Vietnam

Making Provider Payment Mechanisms More Strategic: Removing the Roadblocks to Implementation

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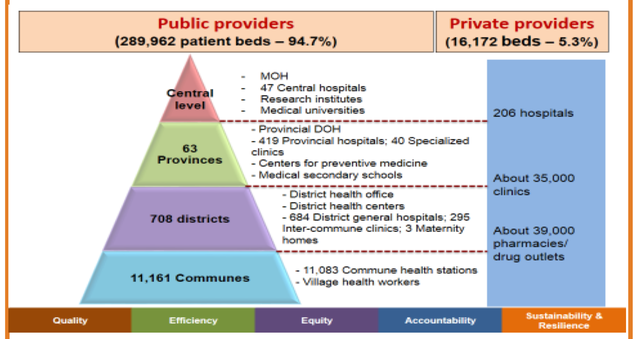
Context:

Population	93M (2016)
GDP/ Capita	$2,110.90 (USD)
THE/ Capita	$117 (USD) *Share of gov't spending in THE: 42%*

Organization of the Health System

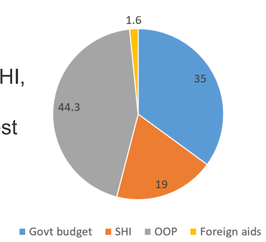


Mixed public-private system: public providers play a key role in prevention, surveillance, research and training

- Network of health facilities widely distributed and easy to access

Revenues come from 3 main sources: government budget, SHI, and household OOP payments

- OOP accounts for the largest share
- ODA and private spending from other sources (e.g. private enterprise health clinics, NGOs, etc.) also provide funding for health, but account for only a small part of total health expenditure.

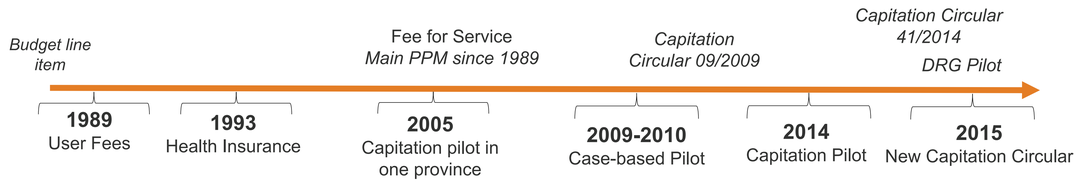


Monitoring

IT System set up from district level to central level at all providers in the system

- Common platforms to collect and transfer data and information for reporting and analyzing
- MOH will establish a PPM Calculation Center. The Center has responsible for data collection, analysis and report and the Center will also monitor PPMs in the system

Provider Payment Mechanisms



PPMs	Successes	Challenges
Capitation	- Control of cost - Increase in efficient use of financial sources by health care providers - Disincentivizes unnecessary referrals - Simple procedures	- Capitation not based on actual cost nor adjusted by health risk yet - Not fair in calculating capitation fund - Hospitals bear high risk of overspending due to costs of referral - Lack of mechanism for monitoring quality of care and out-of-pocket payments for insured patients
DRGs	- Started piloting in one province in 2017	Not evaluated yet

Grassroots Healthcare Level

- Includes commune and district level
- Functions of district health center/hospital: to deliver preventive, curative, rehabilitative care
- Function of commune health station: deliver PHC for people in the commune (preventive care, curative care, reproductive care, supply of essential medicines, management of community health, IEC on health)

Financing Grassroots healthcare:

- Government budget: salary, operational costs, budget per capita
- National target programs: activity-based budget by specific programs
- SHI reimbursement for curative care only: examination fees and medicine (in kind through District Hospital)
- Direct payment from patients not having health insurance

Innovations

Objectives

- Reform health financing due to current global budget deficit resulting from usage of services in inefficient ways
- Strengthen healthcare system at grassroots level
- Implement strategic purchasing of health services to improve quality, efficiency and equity of health system

Lessons Learned

Positives:

- ✓ Leadership support from central government, ministries and providers.
- ✓ Infrastructure must be ready, including IT system, software
- ✓ Human resources: organization, training
- ✓ Financial issues: investment and provide specific financial mechanism for PPM reform

Challenges:

- ✓ Cost escalation
- ✓ Inefficiency in healthcare
- ✓ Limited resources: human, finance and poor infrastructures and quality control
- ✓ Fragmentation in healthcare delivery and health financing
- ✓ Inequitable allocation of SHI fund

Challenges for Achieving UHC

Slow Expansion of Coverage for the Rest

- Low compliance in the formal sector (50%), especially in private enterprises, attributed to inadequate enforcement and lack of effective enforcement measures
- Low coverage of the informal sector due to limited capacity of individuals to pay premiums.
- Household coverage replaced individual coverage in 2015 in an effort to increase coverage of voluntary SHI among the informal sector. However, it has led to declines in coverage in this group as those who previously had contributed to voluntary SHI are unwilling to pay for their whole household to be covered and are no longer eligible for individual coverage.

Financial Protection

- Enrollees still pay OOP for some health services in state facilities (co-insurance payments, items not covered in the health insurance package and informal payments), especially at higher level facilities resulting in continued high incidence of catastrophic payments and impoverishment due to health spending

Health Service Coverage

- Preventive services continue to be expanded and are fully subsidized by the state budget but there is little coordination or integration of preventive and curative care service provision
- Basic curative services have been upgraded to improve healthcare service delivery capacity, but in many disadvantaged localities facilities or staff are still unable to meet basic medical needs.
- Secondary and tertiary hospitals remain overcrowded
- Continuity of care between levels and between facilities remains weak
- Selection of healthcare interventions and pharmaceuticals to be covered by health insurance is not based on cost effectiveness criteria.

Next Steps

- In 2018, MOH will issue a circular on capitation and apply in 5 provinces selected and then expand to whole country in 2020 if the model is successful.

- In 2018, MOH also carries out a pilot on DRG in 1 province; expand to 5 provinces in 2019 and whole country in 2020. In this period, a circular on DRG is also developed and issued.

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