation in provider payment.</td>
</tr>
<tr>
<td>Copayment policy to manage utilization with exemptions and lower rates for the poor.</td>
<td>• The copayment rates for bypassing do not appear to have much disincentive to bypass primary care providers.</td>
</tr>
<tr>
<td></td>
<td>• Copayments for inpatient services may be an access barrier for the poor.</td>
</tr>
<tr>
<td>Balanced billing is not permitted.</td>
<td>• Balanced billing remains widespread, and hospital autonomy encourages hospitals to increase high-cost services, so out-of-pocket payments remain high.</td>
</tr>
</tbody>
</table>

*Sources: Cashin 2013; peer reviewer comments.*

### 4. Pending Agenda

This case study has identified two major areas of reform that need to be tackled effectively if Vietnam’s SHI is to provide effective coverage for the poor and make substantial progress toward achieving universal coverage.

*The capitation payment method needs to be revised to avoid fragmentation of risk pools.* The most important revision to the capitation payment system is not to base it on actual costs of service delivery. The most important changes are (a) to equalize the per capita rate as a way to overcome fragmentation in pooling across insured groups and adjust it according to health need rather than revenues of the group, and (b) no longer hold district hospitals at risk for provincial referrals in order to prevent weakening of the district-level health system relied on by the poor. It is probably not reasonable to expect dramatic, overnight improvements in revenue allocation and pooling. Differences among population groups and areas will need to be reduced gradually over time.

*Stronger efforts are needed to stem the continued growth of OOP payments.* Fee-for-service, combined with the existing resource allocation methods, hospital autonomy, and weak
governance is contributing to rapid cost escalation. Pilots of case-based payment methods are underway. However, it is important to recognize that unless steps are taken to strengthen SHI governance, through measures to effectively control balance billing, for instance, growth of OOP payments will continue to be a problem with or without fee-for-service. Strengthening the purchasing capacity of VSS and enabling it to become a more strategic purchaser are especially critical for improving SHI governance.
Annex 1 Background to the Case Study

The Economic Context

Vietnam is one of the fastest growing economies in the East Asia and Pacific region. Since 1989, the country has experienced rapid development associated with an economic and social reform program known as Doi Moi, characterized by a shift from a centrally planned economy to a market economy. The country has made good progress in improving economic conditions, educational levels, and the health status of the population, marked by significant improvements in people’s livelihoods in both urban and rural areas. The number of poor households (income insufficient to provide meals of 2,100 calories per person per day) fell from 58 percent in 1993 to 22 percent in 2005. Gross domestic product was US$1,064 per capita in 2009 (World Bank 2011), which moved Vietnam from low-income-country to lower-middle-income-country status.

Vietnam is also one of the most populous countries in the East Asia and Pacific region, with a population of 85.8 million in 2009 (Central Population and Housing Census Steering Committee 2010) and a population density of 230 people per square kilometer. The most densely populated areas of the country are the Mekong Delta Region and the Red River Delta Region. Despite growing urbanization, the majority of the population (about 69 percent) still depend on agriculture. Vietnam is witnessing a gradual transition of its labor force from agriculture to industry and services.

Economic development has led to large improvements in health outcomes and access to health care, although large disparities exist between the rich and the poor, and the poorer and better-off regions of the country. Infant mortality rates declined from 30 per 100,000 live births to 16 per 100,000 live births, and under-five mortality rates declined from 42 per 100,000 live births to 25 per 100,000 live births between 2001 and 2009. Life expectancy at birth was 70 for males and 76 for females in 2009 (World Bank 2011).

The Public Health System

The public health system in Vietnam is organized into three levels. At the central level, the Ministry of Health (MOH) formulates and executes health policy, and directly controls and finances research institutions, general and specialized hospitals, and vertical National Health Targeted Programs. At the provincial level, there are 63 provincial health bureaus, which follow MOH policies and are part of local provincial governments under the Provincial People’s Committees. The provincial health bureaus manage the provincial hospitals and Centers for Preventive Medicine,7 while the Provincial People’s Committees control their administration and financial aspects. At the primary care level, there are CHS and village health workers and district hospitals.

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7 Centers for Preventive Medicine are responsible for disease surveillance activities at the provincial level.
Primary Care and Referrals

The CHSs are the first point of contact for much of the population, especially in rural areas, but do not provide many of the services they are designated to provide. There are more than 10,000 CHSs in the country, one for each commune, covering about 10,000 people. Recent studies have found that many services such as malnutrition programs, child health exams, and diagnosis and treatment of noncommunicable diseases, which should be delivered at the CHS level, are not actually provided (Duong et al. 2010). Possible reasons for this include lack of personnel, since 35 percent of CHSs do not have doctors; limited drug availability; and poor-quality equipment. CHS health workers also have limited access to continuing medical education, which impacts quality of services provided.

Primary care is also provided by intercommune clinics, district hospitals, and polyclinics at the district level, all of which admit inpatients and provide emergency services and basic treatment for common illnesses. District hospitals have 80 beds, on average, but are characterized by large variations in technical sophistication and quality of services provided.

Poor quality at the lower levels worsens inequalities in access to services. A survey in 13 provinces in the Mekong region showed that 61.3 percent of patients in the poorest quintile selected CHSs compared to only 35.5 percent among the richest quintile (Center for Community and Research Development 2012).

According to the referral guidelines set out in a 2009 MOH Circular,8 insured members can only use health services from the CHS or district hospital where they are registered, and must be referred to secondary or tertiary hospitals. Insured patients who bypass lower-level referral facilities must pay a higher copayment rate, depending on the level at which they access health care: 30 percent at district hospitals, 50 percent at provincial hospitals, and 70 percent central and tertiary hospitals.

In practice, the referral mechanisms remain ineffective because of relatively poor quality at the primary-level facilities. The insured prefer to bypass the lower-level facilities despite the significantly higher copayment that this involves. A 2011 study (Le Quang et al. 2011) showed that of those surveyed, only 40 percent of patients at general hospitals and 7 percent of patients at specialized hospitals had been treated at those hospitals; the rest could have been treated at lower-level hospitals. Similarly, 40 percent of patients surveyed at provincial hospitals could have been treated at the district level, and 11 percent could have been treated at the commune levels. At the Central Obstetrics and Gynecology Hospitals, 34 percent of patients came for normal prenatal checkups and minor diseases, and 60 percent of admissions were for normal delivery. At the provincial level, normal deliveries accounted for more than 50 percent of admissions, although district- and commune-level facilities are able to perform normal deliveries.

8 Circular No. 10/2009/TT/BYT guiding the registration of the first point of care for insured patients and referral mechanisms
Supply-side Infrastructure

There are large differences across the country in the numbers of beds per capita across regions. The North Central and Central Highlands regions have far fewer beds per capita, and in particular fewer provincial beds than other regions. The rural/urban population ratio is highly positively correlated with the district/provincial bed ratio, implying that the more rural the province, the greater the reliance on district hospitals.

In recent years, the government has made significant investments in improving the public health infrastructure, with some emphasis on primary care. Since 2008, the government has used the sale of government bonds to finance upgrading of CHS and district hospitals.\(^9\) In addition, in 2008, a project for upgrading district hospitals received VND 3,750 billion (US$202 million) and a project upgrading general hospitals received VND 3,000 billion (US$162 million). In 2009, VND 500 billion (US$26.9 million) from government bonds was allocated for building and upgrading specialist provincial hospitals and general hospitals in disadvantaged provinces.

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\(^9\) Decision No. 47/2008/QĐTtg from the Prime Minister approved project investment for building and upgrading health facilities using government bonds from 2008 to 2010.
I. Outcomes comparisons: Vietnam and Lower Middle Income Countries

Note on interpretation:
In this plot ‘higher’ is ‘worse’ – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR</td>
<td>18.8</td>
<td>50.3</td>
<td>-62.4%</td>
</tr>
<tr>
<td>U5MR</td>
<td>23.3</td>
<td>69.4</td>
<td>-66.2%</td>
</tr>
<tr>
<td>Stunting</td>
<td>38.5</td>
<td>28.2</td>
<td>35.2%</td>
</tr>
<tr>
<td>MMR</td>
<td>9.9</td>
<td>160.0</td>
<td>-94.1%</td>
</tr>
<tr>
<td>Adult Mortality</td>
<td>73.8</td>
<td>164.1</td>
<td>-54.0%</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>71.8</td>
<td>134.5</td>
<td>-46.6%</td>
</tr>
<tr>
<td>Neonatal Mortality</td>
<td>12.0</td>
<td>29.7</td>
<td>-58.8%</td>
</tr>
<tr>
<td>CD mortality</td>
<td>25.0</td>
<td>47.0</td>
<td>-48.0%</td>
</tr>
</tbody>
</table>


II. Inputs comparisons: Vietnam and Lower Middle Income Countries

Note on interpretation:
This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inputs comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2005 USD)</td>
<td>393.8</td>
<td>592.4</td>
<td>-33.1%</td>
</tr>
<tr>
<td>THE as % of GDP</td>
<td>6.0</td>
<td>4.2</td>
<td>40.7%</td>
</tr>
<tr>
<td>Hosp. bed density</td>
<td>3.1</td>
<td>1.4</td>
<td>121.9%</td>
</tr>
<tr>
<td>Physician density</td>
<td>1.2</td>
<td>0.8</td>
<td>57.1%</td>
</tr>
<tr>
<td>Nurse/Midwife density</td>
<td>1.0</td>
<td>1.5</td>
<td>50.0%</td>
</tr>
<tr>
<td>GHE STHE</td>
<td>55.8</td>
<td>40.2</td>
<td>38.8%</td>
</tr>
</tbody>
</table>

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hosp. bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/Midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank’s World Development Indicators.
III. Coverage comparisons
Vietnam and Lower Middle Income Countries

Note on interpretation:
In this plot ‘higher’ is ‘better’ – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes coverage comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2005 USD)</td>
<td>395.8</td>
<td>592.4</td>
<td>-31.2%</td>
</tr>
<tr>
<td>DPT immunization</td>
<td>93.0</td>
<td>78.7</td>
<td>18.1%</td>
</tr>
<tr>
<td>Prenatal services</td>
<td>96.8</td>
<td>76.1</td>
<td>21.2%</td>
</tr>
<tr>
<td>Contraceptive</td>
<td>79.5</td>
<td>54.1</td>
<td>35.4%</td>
</tr>
<tr>
<td>Skilled birth</td>
<td>97.7</td>
<td>96.9</td>
<td>0.8%</td>
</tr>
<tr>
<td>Sanitation</td>
<td>76.0</td>
<td>47.0</td>
<td>61.2%</td>
</tr>
<tr>
<td>TB success</td>
<td>92.0</td>
<td>88.0</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank’s World Development Indicators.

IV. Infrastructure comparisons
Vietnam and Lower Middle Income Countries

Note on interpretation:
In this plot ‘higher’ is ‘better’ – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2005 USD)</td>
<td>395.8</td>
<td>592.4</td>
<td>-31.2%</td>
</tr>
<tr>
<td>Paved roads</td>
<td>47.6</td>
<td>49.5</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Mobile phones</td>
<td>143.4</td>
<td>79.3</td>
<td>60.9%</td>
</tr>
<tr>
<td>Internet</td>
<td>35.5</td>
<td>16.0</td>
<td>121.0%</td>
</tr>
<tr>
<td>Water</td>
<td>95.0</td>
<td>87.3</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank’s World Development Indicators.
V. Demography comparisons
Vietnam and Lower Middle Income Countries

Note on interpretation:
Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2000 USD)</td>
<td>395.8</td>
<td>592.4</td>
<td>-31.3%</td>
</tr>
<tr>
<td>TFR</td>
<td>1.8</td>
<td>2.9</td>
<td>-33.9%</td>
</tr>
<tr>
<td>Dependency (Total)</td>
<td>42.6</td>
<td>58.6</td>
<td>-33.5%</td>
</tr>
<tr>
<td>Youth share</td>
<td>79.8</td>
<td>86.7</td>
<td>-8.0%</td>
</tr>
<tr>
<td>Rural pop.</td>
<td>71.2</td>
<td>60.6</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank’s World Development Indicators.

VI. Inequality comparisons
Vietnam and Lower Middle Income Countries

Note on interpretation:
In this plot “higher” is “inequal” and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).

<table>
<thead>
<tr>
<th>Country Data</th>
<th>Vietnam</th>
<th>LMIC</th>
<th>% Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI pc (2000 USD)</td>
<td>395.8</td>
<td>592.4</td>
<td>-31.3%</td>
</tr>
<tr>
<td>IMR Q1/Q5</td>
<td>2.8</td>
<td>2.0</td>
<td>42.1%</td>
</tr>
<tr>
<td>U5MR Q1/Q5</td>
<td>3.3</td>
<td>2.6</td>
<td>28.8%</td>
</tr>
<tr>
<td>Stunting Q1/Q5</td>
<td>NA</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>ARI Q1/Q5</td>
<td>1.3</td>
<td>1.3</td>
<td>0.4%</td>
</tr>
<tr>
<td>Diarrhea Q1/Q5</td>
<td>2.1</td>
<td>1.5</td>
<td>41.7%</td>
</tr>
</tbody>
</table>

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (http://data.worldbank.org/data-catalog/HNPquintile).
References


Hurt, K. 2012. Personal communication with authors. Hanoi, June.


The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.