Basic Information Survey for BHSP and Provider Payment Mechanism in Viet Nam

Final Report

February 2017

Japan International Cooperation Agency
(JICA)

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Glossary

Abbreviations/ Terms	Description
ADB	Asian Development Bank
ASEAN	Association of Southeast Asian Nations
BHSP	Basic Health Service Package reimbursed by the Health Insurance
BHSP Roadmap	The Roadmap to Develop and Implement the Basic Health Service Package (BHSP) reimbursed by the Health Insurance in Viet Nam
Benefit Package	A description of the healthcare services and supplies to be covered by health insurance fund
CHS	Commune Health Station
CIO	Chief Information Officer
CPI	Consumer Price Index
CSMBS	Civil Servant Medical Benefit Scheme
Capitation	A method of reimbursement in which payment is made to a healthcare provider on a per-patient rather than a per-service basis.
Claim	A bill for medical services rendered, typically submitted to the insurance company by a healthcare provider.
Cost Sharing	The share of costs covered by insurance that individuals pay out of their own pocket. This term generally includes deductibles, co-insurance, and co-payments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
DF/R	Draft Final Report
DHIS	District Health Information Software
DHS	Demographic and Health Survey
DOH	Department of Health (provincial and district levels)
DOHA	Direction Office for Healthcare Activities
DPC	Diagnosis Procedure Combination
DPF	Department of Planning and Finance, MOH
DRG	Diagnosis Related Group
DSS	District Social Security
EMR	Electronic medical records
EU	European Union
EUR	Euro
F/R	Final Report
GDP	Gross Domestic Products
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit (Germany)
GSO	General Statistics Office
HDI	Human Development Index
HEMA	Health Care Support to the Poor of the Northern Uplands and Central Highlands Project (EU)
HFG	Health Finance and Governance Project
HID	Health Insurance Department, MOH
HIS	Hospital Information System
HL7	Hospital Level 7
HMIS	Health Management Information System
HMU	Hanoi Medical University
HPG	Health Partnership Group
HRH	Human Resource for Health
HSPI	Health Strategy and Policy Institute
IC/R	Inception Report
ICD-10	International Classification of Disease, 10th Edition
ICD-9-CM	International Classification of Disease, 9th Edition, Clinical Modification
ICHI	International Classification of Health Interventions
ICT	Information and Communication Technology

Abbreviations/ Terms	Description
ID	Identification
ILO	International Labour Organization
IPPM	Institute of Public Policy and Management
ISSA	International Social Security Association
IT	Information Technology
IT/R	Interim Report
JAHR	Joint Annual Health Review
JICA	Japan International Cooperation Agency
JKN	National Health Insurance of Indonesia
KENPOREN	National Federation of Health Insurance Societies
KKR	Federation of National Public Personnel Mutual Aid Associations of Japan
KOICA	Korea International Cooperation Agency
KPI	Key Performance Indicators
KRI	KRI International Corp.
KfW	Kreditanstalt für Wiederaufbau
LIS	Laboratory Information System
LuxDev	Lux-Development S.A. (Luxemburg)
MCH	Maternal and Child Health
MHWL	Ministry of Health, Welfare, and Labour of Japan
MOF	Ministry of Finance
MOH	Ministry of Health of Viet Nam
MOLISA	Ministry of Labour, Invalids and Social Affairs of Viet Nam
MOPH	Ministry of Public Health, Thailand
MPI	Ministry of Planning and Investment
MSA	Medical Service Administration
M&E	Monitoring and Evaluation
NCD	Non-communicable Disease
NACHIP	National Advisory Council for Health Insurance Policy
NEU	National Economics University
NGO	Non-governmental Organization
NHA	National Health Account
NHS	National Health Service
NHSO	National Health Security Office
NI	National Insurance: a health insurance scheme for the informal sector in Japan
NIHE	National Institute of Hygiene and Epidemiology
OOP	Out-of-pocket (expenditure): any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.
P/R	Progress Report
PC	People’s Committee
PHC	Primary Health Care
PPP	Public-Private Partnership
PSS	Provincial Social Security
PhilHealth	Philippine Health Insurance Corporation
Premium	The amount that must be paid for health insurance or plan. Employees and/or employers usually pay it monthly, quarterly, or yearly.
Review	Review of health insurance to examine claims submitted by the health service providers
SEDS	Socio-economic Development Strategy
SHI	Social Health Insurance
SHS	Second-hand smoke
SME	Small and medium-sized enterprise
SMS	Social Security Management System

Abbreviations/ Terms	Description
SS	Social Security
SSO	Social Security Office of Thailand
SSS	Social Security Service: a health insurance scheme for formal professional sector in Thailand
Social Security Institution	VSS, PSS and/or DSS
Survey	The Survey on Health Insurance System in Viet Nam
Survey Team	A team formed by KRI for the Survey on Health Insurance System in Viet Nam
TOR	Terms of Reference
TWG	Technical working group
Total Health Expenditure	The sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation
UC	Universal Coverage: a health insurance scheme for the informal sector in Thailand
UHC	Universal Health Coverage
UHI Roadmap	The Roadmap towards Universal Health Insurance for 2012 and 2020
UHS	Universal Health System, Thailand
UK	United Kingdom
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USD	U.S. Dollar
VAAC	Vietnam Administration of AIDS Control
VASS	Vietnam Academy of Social Science
VGCL	Viet Nam General Confederation of Labour
VHW	Village heath worker
VND	Vietnamese Dong
VNPT	Vietnam Post and Telecommunication Group
VSS	Viet Nam Social Security
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

Executive Summary

This report provides basic information and situation analysis on universal health coverage (UHC) in Viet Nam focusing on the health insurance system. The Basic Information Survey for Basic Health Service Package (BHSP) and Provider Payment Mechanism (the Survey) was conducted from November 2015 to February 2017 by literature study, key informant interviews, discussions with stakeholders, and field observation. The Survey covered situation analysis including overview of UHC in Viet Nam, overview of health insurance system and its implementation, information technology (IT) system for health insurance, relevant health information management system to health insurance, and relevant external cooperation. Also, the health insurance system in Japan and some countries are summarized to provide reference for future development or improvement of the health insurance system in Viet Nam. Based on the above situation analysis and reference information, conclusion and recommendations are described.

Situation Analysis (from Chapters 2 to 7 and Section 9.1)

Although health insurance coverage was more than 80%, out-of-pocket (OOP) expenditure accounted around 40% of the total expenditure. Regarding the health insurance coverage, aiming to achieve 90%, the Government of Viet Nam has been taking actions to promote subscription of health insurance such as household enrollment and subsidization of premium for the vulnerable population (the poor, the near poor, etc.). To allocate more budgets to such subsidization, medical fee schedule to be covered by health insurance has been raised to cover more cost items of medical services and the budget allocation to the hospitals will be declined accordingly. At the same time, to ensure sustainability of health insurance fund, reviewing of the benefit package based on evidences has been discussed, and development of the BHSP has been implemented according to the roadmap. Also, several pilot projects of provider payment methods have been conducted to introduce more feasible ones to make the health insurance fund sustainable.

Regarding policy and administration, the Survey draws attention to the challenges in coordination within the Ministry of Health (MOH) and with other relevant agencies such as the Vietnam Social Security (VSS), consistency of legislations, as well as long term and overall strategic viewpoints on health insurance system and relevant health policy, especially health financing. Also, expenditure of health insurance fund has been increasing due to raise of medical fees. Expansion of the coverage, aging, and change of disease burden may also bring a certain impact to the health insurance fund in the near future.

From the viewpoints of users, the utilization rate of health insurance is not very high due to some reasons. For instance, health insurance user may require more process in the hospital; less or no costs may be covered by the health insurance fund at the top referral hospitals. It is also relevant to the care seeking behavior among the people that they tend to go directly to higher level hospital and the rich prefer to go to private hospitals in which they cannot use public health insurance. Also, the drug price is generally higher than the international average. Those also may affect to high OOP.

To the above challenges, the Government of Viet Nam has been taking various measurements in addition to the development of BHSP and provider payment method. To make the health insurance system transparent and evidence-based, the National Advisory Council for Health Insurance Policy (NACHIP) has been established. The NACHIP involves all the stakeholders in MOH, VSS, health service providers, users, and academic agencies. It aims to provide advice on health insurance policy especially in the list of drugs, medical services, and materials to be covered by the health insurance fund and those prices, as well as the balance of health insurance fund. Also, IT has been introduced to increase efficiency of claim and examination to review more claim to optimize expenditure of the health insurance fund.

Experiences in Japan and Other Countries (Chapter 8)

To develop the health insurance system in Viet Nam, experiences and lesson learned in other countries could be valuable. In Japan, evidence-based management mechanism has been functioning to review the medical fee schedule regularly to be consistent with the health policy. Regarding provider payment method, Japan has introduced case-based payment with Disease Procedure Combination (DPC) method which is similar to Disease Related Group (DRG) method. Thailand has achieved and been maintaining universal health insurance. It expanded coverage to informal sector with careful consideration on socio-economic situation of farmers who makes up the majority of the informal sector.

Recommendations on Roadmap for Future Development of Health Insurance System (Section 9.2)

Considering the situation analyses made in the previous chapters, the Survey Team proposed a roadmap to future health insurance system development until 2020 and prepared the recommendations on options to ensure financial protection and sustainability of the health insurance fund for the following factors:

- Health financing;
- Health insurance scheme;
- Management mechanism of health insurance system, particularly benefit package and provider payment mechanism;
- Provider payment methods;
- Benefit package and BHSP;
- Information management to manage health insurance system based on evidences; and
- IT system to strengthen the efficiency of works which are relevant to health insurance.

Recommendations on Future Cooperation (Chapter 10)

For future technical cooperation of Japan, with matching between the above recommendations and relevant resources in Japan, the following components are proposed:

1 Improvement of data entry and management capacity of accounting, claiming, and clinical staff;
2 Capacity development of the council/ sub-committee to manage benefit package, medical fee schedule, and provider payment method;
3 Continuous review of BHSP to be paid by the health insurance fund;
4 Development of standard clinical practice guidelines to be covered by health insurance; and
5 Development of DRGs.

Chapter 1 Outline and Progress of the Survey

1.1 Background

To achieve universal health coverage (UHC) with increasing health insurance coverage, the Roadmap towards Universal Health Insurance for 2012 and 2020[1] (UHI Roadmap) was promulgated in March 2012. It aims to achieve more than 80%[2] of health insurance coverage and less than 40% of out-of-pocket (OOP) expenses against total health expenditure by 2020. According to the UHI Roadmap, these goals should be achieved through improvement of benefit package services, patient satisfaction, capacity of claim, claim examination and reimbursement of medical fees, as well as, soundness of the health insurance fund.

In order to achieve the above roadmap, the Ministry of Health (MOH) of Viet Nam has amended the Health Insurance Law in 2014[3] and approved the Roadmap to Develop and Implement the Basic Health Service Package (BHSP) reimbursed by the Health Insurance[4] in Viet Nam (BHSP Roadmap).

The BHSP Roadmap is one of the measures being taken in order to achieve the above-mentioned goals of the government of Viet Nam. It aims to establish appropriate benefit package of health insurance, BHSP. MOH aims to establish BHSP to be applied nationwide from January 2018 as defined in the Amendments on the Law on Health Insurance (June 2014).

At the same time, provider payment methods have been reviewed to regulate health insurance expenses because the health insurance fund might be in deficit after 2020 with the current payment methods.

To accelerate the relevant activities of the pilot project, the Government of Viet Nam requested the Government of Japan for assistance to strengthen the management of provider payment mechanism and BHSP. To obtain the latest information for designing future technical cooperation program, a more detailed study is considered on the above request. Then, the Japan International Cooperation Agency (JICA) agreed to conduct the Basic Information Survey for BHSP and Provider Payment Mechanism in Viet Nam (the Survey).

1.2 Objectives

The purpose of the Survey was to collect necessary data and information for JICA to fully provide details on the need for technical cooperation that could effectively utilize relevant resources in Japan. Therefore, the Survey aimed to achieve the three objectives shown in Table 1-1 in close collaboration with the stakeholders in Viet Nam.

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[1] 538/QD-TTg
[2] The target was increased to 90% in June 2016.
[3] 46/2014/QH13
[4] According to the interviews and discussions in the Survey, BHSP reimbursed by the health insurance seems to be understood as the revised benefit package of health insurance to cover “basic” services. However, concrete definition has not been agreed among the stakeholders.

Table 1-1 Objectives of the Survey

1. To sort out the preconditions of the technical cooperation project

To draw the needs for technical cooperation on drafting BHSP and its finalization to be introduced nationwide. Also, to study cooperation resources both in Japan and in other Association of Southeast Asian Nations (ASEAN) member states.

2. To make recommendations to enhance the drafting of BHSP and the implementation of the pilot project

Firstly, to collect information on the current situation of BHSP drafting, concept, and implementation plan of the assessment, availability of necessary data for further data analysis, and capacity of pilot provinces. Then, to make recommendations together with the necessary training subjects based on the above situation analysis and to draft a roadmap toward nationwide development.

3. To make recommendations on policy development of MOH

To analyze the current situation of policies and its implementation on health insurance and human resource for health to achieve UHC and identify challenges and priority issues. Also, to identify cooperation resources in Japan to contribute to resolving the issues and then draft policy matrix for medium term (three to five years) based on the above analyses.

1.3 Period of the Survey

The Survey started on 20 November 2015 and was finished until the middle of March 2017, which was the submission of the final report (F/R).

Figure 1-1 presents the workflow of the Survey. It was revised according to the following changes of preconditions:

- Regarding development of BHSP, preliminary results of statistical analysis on use of health insurance fund and services in the pilot provinces have been presented in the end of November 2016. Although the draft options of BHSP were also presented, definition and criteria to select the options seemed not to be clearly agreed among stakeholders until the later stage of the Survey.
- Through interviews and meetings with MOH stakeholders, it was found that common understanding on objectives, concept, definition, and contents of BHSP has not been well discussed and established.
- Based on the instruction of the Prime Minister in June 2016, BHSP has to be promulgated by January 2017, instead of 2018. Therefore, circulation of BHSP will be developed without pilot activities. Also, HSPI has been involved more in BHSP development although DPF is still the focal point.
- Although BHSP council was to be established in December 2015, the National Council for Health Insurance Policy which was decided to establish in March 2016 includes a task for BHSP development. In August 2016, the revised decision on establishment of the National Advisory Council on Health Insurance Policy (NACHIP)[5] was issued with a new list of the council members and five sub-councils. Also, the draft working regulation of the council was presented. However, terms of reference for the sub-councils seemed to be under drafting.

1.4 Methodology

The Survey was carried out by a consultant team contracted by JICA (the Survey Team). Document research both in Japan and Viet Nam was carried out to collect relevant reports, statistics, legislations, and

[5] English translation of the council name was changed based on discussions with Department of Health Insurance.

other documents. Semi-structured and open-ended interviews were conducted during the field survey. Direct observation of health facilities and health insurance organizations were also done in the survey in the selected provinces.

At the central level, the Survey Team had meetings with MOH, Viet Nam Social Security (VSS), donor agencies, and relevant private sectors. As for the local level, four provinces, namely: Hoa Binh, Gia Lai, Binh Dinh and Dong Thap were selected through discussion with MOH. Those were selected from six target areas of data collection for BHSP[6] development to see the current situation relevant to operation of health insurance system at local level. Also, according to MOH, these four provinces were selected for the data collection because those are considered to represent each region in terms of socio-economic key indicators[7]. In the four provinces, the Survey Team met with the provincial Department of Health (DOH), Provincial Social Security (PSS), provincial and district hospitals and commune health stations.

The Survey Team carried out field surveys in Viet Nam as follows:

- First Field Survey: from 25 November to 28 December 2015
- Second Field Survey: from 31 January to 3 February 2016
- Third Field Survey: from 16 February to 29 March 2016
- Fourth Field Survey: from 29 May to 10 June 2016
- Fifth Field Survey: intermitted from 29 August 2016 to 21 February 2017

The survey itinerary is presented in Appendix 1.

Due to some changes in the pre-condition part of the Survey (Section 1.3), some work items have been reviewed and modified through discussion with stakeholders both in Japan and Viet Nam, and the workflow and schedule were modified accordingly. The final versions were presented in Figure 1-1 and Figure 1-2. The following sections describe the detailed process and methodology of each work item.

1.4.1 Preparatory Works

The Survey Team organized available information in Japan through JICA, internet, and relevant previous surveys. Then, the field survey plan was prepared and the IC/R was submitted to JICA.

1.4.2 Objective 1: To sort out the preconditions of the technical cooperation project

1-1 Situation analysis, identifying challenges, needs assessment for technical cooperation and recommendation on matching the resources of Japan in drafting BHSP in the pilot areas

The Survey Team analyzed situation relevant to BHSP drafting in the pilot areas. The details were described in Section 3.3.5(2). The recommendation on resource matching for future JICA's cooperation was described in Chapter 10.

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[6] Hoa Binh, Binh Dinh, Gia Lai, Dong Thap, Hanoi, and Ho Chi Minh

[7] Such as poverty ratio, aging rate, gross domestic products (GDP) per capita, etc.

1-2 Situation analysis, identifying challenges, needs assessment for technical cooperation and recommendation on matching the resources of Japan on nationwide development and implementation of BHSP

Although the draft options were not presented during the Survey, the Survey Team analyzed situation surrounding and relevant to BHSP development (Chapters 3 to 7 and Section 9.1) and identified challenges and needs for technical cooperation. At the same time, relevant experiences in Japan and some other countries in dealing with those challenges and needs were sorted out (Chapter 8).

1-3 Information collection and mapping of donors/research institution in the health insurance sector

Through interviews and document research, the Survey Team collected relevant information of donors' activities in the health insurance sector. The updated results were summarized in Chapter 7.

1-4 Exploring a demarcation line and methods in case of coordination with ADB

The Survey Team exchanged information with ADB on future cooperation on health insurance. However, the discussion was not made on concrete collaboration or coordination. Due to change of situation regarding to BHSP and the council, the Survey Team could not make concrete recommendation of future coordination with ADB.

1-5 Proposal of overseas training program (in Japan and the other ASEAN country) to be included in the Master Plan Development Study

The Survey Team visited relevant organizations in Thailand to have discussions on future cooperation for Viet Nam in health insurance field. Proposed overseas training program to be included in the future cooperation project was described in Chapter 10.

1-6 Information collection and mapping of concerned agencies in health insurance sector

The Survey Team sorted out the working items and information necessary to operate evidence-based health insurance system and collected information on a ministry/an agency/a department which is responsible for each item. The results are described in Section 3.4.4. Then, the Survey Team recommended to involve all such agencies in operating health insurance system.

1.4.3 Objective 2: To make recommendations to enhance the drafting of BHSP and implementation of the pilot project

2-1 Technical recommendation for BHSP development, the pilot project planning and other factors based on 1-1 and 1-2

Based on the situation analysis and results of discussions with stakeholders, the Survey team made technical recommendations on BHSP development as presented in Section 9.2.5.

2-2 Situation analysis and recommendation on developing and revising provider payment mechanism and institutional setting

Based on the situation analysis in item 1-2 and through discussions with stakeholders in Viet Nam and Japan, the Survey Team made recommendations on options of health insurance scheme, health financing, provider payment method, and benefit package/BHSP as described in Chapter 9.

2-3 Recommendation for the current and further concept and implementation plan of the pilot project

In relation to item 1-2, the Survey Team made recommendation for the possible timeline and concept of the pilot project. However, because the definition and concept of BHSP and the methodology of the

development was changed at the later stage of the Survey, recommendations on BHSP and the benefit package were made as described in Section 9.2.5.

2-4 Recommendation for the training program on provider payment mechanism and BHSP for implementing the pilot project

Because the pilot project could not be designed due to a change of situation in BHSP drafting and the council, recommendations for the training program could not be made.

2-5 Draft roadmaps towards nationwide development of BHSP

In relation to items 1-2 and 2-3, the Survey Team proposed the roadmap towards UHC instead of nationwide development of BHSP as presented in Chapter 9.

2-6 Advises on the National Advisory Council on Health Insurance Policy (NACHIP)

The Survey Team provided technical advises for developing the working regulation of NACHIP and scope of works of five sub-committees. The team closely collaborated with DHI to review the draft regulation and sort out necessary work items for sub-committees based on outputs of Item 1-6 above.

1.4.4 Objective 3: To make recommendations on policy development of MOH

3-1 Situation analysis of health insurance system and recommendation for capacity development to enhance the management of health insurance system and UHC

The Survey Team has been trying to collect wider range of information on health insurance system and UHC and not limited to human resources because through the initial interviews, the Survey Team found out that BHSP was not the only way to improve the health insurance system and contribute to UHC. In addition, supplemental survey was carried out to study the latest situation after free access at the district level and the new medical fee schedule. The findings were described in Chapters 2 to 6.

Based on the situation analysis, the Survey Team proposed a roadmap toward enhancement of health insurance system with suggested actions to be taken (Chapter 9). Then, draft policy actions were suggested.

3-2 Proposal of a draft policy matrix or mid-/long-term roadmap on UHC or health insurance system enhancement

The suggested draft policy actions were compiled in the draft policy matrix presented in Chapter 10.

3-3 Recommendation for developing health insurance system in Viet Nam, compared with the cases of Japan, ASEAN, and other developed countries

The Survey Team summarized the process of development and revision of benefit package and medical fees in Japan, Thailand, the Philippines, the United Kingdom, Germany, and the United States (Chapter 10). Based on the findings, recommendations for health insurance system development and future technical cooperation are described in Chapter 9 and 10 accordingly.

3-4 Recommendation on matching between each policy action and cooperation resources in Japan

In relation to the above, the Survey Team analyzed cooperation resources in Japan suitable to fulfill the technical assistance needs of Viet Nam as presented in Chapter 10.

1.4.5 Workshops in Viet Nam

The first workshop was held on 1 March 2016 with participants from MOH, VSS, provincial representatives, academic institutions, and relevant donors. In the workshop, the Survey Team reported preliminary findings of the Survey. Also, the outline of management mechanism of medical fee schedule and linkage to policy implementation in Japan were presented to respond to the needs of stakeholders in Viet Nam. In the discussion, cross-sectoral collaboration was recognized as one of important factors to develop health insurance system and achieve UHC. The program, record and participants of the workshop are presented in Appendix 2.

The second workshop was canceled according to the results of discussion between the Survey Team and DPF-MOH. Instead, the Survey Team presented the outline of the findings and recommendations to major stakeholders.

1.4.6 Study Tour in a Third Country

Among the ASEAN member states, Thailand, Philippines and Indonesia have developed health insurance system. The overviews are presented in Chapter 8. Out of these three countries, the Survey Team proposed Thailand for the study tour for the following reasons:

- Thailand have been accumulating experiences and lessons learned in developing a medical security system to cover nearly 100% of the population through the success of the Universal Coverage (UC, health insurance for informal sector) and implementing Social Security Service (SSS, health insurance for formal sector) by the Social Security Office (SSO). Viet Nam could consider the cost analysis method of UC, provider payment mechanism which includes capitation, fee-for-service and case-mix, budget allocation, accountability on the concept of OOP in UC and SSS, as well as development of appropriate health service providing system. Also, it is important to know that the different organizations operate each UC for informal unlicensed sector and SSS for the formal professional sector.

However, through discussions with MOH and JICA, the study tour to a third country was canceled for the following reasons:

- Most of the key persons have already learned ideas from Thailand’s experience; and
- Although it has similar payment mechanisms with the future vision of Viet Nam and could provide basic and useful information to develop a health insurance system, for the Viet Nam side, it would like to focus on the management mechanism of provider payment and medical fee of Japan.

The Survey Team and MOH also discussed possibility for the other two countries, Philippines and Indonesia as follows:

- In the Philippines, the PhilHealth have been centrally providing public health insurance services including informal sector. The hospital accreditation system could be referred to improve health

service providing capacity. However, the circumstances are different; private sector occupies larger portion in health service providers, and OOP is still high despite of high coverage of health insurance.

- In Indonesia, the entire public health insurance schemes are being integrated under National Health Insurance (JKN). Although it is similar to VSS, it is still at the initial stage and there seem to be lots of challenges as well as tri and error.

1.4.7 Study Tour in Japan

(1) Study Tour on Health Insurance System in Japan

The Survey Team discussed with the concerned agencies in Viet Nam and Japan on appropriate program which could respond to the above mentioned intention on the study tour in Japan. The objective of the study tour was to learn the experience of the Japanese government and local government in developing a local health service network and maintaining UHC in mountainous and farming area. During the first field survey, stakeholders in Viet Nam seem to be interested in the following points:

- System and mechanism of data collection and analysis to provide evidences of medical fee review;
- Coordination mechanism of consensus building on medical fee review among stakeholders from different agencies;
- System and mechanism to ensure transparency and accountability of medical fee claim and provider payment; and
- Control system of medical treatment and examination services of health service providers.

In the second field survey, the Survey Team presented the draft program of the study tour in Japan to MOH. Based on the agreement with MOH during the second field survey, the study tour in Japan was held for ten days from 15 to 24 May 2016 in Tokyo and Nagano Prefecture. The final program of the study tour is shown in Table 1-2. Participants were from MOH, VSS, Ministry of Finance, HSPI, Department of Health in Hanoi City, Hoa Binh Province and Gia Lai Province. The list of participants is presented in Appendix 3.

Table 1-2 Program of the Study Tour in Japan

Date	Time	Activity	Place
15 May (Sun)	15:05	Arrived at the Haneda International Airport (VN384)	Tokyo
	17:30 - 18:30	Orientation	
16 May (Mon)	9:30 - 10:00	Courtesy Call in JICA	Tokyo
	10:10 - 12:10	Lecture by Prof. Yoshinori Hiroi from Kyoto University	
	13:30 - 16:00	Lecture by the Ministry of Health, Labour, and Welfare	
17 May (Tue)	10:00 - 11:30	Lecture by the Health Insurance Claims Review and Reimbursement Services	Tokyo
	13:30 - 16:00	Lecture by the Ministry of Health, Labour, and Welfare	
18 May (Wed)	10:00 - 12:00	Lecture by the Japan Health Insurance Association	Tokyo
	13:30 - 15:30	Lecture by the National Federation of Health Insurance Societies	
19 May (Thu)	9:00 - 11:30	Travel to Saku City, Nagano	Saku City, Nagano
	13:30 - 16 :00	Lecture by Official of Saku City Office	
	18 :00 – 21 :00	Dinner	
20 May (Fri)	9:00 - 11:00	Official Visit to Saku Central Hospital founded by Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare	Saku City, Nagano
	13:00 – 14:50	Lecture by Official of Sakuho Town Office	
	15:30 - 17:00	Official Visit to Kitaaiki Vilage Clinic	
21 May (Sat)	10:00 – 12:00	Travel to Tokyo	Tokyo
22 May (Sun)		Preparation of Group Presentation	Tokyo
23 May (Mon)	9:30 – 12:30	Lecture by Prof. Kenji Shimazaki, National Graduate Institute for Policy Studies	Tokyo
	13:30 – 16:30	Wrap up Workshop	
24 May (Tue)	16:35	Departure for Hanoi from Haneda International Airport (VN385)	

As explained before, participants from Viet Nam were expected to learn about Japanese public health insurance. The contents of the program were designed to cope with such expectations.

(1) Learning the historical development of public health insurance system in Japan
(2) Relationship between Insurance Policy and Health Policy
(3) Features of the present public health insurance system in Japan
(4) Measures for population ageing
(5) Measures for reduction of public medical costs
(6) Roles and responsibilities of the Central Social Insurance Medical Council
(7) Administrative responses against frauds in medical treatment and medical claims
(8) Insurers' activities for moderation of medical cost
(9) Data analysis by insurers and strengthening insurers' function
(10) Current situation and challenges of medical claims review using the IT system
(11) Collection of data and data analysis for revision of medical fees used by the Ministry of Health, Labour and Welfare
(12) Situation of preventive health care in rural area
(13) Situation of preventive health care by medical institution
(14) Examples of health promotion activities by a local government
(15) Example of delivery mechanism of medical services in rural areas

The details of each session are presented in Appendix 3.

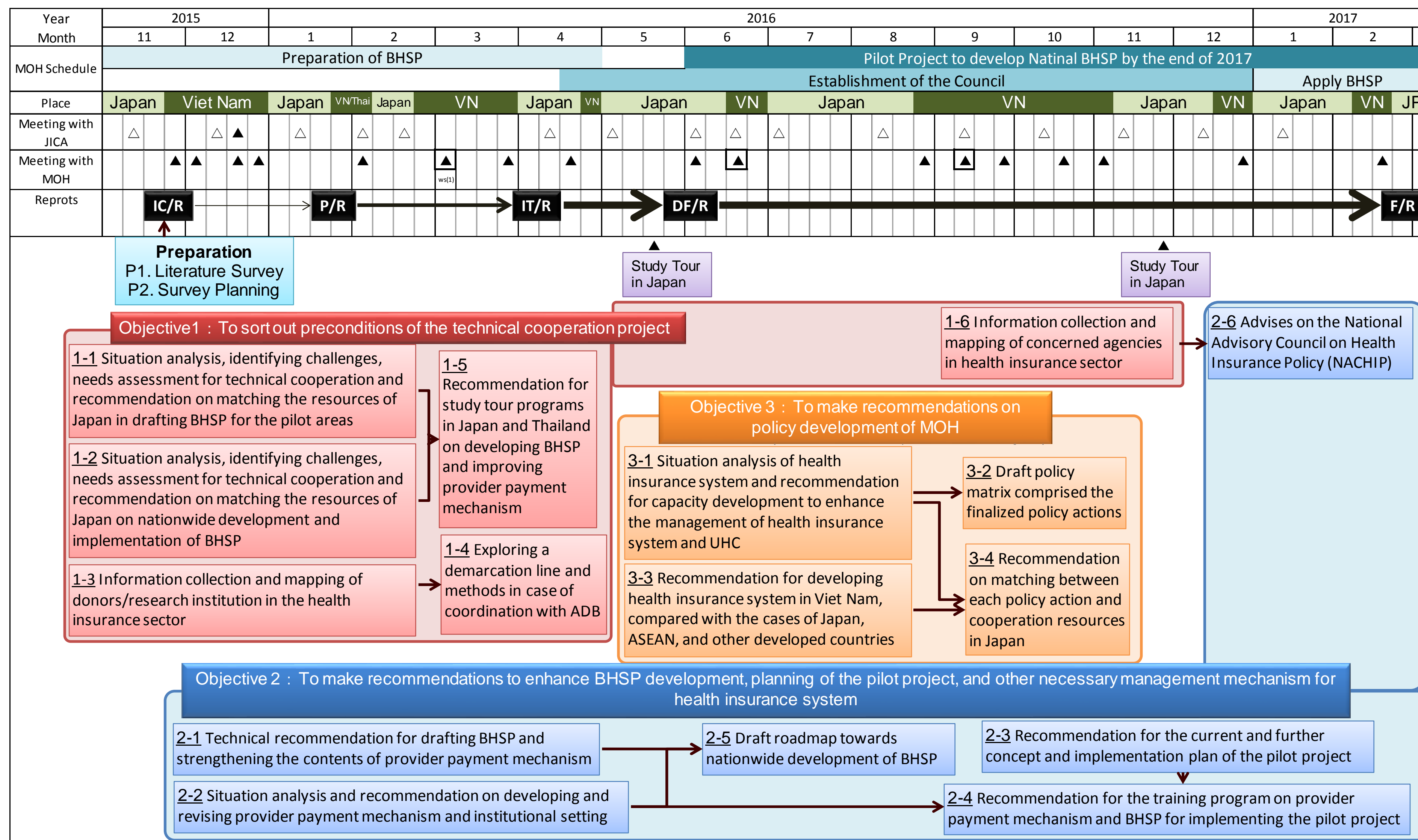
At the timing of the orientation on 15 May 2015, the participants were divided into four groups and each group was informed to present the summary of the study tour on 23 May 2016. Based on this, in the last session of this program, each group delivered their presentation. The purpose of the presentation was to sort what they learn learned in the program and what could be the possible countermeasures to the major challenges faced by the Health Insurance System in Viet Nam. The details of presentations are shown in Appendix 3.

In addition to this, all participants are requested to submit the 'Report on Training in Japan' to their direct supervisors in order to share the information and experience learned so as to utilize such information in their workplaces if possible.

At the final session of the study tour, Deputy Head of the Health Insurance Department, MOH, concluded that the study tour was successful and participants obtained much information which could contribute to the effective service delivery and conceptual ideas of the Japanese public health insurance towards the UHC in Viet Nam.

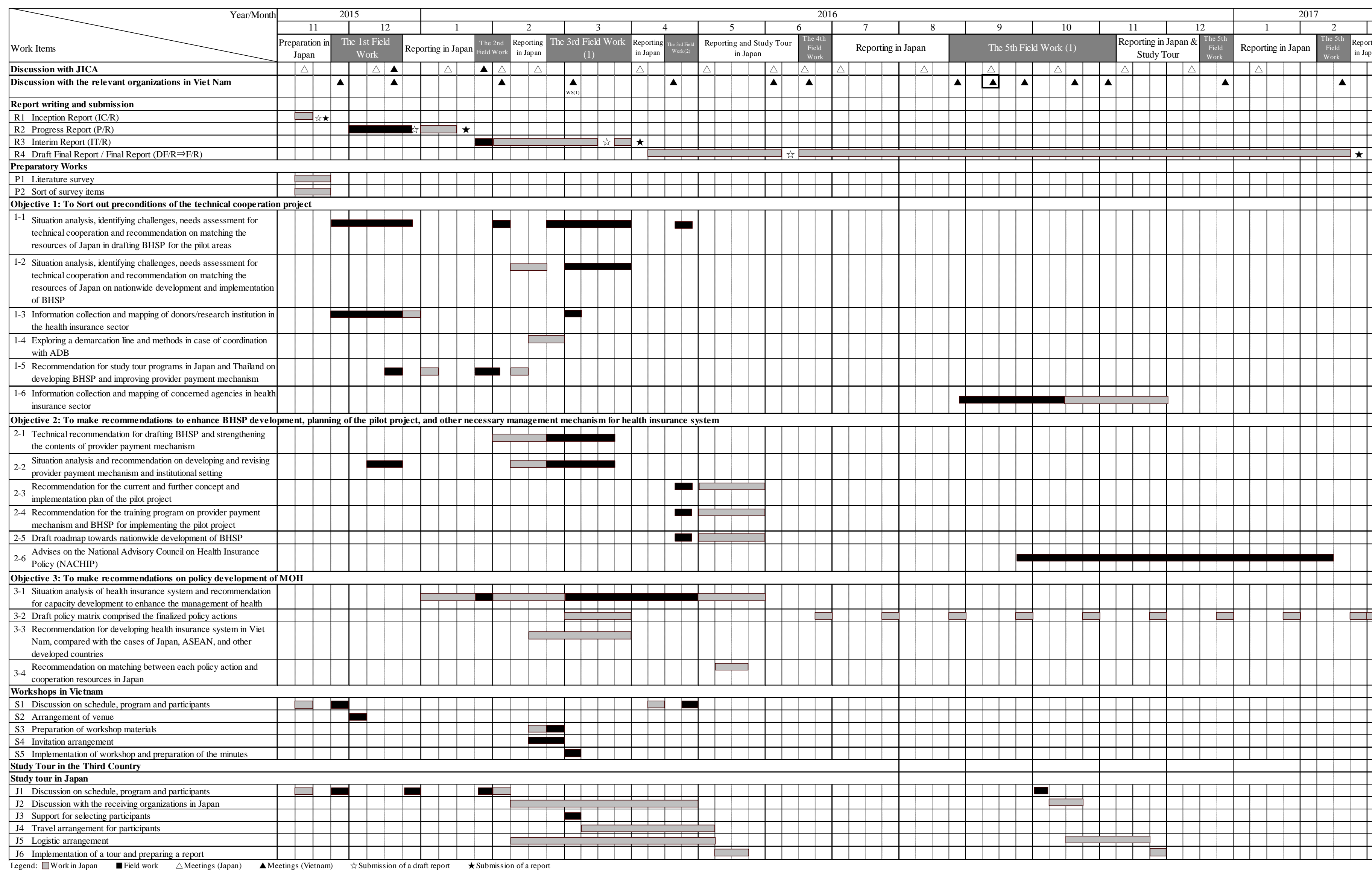
(2) Study Tour on IT in Claim Examination

In response to the request from VSS, the Survey Team provided assistance for the study tour in Japan of a mission consisting of representatives from Central Economics Commission, Central Organization Commission and VSS in November 2016. The main focus of the mission was IT in claim examination aiming to apply experience and technology of Japan to improvement of claim examination by IT. Itinerary and participants are presented in Appendix 3.



Nc WS=Work Shop, IC/R=Inception Reprot, P/R=Progress Report, IT/R=Interim Report, DF/R=Draft Final Report, F/R=Final Report

Figure 1-1 Work Flow



Source: Survey Team

Figure 1-2 Work Schedule

Chapter 2 Overview of the Universal Health Coverage in Viet Nam

To achieve universal health coverage (UHC), the following three dimensions should be considered: (1) to increase population coverage; (2) to expand health service coverage and ensure equity; and (3) to reduce cost sharing and fees. In Viet Nam, the focus is just on how to increase the coverage, while the other two dimensions, especially equity and financial protection, are relatively neglected. Although Viet Nam has made great progress toward promoting universal coverage of health insurance for these 20 years, there are challenges in both demand side and supply side of the health sector (Table 2-1).

Table 2-1 Challenges Regarding UHC in Viet Nam

Demand Side	Supply Side
- High out-of-pocket (OOP) expenses (42.25% of total health expenditure, 2013) - The informal sector, who is difficult to be identified and to be covered by health insurance, accounts for 80% of the population - Low utilization of services with health insurance (60 to 65%, 2013)	- Low quality of public health services - Referral system does not work well - Too broad benefit package - Payment mechanism induces over-supply - Number of health facilities contracted with VSS is limited in non-public sector (48.7%)

Reference: [Dr. Pham Luong Son, 2015], [MOH, 2014], [MOH and HFG, 2016]

This chapter overview UHC in Viet Nam from the above three dimensions considering the socio-economic situation.

2.1 Socioeconomic Situation

2.1.1 Demography

According to the statistics in 2014, the total population of Viet Nam in that particular year was about 90.7 million with an increase of 1.08% over the previous year. Table 2-2 presents the total population and population growth rate in Viet Nam and selected provinces[8] for the past five years.

Table 2-2 Total Population and Population Growth Rate in Viet Nam and Selected Provinces for the Past Five Years (2010-2014)

(Unit: 1000)

	2010		2011		2012		2013		2014	
	Population (thous.)	Growth rate (%)	Population (thous.)	Growth rate (%)	Population (thous.)	Growth rate (%)	Population (thous.)	Growth rate (%)	Population (thous.)	Growth rate (%)
Whole Country	86,947.4	1.07	87,860.4	1.05	88,809.3	1.08	89,759.5	1.07	90,728.9	1.08
Hanoi	6,633.6	2.50	6,761.3	1.93	6,865.2	1.54	6,977.0	1.63	7,095.9	1.70
Ha Nam	786.3	0.02	786.9	0.07	792.2	0.68	796.0	0.48	799.4	0.43
Hoa Binh	791.6	0.67	799.0	0.93	805.2	0.77	810.3	0.64	817.4	0.86
Nghe Anh	2,934.1	0.67	2,955.9	0.75	2,983.3	0.92	3,011.3	0.94	3,037.4	0.87
Binh Dinh	1,492.0	0.31	1,498.2	0.42	1,502.4	0.28	1,509.3	0.46	1,514.5	0.34
Khanh Hoa	1,164.3	0.53	1,171.4	0.61	1,180.1	0.75	1,188.4	0.70	1,196.9	0.71
Gia Lai	1,301.6	1.61	1,321.7	1.55	1,340.5	1.42	1,359.1	1.39	1,377.8	1.37
Ho Chi Minh	7,346.6	2.09	7,498.4	2.07	7,660.3	2.16	7,820.0	2.08	7,981.9	2.07
Dong Thap	1,669.6	0.18	1,671.7	0.12	1,675.0	0.20	1,678.4	0.20	1,681.3	0.17

Reference: [General Statistics Office, 2014]

8 The provinces which presented statistical data in this chapter are the targets in the phase 1 and 2 projects for development of BHSP, supported by LuxDev and USAID, accordingly. The details are described in Section 3.2.2 (2).

The population growth rate in large cities such as Hanoi and Ho Chi Minh is higher than in other provinces, and this situation could be partially resulted from the migration rate as shown in Table 2-3.

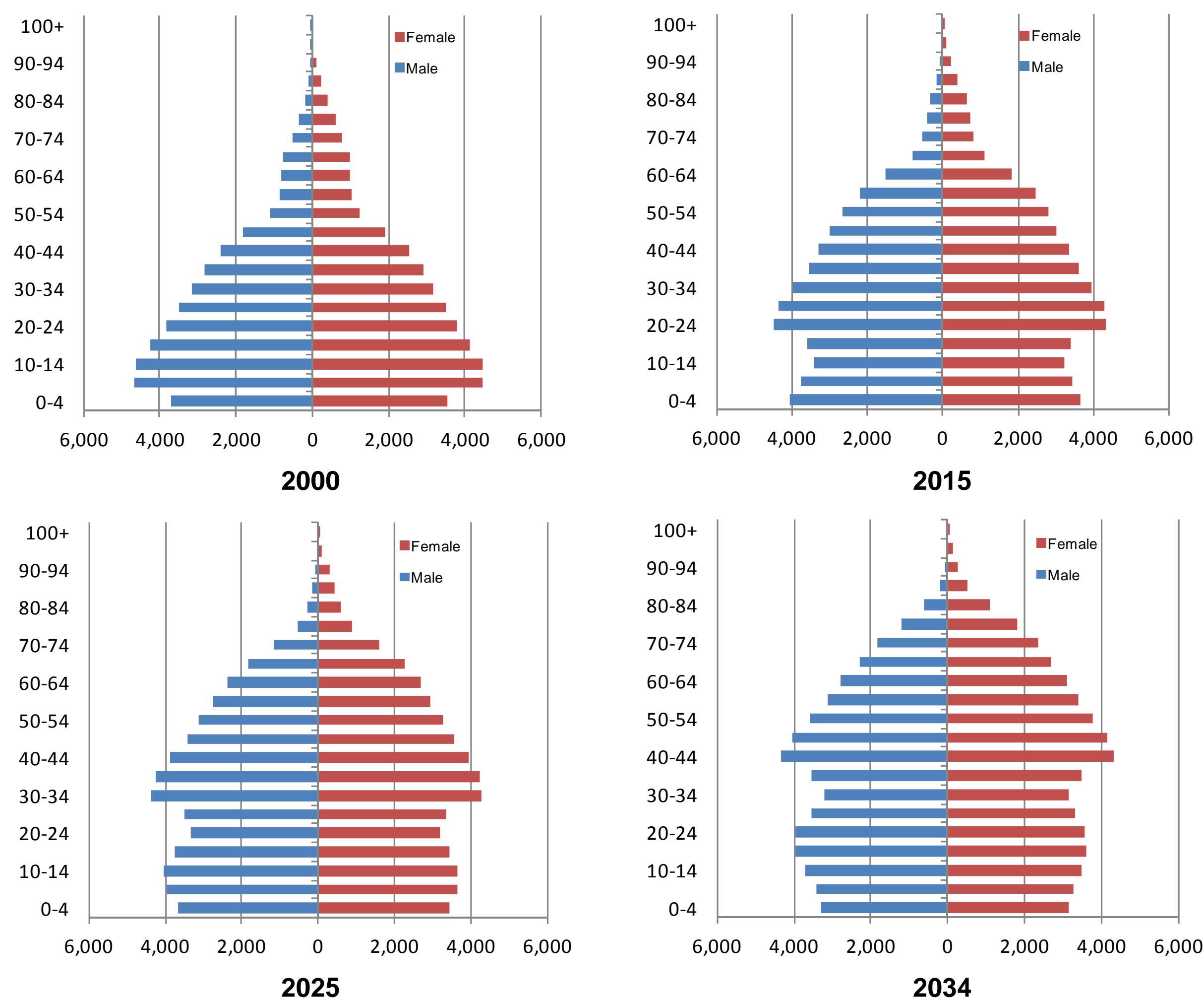
Table 2-3 Net Migration Rate in Selected Provinces

(Unit: %)

	2010	2011	2012	2013	2014
Hanoi	5.9	4.7	2.7	0.3	-0.4
Ha Nam	-4.6	-4.0	-4.2	-0.1	-2.0
Hoa Binh	-2.0	-2.2	-3.7	-8.1	-5.0
Nghe Anh	-7.6	-7.0	-9.6	-5.7	9.3
Binh Dinh	-3.9	-3.4	-7.1	-3.8	-3.9
Khanh Hoa	-8.3	-3.4	-2.3	-1.2	-3.8
Gia Lai	-2.2	-1.9	-0.4	-0.1	-1.8
Ho Chi Minh	18.3	11.5	7.6	6.2	5.5
Dong Thap	-6.7	-5.4	-6.3	-5.7	-6.4

Reference: [General Statistics Office, 2014]

The population pyramid of Viet Nam from 2000 to 2034 is shown in Figure 2-1. As can be seen from the shape of the pyramids, it is clear that Viet Nam will face serious concerns on population aging.



(Unit: thousand)

Reference: [United Nations Department of Economic and Social Affairs, 2015]

Figure 2-1 Population Pyramid in Viet Nam from 2000 to 2034

In addition, Table 2-4 and Table 2-5 indicate the prospects of rapid population aging in Viet Nam. The population growth rate is becoming lower as a whole; however, the population aged over 65 years old is projected to be doubled by 2034, although the population of the youth (0-14 years old) and economically productive age (15-64 years old) will be decreased.

Table 2-4 Prediction of Population Growth Rate by Age Group in Viet Nam

	2019		2024		2029		2034	
	Population (thous.)	Growth Rate (%)	Population (thous.)	Growth Rate (%)	Population (thous.)	Growth Rate (%)	Population (thous.)	Growth Rate (%)
Total	95,354	5.18	99,466	4.31	102,678	3.23	105,092	2.35
0-14 years	22,035	3.80	22,171	0.62	21,236	-4.22	20,008	-5.78
15-64 years	66,712	4.58	68,673	2.94	70,291	2.36	71,524	1.75
65+ years	6,606	17.19	8,622	30.52	11,150	29.32	13,560	21.61

Reference: [GSO, 2011]

Table 2-5 Prediction of Population Aging Rate in Selected Provinces

(Unit: %)

	2019	2024	2029	2034
Whole Country	6.93	8.67	10.86	12.90
Hanoi	7.67	9.52	11.74	12.75
Ha Nam	9.51	11.76	14.83	16.65
Hoa Binh	6.29	8.46	11.34	13.79
Nghe Anh	7.73	9.17	11.25	12.88
Binh Dinh	8.03	9.07	10.46	13.04
Khanh Hoa	6.44	7.91	9.99	12.68
Gia Lai	4.30	5.41	6.96	8.49
Ho Chi Minh	5.55	7.52	9.81	12.23
Dong Thap	7.38	9.13	11.30	14.12

Reference: [GSO, 2011]

2.1.2 Poor Household

The People's Committee of Communes and Districts conducted a survey to identify the poor and near poor household following the guidance of the Ministry of Labour, Invalid, and Social Affairs (MOLISA). Poverty rate is calculated by monthly average income per capita of household.

The government's poverty line for the period from 2011 to 2015 which is updated by the consumer price index (CPI) is as follows [The Prime Minister, 2011]:

- Poor household in rural area: average income: VND 400,000/person/month.
- Poor household in urban area: average income: VND 500,000 /person/ month.
- Near poor household in rural area: average income from VND 401,000 to 520,000/person/month
- Near poor household in urban area: average income from VND 501,000 to 650,000/person/month.

Table 2-6 presents the poverty rate in selected provinces, indicates that the poverty rate has been decreasing, yet there is a wide gap between provinces.

Table 2-6 Poverty Rate in Selected Provinces

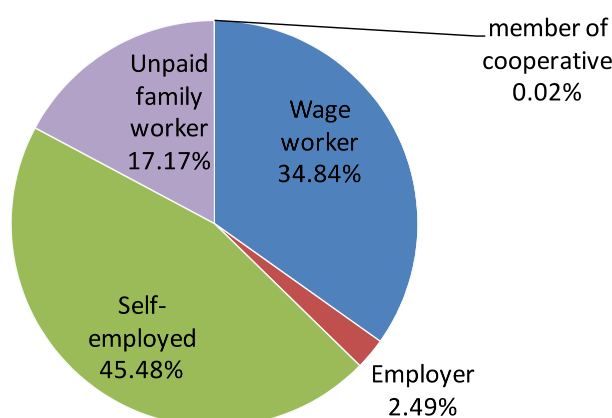
(Unit: %)

	2010	2011	2012	2013	2014
Whole country	14.20	12.60	11.10	9.80	8.40
Hanoi	5.30	4.30	3.60	2.90	2.30
Ha Nam	12.00	10.50	9.10	7.90	6.60
Hoa Binh	30.80	27.70	24.50	21.80	18.30
Nghe Anh	24.80	22.50	19.80	17.40	14.40
Binh Dinh	16.00	15.20	13.60	12.50	10.70
Khanh Hoa	9.50	8.80	8.00	7.30	6.20
Gia Lai	25.90	24.50	22.40	20.80	18.10
Ho Chi Minh	0.30	0.10	0.05	0.02	0.01
Dong Thap	14.40	12.90	11.60	10.20	8.60

Reference: [GSO, 2015]

2.1.3 Working Population

In Viet Nam, 68% of the working population is under any form of employment. Eighty six percent (86%) are in the private sector which contributes 44% of the gross domestic product (GDP) [GSO, 2015]. Regarding employment status, as shown in Figure 2-2, about 60% of the employed population is employed in the informal sector.



Reference: [GSO, 2015]

Figure 2-2 Employed Population (≧15) by Employment Status

Table 2-7 explains the percentage of workers by industrial sectors.

Table 2-7 Distribution of Employed Population Aged 15 and Above by Major Industrial Group (2014)

	Whole Country (%)
Agriculture, forestry and fishery	46.3
Manufacturing	14.4
Wholesale and retail trade, repair of cars, motorcycles	12.4
Construction	6.0
Hotels and restaurants	4.4
Training and education	3.5
Transport and storage	2.9

Reference: [MPI & GSO, 2015]

In Viet Nam, agriculture is by far the largest sector which accounts for nearly half of the working population. The share of manufacturing, the second largest sector, is only one-third of that of agriculture. This large population of farmers is considered to be the majority of the informal sector in Viet Nam.

2.1.4 Economic Situation

After launching its Doi Moi reforms in the late 1980s, when Viet Nam switched from a central subsidy system to a market economic system, its economy has successfully recovered and GDP growth rate reached 9% in 1995-1996. Although, the Asian economic crisis gave a negative impact, increased inflows of foreign direct investment into manufacturing have promoted Viet Nam's exports so that the average GDP growth rate was 7.2% from 2000 to 2010. Viet Nam became an official member of the World Trade Organization (WTO) in 2007 and GDP per capita exceeded USD 1,000 in 2008. Recently, imports rose at a much faster pace than exports, reflecting strong domestic demand for capital and consumer goods. GDP growth is forecast to edge up to 6.5% in 2015, although there are concerns over rising public debt, while inflation remains relatively low (Table 2-8).

Table 2-8 Trend of GDP Growth Rate

(Unit: %)

2000	2005	2007	2008	2009	2010	2011	2012	2013	2014
6.7	7.5	7.1	5.6	5.4	6.4	6.2	5.2	5.4	5.9

Reference: [IMF, 2015]

2.2 Health Financing

2.2.1 Relevant Policy

In the National Health Account (NHA) 2012, situation analysis and recommendations were made on health finance development as summarized in Table 2-9. It shows an orientation to seek countermeasure on the increasing government health expenditure. Regarding the long-term plan, MOH has been working on drafting a health finance strategy. Such long-term vision is essential to set clear direction and overall goal of the health insurance system development.

Table 2-9 Summary of Development Orientation for Health Finance

General Orientation	Basic Solutions
1. Reform of public health facility management ・ To promote public-private partnership (PPP) or other forms of private investment to reduce the burden of public health facilities and provide variety of alternatives to the people.	- Proportion of non-government budget raised from hospital fees and health insurance fund is to increase to cover 40% of total public health expenditure. - Budget for research and development is to be increased. - Basic health service facilities are to be upgraded to meet the national standards. - Autonomous financial management is to be introduced to national and provincial hospitals. And the roadmap is to be developed. - Hospitals are encouraged to seek alternative sources of income. - Private organizations are to be encouraged to invest in health services to reduce the burden of public hospitals.
2. Reform of medical fee policy ・ To consider all the actual cost of medical services to improve the salary of health personnel and support for the vulnerable people.	- To increase financial resources for treatment, income of health insurance is to be increased by increasing coverage including household subscription. - To reduce the burden of central hospitals, the fee system is to be modified to motivate people to access lower level facilities.
3. Quality improvement of health insurance services. ・ To review the provider payment mechanism considering to mobilize the state budget, community resources, and external assistances to enhance support for the vulnerable people.	- Appropriate budget control mechanism is to be introduced to reduce the financial gap among the health facilities.
4. Establishment of a long-term strategy and a short-term plan.	- Budget mechanism is to be established based on the long-term strategy and short-term plan.

Reference: [MOH & WHO, 2013]

MOH is in the process of developing financial strategy for 2016-2025. The draft had been prepared in collaboration with MOH, Health Strategy and Policy Institution (HSPI) and WHO and Table 2-10 summarizes its vision, strategic objectives and targets to be met by 2025. The strategy will be further elaborated based on the inputs and comments from concerned agencies and development partners, and will be finalized by the end of 2016.

Table 2-10 Summary of Health Financing Strategy of Viet Nam (2016-2025)

Vision	To develop a health financing system which is sustainable, equitable and effective in addressing the health care needs of the people and to increase its coverage that would cover the whole population so that people will have access to quality health care services without paying high rates or costs.
Strategic Objectives	1. To increase the health insurance coverage in a sustainable manner toward universal health coverage. 2. To ensure access to and use of quality health services in an equitable and effective manner, especially primary health care services 3. To strengthen the people's financial protection
Target	- The rate of participation in health insurance: 85-90% - Having policies and mechanisms for payment for primary health care services, especially prevention of non-communicable diseases (NCDs) at the grassroots level. - The proportion of health public expenditures in GDP: >4.5% of GDP - The proportion of OOP expenses: < 30% of the total health expenditures - The rate of family households having to pay catastrophic health costs: < 2% *Targets are still under discussion in order to make them more feasible.

Reference: [MOH, WHO, 2016]

2.2.2 Health Sector Budget

The state budget was increased by nearly 30% in 2010 and 2011; however, in 2012 it increased only by 2% and 12% in 2013. The expenditure for social and economic services was increased by 29% in 2012 and 15% in 2013. The proportion of the health sector budget in the total state budget was increased from 3.45% in 2009 to 5.85% in 2013 [GSO, 2015]. According to the Plan for People's Health Protection, Care and Promotion 2016-2020 (Health Sector Five-Year Plan 2016-2020) (refer to Section 3.3.2), VND 742,320 billion of the government budget is required for the five years[9]. In average, VND 148,464 billion is required annually from 2016 to 2020. It is approximately 1.2 times of the total health expenditure in 2013.

However, the Health Sector Five-Year Plan 2016-2020 requires VND 1,371,853 billion (Table 2-11). According to the plan, the Government of Viet Nam has been considering to mobilize new financial resources such as tobacco and alcohol tax, external investment, and other financial sources. Also, financial autonomy of hospitals will be promoted to save in government budget expenditure. To promote the financial autonomy, payment from health insurance fund has been increasing by including recurrent cost items to the medical fee (refer to Section 4.1.3). As shown in Table 2-11, item 1, 2 and 3 seem to be covered by the government budget and item 4 seems to be the other financial sources. Payment from health insurance fund is 73% of item 4 which is VND 91,092 billion per year. Meanwhile, as shown in Table 2-14, annual income of health insurance fund in 2016 was estimated at VND 66,228 billion.

Table 2-11 Estimated Budget for the Health Sector Five Year Plan 2016-2020

Item				Estimated Amount
1	**Investment and Development**			**176,148**
	1-1	Commune level		17,688
	1-2	District level		9,130
	1-3	Provincial level		66,000
	1-4	Central level		60,374
	1-5	Central institutes/tertiary referral hospitals		22,956
2	**Non-business Health Expenditures**			**550,314**
	2-1	Central budget		178,939
		a)	Recurrent expenditure	98,687
		b)	Expenditures of national targeted programs on health and population	19,392
		c)	Additional allocation for localities	60,860
	2-2	Local budget balance		432,234
3	**Health Expenditures in National Security, Defense and Reform of Salaries**			**19,750**
4	**Expenditures from the Other Revenue**			**625,641**
	4-1	Direct service fee		164,402
	4-2	Payment from health insurance fund		455,462
	4-3	other non-business revenue		5,777
Total				**1,371,853**

Source [MOH, 2016]

[9] For the previous five-year plan, 2011-2015, total expenditure was VND 357,971 billion.

2.2.3 Total Health Expenditure

The total health expenditure has significantly increased during these 20 years. In nominal terms, per capita health expenditure went up from USD 14 in 1995 to USD 111 in 2013, which increased almost eight times in 18 years (Table 2-12). However, the total health expenditure, as a share of GDP, did not increase from 5% to 6% as the following table shows, and government health spending is considerably less than expected. Especially, the share of MOH budget in total health expenditure is quite low, just around 2%, while the share of the fund from Viet Nam Social Security (VSS) has increased from 2.4% in 1995 to 15.5% in 2013.

Table 2-12 Trend of Total Health Expenditure

	1995	2000	2005	2010	2013
Total health expenditure as % of GDP	5%	5%	5%	6%	6%
Total health expenditure per capita (USD)	14	20	36	83	111
Out-of-pocket expenditure per capita (USD)	9	13	25	37	55
Total percentage of the general government health expenditure (GGHE) in the general government expenditure (GGE)	7%	7%	5%	10%	9%

Reference: [WHO, 2015]

It is important to note that out-of-pocket (OOP) expenses for health care still accounted for nearly 50% in 2013[10], although it was decreasing gradually, which is very high compared with internationally recommended level of below 30% of the total health expenditure (Table 2-13).

Table 2-13 Composition of National Health Expenditure

(Unit: Million VND)

	1995	2000	2005	2010	2011	2012	2013
Public health expenditure	**4,023,607 (34.5%)**	**7,215,164 (30.9%)**	**12,974,880 (26.4%)**	**63,892,567 (46.5%)**	**77,975,714 (45.2%)**	**82,501,680 (42.5%)**	**89,365,355 (41.8%)**
- MOH	544,300 (4.6%)	880,375 (3.7%)	1,295,041 (2.6%)	2,949,212 (2.1%)	3,095,718 (1.7%)	4,078,371 (2.1%)	4,417,668 (2.0%)
- Social security expenditure	283,000 (2.4%)	1,418,010 (6.1%)	4,340,499 (8.8%)	23,579,170 (17.1%)	30,894,605 (17.9%)	30,550,663 (15.7%)	33,092,306 (15.5%)
- others	2,783,410	4,319,090	6,022,651	33,221,102	39,437,621	43,143,948	47,161,603
Private health expenditure	**7,636,133 (65.5%)**	**16,097,199 (69.1%)**	**36,167,870 (73.6%)**	**73,363,620 (53.4%)**	**94,422,273 (54.7%)**	**111,332,731 (57.4%)**	**123,987,817 (58.1%)**
- NGO	18,969	31,861	103,233	233,378	620,824	653,107	727,345
- OOP	7,463,789 (64.0%)	15,392,472 (66.0%)	33,239,505 (67.6%)	61,541,169 (44.8%)	78,570,549 (45.5%)	94,656,716 (48.8%)	105,416,255 (49.4%)
- others	153,375	672,866	2,825,132	11,589,073	15,230,900	16,022,908	17,844,217
Total health expenditure	**11,659,740**	**23,312,363**	**49,142,750**	**137,256,187**	**172,397,987**	**193,834,411**	**213,353,172**

Reference: [WHO, 2015]

2.2.4 Income and Expenditure of Health Service Providers

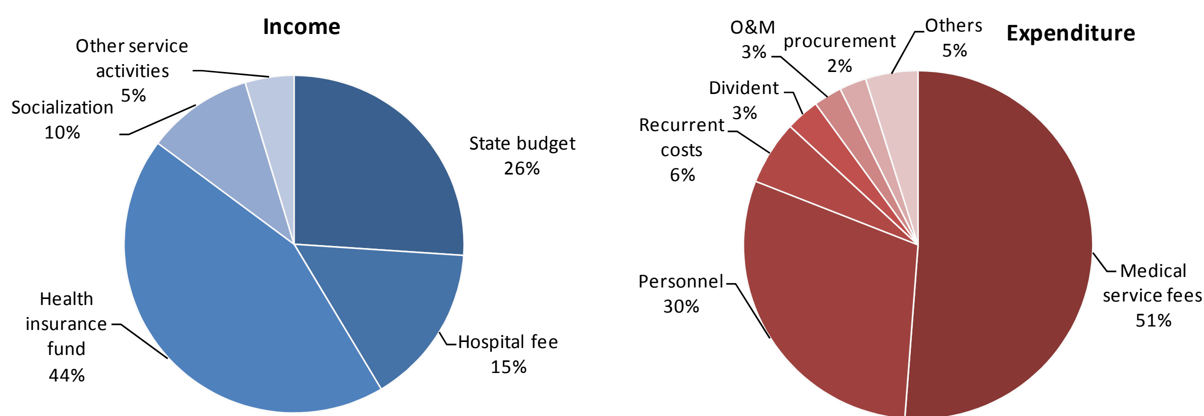
According to the decree on the financial autonomy of health institutions[11], proportion of the state budget in revenue has been decreasing. According to the Survey, it is less than 10% in the central hospitals, 20%

[10] According to MOH-DPF, it is estimated as 38% in the National Health Account 2013 to be published in 2016.

[11] Decree on the Operational and Financial Regimes Applicable to Public Health Non-business Units and the Prices of Medical Examination and Treatment Services of Public Establishments (85/2012ND-CP October 15, 2012)

in provincial hospitals, and 30% to 50% in district hospitals. Therefore, each health facility has to make their own effort to develop new financial sources such as parking services, canteen, kiosk, etc. Also, "socialization" has been introduced in some hospitals. It seems like joint investment with society to purchase medical equipment or other service improvement. The investors could obtain dividend from benefit of the particular operation. Although it could be effective to make a certain scale of investment to improve services, it may cause unnecessary services using the particular equipment.

Figure 2-3 shows a sample of income and expenditure of a provincial hospital. Income from health insurance fund is 44% of total income.



Reference: Binh Dinh Provincial Hospital

Figure 2-3 A Sample of Income and Expenditure of a Provincial Hospital

When the medical fee schedule includes all the necessary costs (seven items, refer to Section 4.1.3), the state budget allocation will be decreased step-by-step.

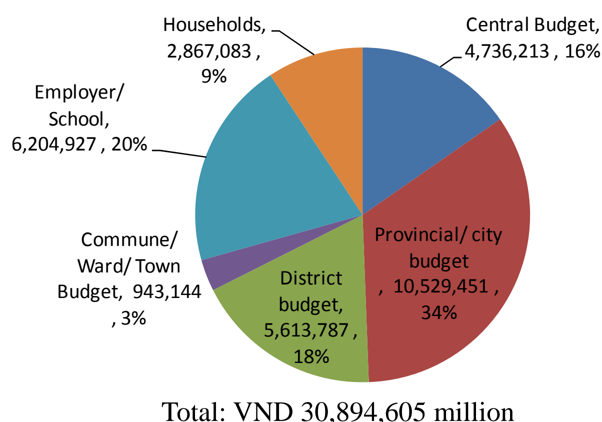
The main issues mentioned by the hospitals interviewed in both provinces are as follows:

- Hospitals can choose a payment system. Among the 31 hospitals at the provincial and district levels in Gia Lai Province, 16 hospitals use fee-for-service system while 15 hospitals use capitation system.
- Local Department of Health (DOH) does not have information regarding the ratio of OOP expenses.
- Commune health stations (CHSs) with no doctor assigned cannot get reimbursement when a nurse provides treatment, which is supposed to be done by a doctor (e.g., suture).
- Surplus generated from less usage of medical services due to the low quality cannot be used in the province. It is used to pay for the deficit of other provinces.

2.2.5 Health Insurance Fund

The Health Insurance Law, passed in 2009, provides a legal basis for earmarking state budget to subsidize health insurance for several large target groups.

Figure 2-4 presents the financial sources of health insurance fund as of 2010. Public sources constitute 70% of the total health insurance fund because more than 70% of subscribers have their insurance premiums on public support.



Total: VND 30,894,605 million

Reference: [MOH & WHO, 2013]

Figure 2-4 Sources of Health Insurance Fund (2010)

As shown in Table 2-14, health insurance fund was deficit in 2007 and 2009. It is estimated to be deficit in 2016. It might be caused by raise of medical fees by 30% in average (refer to Section 4.1.3).

Table 2-14 Income and Expenditure of Health Insurance Fund (2001-2013, and Estimate of 2016)

(Unit: VND in millions)

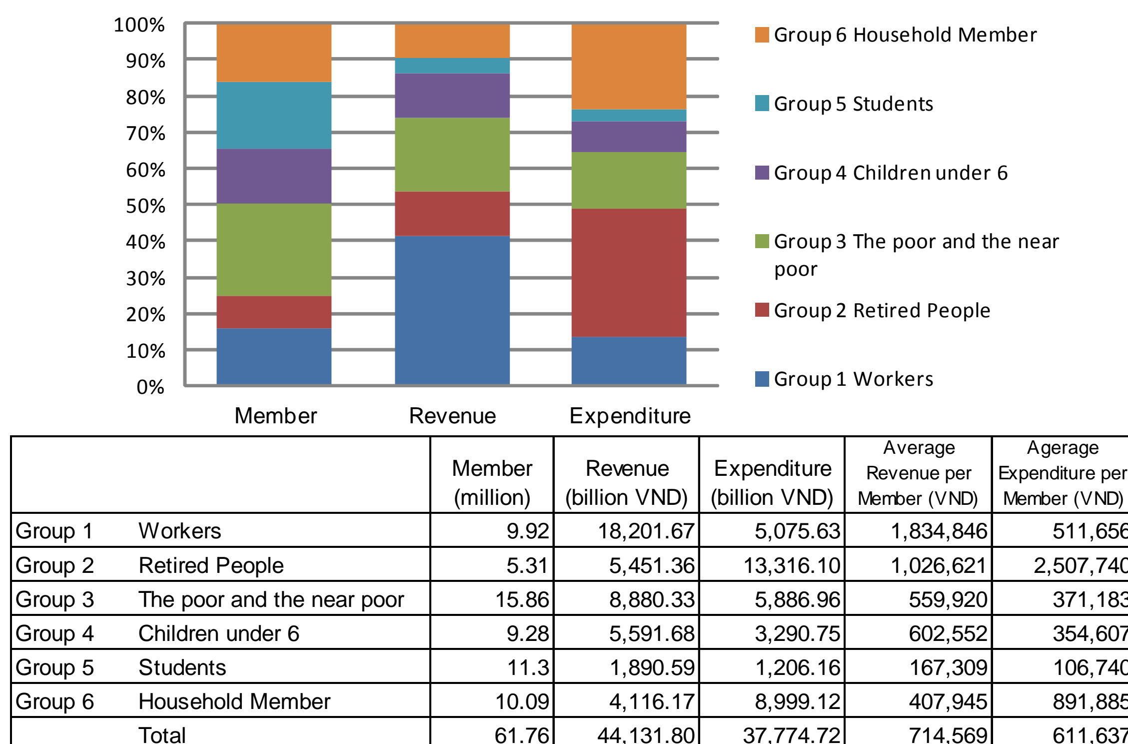
Year	Income	Expenditure
2001	1,151,000	1,063,000
2003	2,027,000	1,524,000
2005	2,973,614	2,774,833
2007	6,284,000	8,124,000
2009	13,037,000	15,482,000
2011	29,266,623	25,330,650
2013	44,131,798	37,774,720
2016 Estimates	66,228,000	72,700,000

Reference: [MOH, 2014] and VSS

Figure 2-5 presents the number of members, revenue and expenditure of the health insurance fund. Average revenue per member of workers is the highest as their premium is calculated based on their salary. Regarding groups two to six, considering the premium amount is calculated based on the minimum wage, the average revenue per member might be similar amount although four types of minimum wage are applied in accordance with characteristics of each province. . It suggests that there might be exemptions in paying the premium or the entire premium might not be collected. Expenditure per member of retired people is the highest because it includes the elderly.

Regarding the total revenue, according to the rough estimation of the Survey Team is VND 50,446 billion. It was calculated according to the Health Insurance Law (2008), the average salary (Group 1), and minimum wage[12] (Group 2 to 6) and was also based on the assumption that all subscribers pay in full the amount of premium (4.5% of salary/minimum wage). The actual revenue for 2013 was 88% of the above estimation.

[12] [GSO, 2015]



		Member (million)	Revenue (billion VND)	Expenditure (billion VND)	Average Revenue per Member (VND)	Agerage Expenditure per Member (VND)
Group 1	Workers	9.92	18,201.67	5,075.63	1,834,846	511,656
Group 2	Retired People	5.31	5,451.36	13,316.10	1,026,621	2,507,740
Group 3	The poor and the near poor	15.86	8,880.33	5,886.96	559,920	371,183
Group 4	Children under 6	9.28	5,591.68	3,290.75	602,552	354,607
Group 5	Students	11.3	1,890.59	1,206.16	167,309	106,740
Group 6	Household Member	10.09	4,116.17	8,999.12	407,945	891,885
	Total	61.76	44,131.80	37,774.72	714,569	611,637

Reference: [MOH, 2014]

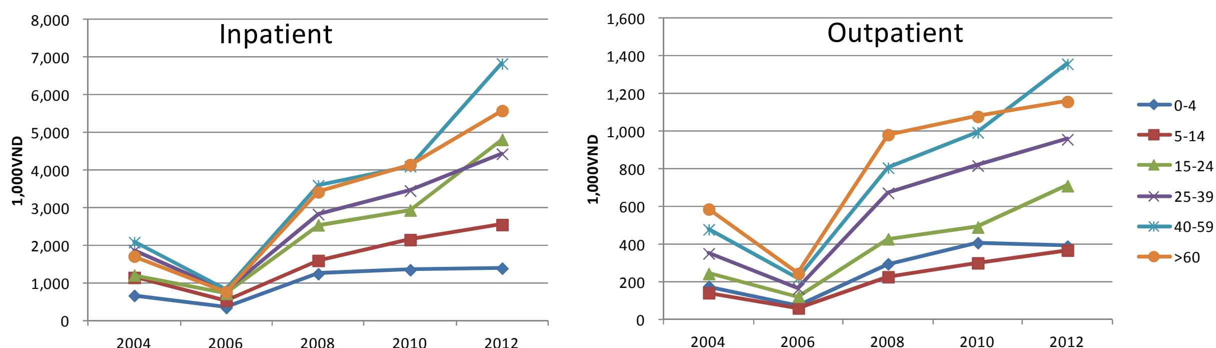
Figure 2-5 Number of Members, Revenue and Expenditure of Health Insurance Fund in 2013

Risk pooling in the health insurance system remains highly fragmented. Viet Nam has 63 provincial funds and only marginal redistributions are made across these funds through central reserves. This redistribution is often regressive, i.e., from poorer to richer regions. When a provincial health insurance fund has a remaining budget, 80% of the surplus should be allocated to the reserve fund and the rest of 20% will be allocated to purchase medical equipment, transportation mode at the district level, or support to the Fund for the Poor by 31 December, 2020. From 1 January 2021, the entire surplus will be allocated to the central reserved fund for general coordination.

2.2.6 Household Health Expenditure

(1) Health Expenditure per Capita by Age Group

Health expenditure per capita by age groups is not very high (Figure 2-6) because children under six years old do not have to pay as co-payment for health insurance. Although co-payment rate for pensioners is low (5%), heath care expenditure per capita for the people more than 60 years old is still high because the elderly that receives pension are only 20% among the eligible and 20% receives either free medical access or old-age welfare allowance (≧80) [JICA, 2014], most of them might belong to other groups of higher co-payment or non-subscribers.



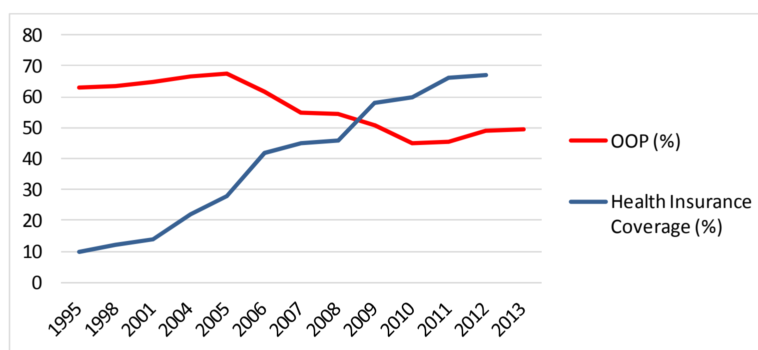
Reference: [GSO, 2013]

Figure 2-6 Healthcare Expenditure per capita by Age Group (2004-2012)

(2) Out-of-Pocket Expenses

Prior to the late 1980s, Viet Nam had a socialist-style health system which provided universal coverage free of charge. After the reform known as Doi Moi started, the official user fees at public health facilities were introduced and pharmaceuticals markets were liberalized. As a result, OOP expenses reached over 70% by the early 1990s. After a series of voluntary health insurance scheme, in 1992, the government started a nationwide mandatory health insurance scheme for civil servants, formal sector workers, pensioners, and so on. In 2002, the health care fund for the poor was established to provide free health services, which led to compulsory scheme for the poor.

These days the coverage in terms of enrollment has reached 70%, while OOP expense has not decreased dramatically and is still around 50% (Figure 2-7).



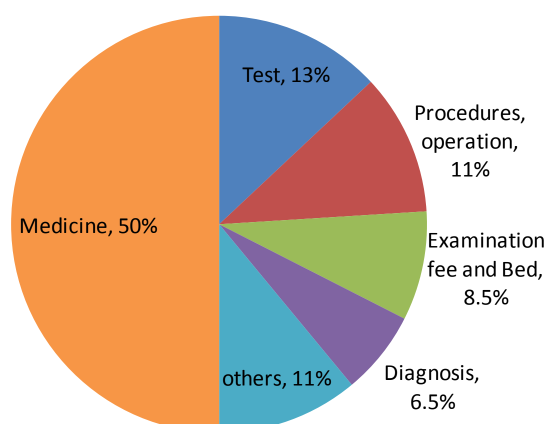
References: [WHO, 2015] [JICA, 2014]

Figure 2-7 OOP and Health Insurance Coverage in Viet Nam (1995-2013)

The high share of OOP expenses, while as much as 30% of the total population has not been covered with any forms of financial protection such as health insurance, means that many households especially the near poor may have financial difficulty when they are sick. Households may choose not to use health services to avoid payment.

Also the reason why subscribers have to pay for OOP is to spend for medicines bought from drug stores, for services of private providers, and co-payments at public health facilities (Figure 2-8). Since VSS reimbursement does not cover the whole benefit package paid by the health insurance, and hospitals recover their costs by charging extra expense to the patient.

Of the OOP expenses in 2009, 44% is spent on user fees at public facilities, 22% on private facilities, and 35% on self-medication [World Bank, 2014].



Reference: [Dr. Pham Luong Son, 2015]

Figure 2-8 Healthcare Cost Structure

(3) Catastrophic Health Expenditure

Among the household expenditure for health, 74% is for treatment and 17% is for over-the-counter (OTC) drugs. As shown in Table 2-15, households with catastrophic health expenditure has been around 4% to 5% even after the Heath Insurance Law was promulgated in 2009. Since 1998, around 2% to 3% of households become poor because of health expenditures.

Table 2-15 Household with Catastrophic Health Expenditure and Impoverishment (%)

	1992	1998	2002	2004	2006	2008	2010	2012
Household with catastrophic health expenditure	8.2	5.8	4.7	5.7	5.1	5.5	3.9	4.2
Household with impoverishment	5.3	3.3	3.4	4.1	3.1	3.5	2.5	2.5

Note: Catastrophic health expenditure occurs when a household's total OOP for health payments equal or exceed 40% of the household's capacity to pay.
Impoverishment: A non-poor household is impoverished by health payment when it becomes poor after paying for health care services.

Source: [Van Minh Hoang, et al., 2015]

2.3 Population Coverage

Viet Nam expanded the health insurance coverage to 72.5 % (Health Insurance Department, MOH) of the population in 2015 and intends to cover 80% by 2020.

As shown in Table 2-16, the overall coverage has steadily increased since the 1990s. However, a closer look on the trend reveals that the number of voluntary members who pay premiums on their own actually does not increase to more than 10 million while the number of compulsory members who receive government or employers' support increases. In order to achieve universal health insurance, the Vietnamese health insurance scheme needs to reach the voluntary sector.

Table 2-16 Trend of Health Insurance Coverage

(Unit: 1000)

	1998	2000	2002	2004	2006	2008	2009	2010	2011
Compulsory	6,069	6,469	6,977	11,990	25,746	29,059	41,168	42,139	47,808
Voluntary	3,823	3,930	6,048	6,400	11,120	10,690	8,901	10,268	10,268
Total No of subscribers	9,892	10,399	13,025	18,390	36,866	39,749	50,069	52,407	58,484

Reference: [MOH & WHO, 2013]

Table 2-17 presents the details in the status of coverage by different member groups. Low coverage rates seem to appear in both low-income and high-income groups. The former would be unemployment allowance recipients, the near-poor, and farmers; while the latter would be self-employed and employees in the private sector. Despite the obligation, employees in the private sector show a low subscription rate. It reflects a low compliance by micro and small enterprises which comprise 95% of the Vietnamese companies[13].

Table 2-17 Status of Coverage in Membership Groups (2010)

Member Group	Population (1,000)	Insured (1,000)	Coverage Rate (%)
4.5% Salary Contribution	**15,238**	**9,506**	**62.4**
Civil servants	3,142	3,142	100.0
Employees in the private sector	11,911	6,361	53.4
Foreign students on government scholarship	3	3	100.0
Commune civil servants (elected)	182	0	0
VSS Contribution	**2,305**	**2,174**	**94.3**
Pensioners	920	920	100.0
Recipients of social security allowance	1,305	1,254	96.1
Recipients of unemployment allowance	80	0	0
Government Contribution (full support)	**30,561**	**24,675**	**80.7**
Commune civil servants	41	40	97.6
Persons of merit	1,791	1,791	100.0
Veterans	374	350	93.6
People who contributed to the revolution	322	0	0
Members of the National Assembly and people's committees	123	119	96.7
Recipients of social protection allowance	843	384	45.5
The poor and minority groups	13,945	13,511	96.9
Dependents of persons of merit	869	0	0
Dependents of officers of the Ministry of Defense and Ministry of Public Security	1,281	297	23.2
Children under six years old	10,103	8,183	81.0
Government Contribution (partial support)	**19,879**	**10,499**	**52.8**
The near poor	6,081	692	11.4
Students	13,798	9,807	71.1
Personal Contribution	**18,552**	**3,917**	**21.1**
Dependents of salaried workers and civil servants	6,820	0	0
Farmers, members of cooperatives, and household-enterprises	11,732	3,917	33.4
Total	**86,866**	**50,771**	**58.5**

Reference: [Tran Van Tien, Hoang Thi Phuong, et al., 2011]

13 Micro enterprises are the ones with less than ten employees. Small enterprises in agriculture, manufacture, and construction sectors are defined by the capital of VDN 200 million and the number of employees being 10 to 200. Small enterprises in wholesale, retail, and service sectors are defined by the capital of VDN 100 million and the number of employees being 10 to 50 (JICA, (2012) "JICA project on empowering the support to SMEs in Viet Nam.", original data is from "White Paper on Viet Nam SMEs 2011.").

Every reachable sector has already been covered because the Government of Viet Nam has provided full support to pay the premiums for socially disadvantaged groups. The coverage goal of 80% in 2020 seems to be difficult as there is not enough room to extend the coverage.

Table 2-18 presents the latest coverage rate according to the interview. Although the exact figure could not be obtained, coverage among the near poor and workers in the agriculture, forestry, and fishery sectors are quite low. Private sector employees are still less than 50%. Voluntary scheme has been changed to compulsory household enrollment under the Amendment on the Health Insurance Law (2014).

Table 2-18 Health Insurance Coverage in 2014

Scheme	%	Scheme	%
Public officers	100	Agriculture, Forestry and Fishery	Very low
The poor	100	Private sector employees	48
Children under six	100	Students	94
Near poor	Very low	Voluntary	34

Source: VSS

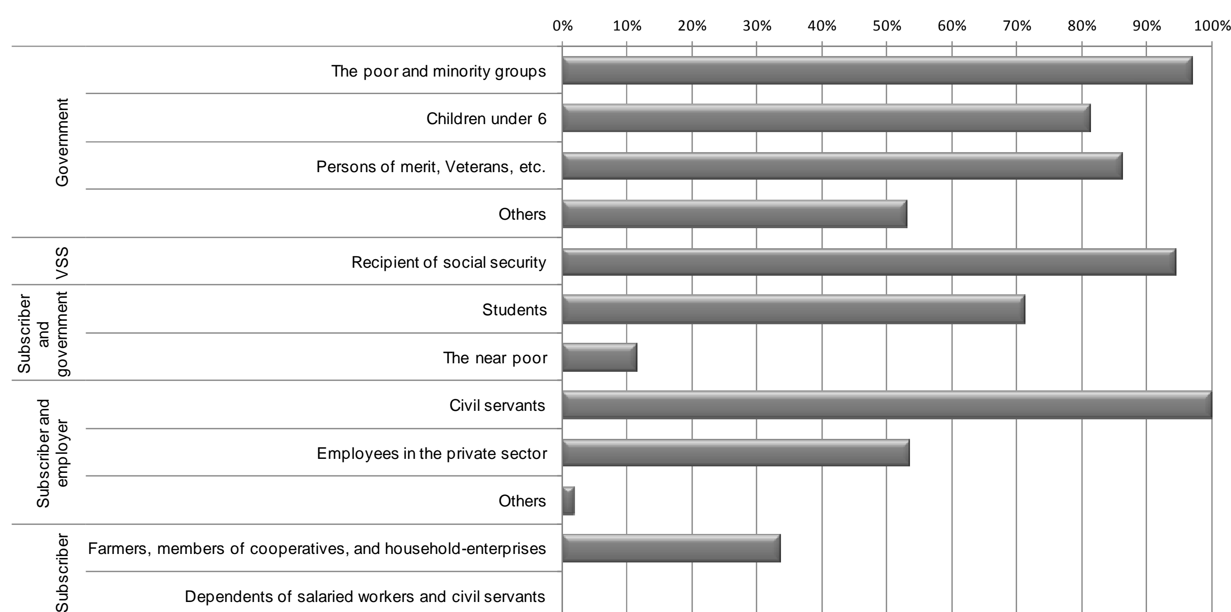
According to VSS, subscription rate of household members was 28% and it is still very low in 2015. Regarding agriculture, forestry and fishery sector workers, it was four to five percent. Especially, people living in the remote island areas seem to be reluctant to subscribe the public health insurance.

According to the interviews, the main reason of the near poor not subscribing for health insurance is due to financial difficulties, while that of the rich are due to the low reputation of public health service and their preference for private health service. Also, the near poor and informal sector workers tend to be hesitate to purchase health insurance because they are still healthy and want to use money to other purpose.

In most countries that are pursuing the goal of universal coverage for health care, reaching the informal sector remains a challenge. The most common problems in providing health insurance for the informal sector include low enrollment rates, difficulties with payment collection, and adverse selection.

Viet Nam also faces the "missing middle-income group" problem where enrollment is high among low-income and high-income groups so that the non-poor informal sector is left behind. In general, the informal sector is defined as "non-salaried" workers who have no formal employee-employer relationship such as a casual worker who works on a temporary or daily basis or is self-employed [World Bank, 2014].

Figure 2-9 shows the coverage of different member groups. It is obvious that the coverage of member group, whose premium is not supported by government subsidy, is low. The coverage rate of the informal sector including farmers, self-employed, and the near poor is quite low between 10% and 30%.



Reference: [Tran Van Tien, Hoang Thi Phuong, et al., 2011]

Figure 2-9 Coverage by Membership Groups (2010)

Looking at the real number of uncovered population by groups, the biggest population who is not yet covered by the health insurance is the self-employed including farmers (Table 2-19). The total number of uncovered farmers and self-employed reaches 7.8 million. The following table presents that 6.8 million of dependents of salaried workers and civil servants, 5.5 million of employees in the private sector, and 5.4 million of the near poor are not covered yet.

Table 2-19 Number of Uncovered Population by Major Membership Groups (2010)

	Member Group	Uncovered Population (1000)
1	Farmers and self-employed	7,860
2	Dependents of salaried workers and civil servants	6,820
3	Employees in the private sector	5,598
4	The near poor	5,412
5	Student	4,001
6	Children under six years old	1,919

Note: Calculated from the data in Table "Status of Coverage in Membership Groups (2010)"

Reference: [Tran Van Tien, Hoang Thi Phuong, et al., 2011]

The Amendment of the Health Insurance Law (2014) abolished the voluntary scheme and shifted to a compulsory one; however, raising the coverage by extending government support to the informal sector inevitable strains public financial resources. In order to achieve sustainable UHC, it is necessary to ensure the quality of public medical services and promote people's understanding on benefit of health insurance for their future to motivate the current non-insured to join the public health insurance scheme.

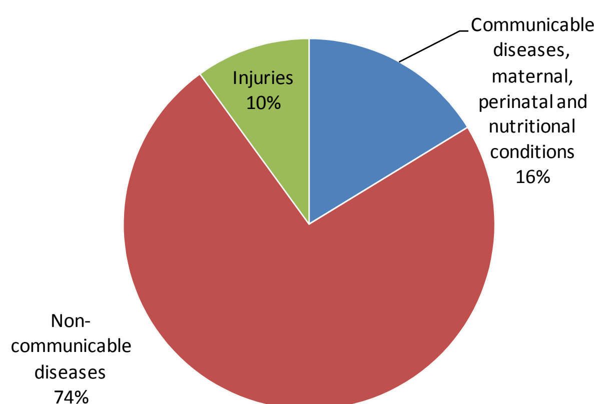
2.4 Service Coverage

2.4.1 Health Service Needs

(1) Disease Structure

According to WHO, the burden of non-communicable diseases (NCD) is high as shown in Figure 2-10. Through the interviews in the Survey, it was frequently mentioned that patient visits caused by NCD, especially hypertension have been increasing recent years.

The proportion of NCD hospitalizations has increased from 42% in 1976 to 71% in 2010. Regarding smoking, 40% of men are smokers. The exposure to second-hand smoke (SHS) is also high, 55% of adults are exposed to SHS at work and 67% are exposed at home. The prevalence of alcohol consumption has rapidly increased from 6.6 liters in 2010 to 7.2 liters in 2012 [HealthBridge, 2015].



Reference: [WHO]

Figure 2-10 Age-standardized Mortality Rate by Cause in 2012 (per 100 000 population)

According to MOH, although viral, respiratory diseases and gastroenteritis are major causes of morbidity, hypertension is the second highest. Injury also causes burden to the people as it is the top cause of mortality. Cerebral hemorrhage and myocardial infarction which are related to life-style may require high cost for emergency care, recovery and rehabilitation (Table 2-20).

Table 2-20 Major Causes of Morbidity and Mortality in 2013 (per 100,000 population)

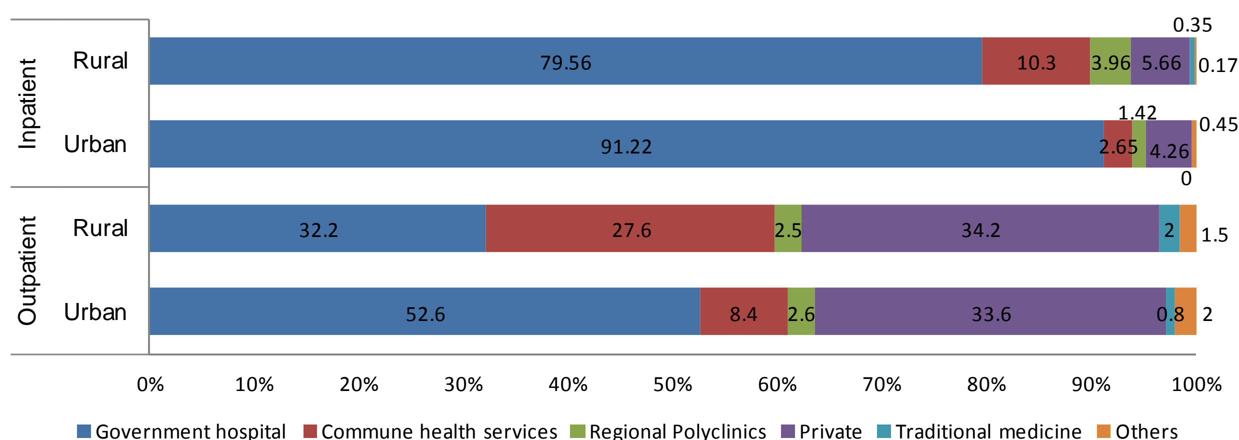
Morbidity		Mortality	
Pneumonia	470.0	Intracranial injury	1.63
Acute pharyngitis and acute tonsillitis	396.7	Pneumonia	1.28
Essential (primary) hypertension	359.3	Other respiratory disorders originating in the perinatal period	1.15
Other injuries: specified, unspecified, and multiple body regions	357.0	Intracerebral hemorrhage	0.82
Acute bronchitis and acute bronchiolitis	289.2	Acute myocardial infarction	0.78
Diarrhea and gastroenteritis of presumed infectious origin	243.3	Other injuries of specified, unspecified and multiple body regions	0.66
Gastritis and duodenitis	211.6	HIV/AIDS	0.64
Other viral diseases	182.9	Septicemia	0.56
Other arthropod-borne viral fevers and viral hemorrhagic fevers	170.5	Other diseases of the respiratory system	0.55
Other dorsopathies	168.8	Heart failure	0.51

Reference: [MOH, 2014]

2.4.2 Health Service Utilization

(1) Care-seeking Behavior

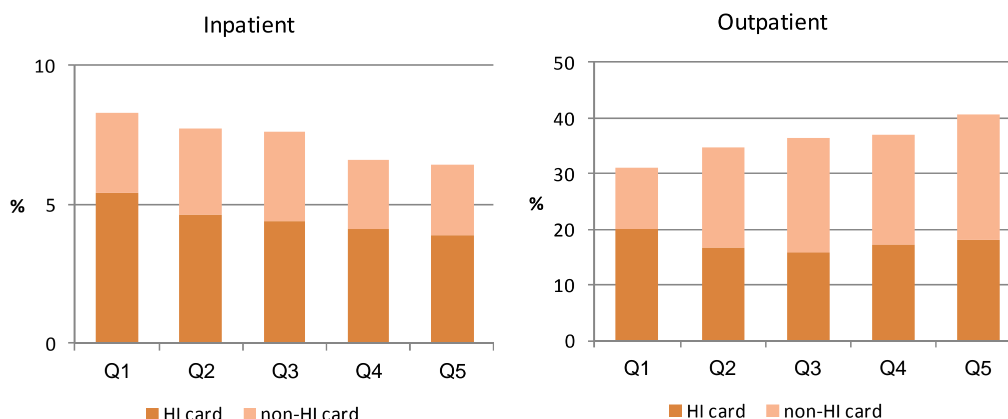
In general, many people use private health facilities for outpatient services both in rural and urban areas as shown in Figure 2-11. For inpatient services, most people seek care from government health facilities.



Reference: [GSO, 2013]

Figure 2-11 Care-seeking Behavior for the Last 12 months

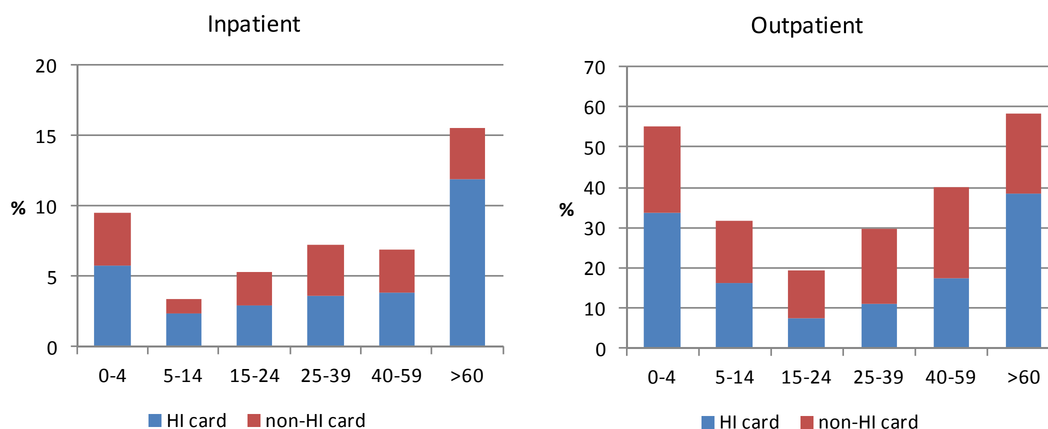
On average, health insurance subscribers access health facilities 2.08 times in a year [MOH, 2014]. Figure 2-12 presents the utilization of health care services by income quintile groups. Wealthy people use more outpatient and less inpatient services compare with the poor. Regarding the utilization of the health insurance card, around 60% to 65% of all groups use the health insurance card for outpatient services. However, it is less than 40% for inpatient, except the lowest income group [GSO, 2013], because the subscribers had to use the health facility described in their health insurance card otherwise they had to pay all the medical costs until the end of 2015. Therefore, patients in serious condition might access central or specialized hospitals without official referral procedure, and therefore, they might not use their health insurance card.



Reference: [GSO, 2013]

Figure 2-12 Utilization of Health Care Services for the Last 12 Months by Income Quintile

As shown in Figure 2-13, children under five and more than 60 years old use health services more frequently because children under five years old need to receive maternal and child health (MCH) services. Also, they are at higher risk of health problems such as infectious diseases, pneumonia and diarrhea. The elderly might have one or more chronic diseases or any other health problems.



Reference: [GSO, 2013]

Figure 2-13 Utilization of Health Care Services for the Last 12 Months by Age Group

(2) Utilization of Health Insurance

According to the Law on Health Insurance, patients are entitled to receive medical services at any health care facility without restrictions related to administratively-set geographic boundaries or technical level of the facility[14]. This allows bypassing lower-level facilities and direct self-referral to higher-level facilities, especially central facilities, resulted in under-utilization of district hospitals and overcrowding in central hospitals. Table 2-21 shows the frequency of health care visit by the subscribers which is just around twice a year, and the figure has not increased these years.

14 Although the law does not prohibit accessing to any health facilities, it does not guarantee application of health insurance.

Table 2-21 Number of Health Care Visits per Year

	Number of Visit (million)	Frequency (No./card)
2010	102	1.95
2011	114	2.01
2012	121	2.07
2013	129	2.1
2014	135	2.2

Reference: [Dr. Pham Luong Son, 2015]

The main issues identified regarding service coverage are:

- The weak capacity of lower-level health facilities (particularly district hospitals) to provide services and the inability of these hospitals to attract patients (district hospitals are able to provide about 70% of the total services that they are supposed to);
- The financial mechanisms and payment methods do not encourage lower-level hospitals to provide better quality services, as their cheaper prices negatively affect the quality of services.
  Moreover, the benefit packages do not incentivize patients to seek treatment at lower-level hospitals;
- Public hospitals are autonomous. Thus, they try to attract and retain patients. Upper-level hospitals have better capacity to attract patients; and
- The referral system is weak. Many prefer to bypass primary health care facilities due to poor quality of services and prefer to go to the hospital-level services which requires more costs.

2.5 Situation of Service Providers

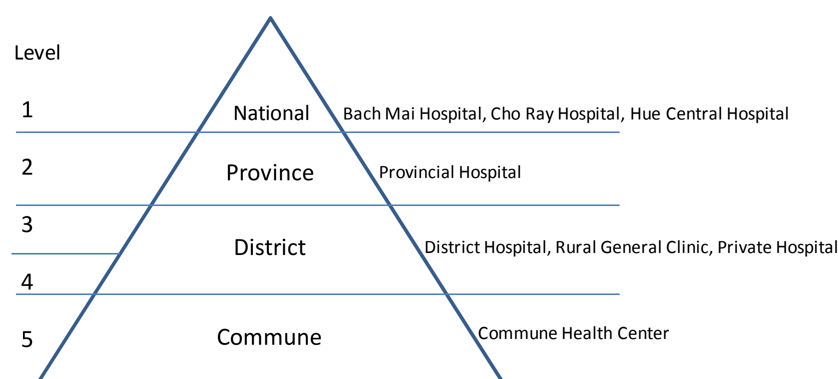
2.5.1 Health Facilities and Medical Equipment

Functions and services of health facilities at each level are defined[15] and each facility needs to fulfill the requirement from different aspects including location, function, activity, educational level of human resource for health (HRH), facility, equipment, and so forth. CHSs mainly provide primary health care including prevention, health promotion activities and simple examination. Higher-level health facilities have hospital function and the three national general hospitals[16] are the top referral hospital in each region.

The entry point for patients is CHSs and referrals are then made to the next level of care at the district, provincial, and central levels (Figure 2-14). However, as mentioned earlier, more people expect higher quality of medical service and they are more likely to visit upper-level health facilities directly, which results in more patients concentrated in the tertiary hospitals.

[15] 23/2005 / TT-BYT 2005/10/8, Guidelines for Classification of Health Service Facilities
33 /2015/TT-BYT 2015/10/27, Guidelines of Functions and Tasks of CHS

[16] Bach Mai Hospital, Hanoi (in the North), Hue Central Hospital, Hue (in Central), Cho Ray Hospital, Ho Chi Minh (in the South)



Reference: [JICA, 2014]

Figure 2-14 Referral System in Viet Nam

In order to reduce the overcrowding of hospitals especially in the five specialties (oncology, surgery/trauma, cardiology, obstetrics, and pediatric specialties) in tertiary hospitals in Hanoi and Ho Chi Minh City, MOH approved the project on satellite hospitals[17] and set up a network of 50 satellites hospitals linked to 14 hub hospitals and added 7,150 beds. Gia Lai Province also plans to apply for establishing satellite hospitals including specialties of oncology and cardiology by 2020.

The hospitals the Survey Team interviewed faced difficulties in improving hospital infrastructure and equipment. Main issues include inadequate infrastructure which is not aligned with the requirement for service provision and lack of budget to purchase and maintain medical equipment.

2.5.2 Human Resources for Health (HRH)

The public sector invested in HRH in Viet Nam to secure the number and strengthen their capacity in order to respond to the growing demand for quality health service. As shown in Table 2-22, the number of HRH has been increasing in general over the past several years.

Table 2-22 Number of Human Resources for Health (HRH) (2010-2014)

(Unit: thousand)

	2010	2011	2012	2013	2014 (estimate)
Doctor	61.4	62.8	65.1	68.6	71.8
% compared with the previous year	*101.0%*	*102.3%*	*103.7%*	*105.4%*	*104.7%*
Assistant Doctor	52.2	54.2	54.6	57.1	58.3
% compared with the previous year	*100.8%*	*103.8%*	*100.7%*	*104.6%*	*102.1%*
Nurse	82.3	88.1	92.2	98.3	102.0
% compared with the previous year	*115.1%*	*107.0%*	*104.7%*	*106.6%*	*103.8%*
Midwife	26.8	27.9	28.0	29.0	29.1
% compared to the previous year	*107.2%*	*104.1%*	*100.4%*	*103.6%*	*100.3%*
University Pharmacist	5.6	5.8	10.3	8.4	9.3
% compared with the previous year	*98.2%*	*103.6%*	*177.6%*	*81.6%*	*110.7%*

Source: [GSO, 2015]

The number of HRH has increased especially at the grassroots level. As of 2013, 76.9% of CHSs had

17 Decision 774/QD-BYT in 2013

doctors and 97.3% of CHSs had obstetrics-pediatric assistant doctors or midwives in Viet Nam[18]. As Table 2-23 indicates, although the gap in the distribution of HRH at the commune level among the regions has become smaller, there are some regions where the proportion of CHSs with a doctor is still far below the national average.

Table 2-23 Distribution of HRH at the Commune Level

	Region	2010	2011	2012	2013	2015[1)]
Proportion of CHSs with doctor (%)	**National**	**70.0**	**71.9**	**73.5**	**76.9**	**80.0**
	Red River Delta	75.7	77.5	78.7	82.5	
	Northern Midlands and Mountains	61.9	63.5	66.4	67.3	
	North and South Central Coast	66.2	66.0	68.8	69.0	
	Central Highlands	57.8	66.5	69.7	75.7	
	Southeast	80.5	85.0	83.4	69.0	
	Mekong River Delta	80.7	82.2	87.2	75.7	
Proportion of CHSs with obstetrics/pediatrics assistant doctor or midwife (%)	**National**	**95.6**	**95.3**	**96.4**	**97.3**	**>95**
	Red River Delta	92.5	95.3	92.2	93.3	
	Northern Midlands and Mountains	95.3	89.7	95.1	91.3	
	North and South Central Coast	96.6	90.5	94.5	96.1	
	Central Highlands	96.7	99.2	97.0	99.6	
	Southeast	97.5	100.0	99.1	99.2	
	Mekong River Delta	97.3	99.1	96.7	100.0	

Remark: 1) Figure shows the targets set in the Five-Year Health Sector Development Plan 2011-2015

Source: [MOH and HPG, 2015]

In order to strengthen the capacity of HRH, upper level health facilities take responsibility for giving technical guidance to lower level health facilities through the Direction Office for Healthcare Activities (DOHA). In order to narrow the gap in the quality of HRH, MOH has another policy that doctors at upper level hospitals transfer medical techniques to doctors at lower-level hospitals and help lower level hospitals provide assigned services[19].

The capacity of district hospitals has been strengthened under the above health policies, but the capacity still needs to be further strengthened, based on the interviews[20]. In particular, there has been an urgent need of responding to increasing number of chronic diseases. According to the Joint Annual Health Review (JAHR) in 2014, priority issues in strengthening response in NCD prevention and control from a human resource management perspective, include deploying HRH for NCD prevention and control with special focus on grassroots level, strengthening training courses that should be combined with post-training support and supervision, organizing support for professional development of HRH in this field directly in the workplace and strengthening remuneration to encourage HRH to work at the grassroots level [MOH and HPG, 2015]. In Gia Lai Province, for example, the provincial hospital conducts needs assessment for district hospitals and provides in-service training for doctors at the Gia Lai

[18] JAHR2014
[19] Decision 1816/2008/QĐ-BYT
[20] Result from interviews with provincial hospitals and other local authorities

Provincial Hospital. In order to respond to chronic disease and cardiovascular disease at the district hospitals, training program has been revised by taking into account these priority areas.

2.5.3 Medical Supply

As mention in Section 0, drug procurement system has changed and pharmacy department of DOH is in charge of drug procurement for all hospitals in the province. The process of new bidding system is as follows: 1) district hospitals submit the list of essential medicines to DOH, 2) DOH makes an official notice and put in a tender, 3) drug price is decided and 4) each hospital contracts with a pharmaceutical company. This new system has contributed to decreasing drug prices which was endorsed by hospitals in both provinces.

On the other hand, challenge still remains in drug supply. In Hoa Binh Province, some CHSs lack of necessary drugs which are supposed to be distributed through a district hospital. In particular, they do not receive enough amount of medicine for children and they use medicine for adult instead as a substitute by reducing the dose of medication.

Chapter 3 Overview of the Health Insurance System in Viet Nam

3.1 History and Progress

Table 3-1 presents the development process of health insurance system of Viet Nam. Health insurance was first introduced in Viet Nam during the economic reform in the late 1980s to early 1990s known as Doi Moi. After that, the government promulgated the first decree on health insurance in 1992, and all provinces implemented health insurance scheme under the supervision of the provincial health authorities.

In 1998, the government unified the provincial health funds into a single national fund, and it also extended the coverage. In 2005, the poor were to be covered by the health insurance through an appropriation of government funds for their insurance premiums.

In 2008, the Law on Health Insurance was passed and enacted on 1 October 2009. It is the first time that the health insurance scheme, which had been administered by ministerial decrees, gained legislated status. With an objective of achieving universal health insurance, the government amended and supplemented some provisions on the Law on Health Insurance in 2014.

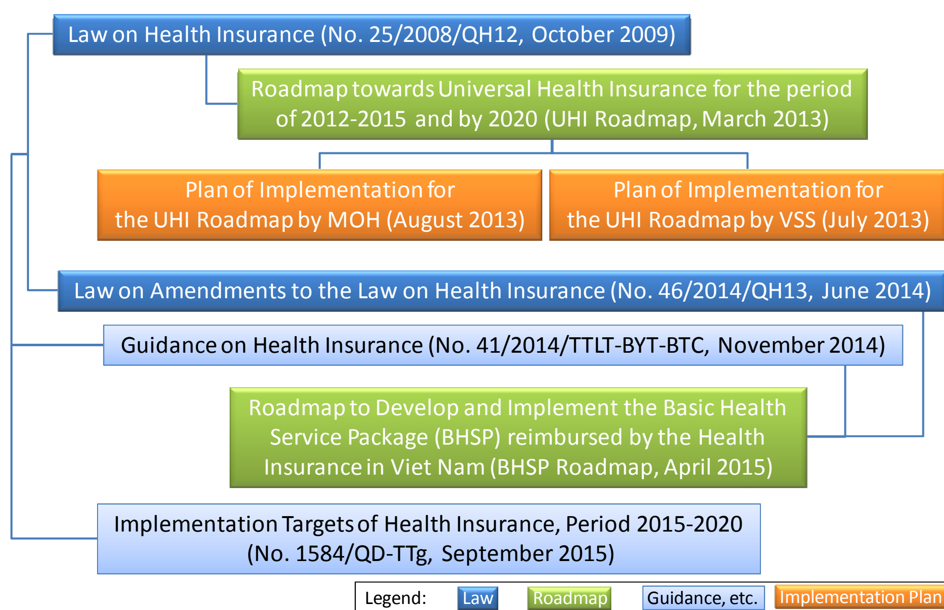
Table 3-1 Development Process of Health Insurance System

Year	Policy concept	Summary of Major Policies
1986	New financing mechanisms for health care	Economic reform led by the Doi Moi policy - Introduction of health insurance scheme - Liberalization of healthcare and pharmaceutical markets - Introduction of user fees in public health facilities
1992		Establishment of compulsory health insurance scheme - Compulsory group includes: civil servants, employees in companies with ten or more employees, pensioners, social assistance recipients, employees in foreign companies
1998	Unified health insurance system/health insurance fund	- Integration of each provincial health insurance fund into a single national fund - Expansion of the insurance coverage
2005	Compulsory and voluntary health insurance	Coverage of the poor supported by the government - Law on Education, Healthcare, and Protection of Children also provides free access to medical treatment for children under six years old
2009	Universal health insurance	Legislation of health insurance scheme which had been administered by ministerial decrees (Law on Health Insurance) - Ensuring the coverage of the poor, the elderly, and children under six years old by full government support - Provision of partial government support to the near poor and students
2014	Compulsory universal health insurance	Amendments to the Law on Health Insurance - Compulsory participation in health insurance scheme - Participation by household - Expansion of benefit levels - Revision of medical fee schedule - Development of Basic Health Service Package

References: [JICA, 2014] [VSS, 2015]

3.2 Legislations, Roadmaps and Implementation Plans on Health Insurance

Relevant legislations, roadmaps and implementation plans are summarized as shown in Figure 3-1. According to the Law on Health Insurance of 2008, the Roadmap towards Universal Health Insurance for the Period of 2012-2015 and by 2020 (UHI Roadmap) was promulgated. Then, MOH and VSS developed the plan of implementation. After the Amendments in 2014, the Guidance on Health Insurance and the implementation target were circulated. Also, BHSP Roadmap was approved to develop the BHSP by 2018.



Source: Survey Team

Figure 3-1 Relevant Legislations, Roadmaps and Implementation Plans on Health Insurance

3.3 Development Strategies and Plans Relevant to Social Security Sector

3.3.1 Socio-Economic Development Strategy (SEDS) 2011-2020

The Government of Viet Nam issued the Socio-Economic Development Strategy (SEDS) 2011-2020, a ten-year development strategy on the socio-economic sector. Table 3-2 summarized the targets and strategies relevant to social security.

Table 3-2 Summary of SEDS 2011-2020

View	Rapid and sustainable development, parallel restructure of policy and economy, human resource development, improvement of science and technology, and establishment of independent and autonomous economy	
Target (2020)	Economy	Gross domestic product (GDP) – average annual growth rate: 7%-8% GDP per capita – from USD 3,000 to USD 3,200
	Socio-culture	Human development index (HDI) – middle-high group Population growth rate – 1.1%; Life expectancy rate at birth – 75 years; Number of medical doctors per 10,000 – 9; Number of hospital beds per 10,000 – 26. Universal health insurance, security of social welfare and public medical services Poverty rate – decline 2% to 3% per year; National income – 3.5 times of 2010; Reduce income gaps
	Environment	Proportion of medical waste treated per regulation - 100%
Strategy	1. Completion of socialist market economy and sustainable macro economy. 2. Modernization of industry. 3. Development of modern and sustainable agriculture. 4. Development of service industry. 5. Infrastructure development. 6. Development of new cities and villages by sustainable regional development (diversification and development of social insurance system, encouraging labors to join such insurances by giving preferable conditions). 7. Improvement of income level and increasing growth of the middle classes. 8. Development of medical services and improvement of health care (strengthening of health service network at each level; standardization of services; improvement of policy and legislations on health insurance and medical care towards universal health insurance; safety net for the poor, children, and the elderly; quality improvement of human resource for health, allocation of medical doctors to all villages, enhancement of preventive medicines). 9. Improvement and development of the education and training system. 10. Rapid development of science and technology to contribute to economic development. 11. Environmental conservation and respond to climate change. 12. Ensuring political and social order and raising the international position.	

Source: [JICA, 2014] [Vietnam Government Portal]

3.3.2 Prime Minister's Decision on Establishment and Development of Medical Facilities Network in the New Situation

On 5 December 2016, the Prime Minister's Decision on Establishment and Development of Medical Facilities Network in the New Situation (2348/QĐ-TTg) was published. It instructs to strengthen health services at primary level provided by commune health stations and district health centers. It aims to establish unified model of health facilities, strengthening operational capacity, introducing IT, and human resources at the primary level to meet requirements of the government and health needs of the people by 2020. Also, the decision directed to establish comprehensive and continuous health care from prevention, treatment and rehabilitation by dispatching medical doctors to areas in socio-economic difficulty, health education, as well as strengthening of elderly care, chronic disease control, and family doctors.

In terms of financial aspects, the decision mentions to strengthen health financing mechanism for primary level services with the following measures:

- To expand health insurance coverage by supporting premium payment to groups which has had low coverage rate such as agriculture, fishery and forestry sector;
- To revise medical services and drugs to be covered by health insurance fund at the primary level;

- To develop a certain standard of medical services and fees to be provided by family doctors which are paid by health insurance fund;
- To develop basic health service package for the primary level health facilities;
- To update costs for preventive services to be covered by the state budget; and
- To develop policy to encourage collaboration with private service providers.

3.3.3 Five-Year Health Sector Development Plan

During the previous five-year plan from 2011 to 2015, the health status of the people has been improved through implementation of seven key activities. Based on the assessment of achievements and challenges in the previous plan, MOH developed the Plan for People's Health Protection, Care and Promotion 2016-2020 (Health Sector Five-Year Plan 2016-2020). Table 3-3 summarizes the goals and specific objectives of the Health Sector Five-Year Plan 2016-2020.

The latest plan indicates 16 targets in the Socio-Economic Development Plan (SEDP) 2016-2020 and the 43 targets. The former includes mainly outcome indicators. Regarding health financing, health insurance coverage is included to achieve 84.3% by 2020. The latter includes input (4), output (23) and impact (16) indicators and 16 out of these are on non-communicable disease (NCD). OOP is included as one of the input indicators to achieve 40% by 2020. It suggests that the latest policy could respond to the changing health needs caused by transition of disease pattern.

Table 3-3 Summary of the Five-Year Health Sector Development Plan 2016-2020

Goal	・To reduce the morbidity and mortality from diseases and epidemics, contributing to an increase in life expectancy and better health status of the people. ・To improve the capacity, effectiveness, and sustainability of health system to meet the people's health care needs in conditions of industrialization and modernization.
Specific Objectives	・To implement UHC, ensuring all the citizens to have access to basic health care services of good quality. ・To improve the quality and efficiency of the network of health service providers, ensuring their collaboration, connectivity and integration among the services such as preventive services, rehabilitation, primary health care, and medical treatment. ・To maintain a reasonable low fertility by reducing defects and congenital diseases, providing family planning services, and increasing people's access to quality reproductive health services. ・To ensure a balance in the allocation and provision of training programs for health workforce among regions. ・To increase the proportion of public expenditure on health toward universal health insurance by improving the efficiency of allocation and use of the budget. ・To ensure an adequate supply of medicines, vaccines, blood and medical equipments to meet the needs of prevention and care of diseases. ・To improve the capacity of managing and implementing policies, and promote administrative reform to meet the needs of development in health sector.

Source: [MOH, 2016]

Table 3-4 summarizes achievements and challenges identified through assessment of the previous plan and major tasks and solutions to be taken in Health Sector Five-Year Plan 2016-2020. From this comparison, the government has been prioritizing the following issues:

- To decrease overload of central, specialized and some provincial hospital;
- To improve service quality;

- To strengthen service providing capacity at lower level (commune and district);
- To optimize referral system;
- To enhance cross-sectoral/inter-specialization collaboration;
- To optimize health care costs;
- To promote evidence-based decision making; and
- To mobilize financial resources other than government budget.

Table 3-4 Achievements and Challenges in the Health Sector Development Plan 2011-2015 and Major Tasks for 2016-2020

Category	Achievements and Challenges for 2011-2015	Major Tasks and Solutions for 2016-2020*
Curative Services and Rehabilitation	Achievements • Key Duty 1: Overcrowded hospitals are reduced. - Upgrading of hospitals (610 out of 766 provincial and district hospitals) - Construction of new hospitals (five central hospitals) - Strengthen satellite hospital network (15 key hospitals with 60 satellite hospitals in 41 provinces) • Traditional medicine departments/sections have been set up in 90% of hospitals and 74.3% of CHSs. • By 2015, 171 private hospitals (11% of total hospitals, 4.8% of total beds) and more than 30,000 private clinics have been operated. • Hospital quality management - 55.4% hospitals have quality management units. - Patient feedback system has been developed. Challenges • Combination among preventive/curative care and rehabilitation, as well as traditional and modern medicines • Healthcare model for the elderly	To reduce overcrowding in hospitals and improve service quality ➢ Increase in the number of hospitals and beds ➢ Expansion of satellite hospital network ➢ Technical transfer from upper level to lower level (DOHA) ➢ Introducing quality management system at all level ➢ Reform of administration procedure ➢ Combinations between PHC and high-tech service/ traditional and modern medicines ➢ Development of gate-keeping function of lower level health facilities ➢ Optimal referral network with simple procedure
Preventive medicine	Achievements • Key Duty 4: Health care at the grassroots level and PHC are strengthened. • Key Duty 7: Effectiveness of health communication and education are improved. • Capacity of prevention of epidemic was strengthened. • EPI coverage was maintained >90%. • Morbidity and mortality of preventable diseases have decreased. (Dengue, HFM, and H5N1) were decreased. • NCD screening for hypertension, diabetes, chronic obesity, COPD, and asthma has been implemented. • School health program has been implemented in collaboration with MOET • Environmental management has been practiced in health facilities • People living with HIV receiving antiretroviral (ARV) treatment increased from 57.7% (2011) to 67.6% (2015). • Inspection visits on food safety has been implemented. Challenges • Newly emerging epidemic diseases • HIV and tuberculosis especially in the northern uplands and other remote areas	To develop the health care network at the grassroots level, to focus on preventive medicine and health promotion ➢ Investment for infrastructure ➢ Restructure of organization ➢ Reform of financing mechanism by applying appropriate service price ➢ Development of appropriate payment method for family doctors, home-/community-based care ➢ Strengthen community health services ➢ EPI, ART ➢ Waste management ➢ Food safety

Category	Achievements and Challenges for 2011-2015	Major Tasks and Solutions for 2016-2020*
	• Epidemic surveillance and notification from hospital • Health service system responding needs for NCD detection and treatment • NCD related projects are overlapping without integration, consistency and continuity. • Low hygienic latrines in 18 provinces • Food poisoning • Inappropriate and inflexible health education and communication are	
Reproductive Health	Achievements • Population growth was maintained 1.05% annually. • Antenatal and postnatal screenings have been expanded from 11 to 63 provinces. • Pre-marriage counseling and check-up model were developed. Challenges • Access to quality ante-natal care • Unmet reproductive health needs	To promote maternal and child health, population and family planning services ➢ Encourage obstetricians to work in remote areas ➢ Enhancing maternal and newborn mortality audit ➢ Strengthening inter-sectoral intervention with hygiene and nutrition ➢ Focusing on unmet reproductive health needs
Human Resource for Health	Achievements • Key Duty 5: Human Resource for Health (HRH) development has been strengthened. - According to the Law on Medical Examination and Treatment 2011, proportion of licensed HRH are 92% under MOH, 67% under other ministries, and 89% under provinces. - Competency standard for nurses (2012), midwives (2014), and GP (2015) were developed. - Code of conduct for medical doctors was developed. - Service attitude reform activities were carried out. • Key Duty 6: Pilot project of demand-based health services delivery was implemented. Challenges • Mal-distribution of HRH • Management capacity • Inappropriate behavior due to inappropriate incentives/salary	Development of health workforce, science and technologies ➢ Training complying to regional and international standard ➢ Competency standards ➢ Appropriate distribution of HRH ➢ Development of family doctors from general physicians ➢ Development of management capacity ➢ Introducing practicing certification To implement well the code of conduct and improve professional ethics ➢ Expanding HCMC model of patient service ➢ Innovation of attitude and behavior
Health Financing	Achievements • Key Duty 2: Renovating financial mechanisms of public non-business health units are introduced. - External financial resources were mobilized through socialization, joint venture, and public-private partnership (PPP). - New medical fee schedule was introduced. - Financial autonomy has been promoted and accordingly, state budget was	Reform of health financing and implementation of the universal health coverage roadmap ➢ Health financing strategy in 2016 ➢ Public expenditure in total health expenditure: at least 60% by 2020 ➢ Mobilization of external investment, new financial source (tobacco and alcohol taxes), loan, PPP, etc. ➢ Awareness of HI benefit and purchase, support for the vulnerable

Category	Achievements and Challenges for 2011-2015	Major Tasks and Solutions for 2016-2020*
	allocated more to subsidize the health insurance premium of the poor. - New financial sources (tobacco tax, 2013, VND 400 to 500 billion/year) are introduced. • Key Duty 3: UHI Roadmap has been implemented. - 39 provinces pay a part of the health insurance premium for the near poor. • Pilot projects of capitation and DRG have been implemented. • A package of basic health service is under development. Challenges • High OOP expense	groups ➢ Health insurance coverage: 84.3% by 2020 ➢ Prioritize investment for hospitals in disadvantaged areas, preventive medicine ➢ Gradually introducing performance and output-based budget allocation ➢ Revising medical fee schedule to include recurrent costs ⇒ Payment from health insurance fund will cover recurrent cost. ⇒ Financial autonomy will be promoted. ➢ Introducing business administration model to hospital management ➢ Evidence-based drug and medical supply, medical service selection, technology and need assessment ⇒Basic health benefit package* by 2018 and PHC package ➢ Capitation and DRG pilot ➢ Change ODA modality from project loan to budget support program ➢ Ensure financial resources to increase salary of HRH
Pharmaceutical Products	Achievements • The project "Vietnamese people prioritize domestically produced drugs" - Many hospitals use domestically produced drugs, which helps reducing costs for patients. • Vietnam Social Security (VSS) has been increasingly enhancing its role in controlling drug prices and costs paid by health insurance fund. • 10 out of 11 vaccines for EPI are produced in Viet Nam. Challenges • Generally, most people and even health workers like to prescribe and use imported drugs in health care and treatment. • No specific mandated authorities to control drug price	To renew the organizational structure of the management apparatus to guarantee the safety of foods, drugs, vaccines, biological and medical equipment ➢ Renew of mechanism to control food safety and drug quality ➢ Enhancing domestic production of medical equipment to meet at least 60% of needs, and drugs to meet at least 80% of needs. ➢ Reviewing regulation on centralization of drug procurement
Medical Equipment and Infrastructure	Achievements • New hospitals, upgrade of hospitals, development of satellite hospital • Medical equipment maintenance team Challenges • Availability in the grass-roots level • Maintenance mechanism	

Category	Achievements and Challenges for 2011-2015	Major Tasks and Solutions for 2016-2020*
Governance	Achievements • Promulgated relevant laws - Family doctor model (2013) was developed and applied to 240 clinics. - Tobacco control (2012), health insurance (2014), etc. • Adjustment of organization structure to actual needs Challenges • Health policies are not issued timely and, are overlapped and inconsistent. • Collaboration between stakeholders is limited. • Information and reliable evidence for health policy development is not sufficiently provided.	To reform, consolidate and complete the health system from central to local levels; to improve the effectiveness of state management for health and strengthen international cooperation ➢ District health centers take care of dual function, preventive and curative. ➢ Curative care functions of provincial preventive facilities are shifted to provincial hospitals ➢ Merging testing functions ➢ Evidence-based policy making to strengthen advocacy capacity ➢ Reform of administrative procedures with IT for management, service delivery, and health insurance payment ➢ Collaboration with neighboring countries
Health Information System	Achievements • Implementation of the Health Information System Development Strategic plan 2014-2020, 2030 • Document management software and web-based administration was installed for MOH and all provincial/municipal DOH • Pilot project of e-health insurance card Challenges • Data dissemination mechanism is unclear without appropriate focal point. • Medical record does not link to others within a hospital. • Quality of data (timeliness and completeness) is concerned. • Private sectors are not involved. • Routine reports are inaccurate and necessary data is not available.	To develop the HIS, to enhance and improve the effectiveness of health communication and education ➢ Strengthening information management capacity to provide appropriate policy evidences to decision markets.

Note: *In the plan 2016-2020, a term of BHSP is not mentioned both in Vietnamese and English versions. According to MOH, to avoid misunderstanding, the term has been changed.

Source: [MOH, 2016]

3.3.4 Legislations

As described in the previous section, the Government of Viet Nam has promulgated and implemented several decrees and laws on health insurance since the late 1980s. The legislations related to health insurance system are described in Table 3-5.

Table 3-5 Relevant Legislations on Health Insurance

Number	Outline
Inter-Ministerial Circular No. 4/2012/TTLT-BYT-BTC (February, 2012)	**Promulgating the Maximum Price Level of the Medical Examination and Treatment Services in State Medical Examination and Treatment Facilities** The circular provides the maximum price level of the 447 medical examination and treatment services in state medical examination and treatment facilities.
Circular No. 27/2013/TT-BYT (September, 2013)	**Promulgating the List of Medical Equipment and Supplies of which Incurred Costs shall be Covered by the Health Insurance Fund** The circular provides the list of medical equipments and supplies covered by health insurance, which includes common and man-made consumable items and equipments used for diagnosis, treatment and life support.
Circular No. 43/2013/TT-BYT (December, 2013)	**List of Medical Services and Examinations to be Covered by Health Insurance** The circular provides routing techniques, decentralization of technical expertise and competent technical approval lists based on medical systems and treatment.
Law No. 46/2014/QH13 (June, 2014)	**Amendments to the Law on Health Insurance (The details of the amendments are described in Appendix 2.)** The law provides amendments and supplements to the law on health insurance No. 25/2008/QH12. The major points of the amendment provided in the law are; - Health insurance is a compulsory scheme implemented by the state. - All household members whose names are included in the family registers or temporary residence book shall be insured. Discount is applied for the premium rate; 100% for the 1st member (6% of minimum wage), 70% for the 2nd member, 60% for the 3rd member, and 50% for the 4th member. - Premium rate will be increased from 4.5% to 6.0%. - Benefit levels are increased. ➢ from 95% to 100% for poor household and other groups in socio-economic difficulties and islands ➢ from 80% to 95% for relatives of persons meritorious services and war veterans - Free-access to health facilities at district and commune level within the province from 1 January 2016. - Free-access to health facilities at provincial level within the nation from 1 January 2021. - BHSP covered by health insurance fund is to be promulgated by 2018.
Joint Circular No. 41/2014/TTLT-BYT-BTC (November, 2014)	**Guidance on Health Insurance** The circular was promulgated by MOH and the Ministry of Finance (MOF) to guide the implementation of the law No. 46/2014/QH13. It provides; - Membership of subscribers (five groups) - Determination and payment of health insurance premiums - Issue of health insurance card and organization/person to make a list of subscribers - Provision, access and claim examination of medical services covered by health insurance - Provider payment methods (Capitation, Fee-for-service, Per-visit) - Payment on medical services directly made between the social insurance organization and subscribers (necessary documents, direct payment) - Management and use of health insurance fund
Circular No. 50/2014/TT-BYT (December, 2014)	**Classification of Surgeries, Medical Procedures and Personnel Norms Applied to Operations and Medical Procedures** The circular promulgates the classification of surgery degree and the number of human resources for each surgery.

Number	Outline
Decision No. 1584/QD-TTg (September, 2015)	**Assign Implementation Targets of Health Insurance Period 2015-2020** The decision assigns the target of the coverage of health insurance for the period 2015-2020 to the People's Committees of each province and city.
Joint Circular No. 37/2015/TTLT-BYT-BCT (October, 2015)	**Unified Regulation of Medical Service Price covered by Health Insurance between Hospitals of the Same Rank in the Nation** The circular regulates the unified price of medical examination and treatment services covered by health insurance between the hospitals of the same rank in the nation. For medical examination and treatment services which are not paid from the health insurance fund, the price made under the provisions of Law on Price, Law on Medical Examination and Treatment, and other related guiding laws and regulations is applied.
Decision No. 4389/QĐ-BYT (August, 2016)	**Establishment of National Advisory Council on Health Insurance Policy** The decision instructs to establish the National Advisory Council of Health Insurance Policy (NACHIP) and five sub-committees; drugs, medical materials, technical services, and finance and medical fee schedule.
Circular No. 35/2016/TT-BYT (January 2017)	**Rate and Conditions of Payment of Medical Fee to be Covered by Health Insurance Fund** The circular stipulate condition of payment for advanced and/or high-cost medical services such as (In total, 124 services are listed and 15 of those, mainly CT, have limit rates to be covered by health insurance fund.) In addition, 16 services, mainly genotyping, are not tentatively covered by health insurance fund.

References: [The National Assembly, 2014] [MOH, 2013] [MOH and MOF, 2014] [MOH and MOF, 2012] [MOH, 2013] [Prime Minister, 2015] [MOH, Aug. 2016] [MOH, Sep. 2016]

3.3.5 Roadmaps

(1) Implementation of the Roadmap towards Universal Health Insurance for 2012-2015 and by 2020 (UHI Roadmap)

In March 2013, the Government of Viet Nam promulgated the Decision No. 538/QD-TTg that approves implementing the UHI Roadmap. The roadmap describes objectives of the scheme, several solutions to achieve the objectives, and assignment of each ministry/organization concerned with health insurance scheme. Table 3-6 summarizes the activities for the objectives to be conducted from 2012 to 2015 and by 2020.

Most of the activities have been successful such as: amendment of the Law of Health Insurance; and expansion of the coverage by household subscription and sharing list of target population. Meanwhile, some are still in the process such as improvement of administrative process with IT; upgrading service quality at the primary level; modification of provider payment method; and enhancement of claim examination.

In June 2016, the Prime Minister instructed to set the national target of health insurance coverage at 90% by 2020.

Table 3-6 Outline of the Roadmap towards Universal Health Insurance for the Period of 2012-2015 and by 2020 (UHI Roadmap)

	Target	Activities
2011-2015	- Coverage: >70%	1. Draft revision of the Law of Health Insurance by 2014. 2. Involvement of local governments. 3. Expansion of the coverage ・ To enhance the control of participation of private companies and premium payment; ・ To increase subsidy for premium of students and the near-poor; ・ To introduce household subscription; and ・ To share list of targets of subsidization among concerned organizations. 4. Improvement of the quality of insurance covered medical services and patient satisfaction. ・ To improve payment process, introduce information technology (IT), review the beneficial package, study on pharmaceutical cost control, technical transfer to lower level hospitals, etc. ・ To allocate physicians to all commune health stations (CHSs), to provide insurance covered medical services, design incentive system aiming to ensure quality human resources at lower level health facilities. ・ To promote participation of private health facilities. 5. Promotion of preventive medicine and primary health care (PHC). 6. Awareness raising on the Law on Health Insurance. 7. Improvement of financial mechanism and payment system of remuneration. ・ To shift from fee-for-service to capitation or case-mix payment; ・ To provide incentive to beneficiaries who do not use insurance covered medical services; and ・ To study the benefit of health insurance appropriate to the premium amount. 8. Enhancement of inspection and examination. 9. Strengthening of management capacity of the government agencies. 10. Maintenance of health insurance fund. 11. Application of IT ・ To study the smart card system for the health insurance card from 2013. 12. Research and international cooperation.
By 2020	- Coverage: >80% - OOP: <40% - Improvement of insured medical services	Development of health care network including specialized medical services (in regard to "4. Improvement of the quality of insurance covered medical services and patient satisfaction")

Reference: [JICA, 2014]

(2) Roadmap to Develop and Implement BHSP (BHSP Roadmap)

In April 2015, MOH issued the Roadmap to Develop and Implement the Basic Health Service Package (BHSP) reimbursed by the Health Insurance in Viet Nam (BHSP Roadmap), indicating the procedure for the period of 2014 and 2017. Aiming at promulgating BHSP by 2018, relevant tasks have been implemented since October 2014; Phase 1 last until April 2015 and Phase 2 has been conducted since May 2015.

Table 3-7 Major Tasks on the Roadmap to Develop and Implement BHSP

Time Frame			Task	Deliverables
Stage I	2014 2015	Nov-Dec Jan- Apr	☑ To establish a Steering Committee at the national and provincial level, BHSP developing a Board and Technical Team ☑ To define the TOR for the council that leads the BHSP reimbursed by health insurance ☑ To finalize the BHSP roadmap ☑ To investigate all available health services ☑ To analyze costs and utilization of health services based on actuarial analysis	☑ TOR for BHSP council ☑ Approved BHSP roadmap ☑ Health service availability report ☑ Draft actuarial analysis on prioritized health services and costs
Stage II	2015	May- Dec	- To identify policy goals ☑ To establish BHSP council ☑ To design and implement communication strategy for stage two ☑ To conduct an actuarial analysis of data on social health insurance based on VSS database - To identify options for prioritized health services - To produce BHSP design option paper and financing - To draft pilot study protocol, implementation manual, and M&E plan - To select an option to conduct a pilot study (or assessment) from option paper - To implement a pilot study on BHSP in 12 months - To revisit the possibility of covering prevention services within BHSP	- Agreed and consistent policy and goals ☑ Decision to establish BHSP council ☑ Detailed communication strategy - All analyses agreed by the council - BHSP option paper covered by health insurance - Protocol of pilot study - Implementation manual - Implementation plan of pilot study - M&E plan of pilot study - Report on pilot study
Stage III	2016	Jan- Dec	- To implement communication strategy for stage three - To conduct impact assessment of the pilot study - To develop an implementation manual for updated BHSP - To draft circular for BHSP - To develop implementation strategy for scale up of benefit package beyond pilot provinces - To release circular on updated BHSP	- Implementation plans and results of communication strategy - Impact assessment of pilot study - Updated implementation manual - Draft circular - Release of the circular on BHSP

Note: ☑=The Survey Team observed its implementation until December 2016

Reference: [MOH, 2015] and Survey Team

1) Implementing Structure

The Department of Planning and Finance (DPF) has been coordinating the activities. Table 3-7 summarizes the functions of major concerned agencies and organizations to implement the BHSP Roadmap.

According to the BHSP Roadmap, a new council for BHSP was to be established. However, it was decided to establish the National Advisory Council on Health Insurance Policy (NACHIP) based on Decision No.900/QD-BYT (March 2016) and Decision No. 4389/QĐ-BYT (revised version, August, 2016). The council is chaired by the Vice-minister of Health and the secretariat of the council will be the Department of Health Insurance. The main tasks of the council includes making the list of techniques, services, drugs and materials covered by the health insurance fund, developing medical service fee, developing BHSP, etc. The council has five sub-councils on drugs and medical materials, technical services, medical fee costing, and development and management of subjects in health insurance scheme.

Table 3-8 Implementing Structure of BHSP Roadmap

	Agencies/ Organizations	Major Functions
MOH	- Department of Planning and Finance (DPF)	Coordinating the activities
	- Department of Health Insurance - Vietnam Administration of AIDS Control (VAAC) - Medical Service Administration (MSA)	Providing consultation and technical inputs
	- Health Strategy and Policy Institute (HSPI)	
Vietnam Social Security (VSS)		Cooperating for data collection
Pilot Provinces*	- Department of Health (DOH) - Health facilities - Local Social Security (SS)	
Donors	- Lux-Development S.A. (LuxDev)	Data collection, analysis, and technical inputs for Phase 1.
	- Health Finance and Governance (HFG) Project /USAID	Data collection, analysis, and technical inputs for Phase 2.

Note: Phase 1 - Ha Nam, Nghe Anh, Khanh Hoa, Gia Lai, and Thua Thien-Hue (central hospital only)
Phase 2: - Hanoi and Ho Chi Minh (central hospital only), Hoa Binh, Nghe Anh, Binh Dinh, Dong Thap

Reference: Interviews

2) Progress

In Phase 1, data on basic information of health facilities, including financial situation and frequency of service utilization, was collected and analyzed.

In Phase 2, more detailed data on medical treatment and examination of approximately 500,000 samples have been collected from all levels of local health facilities. Generally, the data collection had been behind schedule because of the insufficient collaboration among the stakeholders especially between central and local, as well as MOH and VSS. According to HFG, the data collection was generally behind the schedule especially at CHSs because they compile the data manually.

Moreover, due to lack of data accuracy, HFG has been verifying the data through logical check and comparing between claim data and hospital data. The team has been working with DOH, health facilities and the social security institutions (VSS, PSS and DSS) to improve data quality. Preliminary results of the actuarial analysis were disseminated in late April 2016. However, the actuarial analysis was based on the limited medical services and options of prioritized health services for BHSP were not presented.

In August 2016, progress of the BHSP development was reported in the workshop. HSPI presented proposed definition and concepts of BHSP, but it seemed difficult to build a consensus on the definition. In November 2016, final rests of actuarial analysis were presented with some proposed options of the package for some selected medical services. In general, it seemed to be agreed to set certain criteria and payment condition for high-cost and advantage medical services. In October 2016, the second draft circular of BHSP was prepared based on the previous discussions and inputs from stakeholders. In January 2017, the draft was prepared and the discussions seem to be continued among stakeholders.

3) Outline of Collected Data

In February 2016, a part of data was provided to the Survey Team. It was for some health facilities in two provinces. In the original plan, the data is to be collected from six provinces for three years, from 2012 to 2014. However, as of February 2016, it seems to be difficult to have a complete set of data of all provinces for all years. Table 3-9 shows the contents of data collected from the target areas.

Table 3-9 Contents of Collected Data

Category	Contents	
Demography	Population per age group, gender, year	
Health insurance membership	List of members (anonymous)	
Inpatient and outpatient	Name of health facility	
	General characteristics	- Year of birth - Gender - Unique number
	Health insurance	- Number - Date of expiry - Registered facility
	Referral	- Official procedure - Facility of origin
	Service utilization	- Date of visit/hospitalized - Date of discharged - Days of stay - Diagnosis with ICD-10 code - Department
	Provided services and cost	- Name of treatment/ drugs - Unit price - Total amount - Amount paid by: ・ Health insurance fund ・ Other financial source ・ Co-payment/OOP

Reference: HFG-USAID

From the above data, the following information may be obtained by simple statistical analysis:

- Total cost and procedure (examination, treatment, and prescription) for one diagnosis; if the patient continues receiving treatment in one health facility until recovery. However, such patient status seems not included in the collected data, it could not be identified whether the patient has recovered from a specific illness, terminated the treatment, or was referred to other health facility.
- Common diseases among the patients by age groups, health insurance membership groups, and level of health facility; however, people who do not have access to health facilities could not be considered.
- Common treatment for each common disease; however, the appropriateness and effectiveness could not be assessed.

4) Recognition of Stakeholders on BHSP

According to DPF-MOH, because BHSP is completely a new concept for Viet Nam, it is quite difficult to share common understanding of concept and definition of BHSP and its development. The Survey Team

found out that the level and contents of understanding vary among stakeholders such as central agencies, donors, local agencies, and health providers. Through a series of discussions, the following understanding and explanation were suggested by stakeholders. Although those seemed not to be consistent and clear, it could be understood that BHSP is a sort of benefit package of health insurances.

- BHSP is to sort out and integrate the existing circulars on its list of services, drugs and medical supplies, and prices to be covered by the health insurance. So far, no services will be excluded.
- BHSP is a package of basic diagnosis, treatment, and drugs for each common disease to be covered by the health insurance. Therefore, items not identified as “basic” will not be included.

At the provincial level, expectations and concerns toward BHSP vary and the Survey Team noted the following in the two provinces.

- BHSP will be developed based on the needs of patients, which will surely improve equity in health and reduce the regional gap.
- BHSP will include prevention services such as immunization. Cost for prevention services can be disbursed from the health insurance fund, which might lead to reducing government health expenditure.
- The government policy on BHSP is not clear; accordingly, there is no clear vision on BHSP in the province.
- If advanced medical treatment and examinations are excluded from BHSP, they are not covered by health insurance, which would increase patient OOP payment.
- BHSP will reduce OOP for people in utilization of healthcare services.

5) Results of Actuarial Analysis

Dissemination workshop on the actuarial analysis for BHSP, which HFG has been working on, was held on 21-22April 2016, and MOH, relevant Vietnamese authorities, and development partners participated in the workshop. The actuarial analysis was conducted in order to analyze utilization and costs of the current health services, and to identify prioritized health services to be included in BHSP.

In the workshop, only preliminary results of the actual analysis were reported. As for service usage, the analysis was conducted using C-section as an example. However, options of prioritized health services for BHSP were not presented. In relation to cost analysis, the reports included outpatient/inpatient visit frequency, OP/IP costs by provinces, health facilities, and ICD grouping. But it was not mentioned how these findings will lead to the development of BHSP and proposal of options for prioritized health services will be carried over to the final reporting. The final results presented in November 2016 also focused on C-section although more comprehensive statistical analyses were provided.

6) Concept of BHSP

According to the latest discussions with stakeholders as of January 2017, BHSP is defined as healthcare services for primary healthcare, including treatment and preventive health service supplied by district health centers, commune health stations and family doctor clinics. The other medical services and drugs to be covered by health insurance fund will be called "benefit package of health insurance".

Then, BHSP is to be developed according to the following concepts:

- To ensure equity in healthcare provision towards to universal health coverage and assessibility of people;
- To ensure capacity of service provision in primary healthcare facilities;
- To be suitable with payment capacity of health insurance fund and state budget source;
- To ensure transparency and accountability; and
- To update regularly, annually/biannually or ad-hoc upon necessity.

The benefit package for secondary and tertiary level has been under review to apply reimbursement condition of health insurance fund for high-cost/ advanced medical services and medicines in accordance with the Circular 35 (refer to Section 3.3.4).

3.3.6 Implementation Plans

MOH and VSS respectively implementation plans complying with the above UHI Roadmap, which is summarized in Table 3-6. Each plan describes the activities to implement the scheme, budget, and roles and responsibilities of relevant departments of the organization.

Table 3-10 summarizes the major contents of the plan of implementation issued by MOH in 2013[21].

[21] 605/KH-BYT

Table 3-10 Plan of Implementation for the UHI Roadmap by MOH

I. Targets
1. To increase the coverage of the health insurance. 2. To improve the quality of medical examination and treatment covered by health insurance. 3. To renovate the financing mechanism.
II. Activities to Implement the Scheme for the Period 2012-2015
1. To develop and finalize the legal documents on health insurance. 2. To strengthen the roles of relevant authorities to increase the health insurance coverage. 3. To implement solutions to improve the quality of health service. 4. To promote preventive medicine and primary health care. 5. To implement solutions to innovate financial mechanism. 6. To propagate and disseminate legislations and policies on health insurance. 7. To inspect and examine the implementation of policies and laws on health insurance. 8. To inspect, monitor, and assess the implementation of the scheme towards universal health insurance.
III. Budget for Implementation
1. State budget 2. Financial support from international organizations
IV. Responsibilities
1. Department of Health Insurance – to advise the Minister for Health and to guide localities on establishing a central steering committee. 2. Department of Planning and Finance – to allocate funds to implement the plan. 3. Departments, Agencies, Inspectorate, and Offices of Departments – to plan and coordinate the implementation of the scheme within their functions and assigned duties. 4. Department of Health in provinces and cities – to advise the People's Committees of the province and the city to develop and implement the scheme and the plan.

Reference: [MOH, 2013]

The major contents of the plan of implementation issued by VSS[22] in 2013 are summarized in Table 3-11.

[22] 2961/KH-BHXH

Table 3-11 Plan of Implementation for the UHI Roadmap by VSS

I. Objectives of Implementation
1. To increase the coverage of the health insurance. 2. To improve the quality of medical examination and treatment covered by the health insurance. 3. To secure the balance of health insurance fund.
II. Implementation Solutions
1. To develop and improve the health insurance policies. 2. To increase the health insurance coverage. 3. To promote propaganda and dissemination activities about legislations on health insurance. 4. To balance and maintain the health insurance fund.
III. Implementation Organization
1. To establish a steering committee in VSS. 2. To establish a local steering committee.
IV. Task Assignment
1. Department of Public Relations – to propagate and disseminate policies and legislations on health insurance to all target groups nationwide. 2. Department of Premium Collection – to develop a plan to extent the coverage for the year 2015 and 2020. 3. Department of Card and Book Issuance – to modernize the health insurance cards towards electronic health insurance system. 4. Department of Health Insurance Policy Implementation – to coordinate with relevant organizations/ departments to revise the health insurance law and other related documents. 5. Department of Pharmaceutical and Medical Material – to coordinate with relevant ministries and authorities to formulate and revise legal documents in pharmaceutical and medical sector. 6. Department of Inspection – to coordinate with relevant ministries and authorities to conduct inspection on the implementation of the health insurance policy. 7. Information Center – to invest in establishing the Sector's Data Center, developing software, and improving infrastructures such as servers and workstations.

Reference: [VSS, 2013]

3.4 Concerned Agencies

Basically, MOH develops relevant policies, regulations and guidance to health insurance system and mentoring the implementation that is undertaken by VSS. Table 3-12 summarizes roles and responsibilities of major concerned agencies.

Table 3-12 Roles and Responsibilities of Major Concerned Agencies

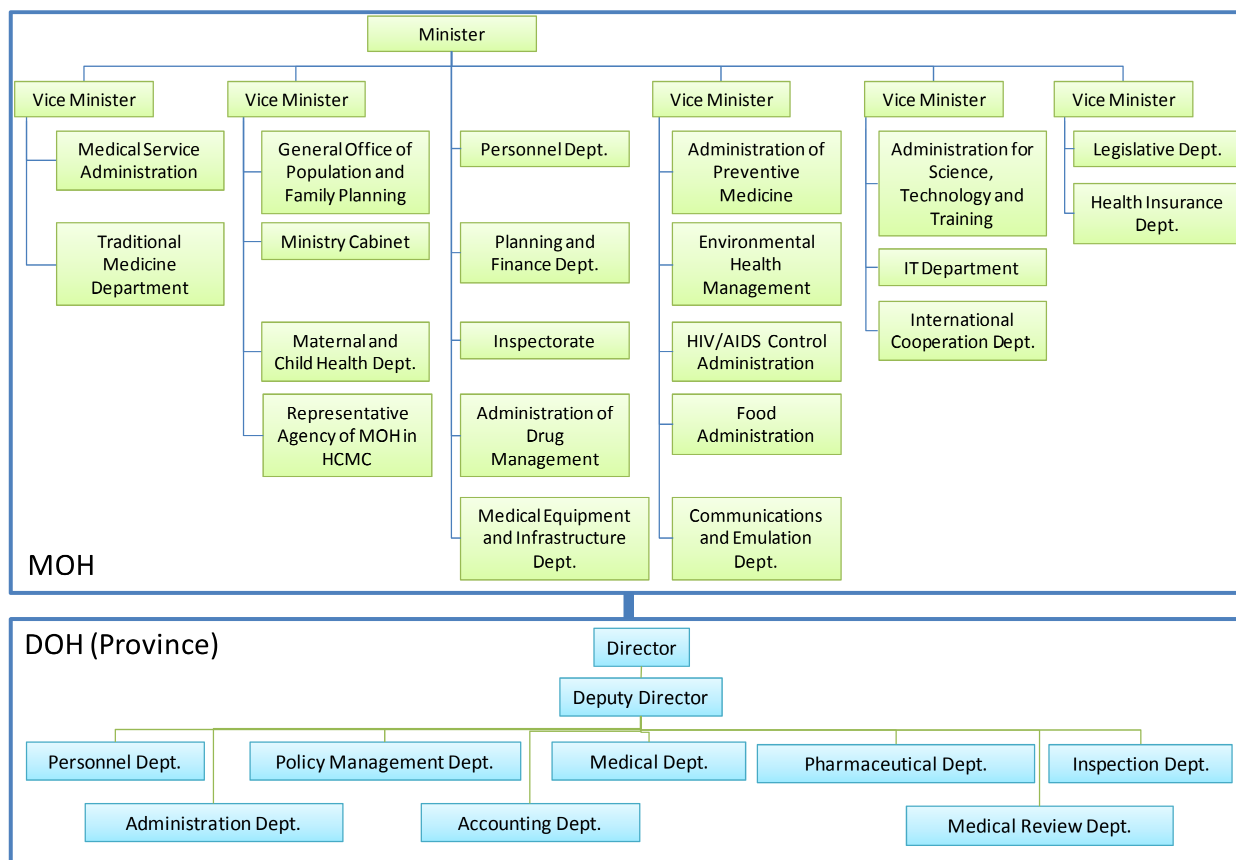
Agencies		Areas of Responsibilities on Health Insurance System
MOH	Promulgating regulations on technical procedures and guidance of medical examination, treatment and referral, in addition to formulating policies and laws, organizing service providing systems	
	Department of Planning and Finance	- Management of provider payment method - Development and revising of medical fee schedule - Development of BHSP
	Department of Health Insurance	- Development and adjustment of legal documents - Development strategies and development plans - Increasing health insurance coverage - Monitoring of health insurance fund
	Medical Service Administration	- Development and revising lists of technical services to be covered by health insurance
VSS	- Implementation of the law and legislations - Management of health insurance fund	

Reference: [The National Assembly, 2014], [Government, 2008], interviews

3.4.1 MOH

With regard to health insurance system, MOH takes the roles and responsibilities in 1) formulating and promulgating policies and legal documents on health insurance, 2) formulating and promulgating lists of drugs, medical supplies, medical examination and treatment covered by health insurance, 3) introducing measures to secure the balance of health insurance fund, and 4) guiding health facilities, organizations and individuals to implement the provisions of the Law on Health Insurance.

Figure 3-2 shows the organizational structure of MOH.



Source: [JICA, 2014]

Figure 3-2 Organizational Chart of MOH and DOH

(1) Department of Planning and Finance (DPF)

DPF has 72 staff in total and seven divisions namely; 1) Coordination and Policy Division, 2) State Budget Division, 3) Investment and Business Management Division, 4) Aid Division, 5) Provider Payment Management Division, 6) Health Defense Division, and 7) Health Statistics and Information Division. DPF is responsible for health financing, such as administration of medical expenses, budgeting of MOH and other authorities under MOH, and development and endorsement of plans on health administration. Regarding to health insurance system, DPF is responsible for management of provider payment method, development and revision of medical fee schedule in cooperation with MOF, and development of BHSP.

Regarding the activities to develop BHSP, DPF is assigned 1) to guide other stakeholders on the steps and procedures for developing BHSP, 2) to analyze legal documents on financial mechanisms and policies and health service prices, and 3) to consult on activity and budget planning.

1) Provider Payment Management Division

The Provider Payment Management Division has seven staff. The major tasks of this division are: to develop and adjust legal documents that would serve as guide and would cover provider payment methods; to research and adjust pricing plans; to supervise, manage and evaluate the implementation plan for payment for the agencies under MOH; and to develop plans for introducing new technology to manage payment system.

2) Health Statistics and Information Division

The Health Statistics and Information Division has seven staff. This division is responsible for aggregating all the information regulated in Circulars No. 27/2014/TT-BYT, 28/2014/TT-BYT and 29/2014/TT-BYT (Section 6.1). The major tasks of the division are: to develop a five-year and annual plans for health statistics; to develop and manage the database to collect and analyze data; to publish an annual report on health statistics; to instruct and supervise all the agencies under MOH to conduct health statistics; and to evaluate the health statistics activities of MOH. According to Decision No. 1168/QD-BYT which stipulates the roles and responsibilities of DPF, data analysis for health statistics is also under the responsibility of this division; however, the division performs data collection only and does not conduct data analysis for now.

(2) Department of Health Insurance

There are 22 staff in the Department of Health Insurance. It organizes the implementation of the scheme towards universal health insurance. The responsibilities of this department are: to develop and adjust legal documents on health insurance; to develop strategies and short- and long- term development plans for UHC; to instruct DOH to encourage people’s enrollment in health insurance and enhance the quality of health services; and to ensure the balance of health insurance fund. In order to implement these tasks, the department works with DPF and VSS for financing and budgeting health insurance and also with other institutes to make lists of medical equipment, drugs and services covered by health insurance.

As for the development of BHSP, the department is responsible for: 1) guiding on steps, procedures, and policy analysis of health insurance; and 2) consulting on development, amendment, and supplement of a list of medicines, medical supplies catalog, and a list of medical services covered by health insurance.

(3) Department of Medical Service Administration (MSA)

The Department of Medical Service Administration (MSA) performs the function of developing and implementing policies in the areas of medical examination and treatment, rehabilitation, tissue donation, medical examiners, and forensic, etc. Regarding health insurance system, MSA participates in

formulating and evaluating the criteria and classification of health facilities, and guiding the implementation of policies on health insurance, and medical examination and treatment. Also, MSA took lead to develop technical lists to be covered by health insurance (circulars No. 43/2013/TT-BYT and 50/2014/TT-BYT) in cooperation with representatives from hospitals.

(4) IT Department

The IT Department is a leading unit in developing and applying IT for healthcare system. It participates in all activities such as planning, developing policies, and implementing IT applications. Regarding the IT applications for health insurance, the Department of Health Insurance takes in charge.

There are six divisions and two centers under IT department. It has three top officials and 63 officers in total. The role and functions of the IT department is described in Decision No. 4048/QD-BYT (2012/10/22).

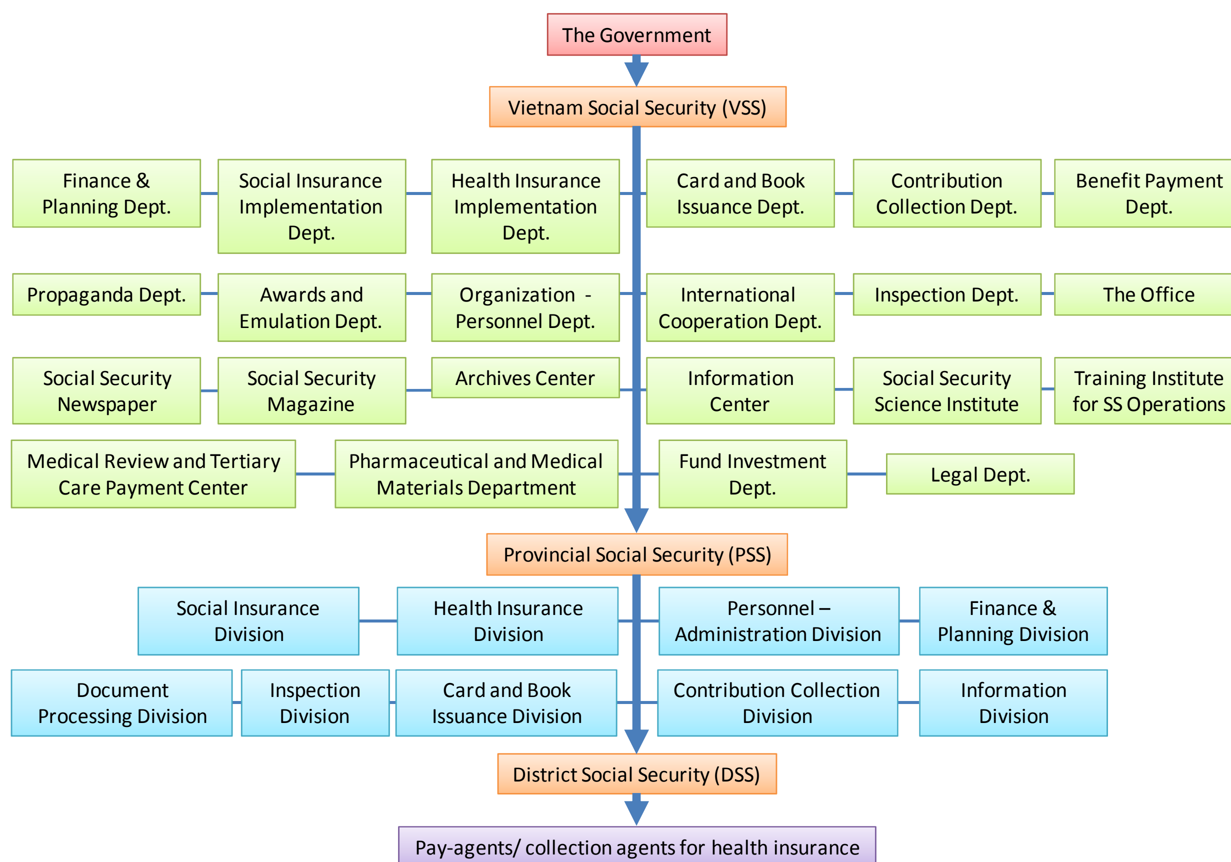
3.4.2 Ministry of Finance (MOF)

At the Ministry of Finance (MOF), the Department of Public Expenditure takes the responsibility on health insurance. The function of this department is to develop and adjust legal documents on financial management of social insurance fund, health insurance fund and other funds related to public expenditure.

3.4.3 VSS

The VSS implements the relevant laws and regulations, as well as manages the social and health insurance fund. VSS submits development strategy and plan of its operation to the Prime Minister, reports on policy implementation to MOH, and reports on health insurance fund management to MOF [Government, 2008]. The organizational structure of VSS is presented in Figure 3-3.

In 1995, long-term insurances (pension, etc.) dealt by MOLISA and short-term insurances (employment injury insurance, maternity allowance, etc.) which was the responsibility of the Viet Nam General Confederation of Labour (VGCL) were integrated and transferred to VSS. Then, the health insurance under the Viet Nam Health Insurance was merged to VSS in 2002 and unemployment insurance was added in 2009.



Reference: [JICA, 2014]

Figure 3-3 Organizational Chart of VSS and Local SS

The collected premium is delivered to VSS to be managed at the central level. The local social security (SS) in each province applies for the budget in case of any shortages in order to attain a balanced budget.

The local SS in the provincial/city level manages the insurance publicity, premiums collection, card issuance, and fund management. It operates a whole regime of social security including health insurance, pension, and unemployment insurance. It also makes contracts with provincial and district health service providers regarding health insurance. The organization of provincial SS offices is identical with each other. VSS has provincial offices and district branches [JICA, 2014].

(1) Provincial Social Security (PSS)

Provincial hospitals and private hospitals are under the control of PSS offices (Figure 3-4 and Figure 3-5), while district-level hospitals and CHSs are supervised by District Social Security (DSS).

Table 3-13 Organizational Structure of PSS

NO.	Name of Department	Total Number of Staff as of 30 November 2015	Number of Regular Employees	Number of Contract Employees
1	Management board	4	4	
2	Issuance of health insurance card	7	7	
3	Social insurance	12	12	
4	IT	5	4	1
5	Claim examination	12	10	2
6	Planning and finance	8	6	2
7	Credit management, demand for payment	4	2	2
8	Audit	7	7	
9	Collection	9	8	1
10	Reception	8	7	1
11	Personnel	4	4	
12	Office management	15	11	4

Source: PSS Gia Lai

Figure 3-4 Entrance of PSS

Figure 3-5 Reception of PSS

When VSS makes a contract with a healthcare institution, the quality standard for it is specified based on the joint notification from MOH and MOF [MOH and MOF, 2014][23]. In medium or large sized hospitals, the claims are reviewed by VSS staff stationed in the hospitals or rotating several hospitals in charge.

3.4.4 National Advisory Council on Health Insurance Policy

As mentioned in Section 3.3.5, the National Advisory Council on Health Insurance Policy (NACHIP) was established according to the Decision No.900/QD-BYT (March 2016) and Decision No. 4389/QĐ-BYT (revised version, August, 2016). NACHIP is to give advice to the Minister of Health in making and deciding important issues relating to health insurance, health financial policies.

(1) Composition

The NACHIP consist of Chairman, Vice Chairman and members. Members are selected from MOH, VSS, Medical Institutions, Academic Institutions and representatives from pharmaceutical companies and consumers. However, while the members of NACHIP are mainly selected from Government side, the balanced composition of the NACHIP for multi angle discussion should be discussed after the implementation of NACHIP.

[23] Article 7

(2) Working Regulation

The main objectives of NHCHIP is to give the advices to the Minister of Health, therefore, NHCHIP needs to work on the specific topics on health insurance by collecting and analyzing health information and statistical data. Also, each member is expected to have specific expertise and provide technical inputs for the stabilization of the health insurance system.

The Council will be held periodically, but important or technical topics which need to discuss continuously with a group of people, such topics will be discussed in the sub-committees to be established under NHCHIP.

(3) Sub-Committees

There are five sub-committees to be established. Five sub-committees are responsible for core components of health insurance system and those are:

a. Subcommittee on Drug list
b. Subcommittee on Medical Devices and Consumables
c. Subcommittee on List of Technical Services
d. Subcommittee on Medical Service Price and Measures for Ensuring Health Insurance Balance
e. Subcommittee on Health Insurance Subscriber Development

Chairmen of each sub-committee are selected from either the Director of MOH and VSS since there are main player of health insurance regulation and operation of the system. Sub-committees are at least held once per year and secretariats of each sub-committee are expected to provide necessary information and materials for the members for their discussion. The result of discussion of each sub-committee will be documented and reported for further discussion at NHCHIP before providing the advice to the Minister

(4) Technical Assistance provided by the Survey Team

The Survey Team provided information about Japanese experience which may be useful for establishing NHCHIP. However, since Japanese experience and system may not be applicable to Vietnamese system, the Survey Team pick up the main challenges by interview with the person nominated as the chairman of each sub-committee. The Survey Team provided draft regulations of Sub-committees and the draft will be discussed in DHI.

3.4.5 Other Concerned Agencies

In addition to the above main agencies on policy and implementation, concerned agencies to other sectors such as social welfare, employment and finance, should be considered and involved in health insurance system implementation. Table 3-14 presents mapping of such concerned agencies to implementation of health insurance system in Viet Nam.

However, this mapping is based on the Japanese case. Therefore, it may need to modify the mapping according to the socio-economic situation in Vietnam.

Table 3-14 Mapping of Concerned Agencies to Health Insurance System

Item		Responsible Ministry/ Department	
Health			
• Population and demography		MOH	General Office of Population and Family Planning
• Public health	- Health promotion	MOH	Dep. of Health Advocacy, Administration of Preventive Medicine (APM)
	- Infectious disease control	MOH	APM
	- NCD prevention	MOH	Medical Service Administration (MSA)
	- Health risk management	MOH	
	- Environmental health	MOH	Dept. of Environmental Health Management (DEHM)
	- Safe water	MOH	DEHM
	- Disease pattern	MOH	APM
• Medical services provision	- Referral system	MOH	MSA
	- Quality assurance	MOH	MSA
• Drugs and medical devices	- Effectiveness	MOH	Administration of Drug Management (ADM)
	- Drug safety	MOH	ADM
	- Blood transfusion	MOH	MSA
	- Drug control	MOH	ADM
	- Safety of chemicals	MOH	DEHM
• License (hospital/pharmacy)	- License for a hospital	MOH, DOH	MSA
	- License for a pharmacy	DOH	
• Patients' behavior, satisfaction		MOH	MSA
• Food safety		MOH	DEHM
• Health insurance	- Policy and strategy	MOH	Dept. of Health Insurance (DHI), Dept. of Planning and Finance (DPF)
	- Benefit package	MOH	DPF
	- Drug/Supply list to be covered by health insurance	MOH	DHI, DPF
	- Medical fee schedule	MOH	DPF
	- Drug price	MOH	DHI, DPF, MSA
	- Provider payment method	MOH	DPF
• Environmental health		MOH	DOH
Child Care			
• Child care and parent support		MOLISA	
Social Welfare			
• Welfare for the disabled (including welfare service)		MOLISA	
• Social safety net (poor family, ethnic minority, remote areas, etc.)		MOLISA	
• Welfare for the elderly		MOLISA	
• Elderly care	- Economic protection	MOLISA	
	- Health Promotion	MOH	Geriatric Hospital
Employment and Labor			
• Employment of the vulnerable		MOLISA	
• Employment condition	- Average salary	MOLISA	
• Labor protection	- Compensation for employees' accident	MOLISA	

Item		Responsible Ministry/ Department	
	- Working environment, - Occupational health	MOH	DEHM
	- Minimum wage	MOLISA	
	- Informal sector workers	MOLISA	
• Vocationally training, equity in employment, labor-management relation, labor policy and strategy		MOLISA	
Pension System			
• Sustainable pension system		MOLISA	
Finance			
• Overall Policy on Health		MOH	
• Health financing strategy		MOH	DPF
• Medical cost	- Medical cost per age group	MOH?	DPF
• Health insurance fund		VSS	
• Total health expenditure	- Government expenditure	MPI	
	- OOP	MOH, General Statistics Office (GSO)	Statistics Division, DPF
• Statistics/Actuarial affairs		MOH	

Source: Interviews

Chapter 4 Implementation of Health Insurance System

4.1 Service Provision

4.1.1 Applicable Healthcare Facilities

Healthcare services covered by health insurance can be provided at the healthcare facilities which contract with the social security institutions (VSS or PSS). In order to contract with VSS/ PSS, each facility has to fulfill the requirements[24] (e.g., number of staff, equipment).

The number of contracted facilities is 2,111 in total as of 2014 (Table 4-1). According to MOH, total number of health facilities was 2,647 in 2013 [MOH, 2014]. Since commune health stations (CHSs) do not have legal entity, it is usually under district hospital. In total, 79.8% are estimated to be contracted in 2014. If it is assumed that definitions of public and non-public are same in MOH and VSS, 95% of public health facilities and 48.7% of non-public ones might be under the contract with the social security institutions.

Table 4-1 VSS-contracted Healthcare Facilities (2014)

Number of Contracted Facilities[1]		2,111
Type of Facilities	Public	1,687
	Non-public	424

Reference: [Dr. Pham Luong Son, 2015]

Subscribers have to register either at the district hospitals or at the commune health stations within his/her neighborhood. The name of registered facility should appear on the health insurance card. Supposedly, subscribers have to seek medical services at the registered facility first, and then is entitled to be transferred to an advanced level of hospital for a more specialized treatment when necessary [Goverment, 2009]. The reality is, however, that health facilities at the lower levels do not function as a gatekeeper to limit patients' bypassing due to limitations in their capacity of service delivery and people's desire for quality service at the higher levels [MOH & HPG, 2013].

On the Amendment of Health Insurance Law (2014), subscribers can receive medical examination and treatment at any health facility at the district and commune levels according to the benefit levels from 1 January 2016 [National Assembly, 2014], and provincial level is free-access within the nation from 1 January 2021.

4.1.2 Medical Services Covered by Health Insurance

MOH determines the services covered by the health insurance. Circular No.43/2013/TT-BYT lists the health services by category (28 categories in total), and 17,216 services are covered (Table 4-2).

[24] The Survey Team could not get detailed information about the requirement.

There are no clear criteria and definition for the selection of services in benefit package and the number of the insured services has been expanded without limitation. Some of the services overlapped, while others include the services that are not being used anymore.

Table 4-2 Category of Insurance-covered Health Services

Category	Services	Category	Services
1	Resuscitation, emergency and poisoning control	15	Otorhinolaryngology
2	Internal medicine	16	Odontostomatology
3	Pediatrics	17	Physiotherapy - Rehabilitation
4	Tuberculosis (surgery)	18	X-ray
5	Dermatology	19	Nuclear medicine
6	Mental health	20	Diagnostic and therapeutic endoscopy
7	Endocrinology	21	Functional examination
8	Traditional medicine	22	Hematology - Blood transfusion
9	Anesthesia	23	Biochemistry
10	Surgery medicine	24	Microbiology, parasitology
11	Burn	25	Pathology and cytology
12	Oncology	26	Microsurgery
13	Obstetrics	27	Endoscopic surgery
14	Ophthalmology	28	Plastic and cosmetic surgery

Reference: [MOH, 2013]

Also, Circular 43 defines health services of service providers at the four levels (central, provincial, district, and commune) should provide (Table 4-3).

Table 4-3 List of Services to be Provided at Each Level (Extract)

Legend: A=central level, B= provincial level, C=district level, D=commune level

NO	LIST OF TECHNIQUES	TECHNICAL CLASSIFICATION			
1	2	3			
		A	B	C	D
	A. CIRCULATION				
1	Continuous blood pressure monitoring at bedside ≤ 8hours	x	x	x	
2	Bed site emergent ECG recording	x	x	x	
3	Continuous bedside emergent ECG recording ≤ 8hours	x	x	x	
4	Esophageal ECG	x	x		
5	Capillary refilled test	x	x	x	x
6	Peripheral venous catheterization	x	x	x	x
7	Placement of single lumen catheterization	x	x	x	
8	Placement of multiple lumen catheterization	x	x	x	
9	Arterial catheterization	x	x		
10	Caring of venous catheter	x	x	x	
11	Caring of arterial catheter	x	x		
12	Placement of intraosseous infusion	x	x	x	
13	Penile intracorporeal infusion	x	x		
14	Pulmonary arterial catheterization	x	x		
15	Measurement of central venous pressure	x	x	x	
16	Continuous measurement of central venous pressure ≤ 8 hours	x	x		
17	Invasive measurement of arterial pressure ≤ 8 hours	x	x		
18	Bedside emergency heart ultrasound	x	x	x	
19	Bedside vascular Doppler ultrasound	x	x	x	
20	Ultrasound guiding emergency venous catheterization	x	x	x	

…continued…

Reference: [MOH, 2013]

In addition to the services listed in Circular No. 43/2013/TT-BYT, Circular No. 50/2014/TT-BYT regulates the service level requirement for each service in order to define the technical fee of doctors[25]. Circular No. 50/2014/TT-BYT also added some new services, which are not included in Circular No. 43/2013/TT-BYT.

In the provinces visited by the Survey Team, Gia Lai Provincial Hospital mostly fulfills the requirement for delivering necessary health services according to Circular 43, while Hoa Binh Provincial Hospital meets 64% of the requirement[26]. At the district level, there is a gap between the regulation and the actual service delivery[27]. According to the local authorities, this is mainly because of low quality of service due to lack of human resources (e.g., pediatrician) and medical equipment (e.g., emergency medical equipment), which lead to patients' seeking to receive better service at the upper level. It is difficult to predict at this moment, but it is expected that the competition among health facilities becomes more severe after 1 January 2016 when patients have free access to any health facilities within the province, and that patients may be more concentrated in reputable hospitals.

4.1.3 Medical Fees

The MOH-MOF inter-ministerial circular (04/2012TTLT-BYT-BTC 29/02/2012) defines the maximum medical fees for the insurance-covered services. The Provincial People's Committees defines by regulations specific price for medical facilities managed by local authorities [MOH, 2015]. Therefore, each province has different price for the same service. In general, medical fees are calculated by DOH based on the estimates from hospitals mainly at the provincial level, then, it is submitted to the Provincial People's Committees and to the People's Council for approval. According to the interviews with the Provincial People's Committee in Binh Dinh Province, medical fees are decided by taking into account the socio-economic conditions, balance of health insurance fund and households' economic conditions

As stated earlier, medical fees are different in each province, but a new medical fee schedule was applied from 01 March 2016, which is in line with the MOH-MOF inter-ministerial circular 37/2015/TTLT-BYT-BTC, and uniformed price is used according to the level of health facilities. Due to the change of medical fee schedule, medical fee for about 1,900 health insured services was increased. But the new price is only applied to insured patients, and people who are not insured are not affected by the higher prices in order to ease their financial burden. According to the interviews with local authorities[28], it is expected that increased medical fees will improve hospital revenue, which can be used for improving facility/equipment and hiring of qualified medical staff. On the other hand, separate price

[25] Doctors, who provides higher technical level of service, are paid higher technical fee.
[26] Results of interviews with Gia Lai and Hoa Binh provincial hospitals
[27] For example, Dac Doa District Health Center in Gia Lai Province meets the requirement 60%, while Tan Lac District Hospital in Hoa Binh Province meets 80% according to DOH and health facilities.
[28] The interviewees include DOH, PSS/DSS and medical facilities at different level

setting for insured and non-insured people would double the burden in collecting fees in the hospitals. There is no concrete schedule yet on when the unified higher prices will be applied to non-insured people.

According to the interviews conducted in Binh Dinh Province and Hoa Binh Province in June 2016, medical fee claim amount has increased in the first quarter of 2016 compared with the corresponding period of a year earlier. There are two reasons for that: one comes from the increased medical fee schedule according to Circular 37, the other comes from the increased number of patient visits due to free access at the district level, which took effect in January 2016. Payments for medical fee claim have been delayed in both provinces since the introduction of the new medial fee schedule. This is caused by the fact that medical fee claim and claim review require more time than before for applying the new medical fee schedule and separate price setting for insured and non-insured people.

In addition, as the terminology and grouping are different from Circulars 43 and 50, MOH and hospitals have to make a list to match between the price in Circular 4 and Circular 37 and the name of medical services Circulars 43 and 50. Such inconsistency between the service list and rice list is caused by weak collaboration within MOH. The service list was prepared under leadership of MSA and medical personnel of the hospital, while the price list was prepared under the leadership of DPF and general planning department of the hospital. When the exact services are not found in the Circular 37, hospitals could apply the price for similar services upon consensus with the administration unit (MOH and/or DOH) and the social security institutions (VSS, PSS, and/or DSS).

On the Amendment of the Health Insurance Law (2014), MOH and MOF have been carrying out preparation for the revision of the prices due to an increase in the number of cost items, which would be the basis for calculating each service cost. Before the amendment, the price of medical services was calculated based on three factors including 1) the cost of drug/medical consumables, 2) the cost of electricity, water, and 3) the cost of maintenance of equipment. After the amendment, another four factors are added and calculation of medical service prices must include seven factors in total. Table 4-4 shows the seven factors and the schedule of adjusting health service price based on each factor.

Table 4-4 Factors for Calculation of Medical Service Prices and Schedule of Adjustment

No.	Factors for Calculation of Medical Service Prices	Schedule of Adjustment
1	Drug costs, direct materials used for medical examination, treatment of bed days and technical services	2012-2014
2	The cost of electricity, water, and waste according to technical and economic rates	2012-2014
3	The cost of maintenance, procurement of substituting assets, tools, and small appliances under the technical and economic rates	2012-2014
4	The cost of salaries, allowances, and premiums under regime; costs of outsourcing hiring; specific costs must not exceed 50% of the costs of services	By 2015
5	The cost of major repairs of fixed assets	By 2018
6	The cost of training, scientific research for application of new technologies; Indirect costs	By 2018
7	The cost of depreciation of fixed assets	By 2020

Reference: [MOH, 2015]

In some provinces, the balance of health insurance fund turned into a deficit in the first quarter of 2016. It is expected that the balance of health insurance fund will get worse when free access is expanded to the provincial level and medical fee schedule is increased again. According to VSS, it is planned to improve the balance of health insurance fund by controlling drug prices and electronic claim, which will make it easier to monitor the medical fee.

4.1.4 Pharmaceutical Drugs Covered by Health Insurance

Insurance-covered pharmaceutical drugs are regulated by the MOH Circular No.40/2014/TT-BYT. The circular includes a list of more than 1,000 drugs and ingredients. The prices of these listed drugs are subject to bidding at each health facility. Accordingly, drug prices are different at each facility and they vary frequently based on bidding. In the revised Health Insurance Law, it is specified that drug prices will be uniformed at the provincial level.

In Viet Nam, drug prices are much higher than the international reference prices. Drugs costs account for a high share of total healthcare costs[29] and approximately 70% of insurance reimbursements [MOH & HPG, 2013]. According to a drug price survey in 2010, drug prices for innovator brand in Viet Nam are 12.1 times higher compared to international reference prices, while drug prices for generic brands are 1.4 times higher [MOH & HPG, 2013]. As mentioned earlier, higher price is mainly due to the fact that drug costs were up to the bidding at each hospital without a centrally controlled mechanism [JICA, 2014]. According to an interview with MOH, it is planned to introduce centralizing the procurement of drugs[30] by establishing a central procurement unit in order to control the drug costs [OECD, WHO, 2014].

4.2 Provider Payment Method

4.2.1 Characteristics of Each Method

The advantages and disadvantages of each model are summarized in Table 4-5.

[29] Expenditure on drug as a share of total health expenditure varies across the countries. For example, in 2010, more than 40% of total health expenditure were spent on drug (including drug, medical chemicals and botanical products used for health uses) in Thailand (50.5%), India (45.6%), China (44.2%), Bangladesh (44.1%), Vietnam (43.2%) and Myanmar (41.4%), while this share was less than 15% in Fiji (13.9%) and Malaysia (12.7%), [OECD, WHO, 2014]

[30] According to MOH, the number of target drugs is still quite limited.

Table 4-5 Advantages and Disadvantages of Capitation, Fee-for-Service and Case-Based Payments

Methods	Merits	Demerits
Capitation	- Tend to focus on preventive care - Income of medical doctors. /institutions are fixed. - Standard treatments are provided - Easy to cover the target population.	- Avoid expensive medical treatment. - Smaller medical institutions have more risk against fluctuation. - Level of medical treatments could be below the expected level of patients. - Long waiting list for hospitalization and operations.
Fee-For-Service	- Necessary medical care is provided. - Each medical treatment is linked with medical fee claim amount (one by one). - Easy to understand the relation between medical treatments and fees for patients. - Doctors can offer necessary medical treatments since this system guarantee the reimbursement such as medical costs.	- Medical check-up and services are tended to be over-provided. - .Hospitalization period tend to be extended. - Fraud on medical claim could occur. - Medical technique is not tended to reflect on the payment amount. (good doctor provide appropriate treatment which shorten the period of treatment or hospitalization)
Case-Based	<Patient> - Shorter treatment period and amount of co-payment is reduced. - Over-examination and over-treatment can be avoided. <Medical Institution> - Medical fee information is standardized. - If quality of treatment is improved, more profit could be generated than fee for service. - Clinical pathway could be introduced to ensure quality of medical services. <Government> - Medical cost could be controlled.	- Quality of medical treatment could be diminished. - Discretion of doctors is limited and performance could be declined.

Source: Survey Team

(1) Capitation Payment

Capitation is a payment arrangement for health care service providers such as doctors or medical institutions. It pays a doctor or hospitals a set amount for each enrolled person assigned to them based on administrative units (such as population coverage), over a period of time. These medical providers generally are contracted with public institutions such as the Ministry of Health. The amount of payment is based on the average expected health care utilization of subscribers. In capitation, therefore, doctors are discouraged from providing medical treatments, including necessary treatments, because they are not paid anything more than the fixed amount provided for additional or necessary medical care.

(2) Fee-for-Service Payment

Fee-for-service is one of the models of medical fee payment. Under this model, medical services are unbundled and paid for separately. This model tends to give an incentive for doctors to provide more treatments because payment is in proportion to the quantity of care rather than the quality of care. Moreover, when patients are covered by health insurance, even with co-payment, they are incentivized to accept any medical service that might work better than the usual treatment that they had received. In the

Japanese health care system, fee-for-service is mixed with a nationwide price setting mechanism to control costs.

As for the health insurance, payments are issued retrospectively after the medical services are provided. It creates a potential financial conflict of interest with patients by which, medical treatments are provided excessively. It should be stressed out that when claims are paid under fee-for-service by the insurers, patients have no opportunity to consider the cost of treatment. Some evidences suggest that medical doctors, who are being paid under a fee-for-service model, tend to treat patients with more procedures than those paid under capitation [Gosden T, et al., 2000], [Jeffery Kluger, 2009].

(3) Case-Based Payment

Case-based payment is a system that medical fee is determined by disease of the patient (diagnosis related groups: DRGs). This payment system is expected to show another approachin order to provide benefits as well for the health insurance system to become financially sustainable.

Firstly, as the benefit to the patient, reduction of unnecessary health care (excessive medical treatment) is expected. In this model, medical fees are determined based on the results of diagnosis from the first treatment. As a result, each cost of medical treatment is deducted from a fixed amount. Therefore, doctors/medical institutions, which provide the shortest treatment for recovery, can generate more profits. For this reason, unnecessary medical treatments, which contribute longer period for recovery, are expected to be avoided.

Secondly, as a benefit to doctors/medical institutions, emergency treatments, which is in general considered to generate losses due to cost constraint, also can generate profits since medical fee and pathway are standardized for such cases.

Thirdly, as a benefit to the government, since the medical services are standardized, it is also expected that medical costs can be controlled.

At present, DRG is introduced in South Korea, Finland (partially), Germany, the Netherland (hospitalization), the United Kingdom (hospitalization), France (hospitalization), Sweden (hospitalization) and the Medicare of the United States of America.

DRG, a system which patients are classified by disease groups, and in combination with Prospective Payment System (PPS), DRG can be introduced based on the clinical pathway. Under this system, therefore, disease patterns are more emphasized than condition of patients. Patients are distributed based on the listed diseases and medical expenses are calculated based on the price of listed diseases.

On the other hand, in Japan, a modified system which is called Diagnosis Procedure Combination (DPC) is introduced. DPC is a calculation method of inpatient medical expenses, which is classified by the medical treatment and diseases based on the classification. This is a method to calculate a combination of

fixed portion defined by the Government and portion of fee-for-service. Number of hospitals applying DPC is shown in Table 4-6.

Table 4-6 Number of Hospitals and Beds applying for DPC in Japan

Year	Number of Hospitals		Number of Beds	
	DPC	DPC (Preparation)	DPC	DPC (Preparation)
2003	82	-	66,497	-
2004	144	-	89,330	-
2006	359	371	175,395	144,057
2008	713	843	286,088	19,2242
2009	1,278	331	430,224	57,965
2010	1,388	266	455,148	41,407
2011	1,447	201	468,362	27,751
2012	1,505	246	479,539	34,502

Reference: Outline on the revision of medical fee, Ministry of Health, Labour and Welfare, 23 April 2013

4.2.2 Current Situation in Viet Nam

According to the Health Insurance Law (2008) and its amendment (2014), Viet Nam has three types of provider payment mechanisms, namely: fee-for-service, capitation, and case-based payment.

(1) Fee-for-Service

Fee-for-service has been the dominant system since 1995. VSS placed a cap on hospital payments to contain costs, but hospitals have strong incentives to spend beyond the cap. According to the Survey, after free access within a province took effect in January 2016, some district hospitals and CHSs have changed from capitation to fee-for-service. Since people can now have access to a district hospital beyond his/her residential district, it becomes difficult to identify actual coverage population of each district hospital.

Payment for health service has been undertaken through the fee-for-service system. According to interviews, it could not regulate health service providers to avoid excess treatment and examination, because the budget for the following period is to be set according to actual expenditure. In addition, there seems no penalty for overtreatment and/or incentives to provide cost effective services. As a result, the health insurance budget will be in deficit from 2020 if Viet Nam continues applying the fee-for-service.

In terms of OOP expenses, patients could request to pay for additional and/or upgraded services which are not covered by health insurance. Those additional payments are generally allocated to supplement the operational costs and incentives of staff.

Therefore, with the support from development partners, MOH is making efforts to develop new provider payment mechanism including capitation and case-mix payment. In addition, the new medical fee schedule is expected to control such behavior because most of the prices were raised by 30% and health service providers could earn enough income to cover necessary expenses of the services.

(2) Capitation

Capitation payment was introduced for primary health care in some provinces in 2004. Capitation was also introduced in 2011 at the district hospital level. Capitation rates are also determined by health

insurance membership group rather than risks or actual cost of health care, and consequently, hospitals receive fewer funds for the poorer groups. Although some pilots had been planned, those were not successfully completed because of mal-coordination for data collection between MOH and VSS.

According to the observation of the Survey Team, capitation seems to be applied with some variations to be quite similar method with fee-for-service or result-based-payment. For example, the amount to be paid to CHSs is calculated based on the fixed unit rate (for example; VND 5,000 for an examination or a treatment and VND 310,000 for a normal delivery) and actual number of patients since 2011. Before that, the amount was calculated based on the capitation rate and coverage population.

MOH has been working on development of modified capitation model in cooperation with EU. In the modified model, capitation rate will be calculated according to age and some socio-economic indicators such as consumer price. The capitation will be applied to CHS and outpatient department of district hospital.

1) Pilots on Capitation

The government has introduced the pilot of capitation three times. It was a response to the limitation of the fee-for-service payment mechanism, and the objective of introducing capitation is to establish efficient cost control emphasizing higher quality of health care at lower costs.

The first capitation pilot in Viet Nam was supported by the Belgium Development Agency in Hoa Binh Province within the framework of The Key Improvements in Community Health Project (2005-2010) in several commune health centers.

The second pilot was supported by the European Union (EU) through the Health Care support to the Poor of the Northern uplands and Central Highlands Project (HEMA), which was a health financing project targeting the poorest communities and ethnic minorities. By 2013, capitation model was introduced to all provinces in Viet Nam. Through this pilot, the following issues were found:

- Capitation model introduced in Viet Nam is different from conventional application in other countries;
- Introduce capitation in both inpatient and outpatient services (usually capitation is used only for outpatient service);
- Calculation based on historical expenditures and does not reflect patients' needs; and
- Lack of defined package of services.

Based on these findings, the MOH decided to implement the third pilot in four provinces in 2014 with revised capitation model based on Circular No. 41/2014/TTLT-BYT-BTC, the Guidance on Health Insurance Law Implementation. In Bac Ninh and Ninh Binh provinces capitation is applied only for outpatient services, while in TT-Hue and Khanh Hoa provinces capitation is applied both for inpatient and outpatient services. Within this third model, the following problems still remain:

- Most of the health facilities ran out of capitation fund and accumulate deficit so providing health services becomes difficult.
- Data management system is fragmented and medical and financial reporting is slow.
- Delay in fund calculation and disbursement.

In 2015, EU conducted an assessment of the third capitation model and concluded that this model does not have significant cost containment potential and keeping capitation budget balanced is difficult. Based on the recommendations by EU, MOH now considers whether to introduce a new model of capitation which is similar to international standard.

(3) Case-based Payment

The five-year health sector development plan (2011-2015) also mentioned the possibility of paying health care costs by case-based payment via Diagnosis Related Group (DRG) methods. The Government of Viet Nam is targeting to apply the case-based payment method after 2020. Although case-based payment is expected to reduce expenditure of health insurance, the evidences have not been obtained yet.

1) Pilots on DRG

The DRG model (Vie-DRG grouper) has been developed based on the Thai-DRG model. According to a pilot study in a district hospital in 2012, it could classify 84% of total cases into 89 DRGs. However, the availability and quality of data as well as capacity of relevant staff in the hospital were the challenges encountered to be able to implement this model effectively [Pham Le Tuan, et al., 2015].

Since 2015, another pilot study has been conducted in Ninh Binh Province by MOH. The objective is to collect necessary data for DRG in cooperation with provincial and district DOH, PSS, provincial and district hospitals, as well as CHSs. The pilot project will be conducted until 2019 targeting five provinces. Four more provinces will be involved in 2017. From the first year of implementation, it was recommended that the quality of data should be improved and all data should be available in each health facility to formulate appropriate DRG and costing.

The Asian Development Bank (ADB) has been supporting another pilot in collaboration with the Hanoi Medical University from 2010 to 2015. It involves 34 health facilities in seven provinces (central 2, provincial 13, and district 20). In this pilot, DRG has been formed according to clinical pathway to ensure quality of care and patient satisfaction. Currently, 26 DRGs have been formed. The clinical pathway was developed in collaboration with medical doctors from 20 hospitals. It took a year to complete the nearly final version. The report will be published in June 2016. Through the implementation, fragmentation of hospital information system (HIS) and accounting information system, as well as availability and quality of data were the major challenges encountered in order to collect and consolidate the data.

4.3 Co-Payment

Table 4-7 shows co-payment rate for each sub-group. After the revision of the Health Insurance Law, co-payment rate for near-poor decreased from 20% to 5%, and the poor are exempted from co-payment and are entitled to free medical services.

Table 4-7 Co-payment Rate

Source of Premium	Membership Groups	Co-payment Rate
Employers and employees	- Employees indefinite or at least 3-month full-time contracts - Salaried business - Executive Managers - Officials and civil servants	20%
	- Part-time officers in communes, wards and towns	
Social insurance organizations	- Pensioners (retirement and disability)	5%
	- Pensioners (worker's compensation, long-term treatment, old-age (≧80)	
	- Social security recipients	
	- Unemployment insurance recipients	
State budget	- Commissioned officers, solders, police officers, public security officers, those students, and their relatives	Exempted from co-payment and are entitled to free medical services
	- State pension recipients	
	- Persons meritorious services and war veterans, and families	
	- Relatives of persons meritorious services and war veterans	5%
	- Incumbent deputies of National Assembly or People's Councils at all levels	20%
	- Children under six-year old (pre-school)	Exempted from co-payment and are entitled to free medical services
	- Social protection pension recipients	
	- Poor household and other groups in socio-economic difficulties, islands	
	- Legal organ donors	20%
Scholarship provider	- Foreign students granted by the state budget	20%
State budget and the subscribers	- Near-poor household	5%
	- Students	20%
Head of household	- Other household	20%
	- Other household members	

Reference: [National Assembly, 2014]

When subscribers seek medical services outside their registered facilities without a formal referral, they were obliged to pay 30% of the medical examination and treatment expenditures at the district hospitals, 40% of the inpatient treatment expenditures at the provincial hospitals, and 60% of inpatient treatment expenditures at the central hospitals. On the Amendment of the Health Insurance Law (2014), the total medical examination and treatment expenditures are covered by the health insurance fund starting from 1 January 2016. Total inpatient treatment costs will be covered by the health insurance fund from 1 January 2021 in all hospitals in Viet Nam

4.4 Coverage and Promotion

The health insurance scheme has been implemented since the commencement of the Health Insurance Law 2008 on 1 July 2009. The law covered not only all the workers of the private sectors and public sectors but also the informal sector workers such as farmers as well as children and the elderly. Although

VSS is promoting the universal health coverage, the subscription rate was approximately 70% as of 2013 and 81.7% as of the end of 2016The law ensured that children less than six years old, the elderly, and the poor would gain full public support and that partial support would be given to the near poor as well as students. Since 1 January 2015, all people are considered to be covered by health insurance based on the unit of household.

The Government of Viet Nam set the target coverage for each province and national target as shown in Table 4-8 towards the year 2020.

Table 4-8 Target Coverage Rate of Health Insurance in the Selected Provinces towards the Year 2020 (%)

	2015	2016	2017	2018	2019	2020
Ha Noi	77.2	79.7	81.6	82.9	83.6	85.0
Ho Chi Minh	71.8	76.4	79.1	81.3	82.9	83.6
Hoa Binh	94.3	94.7	97.3	97.9	98.7	99.0
Nghe An	76.5	78.0	79.0	79.9	80.2	80.7
Gia Lai	75.0	75.8	79.7	83.3	86.1	90.1
Khanh Hoa	70.0	71.8	75.2	77.8	79.4	80.8
Nationwide	75.4	78.0	79.8	81.4	82.5	84.3

Reference: [Prime Minister, 2015]

Near-poor group and farmers hesitate to subscribe because of self-pay premium and uncovered costs such as transportation especially in the remote areas as well as due to the irregular income pattern and difficulties with paying their premium. On the other hand, the rich self-employed tends to prefer private insurance and private hospitals.

Reliability of public health facilities, especially at the district level, might be another important factor to increase the coverage. People tend to seek care directly to top referral hospitals despite of more out-of-pocket expenses.

At the provincial, district and commune levels, different communication channels are utilized to encourage people to use insured health services. Examples of efforts taken in the two provinces are as follows:

- Advocacy activities are conducted in collaboration with the education sector in order to promote enrollment of students in health insurance. (DOH)
- In order to ensure the access to health care for ethnic minority people, local organization such as social protection union, agricultural association are also involve in awareness raising to make people understand the benefit of health insurance.(DOH)
- Role of collaborators is important. They are hamlet health workers and speak the same language with ethnic minority people, which enable a smooth communication with them. (District Health Center)

4.5 Premium Collection

The law defined the premium rate of 6.0%[31] for formal sector workers which is shared between employers (2/3=4.0%) and employees (1/3=2.0%). On the other hand, informal sector workers including near poor people[32] are expected to pay their premium which is equivalent to 6.0% of the monthly minimum wage[33].

MOH has introduced comprehensive application based on the household unit which is considered to cover larger number of informal sector workers and their family. However, according to PSS and DSS, there are still many cases of adverse selection due to the lack of understanding about 'insurance'.

Premium collection of health insurance is responsible for the Provincial and District Social Security (PSS and DSS), which is the branch organization of the Viet Nam Social Security. Although those function as the collecting authority of premium and agents who were nominated by Commune People's Committee and post offices are responsible for premium collection, it has no authority to visit directly to each household and demand for payment of their premium. Informal sector households can choose payment terms from three months, six months, and annually. However, the renewal of health insurance status is not properly done by the informal sector household since PSS/DSS does not actively promote the renewal of subscription and therefore, such households do not prioritize health insurance as they are not afford to pay premium.

Promoters, who are designated by the Commune People's Committee, function as the collecting agents by using the list of households with premium in arrears, which is provided by the Commune People's Committee. The list of households with premium in arrears is created based on the information of 'Family Book' which refers names, ages, marital status, and transmigration record.

Based on the Decree on Defining on Administrative Sanctions in the Field of Health Insurance (92/2011/ND-CP2011), when companies fall behind in their premium payment, VSS reports the fact to MOLISA who is responsible in taking legal action, if necessary. According to the decree, companies are expected to pay the penalty as shown in Table 4-9.

Table 4-9 Amount of Penalty in Case of Delinquency

Number of Workers	Amount of Penalty (VND)
1-10	500,000 - 1,000,000
11-50	1,000,000 - 5,000,000
51-100	5,000,000 - 10,000,000

Reference: [Government, 2011]

According to the interviews with DOH and PSS, promotion of the subscription of health insurance is critical for the extension of coverage towards UHC. PSS and DOH are the responsible organizations. PSS

[31] Before the amendment of the Health Insurance Law, it was 4.5%. The new rate has been applied since January 2016.

[32] People below poverty line are not required to pay their premium but they have right to access health insurance financed by the government.

[33] Minimum wage differs among provinces [JETRO, 2014].

has been enhancing awareness raising through dialogue community based organizations such as farmers' associations, women associations and cooperative alliance and direct DSS to mobilize community to have agents at commune level. Although PSS and DOH prepare some promotional materials on health insurance, these are rarely used in the promotion for the extension of coverage. TV commercial is also used but the approach or contents can be improved to attract people in the informal sector households.

For instance, a private insurance company utilizes an agent in the community. The health insurance agent is a side-business and he/she promotes subscription to his/her colleagues and/or neighbors. The insurance company pays incentives of a certain percent of the premium[34]. Therefore, the agent could be motivated to expand the coverage.

4.6 Claim, Review, and Provider Payment Flow

Health service providers that accept health insurance should contract with VSS or PSS[35] annually. Initially, the contracted provider receives an advance payment of 80% of the previous expenditure for medical services covered by health insurance. Then, an expenditure report of medical services covered by health insurance is submitted to VSS on a quarterly basis. VSS inspects the report and settles the differences with the advance payment within the budget. At the same time, VSS pays in advance 80% of the actual expenses for the next quarter.

4.6.1 Claim from Health Service Providers

Each health service provider quarterly submits health insurance claims to the VSS office in-charge based on the records of medical practices and medications covered by the insurance. Form79 and Form80 specified by VSS (Figure 4-1 and Figure 4-2) should be used for making claims. The claim is prepared by the accounting department[36]. If a hospital information system (HIS) is introduced, it is possible to output these formats automatically. If not, the software VSS provided can be used for the preparation. In lower level facilities, especially CHSs, the claim is prepared manually.

Hospitals submit claim data to VSS in Excel files through e-mail. Although the format is specified by VSS, a previous version is sometimes submitted. It causes additional work load for VSS staff to convert the format manually. In addition, according to the observation of the Survey Team, the current software of VSS is not user-friendly and well performed.

[34] The incentive may vary among the company, i.e., 4% or maximum 20%, etc.
[35] Health service providers at the provincial and lower levels contract with PSS.
[36] In the provinces visited during the first field survey, there are some (three to seven) staff involved in claim both in the provincial and district hospitals.

Figure 4-1 Claim Format for the Outpatient (C79a-HD)

Figure 4-2 Claim Format for the Inpatient (C80a-HD)

However, as the current formats require total amount only, detailed description of medical services are not to be recorded. Therefore, a new format was specified by MOH[37] to be used from 2016 as follows:

- Form1：Total index of insured health treatment
- Form2：Detailed index of health products covered by health insurance
- Form3：Detailed index of medical practices and materials covered by health insurance
- Form4：Index of pre-clinical results
- Form5：Clinical monitoring index

Forms 1-3 should be used from January 2016 and Forms 4-5 should be used starting by the end of 2016. Detail format of form 1 and form 2 is shown in the Chapter 6.

4.6.2 Claim Examination

In medium or large sized hospitals, the claims are reviewed by VSS staff stationed in the hospitals or rotating several hospitals in charge[38]. They closely cooperate with the accounting department of the hospital.

The submitted claims are reviewed systematically whether necessary information is provided in appropriate manner The Survey Team observed that from 20% to 40% of the claims are picked up for detailed inspection with medical records whether the examination and/or treatment had been provided appropriately. The proportion and sampling methods vary among VSS or hospital; random or picking up the ones of expensive amount.

VSS staff reviews the claim data in the following three points: 1) whether the data are entered correctly; 2) medical services or medications provided are surely insurance-covered; and 3) the co-payment ratio is correctly applied. For example:

[37] 9324/BYT-BH

[38] In the case of PSS in Gia Lai Province, six staff are responsible for visiting four hospitals.

- Condition of payment (check for the amount claimed);
- Implementation of services (check for description of medical treatment by a physician in charge of VSS operation); and
- Summarize payment (check for the overall payment amount).

Also, VSS staff reviews whether the amount claimed does not exceed the prices defined by the provincial government.

Then inappropriate medical services are found, VSS staff inquires medical doctors in the hospital further clarification and justification. In case that it is still not proper service, the particular claim will be rejected. The return rate (rate of payment rejection after examination) is about 1.4% to 1.5%. For example, in Gia Lai Province, the amount rejected is VND 5 billion out of the total amount claimed of VND 360 billion.

(1) Difficulties in Claim Examination

From January 2016, VSS has introduced a new decision which regulates the criteria for inspection and review of health insurance claims including the following points:

- Name of diagnosis group
- Signature by a patient
- Consistency between statistical data in a hospital and claim data in Form No. 02
- Consistency between examination and treatment services stated in the claim and actual practice

However, those criteria still seem not to be specific enough to identify fraud and over-supply of medical services along with a certain standard. Therefore, the quality of claim examination depends on the capacity and awareness of each inspector.

In addition, the current claim examination is not well conducted comprehensively over multiple claim bills. For instance, in such a case that the same person receives a large quantity of drugs from multiple health service providers to resell them, it is required to examine the appropriateness of the insurance claim by focusing on the name of a specific person and examining information from multiple claim bills within a certain period of time.

Claim examination from the viewpoint of appropriateness of clinical procedure has hardly been performed because it requires medical expertise and it is financially difficult for VSS to hire medical personnel for claim examination. Also, a professional guideline on appropriate medical procedure for health insurance has not been developed. According to VSS, it has tentatively developed an approximately one hundred criteria to review the clinical practice in 2015. For example, “A man is unable to become pregnant (cross-check with sex).”, “claims are not acceptable when the same person receives several medical practices for the same disease on the same day (cross-check with other several medical

records of the patient).", "co-payment ratio in accordance with the relevant qualification (cross-check with the membership group of the patient)". Figure 4-3 presents examination department in PSS.

Figure 4-3 Examination Department in PSS

(2) Identification of Fraudulent or Incorrect Claims

VSS has no way to check whether the relevant medical practice was actually provided to the patient. The information is compared with what is described in medical records; however, if the medical record itself is falsified, there is no choice but to approve the claim.

VSS possesses health subscribers' information (name, address, etc.) and by using this information, it is possible to inform each subscriber the reason or situation of hospital visit, health insurance usage, and provided medical services for their own verification; however, such an action has not actually been conducted.

Claim information from health service providers may be prepared by a staff member from the accounting department or a nurse who is not always familiar with practices regarding insurance claims. Those who have undertaken adequate training for insurance claim practices and moral education should be responsible for entering claim information appropriately.

Although it seems that MOH or DOH is responsible for supervising health service providers may take measures to rescind the authorized insurance health care institution after confirming the occurrence of false claims, health service providers make contracts with VSS and the supervisory system by the central government organizations has not been well established at present.

4.6.3 Budgeting and Provider Payment

The budgeting flow of the health insurance fund is shown in Figure 4-4. Basically, the medical fees will be paid within the budget which was set in accordance with actual expenses in the previous term. When the expenditure exceeds it, a health service provider should submit the report to explain the details and reasons to VSS. If there are surplus, 80% should be allocated to reserved fund and 20% can be allocated for investment to expand the services at the provincial level [The National Assembly, 2014].

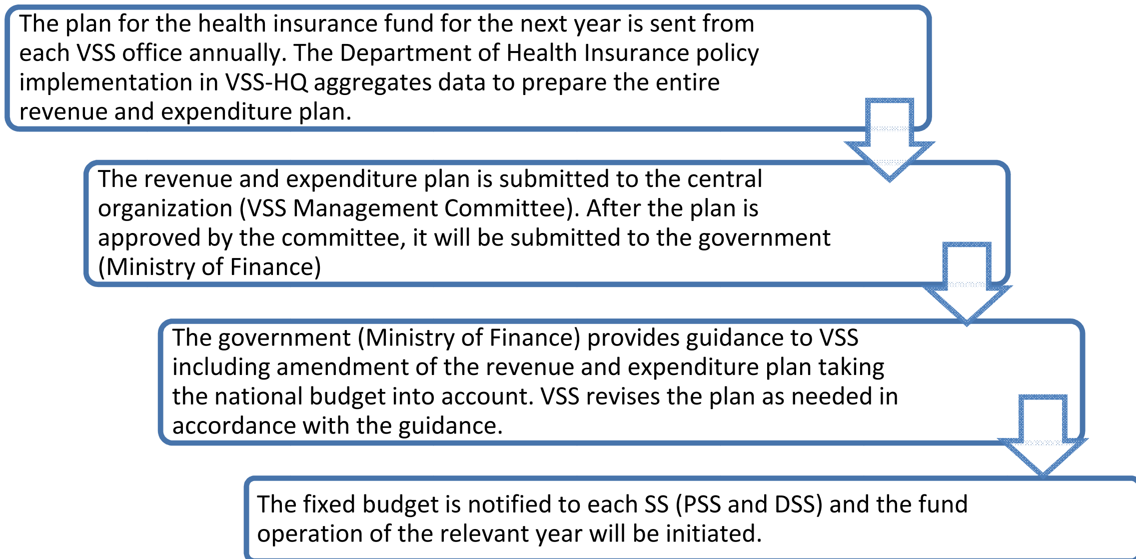
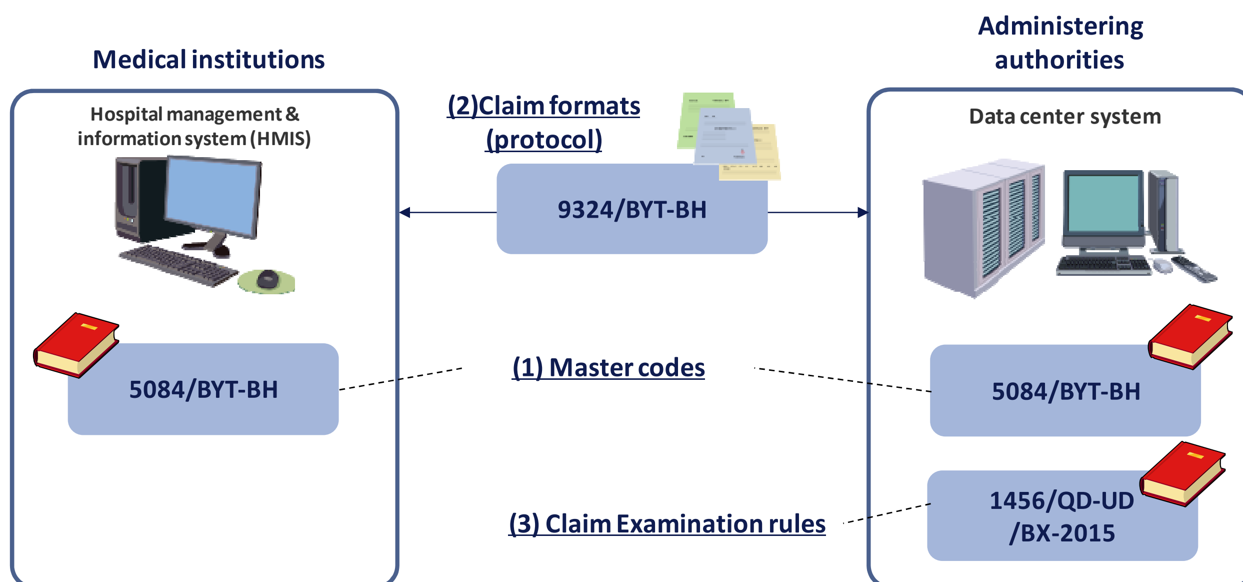


Figure 4-4 Budgeting Flow of Health Insurance Fund

Chapter 5 IT System for Health Insurance

5.1 Technical Standards for the Deployment of IT Systems for Health Insurance

Three types of information, master code, claim formats and claim examination rules, should be well prepared to develop IT systems contributing to the efficient management of the health insurance system (Figure 5-1).



Source: Survey Team

Figure 5-1 Three Types of Information for IT System Development

5.1.1 Master Codes

The master codes are the common codes used among the health service providers at the time of medical care, claim and claim examination for data entry of medical care, medicine and those costs. As a fundamental rule, data has to be entered using unique and systematically organized codes.

While an MOH Decision[39] specifying the eight master codes as listed in Table 5-1, the content of No. 6 (List of Diseases according to International Classification of Diseases 10th edition (ICD-10)) has not been published after the announcement of the decision.

Table 5-1 List of Master Codes

No.	Name of Master Code	# Item	Authority In-charge
1	List of technical services	18,139	Medical Service Administration (MSA)
2	List of medicines	20,256	Administration of Drag Management
3	List of consumable supplies	603	Medical Equipment and Infrastructure Department
4	List of drugs and traditional medicine herbs	N/A	Traditional Medicine Department
5	List of diseases in traditional medicine	412	Traditional Medicine Department
6	List of diseases according to ICD-10	N/A	MSA
7	List of blood and blood products	45	MSA
8	List of clinics and treatment	13,572	MSA

Source: [MOH, 2015]

39 5084/BYT-BH dated November 30, 2015

Services should be carefully verified to avoid duplication and contradiction and appropriateness or feasibility of the actual medical service practice should be well assessed in accordance with the international standard such as ICD-10 and ICD-9-CM (ICD 9th edition, Clinical Modification). After a certain period of operation, the master codes should be reviewed from the above viewpoints to reduce unnecessary workload of relevant staff. Also, common glossary of technical terms should be developed in line with international standard such as ICD or the International Classification of Health Interventions (ICHI) for diseases and medical services. Also, master code of medical devices and nursing should be developed.

In addition, the master code seems not to be appropriately linked with other relevant circulars such as the latest medical prices.[40] Moreover, the data was published in a format that seems to be difficult to customize according to actual needs and practices in each health facility. According to the interviews, it has been causing heavy work load on administrative and IT staff to adjust their operation and causes confusion in patient services.

5.1.2 Claim Formats (Protocol)

The claim data is prepared by health service providers submitted to the administering authorities, VSS. It consists of detailed information about the patients, examination and treatment, and prescribed drugs together with those costs, as well as amount covered by health insurance.

The Circular 9324/BYT-BH specified new claim formats, Forms 1 to 5. However, according to the interviews, some hospitals, especially those who cannot afford to invest on IT system development, seem to have difficulty into adapting to such format change immediately. Therefore, it might take some more years to introduce these new formats all over the country.

In addition, the following formats should be developed in the future to collect necessary information for IT system development to increase effectiveness on hospital management: clinical exam data protocol, prescription data protocol, radiation data protocol, sanitary inspection data protocol, disease name information data protocol, endoscopic data protocol, injection data protocol, pathology and clinical cell data protocol, and radiation therapy data protocol.

5.1.3 Claim Examination Rules

Claim examination rules serve as criteria to judge appropriateness of the claim submitted by health service providers to the social insurance institutions. The rules should include various viewpoints such as membership category and status of health insurance, accuracy of mathematical calculations, clinical and epidemiological appropriateness.

[40] 37/2015/TTLT-BYT-BTC dated October 29, 2015

VSS has published the claim examination rules in 2015[41]. However, the operational guidelines have not been provided to show how to identify the claims which should be rejected. According to VSS, although there are about 100 check items that were defined in 2015, those have not been published.

5.2 Future Visions and Plans to IT System Development

The Government of Viet Nam has shown directions for modernization of health insurance system as indicated in Table 5-2.

Table 5-2 Visions for IT System Development

Vision	Outline
e-government	As promulgated by Resolution No.36a (October 2015), the government is promoting e-government to improve efficiency of works, mutual collaboration among relevant agencies, and quality of service to the people.
Computerization of Health Insurance	In order to ensure the enabling environment to make the health insurance system (e.g. management of healthcare, health insurance payment) more transparent, Decision No.102/TB-VPCP (March 2015) indicates tasks of concerned authorities. It is required that MOH, in collaboration with VSS, cooperate with IT enterprises to develop and provide software in order to unify output data from the health facilities.
IT System Development in 2016-2020	The national programs for introducing IT system in state agencies' activities for the period of 2016-2020, which includes the field of health insurance, were approved by Decision No.1819/QD-TTg (October 2015). According to the IT Department of MOH, they have been developing an IT System Development Plan for Health Insurance from 2016 to 2020 based on the decision.
IT Service Lease	The Prime Minister's Decision No. 80/2014/QD-TTg (December 2014) specifies the rules of IT service lease by governmental organizations in order to reduce investments from the national budget
Linkage between HIS and Health Insurance Information System	Resolution No.18 promulgates the implementation of linkage between HIS and the Health Insurance Information System which is to be achieved by 2018. In accordance with the resolution, MOH published the documents concerning the deployment of IT systems for health insurance system in 2016 and subsequent years.
Major IT projects of MOH in 2016	Decision 5614/QD-BYT approved the MOH IT Application and Development Plan in 2016. This indicates the targets of IT system deployment such as - A database should be configured for the eight common master lists published by MOH (5084/QD-BYT). - HIS shall be deployed 100% on all MOH hospitals[42]. 30% of these hospitals have a laboratory information system (LIS) which shall be integrated to the HIS. As part of encouraging multiple funding options for promoting IT system, public-private partnership (PPP) is also recommended.

Source: Survey Team

In line with the above policies, VSS and MOH have been conducting future plans regarding health insurance claim and examination (Table 5-3). Each project has quite specific objectives and limited scope to respond to a particular purpose.

41 1456/QD-UD/BX-2015

42 MOH hospitals include central hospitals and specialized hospitals under direct operation of MOH.

Table 5-3 Future Plans on Health Insurance System

Objecrtives	Project Description	Relevant Organizations
Business Process Improvement	To improve the business process on social security in VSS, activities to strengthen initiatives relevant to IT system development for business procedure and human resource development were included.	VSS
Hospital Management and Information System Deployment	To introduce a new model to transfer claim data collected from health facilities to the database center. HIS solutions of the different vendors were used to send the claim to VSS in MOH-specified data formats.	MOH VSS
National Personal ID No. System Development	The project aims to develop a national personal ID number database for the social security and health insurance system. Using the household subscription data of health insurance, the raw data on 95 million households has been entered to the database.	VSS

Reference: Interviews

5.3 IT in Hospitals

IT application in hospitals seems to be still in the early stage. MOH tried to integrate and develop the IT system in hospital. The hospitals and central and local health administrations have been taking various measurements to develop the IT system and to improve efficiency of management and service provision. Situation and challenges in IT system development in hospitals are summarized in Table 5-4. According to VSS and local hospitals, electronic claim submission will become mandatory from July 2016. At the same time, automatic claim examination will be introduced in the social security institutions.

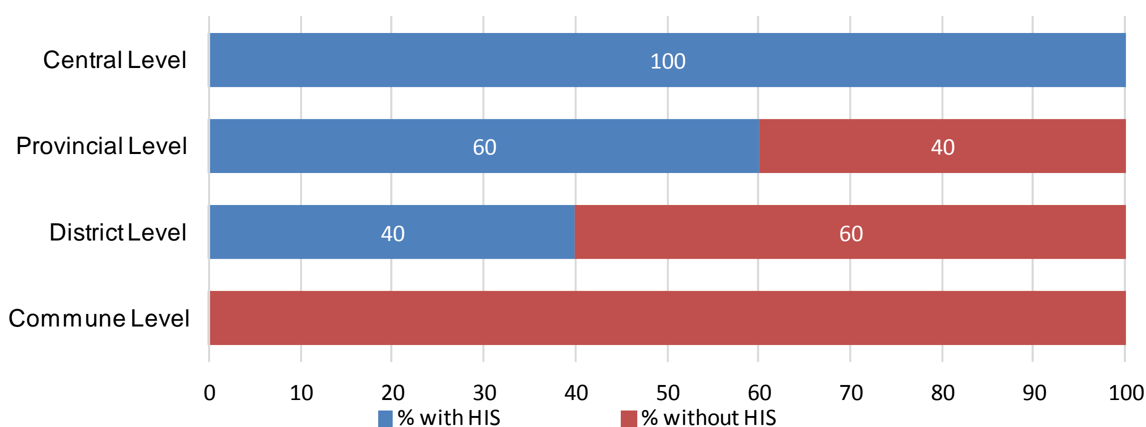
Table 5-4 Situation of IT System Development in Hospitals

Hardware and Infrastructure	- Overall, computer hardware has been installed in most of health facilities from central to district level. However, MOH does not designate standard specification of hardware and IT infrastructure for the state health facilities. - Internet connection is generally not stable especially in rural areas and not available in hard-to-reach areas. - Most of local hospitals use desktop computers that need to be replaced in a few years. - Patient to computer rate is around 100 in central hospitals and higher in provincial and district hospitals.
Software	- There has been several software programs built and applied for management purposes at hospitals, wards, departments, institutes, etc. However, a comprehensive and uniform package of professional software has not been well developed.
Human Resource Development	Although IT staff in hospitals has some relevant education background, the number is not sufficiently allocated. In-service training and overseas training opportunities on IT for hospital management have been provided. However, quantity and quality of such human resources are not sufficient.

Reference: Interviews

5.3.1 Application of Hospital Information System (HIS)

According to MOH, all central hospitals have hospital information system (HIS), whereas the proportion among provincial and district hospitals is from 60% and 40% respectively, and much lower among CHSs (Figure 5-2).



Source: MOH

Figure 5-2 HIS Application Rate by Hospital Level

5.3.2 HIS

HIS is an essential computer system that can manage all information to allow health service providers to do their tasks effectively. Modern HIS includes many applications addressing the needs of various departments in a hospital. The system is integrated to communicate among all the relevant departments including clinical, pharmaceutical, nursing, laboratory and accounting. HIS could provide rapid access to reliable information of patients including general characteristics, history of diseases, situation and progress of treatment. Quality HIS could contribute quality patient services and effective financial management by enhancing information integration, reducing transcription errors and duplication in data entry, and optimizing reporting tasks. It could also be used to monitor and provide information about the needs and common behavior of patients and staff and could also promote and achieve financial sustainability.

According to MOH, the criteria for the HIS software and content of some computer software in hospital management is defined in the circular[43]. Every IT vendor applying for a bidding or contract with hospital has to introduce HIS software in accordance with the designated criteria in the above circular.

The state hospitals all over the country have to develop or procure HIS software in accordance with the criteria. Five functions that should be included in HIS are summarized below:

- Management of clinics (patient reception, room management, treatment of patient in outpatient)
- Management of inpatient (patient information, disease management, hospital bed, statistical report)
- Management module subclinical
- Management of pharmacy (drag information, inventory)
- Management of hospital fees and health insurance (medical services, disclosure of financial expenses, Print invoices, financial statements)

[43] 5573/QĐ-BYT (2006/12/29)

5.3.3 Progress and Future Plan of HIS Development

During the period between 2000 and 2010, HIS application in Viet Nam was mainly at the level of issuing guidance and trials of HIS software. For the next five-year period (2016-2020), MOH plans to provide a synchronous data exchange among hospitals in order to build s feasible HIS.

After a decade of unstructured development of HIS, no centralized database to be connected among the hospitals with HIS has been developed yet. Therefore, the fragmented data has been collected from hospitals and has not been integrated and analyzed.

In the period between 2016 and 2020, MOH focuses on development of HIS and sharing of patient records across hospitals. In order to achieve the goal of 100% hospitals applying HIS, MOH has initiated the project on EMR and healthcare management system.

The key objective of this project is to increase the exchanges of patient records across hospitals and MOH via Hospital Level 7 (HL7)[44] protocol; build the electronic medical records at hospitals; the standard of exchange, record and securitize information, etc.

5.3.4 Major Projects on HIS

Table 5-5 summarizes major project relevant to IT development undertaken by MOH.

[44] A standard for exchanging of medical information and ensuring representativeness such as unification of format

Table 5-5 Major Projects on HIS

Project Name	Project Description	Timeline of implementation	IT Vendors
EMR Developing Pilot Project	A pilot project to build a synchronous EMR system among six hospitals and MOH, to transfer data from one hospital to another and to the administrative body	Pilot project completed in 2015 and application since 2016	DTT-Hanel FPT Soft VNPT
Electronic Health Insurance Card Pilot Project	A project to pilot e-health insurance card in two hospitals, to enhance patient information exchange among hospitals.	On-going	Viettel
Health Insurance Claim Examination (Inspection) Pilot Project	A project to strengthen IT application in health insurance sector in the following three phases Phase 1: Investigation Phase 2: Pilot project in some health facilities in six provinces Phase 3: Pilot at all of health facilities in six provinces The vendor will conduct participant database and a system for insurance inspection then pilot project in six provinces from 2014 to 2017.	Phase 1: 10/2014 – 01/2015: Phase 2: 07/2015 – 12/2015: Phase 3: 01/2016 – 12/2017:	Viettel
Synchronize IT System of MOH to Support Management Purposes	A project to synchronize healthcare database and application software including searching, analysis, and assessment of health database with MOH The database system will support MOH management in making timely decision.	2016 - 2017	-
IT Application in Management of Healthcare Facilities	To build an IT system to manage operation of health facilities at the district and commune level, to support the reporting	2016 - 2018	-
Electronic Library of Healthcare sector	To build a database of electronic document library in order to connect electronic libraries across facilities in healthcare sector	2017 - 2019	-

Reference: Interviews

5.3.5 Central Hospitals

The Bach Mai Hospital has applied IT in operation since 1990. HIS at Bach Mai Hospital is very complex and there is no synchronization across all departments. Regarding HIS application, Bach Mai Hospital uses a unique approach because each department can decide an investment at a certain level, HIS varies among the departments. Currently, there are 17 HIS software provided by five to six IT vendors; however, these HIS softwares are operated independently and it is difficult to synchronize and transfer data from each other. Such situation might cause the following challenges:

- Each department is not motivated to collaborate with each other to integrate and/or link the workflow
- No direction from the hospital management is provided for compliance.
- Capacity of IT officers is generally limited.

FPT is one of the key vendors installing HIS for Bach Mai Hospital. Currently, FPT is providing HIS service for the medical examination department. It could be expanded to other department or institutions within the hospital in the future.

Cho Ray Hospital has applied eHospital HIS provided by FPT since 2013. It was chosen through public bidding.

The FPT-eHospital includes 41 modules. Among those, several key modules have been implemented, such as pharmacy management, patient registration, emergency admissions, health screening, health record management, accounting, inventory management, and asset management. The HIS has been applied in four outpatient and 34 inpatient departments.

5.3.6 Local Hospitals

In the provinces visited by the Survey Team, HIS has been introduced in both provincial and district hospitals. According to the interviews, each hospital uses various HIS products developed by local IT companies. The hospitals seem to have enough financial ability to buy and implement the software on their own. Table 5-6 shows the names of software and relevant costs paid by the hospital.

Table 5-6 HIS Software Cost in the Hospital

		Name of Software (Provider)	Initial Cost (Invester)	Recurrent Cost Per Month
Gia Lai	Province	VIMES (VIMES., JSC)	VND 3 billion (USD 132,000) (Provincial Hospital)	VND 16.7 million (USD 735)
	District	VIMES (VIMES., JSC)	- (District Hospital)	VND 6.7 million (USD 295)
Hoa Binh	Province	Smart IT Solution (Smart IT Solution)	- (Pay only recurrent cost)	VND 70 million (USD 3,080)
	District	- (Minh Lo)	VND 35 million (USD 1,540) (District Hospital)	VND 0.58 million (USD 25.5)

Source: DOH of Gia Lai and Hoa Binh Provinces

Although almost all the hospitals have already introduced HIS and most of them have a function to create standardized claim format which VSS defined, they still have to send medical fee claim data to VSS by an old fashioned way (by e-mail).

Regarding IT staff in the hospitals, the number of IT staff and relevant trainings are still insufficient. Table 5-7 shows the number of IT department staff compared with the number of total hospital staff. It shows 1% of the entire staff assign to IT department. This proportion is similar to Japan and means the quantity might not be problem. However, in most of the hospitals that survey team visited, IT staff also serves for other posts such as department of pharmacy.

Table 5-7 IT Staff in Local Hospitals

		Number of Hospital Staff	Number of IT Department Staff
Gia Lai	Province	930	8
	District	74	1
Hoa Binh	Province	627	9
	District	99	1

Source: Provincial and District Hospitals in Gia Lai and Hoa Binh

Originally, IT staff in the hospital should be involved in two tasks. Firstly, they manage and maintain the information system (hardware and software) in the hospital. Secondly, they manage clinical data. However, IT staffs in these hospitals seem not to have sufficient capacity to manage clinical data

appropriately. Also, they have not received sufficient training on clinical data management and data analysis.

5.4 IT in VSS/ PSS

Aside from health insurance, VSS is responsible for a wide range of social insurance operations such as pension and industrial accident insurance. VSS has introduced IT systems to support these operations. It has the department in charge of introduction and maintenance of IT systems and networks in its office. Currently, VSS staff can use the IT system in limited operation such as performing data aggregation because data entry or submission is mainly done by using soft files and paper files

IT systems are independent of each other according to each operation and it causes lack of data linkage between systems. VSS staff uses some types of software for operating health insurance, pension, and social insurance. Table 5-8 shows the types of software used in the PSS office in Gia Lai Province.

HMS is the main software for aggregation and examination operation of claim data. It has the following features:

- Function of importing data claimed from medical institutions.
- Function of checking whether necessary information for claims is entered in the data claimed （example an error message displays when necessary information is not entered including the insurance certification number and subscriber’s name).
- Function of checking whether there is inconsistency between information in the data (example an error message displays when a record is found that the same insurance certification number is given for several different names).
- Function of reporting to notify the examination results to medical institutions.
- Function of reporting to the upper-level VSS office.

Table 5-8 List of Software Used in the PSS Office

Name of Software	Purposes	Developer	Number of Staff using the Software
SMS (Social Security Management System)	To manage social insurance collection	FBsoft Co., Ltd	91
Xet duyet	To determine and approve the amount of pension benefit	VSS IT Bureau	29
ODTS	To examine and approve payment for industrial accident and childbirth		29
In So the 1.0	To count the number of health insurance certifications		24
Vien phi 3.0	To manage hospital fees		29
HMS	To examine and aggregate health insurance claims		29
Quan ly chi	To manage expenditure		29

Source: PSS Gia Lai

5.5 Major IT Companies in Viet Nam

There are three possible large IT companies in Viet Nam, i.e., Viet Nam Posts and Telecommunications (VNPT), FPT Corporation (FPT) and Vittel, which are capable to develop and maintain nationwide IT system for health insurance. Actually, some have been working with MOH, VSS and/or hospitals to develop and introduce IT system for health insurance and HIS.

(1) VNPT

The VNPT Group is one of the state-owned companies[45]. VNPT has approximately 90,000 employees in which 5,000 are in charge of IT-related projects (500 of them are IT engineers). The revenue in 2014 was VND 101,000 billion.

VNPT have experiences in social service fields such as health, education, security, and social security insurance. Although VNPT has some experience of introducing IT system to several ministries, those were mainly limited to a particular level, central or local only, and not connecting multiple levels of administration. VNPT has strong advantage to deliver products or services quickly and nationwide because they have branch offices in all 63 provinces and maintain close communication with local authorities.

VNPT is currently conducting a project in collaboration with MOH to introduce HIS to 400 hospitals[46]nationwide.

VNPT has enough capacity to develop solutions to improve hospital management. However, it is rather weak to develop integrated management system that is connected with multiple administrative levels.

(2) FPT

FPT is a private company established in 1988. It has approximately 25,000 employees in which 8,500 are IT engineers or technology experts. The revenue in 2014 was VND 37,500 billion.

FPT is currently conducting two pilot projects with regard to health insurance management.

- From December 2013 to December 2015, FPT has been conducting a pilot project to introduce HIS to six hospitals with the Administration of Health Information Technology of MOH. In this project, FPT has developed HIS software and installed to the pilot hospitals.
- From April to July 2015, FPT has conducted a pilot project to introduce the automatic claim examination system to VSS offices (provincial and district levels) in three provinces. The objective of this project is to examine claim data from hospital automatically in the perspective of “calculation validity” and “doctor’s judgment”. After the pilot project, MOH decided to request all public

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[45] It was established in accordance with the decision NO.VN249/TTG dated 29/4/1995 of the Prime Minister

[46] The details were not presented to the Survey Team.

hospitals to collect medical fee data[47] in the newly developed format[48], and submit to VSS. FPT has developed the data collection software for hospitals to be able to download from the website.

FPT well understand the detailed procedure of health insurance claim, review, and payment mechanism. Therefore, FPT has enough capacity to develop relevant software. However, because of its domestic network relying on the headquarters and three branches only, it is rather weak to introduce software and hardware to hospital and/or VSS at each level nationwide.

(3) VIETTEL

The Viettel Group is one of the state-owned companies which was established in 1989. Viettel has approximately 30,000 employees and revenue in 2012 was VND 140,000 billion. All the stocks are owned by the Ministry of Defense in accordance with 2097/2009/QD-TTg.

- From 2014, Viettel has been conducting the pilot project on health insurance claim examination. The Project aimed to strengthen ICT application in health insurance sector.
- Viettel have been conducting the Electronic Health Insurance Card Project. The Project aimed to pilot the e-health insurance card in two hospitals, to enhance patient information exchange among hospitals.

Viettel has strong advantage in terms of financial capability to invest in IT system. Also, it has a wide area network and facilities all over the country since it is a military telecommunication company. However, Viettel does not have enough experience in social security, health insurance, and hospital management field.

[47] 8623/BYT-BH 9/11/2015
[48] 9324/BYT-BH

Chapter 6 Information Management Relevant to Health Insurance System

To manage the benefit package, medical fee, and provider payment mechanism evidence based, a wide range of information needs to be collected and analyzed regularly. It could include routine clinical and public health information such as disease structure, service provision and utilization, human resource for health, facilities, as well as equipment. Also, demography, household and local economy, care seeking behavior, hospital finances, and pharmaceutical prices could be important to maintain an appropriate health insurance system. Therefore, this section describes the availability of such relevant information.

6.1 Relevant Policies on Health Information Management

The existing policies related to health information system do not regulate the detailed functions and tasks for collecting, processing and sharing information among sub-information system of health sector. The information collection is overlapped, and in addition, the concerned agencies, such as the Ministry of Health (MOH), the General Statistics Office (GSO), the Ministry of Finance (MOF), the Ministry of Planning and Investment (MPI) and the Vietnam Social Security (VSS), still do not establish coordination and collaboration mechanism on information collection and sharing each other.

6.1.1 Development Plan

As described in Table 6-1, MOH presents the vision, goals and objectives toward the year 2030 in the Master Development Plan for Health Information System for 2014-2020 and 2030.

Table 6-1 Vision, Goals and Objectives toward 2030

Vision for 2030	The Health information system meets the international standards and the information needs of governments, organizations and individuals in the country and abroad.
Overall goals	・By 2020, the health information system will be improved at all levels, from the central to the commune, with efficient operation, and timely and accurate information. The management and administration of health activities at all levels in all sectors contribute to improve the people's health status. ・Toward the year 2030, the health information system in Viet Nam will be developed as a unified and synchronized system with IT technology and achieve the advanced level in the region.
Specific objectives	<Leadership and Governance> ・To strengthen the capacity of governance on the health sector through integrated information. ・To strengthen the capacity of governance on the health sector through the standardized information. ・To strengthen governance through improved monitoring of mortality and analyze the causes of deaths. <Human Resources, Financing, and Medicines> ・To strengthen the health workforce in statistical work through improved inventory databases and trainings ・To improve policies, resources and activities through computerized financial data including health insurance. ・To improve resource planning through upgrading the computer system in the drug unit and vaccine products. <Service Providers> ・To develop and implement computerized health system from grassroots level to improve the quality and integration of information. ・To expand the coverage of surveillance activities, involving the private sector, to increase the quality of public health programs, including NCDs and disabilities. ・To standardize the records at hospitals, medical terminology and technical processes to improve the quality of services and hospital management. ・To enhance the access of patients to information of their own health with improved security and privacy of patient medical records.

Source: [MOH, 2014]

6.1.2 Relevant Legislations

In order to strengthen the management of health information, the Government of Viet Nam has issued a series of policies related to health statistical information system (Table 6-2).

Table 6-2 Relevant Legislations on Health Information System

Legislation	Title / Description
Circular No. 06/2014/TT-BYT (February 2014)	List of Key Health Indicators
	The circular provides the list of 88 key health indicators on health financing, health workforce, medical facilities, medical services and health conditions.
Circular No. 32/2014/TT-BYT (June 2014)	Issuing a List of Statistical Indicators of Basic Health Applied in Provincial, District and Commune Levels
	Based on Circular 06/2014/TT-BYT, this circular regulates which statistical indicators are to be applied at each level.
Circular No. 27/2014/TT-BYT (August 2014)	Regulating the Statistical Medical Form System for Medical Facilities in the Province, District and Commune
	The circular stipulates the medical statistic form system for medical facilities in the province, district, and commune. The regulated forms include 1) notepads on health management for commune health facilities, 2) statistical reporting forms for the facilities in communes and towns under the districts, 3) statistical reporting forms for the facilities in districts, towns and cities under the provinces, and 4) reporting forms for the facilities in provinces and cities under the central authority
Circular No. 28/2014/TT-BYT (August 2014)	Regulating the Content of Health Statistical Indicator System
	The circular regulates the content of health statistical indicators. In addition to the 88 key indicators provided in 06/2014/TT-BYT, it also gives the purpose, concept, suggestion/discussion, and relevant parameters for each indicator.
Circular No. 29/2014/TT-BYT (August 2014)	Defining Forms and Regulations on Health Statistical Reports for Private Medical Examination and Treatment Facilities
	The circular stipulates forms and the reporting system for private medical facilities. The forms include 1) record book, 2) statistical reporting form for private health care facilities, 3) statistical reporting form for the private facilities with beds, and 4) reporting form on clinical activities for the private medical facilities.
Law No. 89/2015/QH13 (November 2015)	Law on Statistics
	The law provides for statistical activities, using state statistical information; rights, obligations and responsibilities of agencies, organizations and individuals in statistical activities, using state statistical information; state statistical organizations and statistical activities, using statistical information outside the state statistics.

Source: [National Assembly, 2015] [MOH, 2014] [MOH, 2014] [MOH, 2014] [MOH, 2014] [MOH, 2014]

6.1.3 National Health Indicators

The Circulars No. 06/2014/TT-BYT and 28/2014/TT-BYT provide 88 national health indicators with data sources to be collected, reporting period, and authorities in-charge of both information provision and collection. The national health indicators are listed in Table 6-3.

Table 6-3 List of National Health Indicators

Category	Indicator
01. Finance for Health Care	・Expenditure on health as % GDP ・General government as % of total expenditure on health ・Household out-of-pocket as % of total health expenditure ・General government as % of total government expenditure ・Per capita health expenditure
02. Health Workforce	・Health personnel density ・Graduation rate from health professional institutions
03. Medical Facilities	・Health facility density ・CHSs with midwife or assistant doctor ・Hospital bed density ・Villages with village health worker ・Pharmacy density ・Villages with trained village-based midwife ・CHSs with doctor ・Communes fulfilling national commune health criteria
04. Intelligence System	・Health information system performance index
05. Administration	・Rules-based policy index
06. Use of Medical Services	・Outpatient utilization rate ・Inpatient admission rate ・Bed occupancy rate ・Average length of stay ・Health insurance coverage
07. Quality and Safety of Medical Services	・Patient satisfaction rate ・Postoperative surgical infection rate ・Medicine samples quality compliance rate
08. Coverage and Impacts of Interventions	・Antenatal care coverage ・Cervical cancer screening rate ・Antenatal care tetanus toxoid coverage ・Breast cancer screening rate ・Fully vaccinated coverage ・Antenatal ARV treatment rate ・Skilled birth attendant coverage ・Domestic violence treatment rate ・Postnatal care coverage ・Hospital morbidity top ten causes ・Pneumonia treatment with antibiotics rate ・Hospital mortality top ten causes ・Traditional medicine treatment rate ・TB treatment success rate ・Epidemic communicable diseases morbidity rate ・Epidemic communicable diseases mortality rate
09. Behaviors and Risk Factors	・Smoking rate ・Low birth weight rate ・Sex ratio at birth ・Malnutrition rate ・Obesity rate ・Contraceptive prevalence rate ・Hygienic toilet use ・Clean water use ・Unmet need for family planning ・Medical waste treatment coverage at health facilities ・Dietary energy consumption < 1,800 Kcal per capita ・Correct HIV prevention knowledge
10. Health condition	・Life expectancy at birth ・Crude birth rate ・Total fertility rate ・Adolescent fertility rate ・Maternal mortality rate ・Neonatal mortality rate ・Infant mortality rate ・Under five mortality rate ・Dengue fever incidence ・Leprosy incidence ・Leprosy prevalence ・Malaria incidence ・Malaria mortality rate ・TB of all types incidence ・TB AFB+ve incidence ・TB AFB+ve prevalence ・TB HIV-ve mortality rate ・Death s in community: top ten causes ・Vaccine preventable disease incidence ・Vaccine preventable disease mortality rate ・HIV incidence ・HIV prevalence for 15-49 years ・HIV/AIDS mortality rate
11. Non-Communicable Diseases (NCDs) and Injuries	・Food poisoning accidents ・Acute food poisoning treatment rate ・Acute food poisoning mortality rate ・Occupational diseases treatment rate ・Schizophrenia treatment rate ・Depression treatment rate ・Epilepsy treatment rate ・Diabetes treatment rate ・Cancer treatment rate ・Hypertension treatment rate ・Injury treatment rate ・Injury mortality rate

Source: [MOH, 2014] [MOH, 2014]

Moreover, Circular No. 32/2014/TT-BYT assigns these indicators to provincial, district and commune health facilities with respect to each level. The number of indicators assigned is 70 for provincial, 60 for district, and 45 for the commune level (Table 6-4). With the exception of three indicators on non-communicable diseases (NCDs), all other information will be collected and reported annually.

Table 6-4 Number of Indicators by Level of Health Facilities

	Indicator Category	Number of Indicators		
		Provincial Level	District Level	Commune Level
Input Indicators	01. Finance for Health Care	2	1	1
	02. Health Workforce	2	1	1
	03. Medical Facilities	8	8	2
	04. Intelligence System	0	0	0
	05. Administration	0	0	0
Output Indicators	06. Use of Medical Services	5	4	1
	07. Quality and Safety of Medical Services	0	0	0
Outcome Indicators	08. Coverage and Impacts of Interventions	13	13	11
	09. Behaviors and Risk Factors	7	5	3
Impact Indicators	10. Health Condition	22	20	19
	11. Non-communicable Diseases and Injuries	11	8	7
Total		**70**	**60**	**45**

Reference: [MOH, 2014] [MOH, 2014] [MOH, 2014]

As for the Indicators No. 04 on Intelligence System, No. 05 on Administration, No. 07 on Quality and Safety of Medical Services, and some in other categories, the central authorities are in-charge in providing data.

6.2 Human Resources

With regard to human resources for health information system, the important issues are both the capacity of personnel and their skills in statistics.

The Health Statistics and Information Division takes the highest responsibility for health statistics activities. Although the division is assigned to do a wide range of tasks (Section 3.4.1(1)2)), there are only five permanent officials and two part-time staff. None of them have academic background of statistics, and they do not have sufficient professional skills to analyze and utilize the data. At the provincial and district level, the number of staff in charge of statistics is only one or two, and they are usually assigned into other activities at the same time.

6.3 Data Sources of Health Information System

The following could be sources of data for health information system: vital statistics, population survey, disease surveillance, and routine reporting.

The accuracy of data has been recognized as a key issue to be addressed, and MOH has been working to improve it.

Until 2014, the data source from regular reporting system had been collected only from public health facilities. The data of private health facilities has been not available, and therefore, the statistics on health status and health services did not reflect the actual situation. In order to address this issue, MOH developed Circular No. 29/2014/TT-BYT which regulates the reporting forms for private health facilities.

Regarding the data on deaths, it also has not reflected the actual number. In the case of death at home, it is difficult to identify the cause of death. Although MOH established the system to collect mortality data from VHW, the reporting form does not require reporting the causes in the community.

Data management should have five steps: 1) data collection and storage, 2) compilation and aggregation, 3) quality control, 4) analysis, and 5) report and feedback. Currently, the management system of health information is not well managed as there is no monitoring mechanism and also the regulation to standardize the quality of data.

6.3.1 Vital Statistics and Population Surveys

(1) Registration System

The permanent residence registration system is under the responsibility of the public security sector. Every household has a residence book to record the full name, date of birth, occupation and place of work of all the family members. The Public Security also takes charge of the registration for migration.

The registration for births, deaths, marriages, and divorces is under the responsibility of the Department of Justice of the Commune People's Committee.

(2) Population and Housing Census

In Viet Nam, census has been conducted every ten years by GSO since 1979. The most recent census was conducted in 2009 in cooperation with the United Nations Population Fund (UNFPA). For the population and housing census, data is collected through both a complete survey and a sample survey. The questionnaire for the complete survey includes demographic data, such as individual information, education level, ethnicity and religion, and housing data. In addition to these questionnaires, the sample survey asks for more detailed information such as disability status, marital status, economic activities, birth history, deaths, and facilities of a house [GSO/UNFPA, 2009].

(3) Demographic and Health Survey (DHS)

GSO also conducts Demographic and Health Survey (DHS) and it has been conducted in 1988, 1997 and 2002 in Viet Nam. The third DHS in 2002 was sponsored by the Committee for Population, Family and Children, and also received technical support from ORC Macro. The information on demographic conditions, family planning, infant and child mortality, maternal health and HIV/AIDS will be collected through a sample survey [GSO, 2002]

6.3.2 Communicable Diseases Surveillance System

The National Institute of Hygiene and Epidemiology (NIHE) and regional epidemiology sub-institutes take charge of directing the communicable diseases surveillance system. The information on morbidity and mortality due to communicable diseases is collected from commune level and reported to the preventive medical center at the district level. The combined data at district level is reported to preventive

health care center, and then to the regional epidemiology sub-institutes and NIHE [MOH, 2006]. According to the Master Development Plan for Health Information System for 2014-2020 and 2030, this surveillance system is well operated. The data on diseases and epidemics has been updated and reported timely [MOH, 2014].

6.3.3 Regular Reporting System

The reporting system of the Health Management Information System (HMIS) has been established and Circular No. 27/2014/TTBYT regulates the registering and reporting forms which are to be applied at each level of health facilities. The forms and the contents to be recorded are summarized in Table 6-5.

Table 6-5 Recording Books and Reporting Forms at Health Facilities

Levels	Forms	Summary of Contents
Commune	12 register books (A1/YTCS - A12/YTCS)	Health record/ vaccination for children/ immunization for encephalitis, cholera and typhoid/ tetanus vaccination for women/ antenatal care/ family planning/ abortion/ malaria/ mental/ TB/ HIV/ health education/ NCDs
	10 forms (1/BCX - 10/BCX)	Population/ health expenditure/ health workforce/ maternal and child health/ EPI/ injuries/ infectious diseases/ social diseases/ deaths in the community
District	16 forms (1/BCH - 16/BCH)	Population/ health expenditure/ facilities/ health situation in commune/ health workers in the district/ maternal care/ maternal morbidity and mortality/ family planning/ child health/ vaccination for children/ child morbidity and mortality/ preventive services/ social diseases/ accidents and injuries/ infectious diseases/ morbidity and mortality at the hospital/ deaths in the community
Province	18 forms (1/BCT - 18/BCT)	Population/ health expenditure/ facilities/ health situation in commune/ maternal care/ maternal morbidity and mortality/ family planning/ child health/ vaccination for children/ child mortality/ preventive services/ social diseases/ accidents and injuries/ infectious diseases/ morbidity and mortality at the hospital/ deaths in the community/ health insurance/ capacity development of human resources

Source: [MOH, 2014]

The focal point of this information system is the Department of Planning and Finance (DPF) of MOH. It is responsible for guiding and supervising the implementation of recording forms, data collection and reporting. The details of reporting system is described in Section 6.4.

6.3.4 Information Management of Quality Control in the Hospitals

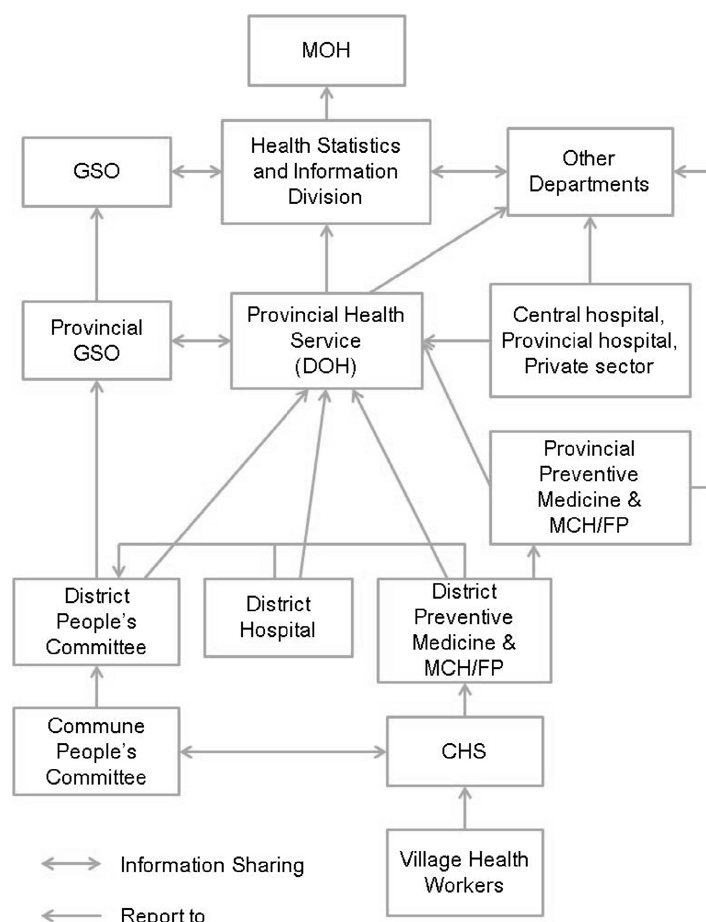
Apart from this reporting system regulated by Circular No. 27/2014/TT-BYT, Medical Service Administration (MSA) also collects data from hospitals. The data from the district and provincial hospitals is aggregated by the Department of Health (DOH), and then reported to MSA regularly. Although the raw data is kept within MSA, the aggregated data could be provided to DPF, the Department of Personnel, HSPI, the Department of Administration for Science, Technology and Training, and the Health Economics Association.

Information of health facilities was collected in paper based. According to MSA, the initiated web-based information collection between MOH and each hospital used the District Health Information Software (DHIS). Information collected through DHIS includes the followings:

- Basic Information
- Key Performance Indicators (KPI)
- List of Technical Service
- Human Resources (qualification, educational background, job history, license, etc.)
- Medical Equipment
- Financial Situation
- Drug (unit price, inventory, annual procured number, etc.)
- Disease Situation (classification by ICD-10, notifiable diseases, accidents)
- Quality Control Activates (self-evaluation, evaluation by DOH, official report)
- Patient Satisfaction (complaint management)
- List of Service Prices (from 2016)

6.4 Flow of Information

Data flows of HIS and most of the national health programs follow the vertical system from commune to district, provincial and central levels. Figure 6-1 shows the flow of information of HIS.



Source: Health Statistics and Information Division, MOH

Figure 6-1 Information Flow

(1) Commune Level

At the commune level, village health workers[49] are assigned to collect information on births, deaths, accidents, injuries and epidemic diseases occurred in the villages. Such information is recorded in the form regulated in Circular No. 27/2014/TT-BYT and reported to commune health stations (CHSs). The CHSs combine information from village health workers (VHWs) with the record of health services at CHSs, and submits to the authority at the district level.

(2) District Level

At the district level, district center for preventive medicine or health center is in charge of collection and aggregation of data on the performance of CHSs in the whole district. The center combines data submitted by CHSs and obtained by the center, and submits it to the District People's Committee and DOH. In case that a district hospital is administrated by district health center, the data on health activities at that district hospital should be aggregated by the district health center.

(3) Provincial Level

DOH is responsible for collecting and aggregating the data on health activities in the whole province. The data includes the reports from health facilities at the provincial level, district center for preventive medicine or health centers, and district hospitals. The reports aggregated by DOH should be submitted to the provincial GSO and Health Statistics and Information Division.

(4) Central Level

At the central level, the Health Statistics and Information Division of DPF takes responsibility for collecting and aggregating the data on health activities from health facilities and institutions in 64 provinces. After aggregating the data, the division compiles the results into a report, such as Health Statistics Yearbook, and submits to the concerned government agencies.

6.5 Infrastructure

The introduction rate of hospital information system (HIS) is estimated at almost 100% for central, 60% for provincial, 40% for district level (Section 5.3.1).

In the provinces, hospitals are already equipped with computers; however, the specifications of the computer are too old and it does not meet the requirement of software for data management. At the district level, some health centers/hospitals have limited number of computers, and so the staff in-charge of statistics has to share the computer with other divisions.

In Binh Dinh and Dong Thap provinces, computers and software for HIS are equipped in all CHSs. However, according to MOH, the number of CHSs which have computers, software, and internet access

[49] Village health workers are assigned to supervise the villages under CHS with some allowance provided by district health center.

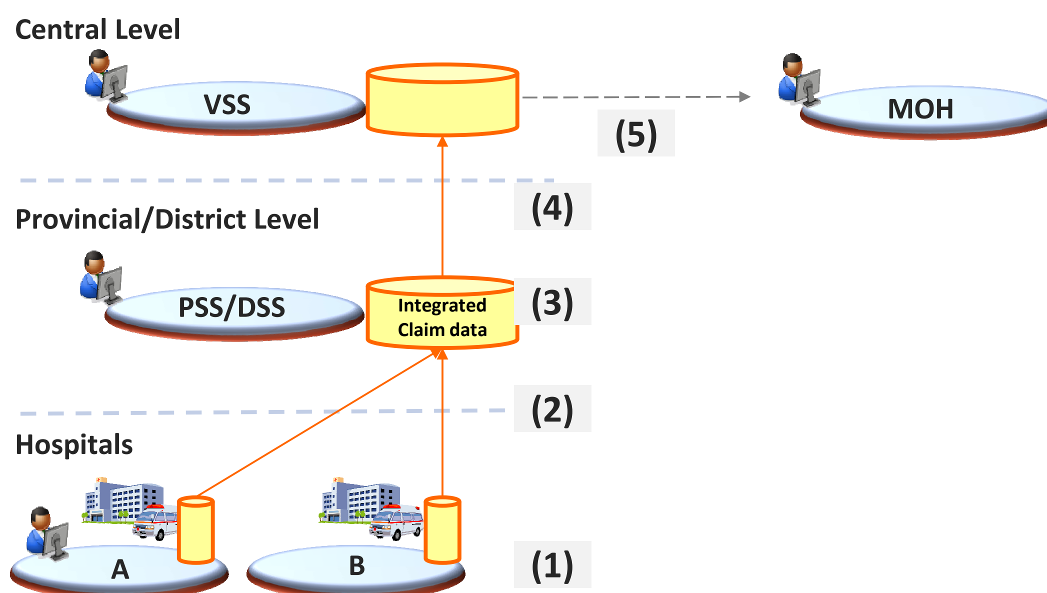
are very limited. Only the CHSs in some provinces are supported by donor agencies and IT vendors, and the rest of CHSs are in poor environment in terms of data management.

6.6 Information Management for Health Insurance Claim and Hospital Management

6.6.1 Flow of Claim Information

The claim data is transferred from the district level via provincial level to VSS headquarter. The procedure is shown in Figure 6-1 and summarized as follows;

(1) Hospital makes claim data every day in accordance with the format[50] defined by MOH.
(2) Hospital sends claim data to DSS/PSS every 25th of the month[51] in the form of CSV by e-mail.
(3) It takes one or two weeks until DSS/PSS complete claim examination.
(4) After PSS compile claim data, they send it to VSS.
(5) MOH receive summary data from VSS quarterly.



Reference: Interviews

Figure 6-2 Flow of Claim Data

However, it is not efficiently shared with MOH. Medical records and information on hospital management are not disclosed; therefore, it is not well consolidated at the central level.

6.6.2 Contents of Claim Information

(1) Format until December 2015

The claim information, to be submitted from health service providers to VSS, mainly consists of basic information of the patients, medical cost breakdown, and amount of insurance coverage. Information on the medical cost breakdown is an aggregated data by categories such as examination, treatment, drugs,

[50] 9324/BYT-BH
[51] In case of Dong Thap

consumables, etc. Therefore, the detailed examination and treatment services provided to the patient and each cost will not be provided to VSS.

Form: C79a - HD
(Issued following circular No. 178/2012/TT-BTC date 23/10/2012 of Ministry of Finance)

Name of health examination & treatment facility:..............
Code number ....

LIST OF PATIENT (OUT-PATIENT) WHO RECEIVED HEALTH EXAMINATION & TREATMENT BY PUBLIC HEALTH INSURANCE REQUEST FOR PAYMENT

Month .... Quater term............ year ....
(to be sent enclosed with data file of every month)

Unit: VND

Ordinal number	Full name	Date of birth		Health Insurance card number	Code of facility registered as first health examination & treatment hospital	Code of disease	Date of examination & treatment	TOTAL MEDICAL FEE (PUBLIC HEALTH INSURANCE PATIENT)												The patient co-payment	Medical fee request for payment	
									Including													
		Male	Female					Total	Test	Image diagnosis	Transfusion fluids	blood	operation	Consumable medicine	Replaced medical material	High technology services	Cancer drug, anti-rejection drug	Examination fee	Transportation fee		Grand total	The medical fee out of capitation fund
A	B	C	D	E	G	H	I	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
A	**PATIENT IN PROVINCE (REGISTERED FIRST HEALTH EXAMINATION & TREATMENT IN FACILITY)**																					
1																						
2																						
...																						
B	**PATIENT IN PROVINCE**																					
1																						
2																						
...																						
C	**PATIENT FROM OTHER PROVINCE**																					
1																						
2																						
...																						
	Total A+B+C					x	x															

Request payment amount (in word): ....

Person in charge	**Chief administration**	**Chief Accountant**	*Date ....* **Director**
(signature, name)	*(signature, name)*	*(signature, name)*	*(signature, name, stamp)*

Source: Circular No. 178/2012/TT-BTC date 23/10/2012 Ministry of Finance

Figure 6-3 Claim Format Used until December, 2015

(2) Format Introduced from January 2016

Based on the issued MOH's Circular, health service providers are required to use new formats (Table 6-6 and Table 6-7) for billing from January 2016. New format includes detailed information on health care treatment and medicine that was not included before.

Table 6-6 Form1：Health Care Basic Information for Health Insurance (Extracted)

No.	Items	Data Type	#Digit	Input	Explanation
1	Patient Code	TXT	15		Managed by medical institution
2	Patient Name	TXT	255	✔	Name of patient
3	Birth Date	TXT	8	✔	YYYYMMDD
4	Gender	Numeral	1	✔	Male＝1, Female＝2
5	Address	TXT	255	✔	Mentioned in insurance card
6	Insurance Card Code	Numeral	15	✔	Issued by VSS
7	Hospital Code Registered for the First Clinic Cisit	TXT	5	✔	Mentioned in insurance card
8	Valid Period(From)	TXT	8	✔	YYYYMMDD
9	Valid Period(Until)	TXT	8	✔	YYYYMMDD
10	Injury/Disease Code	TXT	5	✔	Main injury/disease code in ICD-10
11	Injury/Disease Name	TXT	255		If no injury/disease code is in ICD-10
12	Dates of In/Out of Hospital				
13	Health Insurance Coverage Ratio	Numeral	3	✔	Apply belonging group ratio of the patient
14	Total Amount of Health Care	Numeral	15	✔	Total amount of health care treatment
15	Payment of Patient	Numeral	15	✔	Amount paid by the patient
16	Coverage of Health Insurance	Numeral	15	✔	Amount covered by health insurance
17	Medical Institution Code	TXT	5	✔	Code of medical institution that the patient received treatment(issued by VSS)
18	Treatment Code of International Compliance	TXT	5		Surgery, treatment code based on ICD 9 CM Vol. 3(usage after issued by the Ministry of Health)

Source: 9324/BYT-BH

Table 6-7 Form2：Drug Specification Information of Health Insurance Coverage (Extracted)

NO.	Item	Data Type	#Digit	Input	Explanation
1	Drug Code	TXT	15	✔	Specified in the master code list
2	Drug Name	TXT	255	✔	Specified in the master code list
3	Account Unit	TXT	50	✔	Specified in the master code list
4	Quantity	Numeral	5	✔	Actually prescribed quantity
5	Unit Price	Numeral	15	✔	Health insurance coverage unit
6	Health Insurance Coverage Ratio	Numeral	3		Ratio of health insurance coverage for drug
7	Payment Amount	Numeral	15		Quantity × Unit Price × Health Insurance Coverage Ratio
8	Department Code	TXT	3		Department that health care was provided
9	Doctor Code	TXT	8		Doctor who was in charge
10	Injury/Disease Code	TXT	5		Main injury/disease code

Source: 9324/BYT-BH

Chapter 7 Relevant Activities of Major Development Partners

Improving medical security system including health insurance is a key element in achieving UHC and many donors in Viet Nam's health sector have been providing support in the field of healthcare financing.

7.1 Technical Working Group (TWG) on Health Financing

The Technical Working Group (TWG) on health financing is reorganized[52] in order to contribute to the successful implementation of the health financing reform in Viet Nam. TWG is one of the subcommittees under the Health Partnership Group (HPG) and it is expected to assist MOH in performing its stewardship function adequately with stronger planning and financing capacity.

The terms of reference and its scope of work have been discussed through preparatory meetings at the 1st TWG meeting (15 March, 2016) among MOH, relevant Vietnamese authorities, and development partners. TWG meeting will be held quarterly and ad hoc informal meetings will be organized as required.

The specific objectives of the TWG's activities will be as follows:

1) To provide effective coordination of support in developing a five-year and ten-year health financing strategy;
2) To support MOH to bring together relevant stakeholders and technical assistance in renovation of the operational mechanism and health financing mechanism, particularly provider payment methods;
3) To share knowledge and experience on health planning and financing;
4) To carry out technical work in the area of planning and financing, in order to support MOH in formulating adequate strategies, policies and plans; and
5) To support MOH to implement broader pilot methods on reforming health financing at sector level.

TWG Members (Tentative)

- Ministry of Health (DPF, Department of Health Insurance, Department of International Cooperation and other related departments)
- Health Strategy and Policy Institute (HSPI)
- Line Ministries: MOF, MPI, VSS
- Development Partners: WHO, EU, USAID, WB, ADB, JICA, etc.
- Relevant authorities, organizations, associations, individuals, experts, etc.

7.2 Relevant Donor Activities in the Field of UHC and Healthcare Financing

In the field of health insurance system, the World Bank led the assessment of the current system of social health insurance and identified rooms for further improvement in its report [World Bank, 2014]. The

[52] It was organized before, but it has not been active until recently.

United States Agency for International Development (USAID) assisted MOH in developing BHSP Roadmap. Luxemburg Agency for Development Cooperation (LuxDev) and USAID have conducted BHSP surveys in selected provinces.

Table 7-1 shows cooperation of major donor agencies in the field of UHC and healthcare financing.

Table 7-1 Aid for UHC and Healthcare Financing by Major Donor Agencies in Viet Nam

Donor	Projects/ Priority Areas	Assistance	C/P
USAID	Health Finance and Governance Project (HFG)	- HFG supports to strengthen health systems, especially focusing on capacity building of health financing. The main purpose of HFG is to ensure the sustainability of HIV/AIDS services through social health insurance (SHI). - HFG has conducted "*Actuarial Technical Assistance for Updating the Basic Health Service Package Paid for by VSS",* which was financially supported by PEPFAR. This actuarial analysis was conducted based on about 17,000 health services covered by SHI in health facilities in six provinces (Hanoi, Gia Lai, Hoa Binh, Binh Dinh, Dong Thap, Ho Chi Minh City), and the relevant data was collected from provincial hospitals, district hospitals and CHSs. The results will be available in June 2016 (the survey was implemented by Abt Associates, an NGO headquartered in US).	VAAC VSS
World Bank	Health Systems	The focus of assistance is on health financing policy, improvement of health services, and revising health insurance law.	MOH
	"Moving toward Universal Coverage of Social Health Insurance in Viet Nam"(2014)	As requested by the Government of Viet Nam, the World Bank assessed the current health financing system and social health insurance, cooperating with WHO, UNICEF, and Rockefeller Foundation. A plan and a roadmap for reform toward UHC are presented in the report.	MOH VSS
	Central North Region Health Support Project (2010-2016)	- A loan project to strengthen health services at the district level and improve their accessibility for economically vulnerable people. - It consists of four components: 1) supporting health insurance for the near poor population (USD 11.60 million), 2) strengthening district health services (USD 29.37 million), 3) developing human resources for health (USD 12.49 million), 4) project management and M&E (USD 4.51 million). The project contributed to bring up the HI coverage of the near poor people up to 90% by 31 December 2014, in which, the project provided direct financial support to 70% of the near poor in the region. - Under the second component, a Results-Based Financing (RBF) pilot was conducted in Nghe An Province in order to improve the performance of hospitals and preventive health centers.	MOH (DHI and DPF)
	Mekong Region Health Project (2006-2012)	- A loan project to strengthen health services at the district level and improve their accessibility for economically vulnerable people. - It consists of five components: 1) supporting the poor and the near poor population (USD 10 million), 2) improving care quality and capacity of hospital services (USD 44.8 million), 3) improving preventive health system (USD 7.8 million), 4) improving capacity of human resources for health (USD 11.2 million), 5) project management and M&E (USD 4.2 million). - The health insurance coverage for the near poor population in the targeted area has been increased from 7.2% (2008) to 42.1% (2011) as a result of the raised support for them to 70%.	MOH

Donor	Projects/ Priority Areas	Assistance	C/P
	Northern Upland Health Support Project (2008-2016)	- A loan project to increase utilization health services especially among the poor and ethnic minorities in the Northern Upland Provinces through 1) strengthening of district hospitals (USD 42.9 million) and 2) reducing financial constraints to accessing health services (USD 10 million). - Utilization rates of in-patient services in district hospitals among the beneficiaries increased from 0.03% (baseline, 2009) to 0.096% (2015), which is above the end target of 0.033% (10% increase).	MOH MARD
ADB	Health Human Resources Sector Development Program (2010-2017)	- A loan project to develop capacity of human resources (USD 76.3 million). There are three components; 1) improving planning and management of human resources (USD 17.09 million), 2) strengthening quality of training of human resources (USD 53 million), and 3) improving health service delivery (USD 6.25 million). - In regard to 3), the project develops benchmarks and costs the care pathways and formulates the guidelines on provider reimbursement per case associated with them. Twenty-four activities out of 30 will be completed by the end of 2015. - The activities include costing studies and simulation of the case-based payment system on 26 major common disease groups at the district and provincial levels. A pilot test has been conducted on the diagnosis-related groups (DRG) as well under the programme.	MOH
WHO	Health Systems	- Within the framework of HPG, WHO leads the health policy dialogue and donor coordination on major health policies in Viet Nam including UHC through HPG meeting and TWG. It contributes to health financing and service delivery in remote areas and also supports revising the Health Insurance Law and the Pharmaceutical Law. - In terms of health equity, WHO supports the establishment of the health service delivery system. The activities include communication/dissemination activities to facilitate enrollment of health insurance, provision of advice on operating benefit package, capacity development of human resources for health, and improvement of access to pharmaceutical drugs (establishment of central drug management system). - WHO supports for the development of Health Care Financing Strategy (2016-2026).	MOH
Luxemburg Agency for Development Cooperation (LuxDev)	Supporting Health Care Policy for the Poor in Cao Bang and Bac Kan (2009-2015)	- The project focuses on improvement of access to quality primary health care services (EUR 6,899,100). It also supports to improve the collection and use of financial data, strengthen the institutional framework for alternative financing mechanisms, improve the financing system of the health sector, and increase its coverage for the poorest in the pilot area. - As part of the above project, a BHSP study was conducted in Cao Bang and Bac Kan. Based on the concepts including 1) equity, 2) good governance, and 3) patient's right, the study attempted to identify from the demand side what kind of services should be guaranteed.	Cao Bang and Bac Kan Provincial People's Committee, MOH
	BHSP study in five selected provinces (2014-2015)	- After the implementation in the two provinces of Cao Bang and Bac Kan, LuxDev conducted a BHSP study in five provinces (Hanoi, Ha Nam, Nghe An, Khanh Hoa, and Gia Lai). - The objectives of the survey are: 1) to provide a list of all curative health activities and services in order to fill the most frequent list of curative services, 2) to isolate preventive services in order to fill the most frequent national preventive	MOH

Donor	Projects/ Priority Areas	Assistance	C/P
		list, 3) to recommend the BHSP for curative and preventive system, and 4) to suggest the relevant cost of the healthcare provider facility regarding the healthcare services provided.	
Rockefeller Foundation	UHC	The foundation builds a Joint Learning Network in 22 countries centering on Asia and Africa to share the experiences for UHC. In Viet Nam, it supports the reimbursement system reform and the cost analysis of health services. JLN supported research activities on provider payment system in Viet Nam, which were collaborated by HSPI and Hanoi Medical University (see Section 7.3 for details)	MOH (DHI)
EU	EU-Viet Nam Health Sector Policy Support Programme HSPSP- 1&2	- The objective of HSPSP-1 (2011-2015, EUR 39,250,000) was to contribute to the improvement of the health status of the poor and most vulnerable in particular through a more effective, efficient, and equitable health system by supporting the implementation of the five-year health plan (2011-2015) of the Government of Viet Nam. - HSPSP-2 (2015-2019, EUR 100,000,000) contributes to the development and implementation of health policy and planning for the new five-year plan (2016-2020). It will particularly focus on 1) progress towards UHC and 2) improvement of availability and quality of services at the lower levels (district and communes), thereby contributing to the reduction of overcrowding in hospitals. - The program particularly focuses on equity in ten provinces53, which are considered to be the poorest. In order to prepare this program, performance indicators have been selected54.	MOH, MOF, MPI, VSS, 10 provinces
	Capitation Pilot and Assessment	- Capitation was piloted through EU bilateral support, "Health Care Support to the Poor of the Northern Uplands and Central Highlands Project" (2006-2012) (HEMA) and "Health Sector Capacity Support Project" (2012-2014) (HSCSP). - The pilot started in CHSs in Gia Lai, Kon Tum. Then it was expanded to CHSs in another three provinces (Bac Ninh, Bac Giang and Ha Nam). - The results of implementing the capitation model showed some rooms for further improvement55 and MOH decided to launch the revised capitation model in line with the Decision No. 5380/QD-BYT in four provinces (Bac Ninh, Ninh Binh, TT-Hue and Khanh Hoa) in 2014. The piloting of the revised capitation model aimed to produce scientific evidence for revision of the capitation payment method prescribed by Circular No.09/2009. - As requested by MOH, EU conducted the assessment of the revised capitation model from September to December 2015. Based on the identified problems and shortcomings of the revised capitation model, EU proposed to elaborate a new capitation model based on age groups and calculate adjustment coefficients based on utilization patterns of the selected age groups. As of March 2016, it is still waiting for approval from MOH.	

[53] Lai Chau, Son La, Dien Bien, Kon Tum, Gia Lai, Ha Giang, Lao Cai, Cao Bang, Yen Bai and Dak Nong provinces

[54] Performance indicators: 1) health insurance coverage of the near poor, 2) progress of health insurance payment system reform, 3) use of health services at the grass roots level in ten poor provinces, 4) rate of CHS having a doctor, 5a) number of trained ethnic village birth attendants, 5b) percentage (%) of deliveries attended by trained health staff, 6) infant mortality rate, 7) introduction of patients' feedback system and its roll-out, and 8) sex ratio at birth.

[55] For example, its application for payment of both inpatient and outpatient services, calculation of total capitation fund based on historical expenditure and lack of a defined package of services to be paid by capitation.

Donor	Projects/ Priority Areas	Assistance	C/P
	EU-WHO Universal Health Coverage Partnership*	In 2012, EU has assigned Viet Nam as one of the seven prioritized countries for policy dialogue in consideration of the past assistances on health sector provided by EU. It contributed to enhance policy dialogue for health financing and service delivery strategy in remote areas.	MOH
UNICEF	"Social insurance as a means to achieving universal coverage and more equitable health outcome" (2011)	In cooperation with MOH, UNICEF conducted a survey on health insurance system. The report describes the impact on the demand side, especially the socially vulnerable (children under six years old, the poor, the near poor, and the minorities) and the challenges toward increasing the coverage.	MOH (DHI)
KOICA	Q-Health Project (2012-2018)	Viet Nam is at the top of development assistance by KOICA and the health sector is the great focus of their assistance. The project supports to improve the capacity of human resources at a general hospital in Quan Nam Province (USD 47 million).	MOH
	Social Insurance Training Programme for Vietnamese Social Security Specialists	In April 2015, a two-week training program on social security program operation (including IT) was implemented in Korea for 15 government officials from VSS and MOLISA.	VSS MOLISA
KfW/GIZ	Strengthening Provincial Health Systems (2009-2015)	The project aims to improve the access to quality health services at 29 hospitals in the five provinces. KfW also provides medical equipment for hospitals (EUR 12.5 million).	MOH

Note: * EU-WHO Universal Health Coverage Partnership is a part of EU/Luxembourg-WHO Universal Health Coverage Partnership which involves 19 countries including Viet Nam.

References: [JICA, 2014], [USAID, 2015], [Aparnaa Somanathan, Ajay Tandon, et al., 2014], [WHO, 2015], [ADB, 2015], [LuxDev Regional Office of Hanoi, 2015], [DucAnh Ha MD, MSc, D.Ph, 2011], [EU], [LuxDev, 2015], [JICA, 2012], [Joint Learning Network], [Doosan Heavy Industries & Construction, 2012], [GIZ]

7.3 Vietnamese Relevant Institutes

(1) Health Strategy and Policy Institute (HSPI)

HSPI is a research institute that belongs to the Ministry of Health[56], and its functions are doing research activities to provide scientific evidence, provide consultations for MOH to build and modify strategies, health policies, training and collaborating with international partners in the field of health policy and healthcare systems. Table 7-2 shows examples of the HSPI research activities in relation to BHSP and health service delivery.

[56] HSPI was established according to the Decision No. 230/1998/QD – TTg issued to the Prime Minister on 30 November 1998.

Table 7-2 Relevant Research Activities of HSPI

Category	Activities
Health Insurance	- Impact assessment of the revised Health Insurance Law; - Currently conducting a survey on improvement of health insurance coverage in rural areas and providing technical advice on capitation, M&E, and so forth; and - Regarding the BHSP development, HSPI has taken the lead in developing its concept/definition, scope and work plans.
Health Service Delivery	- Setting up a task force in relation to UHC which mainly focuses on health services provided at the primary level. - Research activities in close collaboration with international organizations (e.g., WHO, World Bank) - Survey on health service delivery at private health facilities. - Conducting intervention survey focusing on "equity in health" (three-year program supported by Rockefeller Foundation). Equity is assessed in terms of accessibility, financial support, key health indicators, quality of care, patient satisfaction, and service provision.

Source: HSPI

HSPI has also participated in research activities with special focus on provider payment system in Viet Nam. It played a key role in the analysis of the actual practice and challenges of each payment system, and provided implications for UHC (Table 7-3)

Table 7-3 Examples of HSPI Research Activities on Provider Payment System

1) Assessment of systems for paying health care providers in Viet Nam[57]	This study was conducted to assess the design and actual implementation of capitation and fee-for-service system in Viet Nam using the Provider Payment Diagnostic and Assessment Guide[58]. The result shows that there is not so much difference in practice between both systems, and none of them are positively evaluated in giving impact on health system although there is a gap in perception between policy-makers, purchasers, and providers. It was pointed out that more fundamental refinement will be required to make Viet Nam's capitation system to be aligned with international practice and bring benefits.
2) Costing of commune health station visits for provider payment reform in Viet Nam[59]	This analysis was conducted to estimate the unit costs of primary care at CHSs in selected places in the country. The result showed there are wide variations in the unit cost of CHSs visits in different geographical areas as well as the maximum fees that CHSs can charge patients for their services. The research provided implications for the importance of developing and adjusting payment rates as capitation is expanded to include CHSs.

Source: [N.K. Phuong et al., 2015], [H.Van Minh et al., 2014]

For the establishment of National Council on Health Insurance Policy, which includes a task for BHSP development, HSPI also provided support for the development of working regulation of the council, which was conducted under the leadership of MOH. HSPI is a member of all 5 sub-committees of the National Council and HSPI is expected to provide technical inputs to the discussion and the activities of each sub-committee.

[57] It was funded by the Japan-World Bank Partnership Program for UHC and the Rockfeller Foundation.
[58] It was developed by Joint Learning Network (JLN) for UHC together with the World Bank, WHO and other partners.
[59] It was collaborated with Hanoi Medical University and funded by JLN for UHC and its funder the Rockfeller Foundation.

(2) Hanoi Medical University, Department of Health Economics

The Hanoi Medical University (HMU) was established in 1902 and was the first university of Indochina. Since its foundation, HMU has taken the lead in training of human resource for health and in scientific research. As a multidisciplinary medical university, HMU has collaborated relationships with international organizations, non-government organizations, and academic institutes, and main areas of the activities include faculty and student exchange, joint research, joint domestic and international training programs and projects.

The Department of Health Economics has collaborated with the Asian Development Bank (ADB) in implementing the DRG pilot that has been conducted in 34 hospitals nationwide. It has provided technical advice with expertise in health economics as well as the local context, and has contributed to analyzing the effectiveness of DRG by working closely with government authorities, health institutes and other relevant people including doctors.

According to the interview with the Department of Health Economics, lessons learned from the DRG pilot include the needs on strengthening the capacity of human resources for implementing DRG, working with long-term partners who really understand the situation in Viet Nam, and electric medical record and accounting system, which ensures the accuracy of coding and calculation.

Aside from DRG, they also showed interest in providing continuous support for health financing through costing in economic evaluation.

(3) National Economics University (NEU), Institute of Public Policy and Management (IPPM)

NEU serves as 1) economic and business educational institute, 2) a center for economic research, and 3) a center for consulting and transfer of technology of economic and business management.

IPPM is in charge of an "Actuarial Technical Assistance for Updating the Basic Health Service Package Paid for by VSS", which is supported by USAID (HFG). The data of about 500,000 people is currently verified and analyzed.

(4) Vietnam Health Economics Association

The Vietnam Health Economic Association[60] is a non-profit organization and its members include relevant authorities from MOH, hospitals and academic institutes. According to the interview with the association, it is financially independent, but the activities may require MOH's approval. The association supports the members in exchanging information and experience, improving the professional skills, and providing consulting services in the field of health economics.

The Vietnam Health Economic Association provided technical inputs to DRG pilot supported by ADB in collaboration with the Department of Health Economics, Hanoi Medical University. The association pointed out that there is not so much difference in medical fees between fee-for-service and case-based

[60] Vietnam Health Economic Association was established in 2008 according to the Decision 1182/QD-BNV.

payment due to the different calculation of the price of medical services between the two systems[61]. The association stresses the importance of further analysis of unit cost of each medical service.

[61] Under the current fee-for service system in Vietnam, calculation of medical service prices includes some of the factors, while calculation in DRG include all relevant factors such as the cost of depreciation of fixed assets

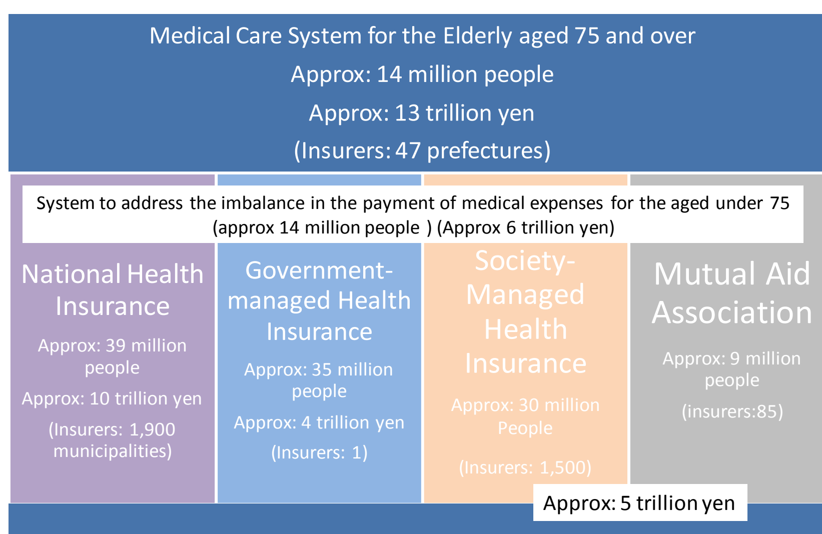
Chapter 8 Relevant Experiences in Other Countries

8.1 Japan

In order to protect the universal health insurance system, which enables anyone to receive medical care anywhere in Japan, the Japanese government has been introducing various measures and policies. Recently, expenditure in health insurance system becomes one of the most critical issues and the Japanese government response to this has taken place.

8.1.1 Outline of Japanese Health Insurance System

All the people must be enrolled in one of the health insurance systems in Japan. Everyone has public health insurance. There are several health insurances which are applicable to respective groups of people. Firstly, the health insurance system, where an employee is subscribed to join is managed by the Health Insurance Society, which consists of the employees of enterprises. And secondly, the Japan Health Insurance Association-managed Health Insurance, which covers all the workers of small- and medium-sized enterprises. Thirdly, the National Health Insurance is a health insurance system that is operated by municipalities, etc., and to which people who are not covered by any other health insurance plan. Furthermore, people aged 75 or older need to subscribe the late-stage medical care system for the elderly. The image of Japanese health insurance system is shown in Figure 8-1.



Reference: Ministry of Health, Labour, and Welfare, Japan (MHLW)

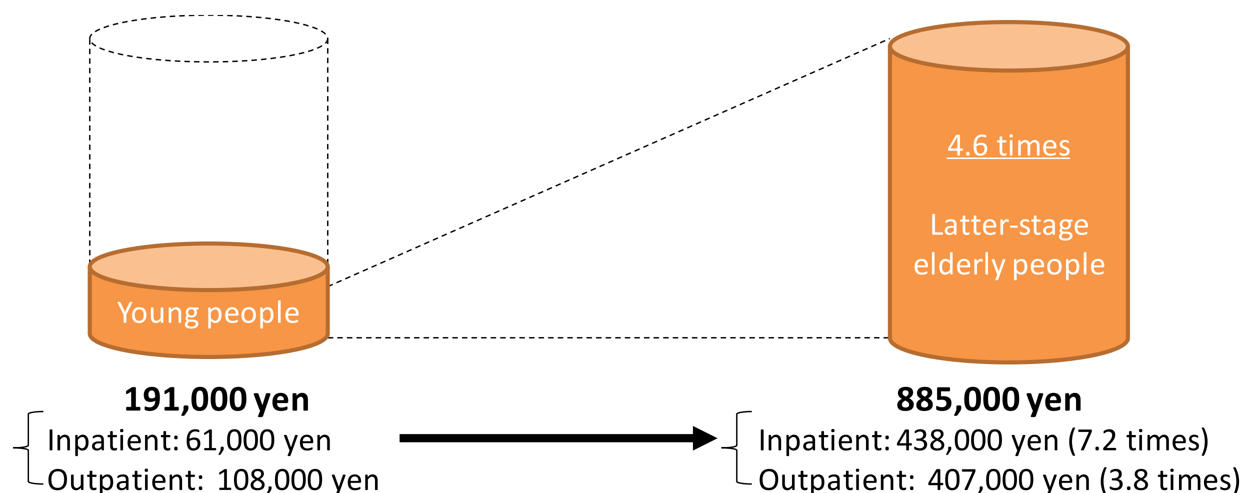
Figure 8-1 Image of Japanese Health Insurance System

As described above, all the people are covered by one form of public insurance system and thus, people can receive necessary medical services at low cost by paying certain insurance premiums and co-payments (10% to 30%) to medical institutions. In addition, 'free access' is also a typical characteristic of the Japanese health insurance system which means that everyone can receive medical services at any medical institution (regardless whether public or private) nationwide.

People's health and lives are protected by the universal health insurance system where people can receive high quality medical services regardless of their income or type of work.

8.1.2 Increased Medical Expenditure and Countermeasures

Due to an increase in national medical expenditure, its financial management has been becoming severe in recent years and thus, countermeasures against such situation have become an urgent challenge to the Japanese health insurance system. The increase in medical expenditure (Table 8-1) has been mainly caused by an increase in medical expenditure on the elderly aged over 65. Examining medical expenditure by age group revealed that medical expenditures increase as the age increase, with medical expenditure per elderly being five times that of young people (Figure 8-2).



Reference: MHLW

Figure 8-2 Comparison of Health Expenditure between the Young and Latter-stage Elderly Population (2009)

Table 8-1 Growth Rate in Medical Expenditure

	1985	1990	1995	2000	2005	2010	2012	2013	2014
National Medical Care Expenditure	6.1	4.5	4.5	▲1.8	3.2	3.9	1.6	2.2	1.8
Medical Expenditure for the Elderly	12.7	6.6	9.3	▲5.1	0.6	5.5	-	-	-
GDP Growth Rate	6.33	5.57	1.94	2.26	1.30	4.71	1.74	1.59	▲0.1

Source: MHLW and [IMF, 2015]

As the aging society advances in the future, this situation will be even more severe. As part of the measures against the challenge of deteriorating health insurance finances, the Ministry of Health, Labour and Welfare (MHLW) tries to stabilize insurance premium revenue by regionally widening the unit of the National Health Insurance which finances from the municipal level to the prefectural level providing advice to individual patients using medical fee points in evaluations of cheaper generic drugs and guiding medical services providers to switch from hospital beds which are too large in number when compared globally to home care.

8.1.3 Measures against Metabolic Syndrome through Specific Health Checkups/Healthcare Guidance

MHLW considers preventive measure is worth a try in order to decrease the health expenditure. Specific health checkup/health care guidance (so-called "metabolic syndrome health checkups") focusing on visceral fat accumulation (metabolic syndrome) commenced in 2008. Specific health checkups are available to those aged 40-74, with specific healthcare guidance being provided to those that do not meet the standard concerning abdominal position, blood glucose, blood pressure, and lipids. You may have heard of this through advertisements in which people worry about the fat around their waists.

Comparing the medical expenses of those with or at high risk of metabolic syndrome and those without metabolic syndrome revealed that the latter is approximately JPY 90,000 less annually than the former. In addition, approximately 30% of those who received specific healthcare guidance no longer had or were no longer at risk of metabolic syndrome the following year. As described above, promoting measures to prevent lifestyle-related diseases can prevent the onset of serious illnesses and thus decrease medical expenses.

8.1.4 Decision Making Mechanism on Medical Fees

The health insurance administration of Japan has been controlled by the revision of health insurance system and amendment of the Medical Law. The compensation of medical institutions/doctors on medical treatments is called 'medical fee'. The points to each medical treatment are determined based on the uniformed points (1 point = JPY 10).

This medical fee is classified into three categories: medical, dental and drugs. The medical fee point table is provided for the calculation of the medical fee. In addition, the drugs that are being used in the public health insurance, the standard drug price is applied.

In order to stabilize the financial situation of the public health insurance system, in once every two years, medical fee revision takes place. First, the revision rate (increasing or decreasing) is determined and then unit price of medical fee table is revised according to the financial balance of the system. It should be noted that the revised rate is handed by the negotiation between the Ministry of Health, Labour and Welfare, and the Ministry of Finance together with the Prime Minister's Office.

The details are presented in Attachment 2-2 and 2-1 to Appendix 2.

8.1.5 Introduction of DPC

DPC stands for Diagnosis Procedure Combination, which is a Japanese-style diagnostic classification combining factors such as the main disease name, treatments, complications, etc. DPC is a comprehensive evaluation in the acute phase of hospitalization using this classification. Therefore, the institutional name of DPC is "Diagnosis related groups by comprehensive evaluation".

(1) Background

At that time, acute inpatient medical care applied is the 'fee-for-service' which accumulates each medical treatment for the calculation of medical cost. However, due to tight budget of medical financing and medical accidents, a case-based method to pay against a series of medical interventions was collectively studied. Since a comprehensive evaluation was already introduced in recuperation beds, DPC, as a comprehensive evaluation, was introduced against the acute phase portion which was considered the most significant part of hospitalization.

At that time, fee-for-service and case-based method were respectively considered as follows:

- Fee-for-service
  - Possibility of quantitative expansion
  - Excess medical care (so-called drugged and inspection pickled)
- Case-based method
  - Possibility of risk due to less medical care given
  - Rough diagnosis care

In Japan, DPC was already been introduced in advanced treatment hospitals such as the University Hospitals from April 2003, and in 2004, 62 hospitals nationwide applied DPC on a trial basis with an extended range of DPC. As of 2014, 7,493 hospitals have introduced DPC.

(2) DPC as a Diagnostic Group Classification

DPC in itself is a name of classification method, while diagnostic group classification is a method for analysis which is commonly used in developed countries. In other words, DPC is a model of diagnostic-related groups developed in Japan. The diagnostic group classification is a technique to group patients by classifying the type of surgery, complications, and treatments for each disease. In other words, it is classifying groups with similar diseases.

DPC tries to visualize the quality of medical care, but it is said that DPC is a common language to measure the quality of medical care and is called the "scale" of medical care. DPC is common across the country and it is possible to evaluate the quality of medical care by using it. In addition, since different average length of stay for each diagnostic group has been published, each hospital can examine their own treatment by comparing similar cases in other hospitals. If the duration of hospitalization is longer than others, such hospital can consider improvement of their treatment policy and medical care system for correction. In this way, DPC provides chances to analyze the data, to evaluate their hospital and quality of medical care compared with other hospitals. For this reason, DPC contributes in establishing better health care provision.

(3) DPC as a comprehensive evaluation

DPC is different from the existing fee-for-service method to calculate the fee for each medical treatment. DPC is a mechanism of case-based payment where fixed amount per day is paid. Being comprehensive is having a consolidation cost of testing and diagnostic imaging, medication, injection, and treatment; therefore, the number of times of each diagnostic imaging or injection during hospitalization is not considered, which means payment will not have additional cost. The difference of DRG-PPS introduced in USA is that DRG-PPS is a comprehensive evaluation for one hospitalization unit while DPC is not a full comprehensive evaluation but introduces a based-on-per-day payment with an additional fee-for-service.

Applicable patients are classified into 1,440 classifications, majority of patients to be hospitalized are applied to DPC with the exception of those who died within 24 hours after admission and patients with clinical trial. Patients with applicable DPC do not exist.

The actual amount of a two-tier medical fee structure is the combination of the following three conditions with fee-for-service part of operation and anesthesia.

(1) Points-per-day of each diagnostic group classification

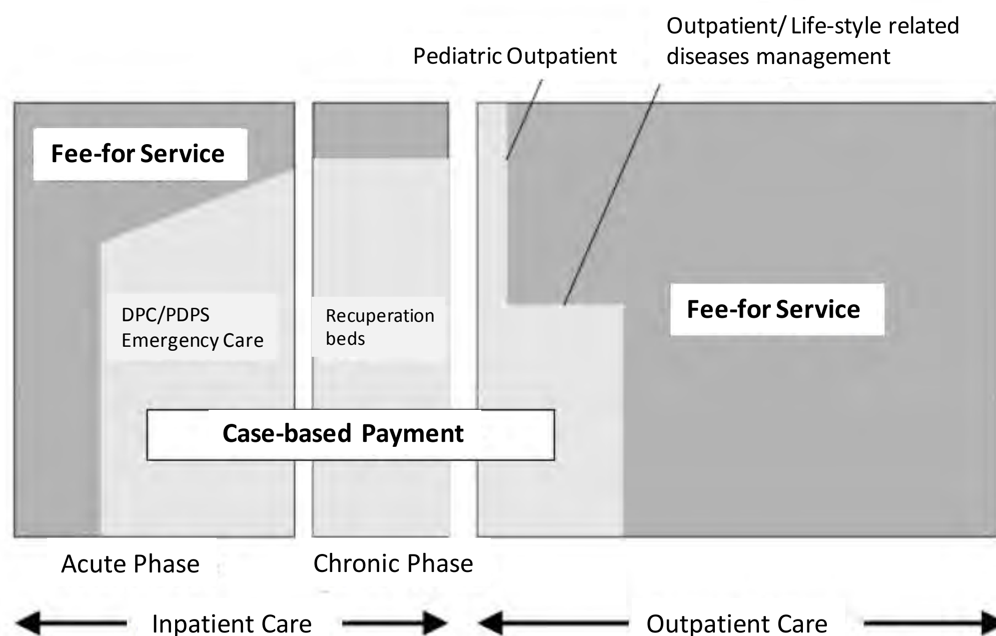
(2) Coefficient by medical institutions

(3) Number of days of hospitalization

Therefore, medical fee is calculated as follows:

- Medical fee = comprehensive evaluation (point × coefficient by medical institution × number of days of hospitalization per diagnosis group classification)
  + volume evaluation (fee-for-service)

Under DPC, the revenue exceeds the average length of hospitalization which is gradually reduced. This is different from that of the United States where DRG-PPS has decided to pay the amount in one hospital unit. However, DPC is a system that has an advantage by shortening the duration of hospitalization since medical expenses of hospitalization for a longer duration is decreased (Figure 8-3).



Source: [Masami Sakoi, 2014]

Figure 8-3 Image of Present DPC

(4) Goal of DPC

It is considered that reducing the medical cost will affect the quality of medical care that is why DPC tries to tackle this issue and aims to introduce its system.

DPC promotes transparency in medical treatment and cost efficiency by introducing the contents and performance of medical institutions. This may contribute to evidence-based medical treatment and promote standardization. On the other hand, it has been pointed out that too little health care may occur; however, the volume of medical care resources is reduced in European countries and the quality of medical care has not been downgraded. Also, a similar study in Japan regarding DPC was published in 2005 that mentions the reduction in the quality of medical care such as increased growth in re-hospitalization rate and mortality rate have not been observed.

(5) Future of DPC

There is a promotion and enhancement of clinical pathway as a standard medical plan. Clinical path, while pursuing efficiency, is very important as a tool to standardize and guarantee the quality of medical care.

While fee-for-service has a link between income and expenditure, there is a need for management analysis as a cost management tool. DPC may create divergence, in other words, medication, injection, and inspection will be the cost in DPC. There is also a need to strengthen the medical care information system (Table 8-2).

(a) There is a review of the drug. Under Fee-for-service, drugs are reimbursed based on the fixed price, but under the comprehensive evaluation, hospitals needs to consider using an inexpensive drug such as generic drugs.

(b) There is a review of nutritional management. Intestinal nutrition may enhance the resilience of the patients, reduce complications, and shorten the length of hospital stay. There are various advantages of reducing the cost.

(c) Medication injection and inspection may be the cost of DPC

(d) There is a transition to the preoperative examination before hospitalization. In the low risk elective surgery, necessary medical examinations are performed on an outpatient basis.

Table 8-2 Comparison of Fee-for-Service Payment and Case-Based Payment

Payment Method	Major Advantage	Major Disadvantage	Countermeasures
Fee-for-service	- Incentive to increase service supply - Efficiency can improve by setting upper limit of budget amount	- Insurers cannot expect the amount of expenditure - Increase of total cost - High administration cost（periodical revision of price and compulsory coverage are necessary for controlling the cost）	Based on the fixed budget amount prior to the operation, expenditure is expected to be suppressed.
Case based payment by each case）	- Strong incentive to effective operation	- Insurers cannot predict the amount of expenditure. - High administration cost (but lower than the amount of fee-for-service) - Case based payment is difficult to apply for outpatient	Define detailed case-mixes and control the cost Combining various provider payment methods

Source: [Hisao Endo, 2005]

8.2 Relevant Countries with Health Insurance System

8.2.1 ASEAN Member States

As shown in Table 8-3, among the ASEAN member states, Thailand, the Philippines, and Indonesia have developed a health insurance system. Thailand has accomplished universal health coverage by introducing tax financed health insurance with capitation concept while Indonesia is trying to expand by using social health insurance. However, Indonesia has decided to provide health insurance free of charge for the poor. Indonesia is facing difficulty in accessibility to quality health care especially in the rural areas. The coverage is gradually expanding but still low percentage of the population is covered by the system.

In this section, experiences of Thailand are described as there are useful implications for Viet Nam.

Table 8-3 Outline of Public Health Insurance System in ASEAN Member States

Legend: a) scheme, b) premium contribution, c) number of enrollments

Conutry	Thailand	Philippines	Indonesia	Viet Nam
Population	65.5million	94million	250million	90 million
Public Service	a) Civil Servant Medical Benefit Scheme (CSMBS) b) No contributions c) 5.9million	a) PhilHealth - Employee program b) Contributions c) 5.94million	a) National Health Insurance (JKN) b) Contributions (government contributions for the poor) c) 152million *To be applied for all the nationals by 1 January 2019.	a) Health Insurance (Compulsory)
Formal Sector	a) Social Security Service (SSS) b) Contributions c) 9million	a) PhilHealth- Employee program b) Contributions c) 17.79million		a) Health Insurance (Compulsory)
Informal Sector	a) Universal Health System (UHS) b) No contributions c) 47million a) Voluntary SSS b) Contributions c) 1.65million	a) PhilHealth - program for the poor b) No contributions c) 38.94million		a) Health Insurance (Compulsory)
Coverage	Nearly 100%	82%	127 million people covered (2015): approx. 50%	76.2%(2015)
Service providing system	Public	Private	Public	Public
Government Subsidy	80.1% (2013)	31.6% (2013)	39% (2013)	41.9% (2013)
Share of GDP	6.5% (2014)	4.7% (2014)	2.8% (2014)	7.1% (2014)[62]
Medical Cost Per capita	USD 360 (2014)	USD 135 (2014)	USD 99 (2014)	USD 142 (2014)
No. of Beds per 1,000 population	2.1 (2010)	1.0 (2011)	0.9 (2012)	2.0 (2010)

Source: [JICA, 2012], [Social Secutiry Administration, USA, 2012], [BJPS Ketenagakerjaan, 2015], [The World Bank, 2016], [WHO]

(1) Thailand

Since 2001, the Universal Coverage (UC) scheme has provided health benefits to approximately three quarters of Thailand's citizens. The scheme is financed from general taxation and administered by the National Health Security Office (NHSO) under the supervision of the Public Health Minister. Hospital providers are mainly from the public sector and are paid for outpatient and preventive services based on prospective capitation whereas the Diagnosis Related Group (DRG)-based retrospective payment was used to compensate for the cost of inpatient care [Krit Pongpirul, et al., 2011].

1) Benefit Package

There is no service package but negative list was introduced. This negative list held wide range of medical services which were considered as unnecessary treatment. The number of medical treatments in the negative list was gradually decreased according to the actual situation of health needs and financial capacity of the National Health Service.

[62] Share of total health expenditure

2) Capitation and 30 Baht System

As for the informal sector workers such as farmers, there is a similarity between Viet Nam and Thailand. Informal sector workers and their families are disadvantaged in terms of the level of income and access to public service such as medical care and education.

Since the income of the informal sector workers is often seasonal or irregular, therefore the Government of Thailand decided to introduce a spot payment mechanism to the National Health System where people used medical care at designated medical institutions in 2002, which was called 30 Baht System. This system was successful in terms of rapid extension of coverage of health insurance system and accessibility of medical institutions for the disadvantaged people who were not entitled to receive such benefits. The Government of Thailand achieved Universal Health Coverage (UHC) at this stage.

Then, the Government introduced capitation mechanism for this scheme since they understood that capturing their income level was hard and nearly impossible to grasp the right information. Based on the statistical data of the National Heath Survey which they regularly conduct, they analyzed the probability of frequency of insurance accident and estimated cost which is used to the calculation of capitation unit cost.

3) Capitation Unit Cost

At the initial stage of the National Health System of the so called 30 Baht System, they estimated the capitation unit cost as indicated in Table 8-4. This amount is being revised every year according to the actual data which is being submitted by each designated medical institution to NHSO and the Ministry of Public Health (MOPH).

Table 8-4 Breakdown of Capitation Unit Cost

Total:	THB 1202.4
Outpatient	THB 574.0
Impatient	THB 303.0
Prevention and Promotion	THB 175.0
Accident and Emergency	THB 25.0
Ambulance	-
Capital Replacement	THB 93.4
Remote Area	-

Reference : [NHSO, 2014]

The capitation unit cost was set at THB 1,202 for the first year but the actual performance was far higher than this estimation, Therefore, NHSO had to revise the unit cost every year as indicated in Table 8-5.

Table 8-5 Revision of Capitation Unit Cost

Year	Capitation Rate (THB)
2002	1202.4
2003	1202.4
2004	1308.5
2005	1396.3
2006	1718.0
2007	1983.4
2008	2194.3
2009	2298.0
2010	2497.2
2011	2693.5
2012	2909.1
2013	2921.6
2014	3028

References: [SIRO, May 2012], [NHSO, 2014], NHSO

Due to political decision, co-payment of the 30 Baht System was abolished in 2006, and the informal sector workers and their family, and family members of the formal sector workers have been covered by the National Health Service free of charge.

4) DRG Model

The Thai DRG model has five official version developments and has been applied for acute inpatient service financing since 1999 [Pham Le Tuan, et al., 2015]. The development of DRG was started with a research in 1993 on emergency medical service. It was started with 100 DRGs and expanded to 1,200 in 2003, to 1,920 in 2007 to cover the payment for all hospitals by covered by NHSO. It was initially developed based on the United States and Australian models and adopted to Thai context. To control DRG, physicians should carefully review relevant clinical information to prepare a discharge summary which would then be used by certified coders to produce appropriate diagnosis and procedure codes to be submitted for reimbursement. However, it is pointed out that it is difficult in a resource-limited setting even in Thailand [Krit Pongpirul, et al., 2011].

5) Implications for Viet Nam

There are many implications for MOH of Viet Nam which tries to extend the coverage of health insurance. In terms of capturing the income level of informal sector workers, considering the cost effectiveness and administrative barriers, a methodology of the collection of premium is needed to be carefully examined. There may be many options such as co-payment in usage (like the 30 Baht System in Thailand), flat rate premium (still remains a challenge in terms of premium collection), and tax financed.

In terms of effective and rapid extension of coverage, the current social health insurance system may not be suitable since it requires complicated administration such as collection of full dataset, examination of claims, collection of premium and record keeping, etc.

Another important point is that NHSO has been focusing on the quality of public hospitals and clinics where informal sector people usually access. By doing this, they have gained the trust among the people.

Also, in case of overload of the patients, NHSO guarantee to allocate a necessary amount of budget from neighboring public hospitals or clinics.

Regarding DRG, because the socio-economical and cultural context of Thailand is similar to Viet Nam, the Thai DRG model could be applied to Viet Nam. In particular, the model has been developing based on Thai model as mentioned in Section 4.2.1(3). However, availability and accuracy of data might be a great challenge.

(2) The Philippines

The medical insurance system in the Philippines was established by integrating the medical insurance part (Medicare) of the Social Security System (SSS) and the Government Service Insurance System (GSIS) in 1995. The system is operated by the Philippine Health Insurance Corporation (PhilHealth) and supervised by the government. Financial resources are from social insurance premiums paid by both employees and employers in addition to government subsidy (Department of Health and local governments). Although the poor are supported by taxes, the health insurance system introduces the social insurance system.

Legally, all citizens are required to join the system. The main insured are the employees in the private and public sectors and the self-employed. In addition, there is a "poverty program (Sponsored Program)" for persons who have no means of livelihood or identified as indigent by PhilHealth, the insurance premium is supported by the national and local governments (equally sharing).

Qualified members are the subscribers, persons under the poverty program, and those who are not required to pay for the premium (retirees and persons who completed paying their premiums) and the dependents of such people. The coverage rate in 2010 was 94% (PHIC, 2012).

An insurance premium is fixed at 2.5% which is equally shared between employees and employers (1.25% each). The premium amount is based on the standard monthly remuneration.

Basically, the cost of inpatient (room charge, meals, drug costs, inspection fees, medical fees, etc.) and outpatient (drug costs, inspection costs, medical expenses, preventive services, such as emergency and transport services) are paid by the health insurance system. Since 2006, new born care and outpatient services to certain diseases and illnesses such as malaria and HIV patients were added to the applicable medical care under PhilHealth.

Benefits are provided in kind and medical expenses are reimbursed based on the level of medical facilities/doctors by PhilHealth. The amount of reimbursement of medical expenses is fixed by each treatment. In case the treatment exceeds the fixed amount, the patient needs to pay the exceeded amount as his/her copayment amount. [MHLW, 2012]

8.2.2 Other Countries

The outlines of the health insurance system in some selected countries are presented in Table 8-6. Among those, overviews of the United Kingdom (UK), Germany and the United States of America (USA) are described in this section.

(1) The United Kingdom

The United Kingdom (UK) is recognized as the country where capitation is introduced. The Beveridge Report in 1942 [William Beveridge, 1942] stressed that all residents are entitled to quality health care which is conceptualized as 'From Cradle to Grave'. The system is called National Health Service (NHS), which is a tax-based health system with capitation model. The system was introduced in 1948 and it has been providing service to all residents. The NHS was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth. It had at its heart three core principles:

(1) That it meets the needs of everyone;
(2) That it be free at the point of delivery;
(3) That it be based on clinical need, not ability to pay.

Based on such core principles, the UK government introduced the system which designates home doctors for residents based on their addresses with capitation concept.

(2) Germany

Germany introduces social health insurance based on a professional group or community. The German system was initially designed at the period of Bismark in 1883. As of year 2013, 83% of the population is covered by the social health insurance other than civil servants and the self-employed. Civil servants and the self-employed can join the social health insurance on a voluntary basis. However, such voluntary insured are requested to purchase private health insurance compulsorily by law. In this context, 100% of the people are covered by one of the health insurance schemes.

Social health insurance originally applied only to low-income workers and government officers, but was gradually extended to cover the majority of the population. The system is usually decentralized with private doctors providing ambulatory care and mostly hospitals providing the inpatient care. At present approximately 92% of the population is covered by the compulsory health insurance which provides a standardized level of coverage through 1,100 public or private health insurance funds. Health insurance is funded by the contribution equally shared between an employee and employer and government subsidies. Self-employed and higher income workers often choose to pay a tax and not choose the standard plan of the public insurance and purchase the private one instead. Historically, the level of provider reimbursement for specific services is determined through negotiations between regional doctors' associations and health funds.

The health insurance system in Germany is a unique system where the private insurances companies provide alternative insurance products for those who are not willing to be covered by public health insurance schemes (health insurance funds). In addition, as a special feature of the German system, there are severe competitions among public health insurance funds as well as between private and public health insurance schemes. The system is established based on the competition-oriented concept. Private health insurance has, on one hand, a complementary function of the public health insurance system, but on the other hand, private insurance provides better medical services than public health insurance to meet the needs of the subscribers.

(3) The United States of America

In the USA, majority of people need to make contract with private insurance companies to be covered by health insurance. The premium of employees of private companies is paid by the employers[63]. Since the premium of private insurance product tend to be extremely expensive, low income people have difficulty in payment of premium for private insurance companies, therefore they tend to not to be covered any health insurance.

The elderly are covered by ‘Medicare’ which is mostly financed by tax but with premium for some parts. Under Medicare, 46 million people are covered. There is also a health insurance for the disabled, which called Medicaid.

The American medical insurance functions based on the private sector initiatives; however, the premium amount and the medical expenses tend to be high which appears in the GDP ratio. Moreover, subscription to private insurance is not compulsory for the people. Low-income people cannot purchase insurance products due to affordability problem. Therefore, there are many cases where patients try to avoid visiting medical institutions until they need emergency transports.

[63] Basically, nearly 100% is paid by the employer, but it depends on the company and type of contract.

Table 8-6 Overview of Health Insurance in Selected Counties with Major Indicators

	UK	Germany	USA	France	Japan
Type of Scheme	Tax based National Health Service	Social Insurance	Social Insurance/Tax Based Medicare/Medicaid	Social Insurance	Social Insurance
Ratio of Co-payment	- None - Fixed co-payment for drugs (outpatient)	- Outpatient: None - Inpatient: EUR 10 per night - Drugs: 10% - (Max: EUR 10, Min: EUR 5)	- Inpatient (mandatory) (part A) <60 days: USD 1,184 60-90 days: USD 296/day 90-150 days: USD 592/days >150 days-: all by patient - Outpatient (voluntary) (Part B): USD 147/year+20% of medical cost	- Outpatient: 30% - Inpatient:20% - Drugs:35% - All the co-payment is based on reimbursement	< age 6: 20% Age 6-69: 30% Age 70-74: 20% > Age 75: 10%
Financial Resource	General Tax	15.5% of salary (Employee: 8.2%, Employer: 5.3.1%)	Part A 2.9% of income (share equally between employee and employer) Part B USD 104.9/month	13.85% of salary (Employee: 0.75%, Employer: 13.1%)	- 10% of salary (government-managed health insurance association) - Equally shared between employee and employer
Government Subsidy		EUR 1.15 billion (2013)	Part A: 100% Part B: 75%	Compensate for the shortfalls	16.4% of total benefit paid
Share of GDP	8.5%	11.0%	16.4%	10.9%	10.2%
Medical Cost per Capita (USD)*	3,235	4,819	8,713	4,124	3,713
No. of beds per 1,000 population*	2.8	8.3	2.9	6.3	13.3
Number of physicians per 1,000 population*	2.8	4.1	2.6	3.3	2.3
Number of nurses per 1,000 population*	8.2	13.0	11.1	9.4	10.5
Average length of stay in hospital (days, all causes)*	7.0	9.1	4.8	5.6	17.2
Number of visit (outpatient per year)*	5.0 (2009)	9.9	4.0 (2010)	6.4	12.9 (2012)

Note: *data in 2013

Reference: [OECD], [MHLW, 2014]

Chapter 9 Conclusion of the Survey Results

This chapter describes the challenges identified based on information compiled in Chapter 2 to 7. Then, the draft recommendations are presented for further improvement of the health insurance system to contribute to the universal health coverage (UHC) in Viet Nam.

9.1 Challenges of Health Insurance System towards UHC in Viet Nam

9.1.1 High OOP Expenses Despite Expanded Population Coverage and Wide Range of Service Coverage

The goal of UHC is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them [WHO]. Health insurance coverage is more than 70% and most of the curative services approved by the Ministry of Health (MOH) are covered by health insurance; however, out-of-pocket (OOP) expenses are still high among the total health expenditure (38%, 2015), and 4.2% of households had catastrophic health expenditure (2012).

Although most of the services could be basically covered by health insurance, the scope of benefit package is currently defined by separate official documents because the lists of services, drugs, medical supplies, and prices were developed separately and those are not consistent with each other. According to the interviews, the lists could be variously interpreted depending on the service providers. Therefore, various interpretations seem to occur in the actual operation, and patients could not know how much they will have to pay until they receive their invoices from the hospital.

It suggests that health insurance is not well functioning to protect the people from financial hardships. From the facts compiled in Chapters 2 to 6, the followings may be possible underlying causes of the above challenges:

- Health insurance coverage among private sector employees (48%), informal sector workers, the near poor[64], and voluntary groups (34%) are very low (2014);
- Utilization of health insurance is low (60 to 70%), especially in inpatient services (>40%);
- Payments for additional and upgraded services are requested to the patients; and
- Patients have to buy over-the-counter (OTC) drugs and the prices of those drugs are high.

(1) Low Health Insurance Coverage among Some Groups

Although the Amendment on Health Insurance Law stipulates that public health insurance is compulsory for all people, according to the interviews, reasons why people are not subscribing are as follows:

- They prioritize other expenses such as daily expense and education rather than health insurance due to limited household income;
- They think they will not get sick; and

[64] As mentioned in Section 2.3, VSS did not provide exact figure of coverage among informal sector and the near poor.

- Wealthy people prefer private health insurance use in private hospitals.

It might be concluded that the current health insurance system and health services which are covered by health insurance could not attract such people. Since the above groups have to pay the entire or part of the premium, they do not think that public health insurance is worth subscribing.

The coverage of voluntary group[65] is expected to increase because the Amendment on Health Insurance Law introduced household enrollment. However, the government should continue their efforts to encourage such people to subscribe to the public health insurance.

(2) Low Utilization Rate of Health Insurance

Although health insurance covers a wide range of medical services and require low co-payment (0 to 20%), as mentioned in Section 2.4.2, 33% to 34% of the population access private health service providers for outpatient services. Although more people go to public health services, less than 40% used health insurance for inpatient services which is more costly than outpatient services (Figure 2-6). According to the interviews, these may be due to following reasons:

- It takes time for the reception and accounting to process services for health insurance card holders;
- The registered (nearest) health facility is not reliable or it takes time to acquire for an official referral procedure, so patients tend to access higher level of hospital directly despite of more or having an entire OOP expenses[66].

Since the co-payment rates in non-registered health facilities without official procedures are reduced[67] (Section 4.3), it is expected that more people will use health insurance card and OOP expenses for co-payment could be reduced.

(3) Balance Billing

As mentioned in Section 2.2.6(2), medical fees do not cover expenses of health service providers sufficiently and there are ceilings on the total amount to be paid by the health insurance fund. The ceiling is set based on the actual expenses in the previous period. Although it could be reimbursed if the health service provider provides reasonable explanation, it requires a certain work load and time. Therefore, health service providers might prefer to compensate through direct payment from the patients.

According to the interviews, the patients and their families are advised to upgrade to a treatment or surgical method, medical devises, and drugs, and/or to use some additional services for better treatment

[65] Under the Health Insurance Law 2008, voluntary group included agriculture, forestry and fishery sector workers, the near poor and spouses of salaried workers and civil servants, and house-hold enterprises. However here, it includes the later two groups (refer to Table 2-17).

[66] Before the amendment, co-payment rate at health facilities which is not registered in his/her health insurance card was 70% and it was 100% at central hospitals.

[67] After the amendment, it is 60% in central hospitals and 40% in provincial hospitals, 30% in district hospitals. After the free access takes effect, it is the same rate for each membership group.

outcome. Although they do not understand the necessity and appropriateness of such upgrade or additional services, they usually follow the advice and spend more OOP.

When the Amendment on Health Insurance Law is fully implemented, and medical fee is revised to include more costs for the medical services, balance billing will be prohibited instead and might be effective to reduce OOP in the future.

(4) Drug Price

As mentioned in previous section, drug prices are much higher than the international reference prices due to a fragmented bidding system. Although the health insurance covers more than 1,000 drugs, patients have to buy OTC drugs because there are some drugs that are out of stock in some health facilities. According to the interviews, patient could reimburse for such drug expenses; however, it is not practiced in actual operation.

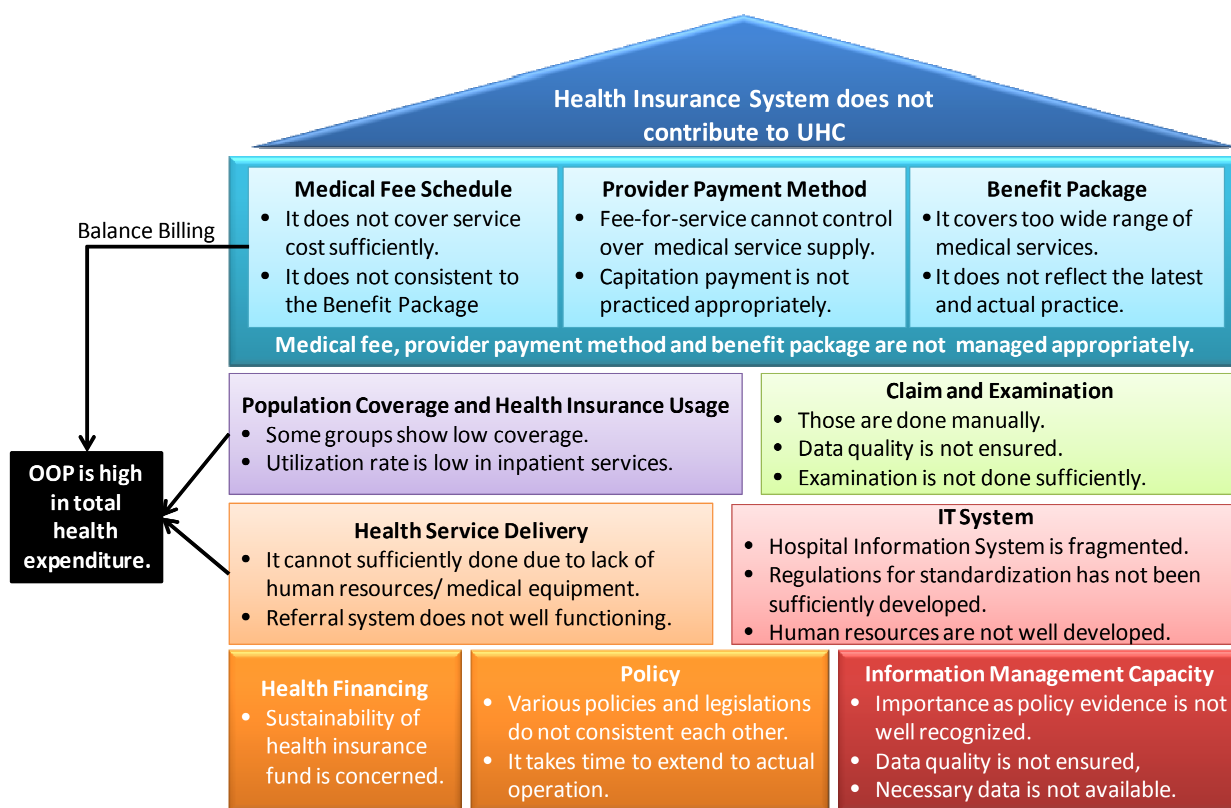
9.1.2 Building Blocks of Health Insurance System

(1) Concept

The above challenges are relevant to health insurance system as shown in Figure 9-1. The health insurance system should be build based on the clear and stable health financing and policy. In addition, information management is important to operate the system with evidence-based, because the evidence is essential to grasp health needs of general population, feasibility of current or proposed measurement, and future projection. Based on these bases, an effective IT system could be established. With such IT system, relevant works to health insurance such as claiming and claim examination could be streamlined. Also, health service could be provided more efficient and effective services for the patients.

The three important factors of health insurance system which are: provider payment method, medical fee schedule, and benefit package, could be managed based on cross-sectoral management system supported by clear and coherent policy and stable implementation in the field.

With considering the above concepts of the building blocks of health insurance system, the following sections describe current situation and challenges of each one.



Reference: Interviews

Figure 9-1 Challenges of Health Insurance System

(2) Policy

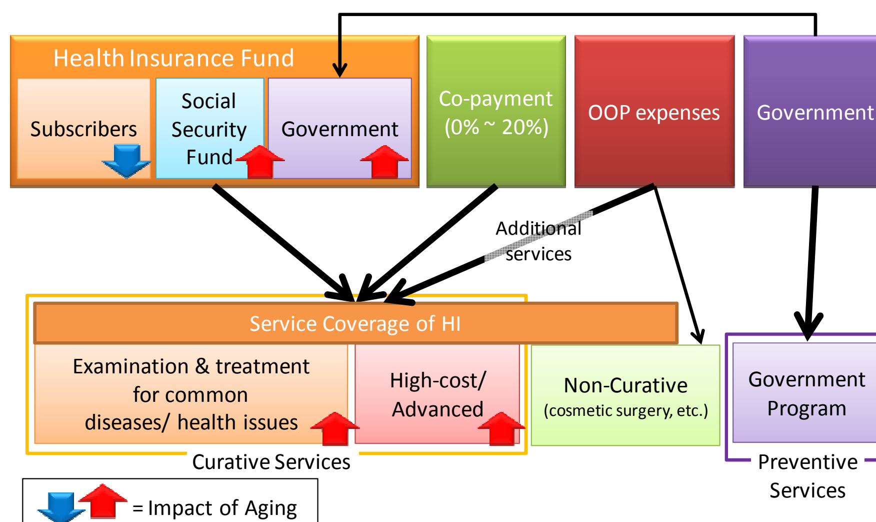
Numerous legislations have been issued on health insurance and presented some major ones in Section 3.3 and Chapter 5. However, these takes time to be understood and practically implemented at the operational level. Usually, a concrete action plan or implementation guidelines are not well prepared in accordance with the policy or development plan. A long-term strategy seems not being well considered in a relevant mid-term plan. For example, the BHSP Roadmap (2015) or review of the benefit package is not mentioned in UHI Roadmap (2013) and the Health Sector Five-Year Plan 2016-2020 does not use the term "BHSP". However, it is defined in the Amendment on Health Insurance Law (2014). Some seem not to reflect the actual situation or consistent with relevant policies or legislations. For instance, Circular 37 (medical fees covered by health insurance) includes some services which are not in Circular 43 (list of medical services covered by health insurance) and name and definition of medical services are different from Circular 43. Also, there are those who do not comply with international standards such as the International Classification of Diseases (ICD).

Such inconsistency and inefficient legislation system could cause confusion in the implementation and various interpretations at the operational level.

(3) Health Financing

1) Source of Health Financing

Figure 9-2 shows the current combination of health financing sources and benefit package. Currently, health insurance covers wide range of medical services even high-tech services (Section 2.4). Health insurance, co-payment and OOP expenses mainly cover medical examination and treatment costs. Preventive and public health services are mainly covered by government budget along with each program such as infectious disease prevention and maternal and child health.



Reference: Interviews

Figure 9-2 Current Combination of Financing Sources and Benefit Package

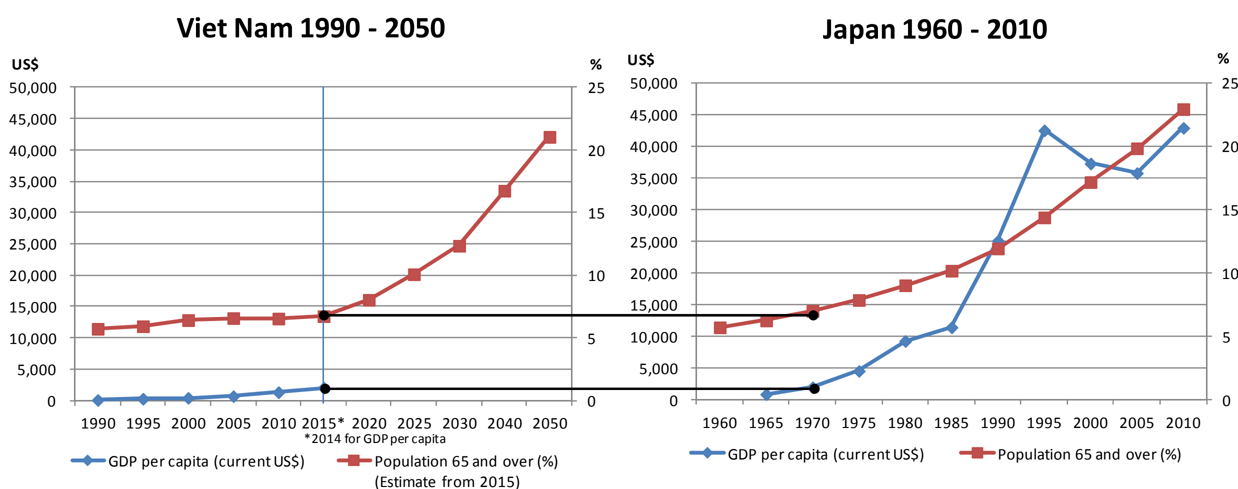
As a result of the Amendment of Health Insurance Law, expenses of health insurance fund will increase because; medical fee schedule has been raised (Section 2.2.4), and co-payment rate for non-registered health facilities are reduced (Section 4.3). The current behavior of health service providers might also consider to increase the expenditure because their budget or global cap is set based on expenditure of the previous period.

Aging is one of the critical factors for total health expenditure and sustainability of health insurance fund. As long as health insurance premium is calculated based on salary, premium revenue from the elderly might be less, therefore, when the aged population increased, premium revenue might be decreased. Expenditure from social insurance fund and government budget might increase to cover such decrease. As shown in Figure 2-5, retired people spend five times more than the working people. Based on that and Japanese experience described in Chapter 8, health expenditure for the elderly will rapidly increase in the near future.

Also, the transition of disease structure from infectious disease type to non-communicable disease (NCD) type will affect health expenditure because NCDs are generally chronic and need life-long treatment or rehabilitation. Injury and progress of emergency medicine will be another factor as more injured patients could be saved and some will need long-term rehabilitation.

2) Impact of Aging

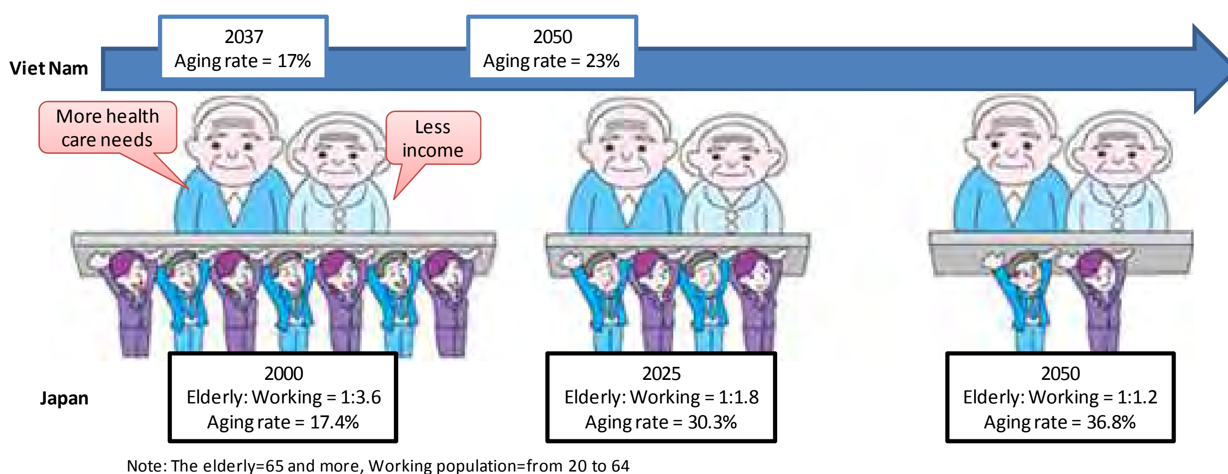
As shown in Figure 9-3, the aging rate and gross domestic product (GDP) per capita in 2015 are similar to Japan in 1970 because Japan experienced rapid economic growth after that and social welfare for the elderly was developed and implemented. Although there is still more time for Viet Nam to become an aged society (aging rate >14%), aging may progress more rapidly than Japan as well as its economic growth. If the elderly are covered in one scheme, the health insurance fund may collapse unless the premium amount/rate will significantly increase. On the other hand, a single scheme of the health insurance fund might be able to maintain efficiency and sustainability to increase inter-generation and inter-scheme risk pooling.



Reference: [World Bank]

Figure 9-3 Aging and Economic Growth

According to Japanese experience, aging may decrease premium revenue as mentioned in (1) in this section. As a result, the burden of younger generation may increase in the future (Figure 9-4).



Reference: [JICA, 2014], [Cabinet Office, Japan], [Arubino]

Figure 9-4 More Aging, More Burden on Younger Generation

Therefore, health insurance scheme for the elderly will need to be considered to avoid collapse of the health insurance fund and protect the elderly in the long-term strategy on health financing.

(4) Health Service Delivery

Although health insurance covers most of the services approved by MOH, health facilities could not provide the designated services due to insufficient human resources or medical equipment. In terms of the quantity of human resource for health (HRH), 97.3% of commune health stations (CHSs) have assistant doctors or midwives and 76.9% have doctors (Section 2.5.2). Regarding quality, HRH will need to strengthen their capacity to respond to the changing health needs caused by the increase in non-communicable diseases (NCD) and aging. Also, to attract people, the capacity and quality of both medical and patient services have room for further improvement.

(5) Information Management

Most of the pilots seemed to have difficulty in availability of necessary data and its accuracy (refer to Section 4.2.2(3)1)). It seems to be caused by low awareness on importance of data management at every level of health service providers and administrations. Health information is being handled by a limited number of officers and most of them have another post in local administration. The data seems not correctly entered at the operational level. Therefore, it is difficult to verify after the data is aggregated. Those may be caused by insufficient awareness of importance of data as evidence for decision making from the grassroots to central level.

(6) IT System

Data of claim, hospital management, especially financial situation, and routine health management information from health service providers are quite useful to consider benefit package, medical fees, and other conditions of health insurance system.

In most health service providers at the central, provincial and district levels, hardware and some software have been installed to manage information. On the other hand, such software and infrastructure are fragmented without linking each other and could not respond to the latest requirements and needs of health service providers. In addition, the IT system is not synchronized among hospitals and related administration unit of MOH, and the social security institutions (VSS, PSS, and DSS). In general, each hospital has a different HIS, and each administration unit has not introduced appropriate IT system in their operations. Through the Survey, the following challenges were identified:

- Insufficient standardization of information required to operate the health insurance system:
    - Master code does not comply with international standard and plural lists of technical service are provided by different departments of MOH without consistency;
    - Understanding and proper utilization of the new claim formats should be established in health service providers nationwide as soon as possible to improve availability and quality of data; and
    - More specific rules should be developed to review the claim to regulate behavior of service

providers.

- Fragmentation of data management:
  - Claim data is sent from hospital to the social security institutions on a regular basis (monthly or quarterly). However, these are not sufficiently shared with MOH in a timely manner.
  - MOH collects data from hospitals (electric and paper basis) on a regular basis (annually, quarterly, monthly, etc.) However, these files are not well consolidated. Although it seems to be done on unofficial basis upon necessity, it is really depends on capacity and willingness of a person.
  - Analyzing and using data have not been done in a systematic way. Although the patient data from the central and some provincial hospitals is submitted in machine-readable formats, compilation cannot be done since those are not compatible.
- Inappropriate data exchange system:
  - Information exchange among agencies and health facilities both vertical (central to community) and horizontal (intra-organization/hospital) seem to be done mainly on a manual basis: by e-mail and/or hard copy.
- Insufficient IT skills and knowledge:
  - Majority of the staff in hospital has limited skills, knowledge, and experience on computer and IT system. These are not appropriate enough to meet requirement for IT development in hospitals although the hospitals has been setting a certain criteria for recruitment of IT staff.
- Insufficient quality and quantity of experts:
  - Although some agencies and hospitals have computer experts, there are no available mechanisms or incentives to encourage them to develop or improve their capacity.
  - Majority of these experts hold other posts such as in the Department of Pharmacy.
- Insufficient awareness of importance of IT:
  - Many agencies and hospital managers still have insufficient awareness of the importance of IT development, and therefore do not invest appropriately to the needs to solve operational issues and/or requirements.

Considering IT system development steps as shown in Figure 9-5, Viet Nam seems to be in the process of Step1 to Step2.

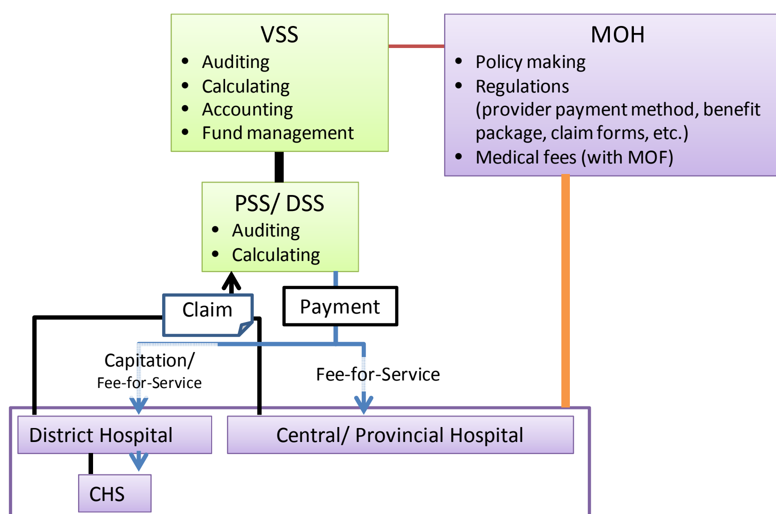
	STEP1 Visualization/ Digitization	STEP2 Sharing Data/ Satisfy Operational Requirement	STEP3 Matured IT/ Manage multiple administrative level
IT for XX (Objectives)	• **Digitization** • **Transparency** • Data **integrity (assurance)**	• **Sharing** information • **Supervising** • Network connection	• **Centralization (**Managing data in multiple administrative level) • Support **policy making** • Business process Re-
Activities	• **Digitize** paper-based documents, information • **Basic** data collection and introduce methodology to assure data **integrity** • **Buy** solution package from IT vender and install it	• Making a **master plan** for IT • **Standardize** data format • **Sharing** data with another department • **Integrated** data collection • **Develop** integrated IT system in relevant departments	• **Standardize** operation • Sharing data with **multiple administrative level** • **Develop** integrated It system in multiple administrative level • Data analysis
Feature of IT system and related cost	• Able to manage only **fixed** form in **simple** operation • **Limited** amount of data • Only **initial cost** (small amount of maintenance cost)	• Able to manage fixed form in **complex** operation • **Big** amount of data • Support **supervising** operation • Take it account to **maintenance cost**	• Able to manage **every respects of data in complex operation** • **Huge** amount of data proceed quickly • Take it account to maintenance cost
Human Resources/ Project Management	• Hire an IT geek • **Independent** activities (no need project management) • **Limited** training methodology	• **Organized** IT professionals in customer's organization • Integrated project management based on the **master plan**	• **CIO** in customer's organization • High-level project management (CMMI level4-5) • Systematic training program

Source: Survey Team

Figure 9-5 Level and Step of IT Maturity

(7) Implementation and Management of Medical Fee Schedule, Provider Payment Mechanism and Benefit Package

Figure 9-6 presents the current management mechanism of health insurance system. MOH is responsible for policies and regulations. VSS implements and manages health insurance fund. Claim and payment data are directly submitted to the social security institutions. Although VSS seems to share some data to MOH, it is sometimes difficult to obtain necessary data for the situation analysis and pilot studies.



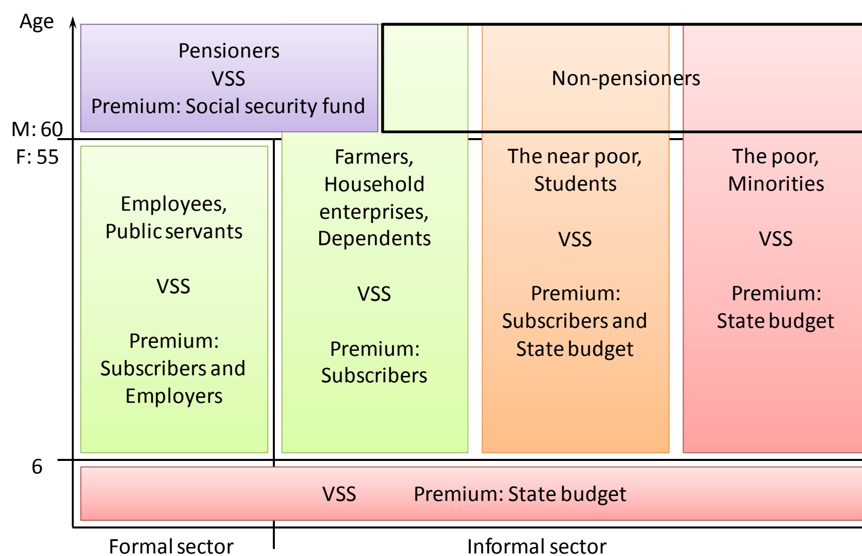
Reference: Interviews

Figure 9-6 Current Management Mechanism

(8) Population Coverage and Health Insurance Usage

1) Scheme

The current health insurance scheme in Viet Nam is presented in Figure 9-7. Under the Amendment on the Health Insurance Law (2014), all the population is covered in a compulsory and single health insurance scheme. A single scheme seems to be easier to manage subscribers, premium setting, and collection.



Source: Survey Team

Figure 9-7 Current Health Insurance Scheme

Private sector employees and informal sector people, except the poor and minority, showed lower coverage than other groups and adverse selection may occur. They never enroll to any health insurance until they get sick. It causes increase of expenditure from health insurance fund although not enough premium revenue is collected.

The pensioners occupied 22% of the eligible population[68]. Among the non-pensioners aged 60 years old and more, 19% received any form of social assistance such as medical cost or old-age welfare allowance (80 and more) [JICA, 2014]. Therefore, around 60% of the elderly seemed not to be supported by social security if they do not have regular income sources, they are at a higher risk in having diseases that could burden their income and savings.

2) Coverage and Premium of Informal Sector

One of the reasons of low coverage among informal sector people may be current health insurance system and/or health services are not attractive and confidence for them. The hospital will need to take some measures to improve patient convenience in reception and accounting procedure, as well as the quality of

[68] Men: 60 and more and women: 55 and more: It will be raised step-by-step up to men 63 and women 60 from 2016.

medical and patient services. Also, people may not understand financial risk caused by payment for health care and benefit of health insurance.

Regarding premium setting, although some of the informal sector people seem to be in the wealthy class, they pay the premium which is 6% of the minimum wage as long as they are in the informal sector group. If the premium amount is set according to their financial capability, the health insurance fund could obtain more revenue. Therefore, effective method to set premium amount or financial capacity of informal sector workers may need to be developed. In fact, the Government of Viet Nam has been considering a personal number system to manage tax collection more efficiently. If it is developed, the premium amount could be efficiently set according to the income of each subscriber.

(9) Claim and Examination

As mentioned in Section 4.6, claim and examination are currently done manually or by fragmented IT system. Therefore, mistakes and frauds might not be sufficiently identified, and overuse of medical services could not be found. Also, since the social security institutions cannot review the applicability of medical services well, oversupply of medical services could not be controlled. In addition, the current system cannot identify overuse of medical services such as doctor shopping and duplication of subscription. It might cause another burden of health insurance fund in future as free access will be expanded.

The Government of Viet Nam concerns that expenditure of the health insurance fund could increase by continue applying fee-for-service because the existing system cannot regulate such behavior of service providers and users.

(10) Benefit Package

As shown in Figure 9-2, the current benefit package covers a wide range of medical services including the high cost ones. However, it seems that it does not contribute to the decrease of OOP and may cause serious deficit on health insurance fund. Although a wide-range of services is covered by health insurance, utilization rate of health insurance is low, especially in inpatient treatment which requires more cost. It is less than 50% as mentioned in Section 2.4.2. Also, additional payments for non-covered services or instruments are common and patient cannot know whether they really need it. Therefore, the Government of Viet Nam has been developing BHSP as mentioned in Section 3.3.5(2).

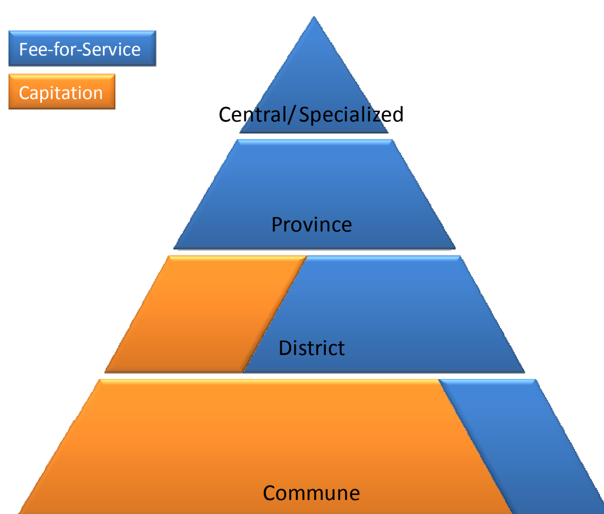
(11) Medical Fee Schedule

As described in Section 4.1.3, medical fees were set based on estimation made by a limited number of hospitals. However, the main concern is that the fees may not reflect the actual costs appropriately and might cause balance billing as mentioned in Section 2.2.6(2). Medical fees have been revised in March 2016 to cover more expenditure of health service providers and integrate the price for each service level. However, the new price is applied only for patients with health insurance cards and the previous price is

applied for people without health insurance cards. Therefore, health facilities have to deal with these double prices. According to MOH, it is not clear when the price will be integrated.

(12) Provider Payment Method

Currently, central and provincial hospitals apply fee-for-service. District hospitals can choose capitation or fee-for-service. According to the Viet Nam Social Security (VSS), around 60% of district hospitals apply fee-for-service (Figure 9-8) because the current fee-for-service mechanism does not have function to regulate behavior of health service providers and patients, oversupply of services has been practiced and additional payments for additional services and balance billing are commonly required to the patient (Section 4.2.2).



Source: Survey Team

Figure 9-8 Current Combination of Provider Payment Methods

According to the Survey, after free access at the district level[69] has taken effect in January 2016, some district hospitals and commune health stations (CHSs) have changed from capitation to fee-for-service because people can access to a district hospital beyond his/her residential district, and hospitals which receive more patient than their coverage population may not be able to cover service expenses by capitation payment.

Regarding capitation for CHSs, based on the Survey Team observation, the current system is different from the general understanding of "capitation" (Section 4.2.2(2)). Capitation payment should be made in advance according to the range of services and population coverage. However, it is made based on actual number of patient and fixed unit rate. If the other costs such as salary and operation and maintenance, as well as drug and other medical supplies are sufficiently provided, the CHSs could utilize such capitation payment for further improvement of its services. Otherwise, it could not provide even designated services because of lack of drugs and medical supplies, or breakdown of equipment.

[69] People can use health insurance card at any CHS and district hospitals within a province.

9.2 Recommendations

Considering the situation analyses made in previous sections in this chapter, the Survey Team prepared the recommendations on options to ensure financial protection and sustainability of the health insurance fund for the following factors:

- Health financing;
- Health insurance scheme;
- Management mechanism of health insurance system, particularly benefit package and provider payment mechanism;
- Provider payment methods;
- Benefit package and BHSP;
- Information management to manage health insurance system based on evidences; and
- IT system to strengthen efficiency of works which are relevant to health insurance.

Then, the Survey Team identified necessary actions and their priority. Those are compiled in a roadmap to future health insurance system proposed as shown in Figure 9-9.

Among the activities listed in the roadmap, the followings should be prioritized to prepare preconditions for future actions:

- 3.1 Establishment of a council to manage medical fee schedule and provider payment method
  Because the council will be involved in the development of BHSP and continuous review of the benefit package/BHSP. Although the National Advisory Council on Health Insurance Policy (NACHIP) has been established, concrete and practical function and terms of references are still under discussion among stakeholders. Considering that scope of BHSP will be clearly defined for the primary level and the other benefit package has been under review, capacity development of NACHIP should be initiated as soon as possible.

- 4.2 Development of criteria of high-cost/advance medical services
  To revise the benefit package appropriately, high-cost/advance medical services to be covered by health insurance should be clarified with reasonable and clear criteria to the people and health service providers.

- 4.3 Development of BHSP and continuous review of the benefit package to be paid by the health insurance fund
  To increase transparency and accountability, as well as promote consensus building among stakeholders, the benefit package and BHSP should be developed or reviewed based on reliable evidences, which should be collected and analyzed regularly.

- 4.4 Development of standard clinical practice guidelines to be covered by health insurance
  Standard clinical guidelines could be effective to control clinical practice and prevent oversupply of medical services, as well as improve efficiency of claim examination.
- 6.2 Identifying the most feasible combination of provider payment method at all level; and
- 6.3 Development of DRG model

  Based on careful consideration of the results of the pilot studies on capitation and DRG, the most feasible payment method for each level should be considered. Because DRG could be one of the preferable solutions to control the quality and scope of services to be covered by health insurance, the model should be developed based on accurate data.
- 8.1 Improvement of data entry and management capacity of accounting, claiming and clinical staff
  This item has an effect on several actions such as the pilot project on BHSP, development of DRG, development of capacity of the council, review of medical fee schedule, improvement of claiming and claim examination capacity. Also, it is an important precondition for IT system development.

The following sections describe the proposed options mentioned above.

Category	Actions	Key player	Years (tentative)					
			2016	2017	2018	2019	2020	2025
1 Policy	1.1 Development of health financing strategy (long-term)	MOH-DPF MOF						
	1.2 Development of mid-term plan and action plan on health financing	MOH-DPF						
	1.3 Reviewing the Heath Insurance Law according to actual situation	MOH-HID						
	1.4 Financial simulation of health care expenditure and health insurance fund	MOH-DPF/ HID						
2 Financing	2.1 Ensuring new tax revenue from tobacco and alcohol for financial protection for the vulnerable people	MOH, MOF						
	2.2 Increasing health insurance coverage (80% or more)	MOH,VSS						
	2.3 Ensuring premium collection from all subscribers (80% or more)	VSS						
3 Management of benefit package, medical fee schedule and provider payment method	3.1 Establishment of the council to manage benefit package, medical fee schedule and provider payment method	MOH						
	3.2 Capacity development of the council and sub-committees	MOH						
	3.3 Identifying necessary data for management of benefit package, medical fee schedule and provider payment method	Council						
4 Benefit package	4.1 Integration and update of the list of medical examination and treatment provided in each level of health facility	MOH-MSA						
	4.2 Development of criteria of high-cost/ advanced medical services	Council						
	4.3 Development of BHSP and continuous review of the benefit package to be paid by health insurance fund	Council						(continuous review)
	4.4 Development of standard clinical practice guidelines to be covered by health insurance	Council						
	4.5 Drug and medical supplies to be covered with standard prices to be included to BHSP	Council						
5 Medical fee schedule	5.1 Revision of medical fee schedule to include two more items as the bases of cost estimation	Council						
	5.2 Revision of medical fee schedule and integration to BHSP	Council						
6 Provider payment method	6.1 Revision of capitation model for the primary level	MOH-DPF						
	6.2 Identifying the most feasible combination of provider payment method at all level	MOH-DPF						
	6.3 Development of DRGs	MOH-DPF						
	6.4 Applying of the DRGs to the central and provincial hospitals	MOH-DPF						
	6.5 Feasibility study on DRGs for the district level	MOH-DPF						
7 Claim and claim examination	7.1 Strengthen of claiming capacity of hospital	Hospitals						
	7.2 Strengthen of capacity and efficiency of claim examination of VSS/PSS/DSS	VSS						
	7.3 Improvement of claim examination role	VSS						
8 Information management	8.1 Improvement of data entry and management capacity of accounting, claiming and clinical staff	Hospitals						
	8.2 Integration of hospital information system (HIS) within a hospital	Hospitals						
	8.3 Establishment of data integration system within MOH and between health facilities	MOH						
	8.4 Strengthening capacity of statistical analysis of information management personnel and the sub-committees	MOH						
	8.5 Development of standards of information management for health insurance (master code, format, claim examination rule)	MOH, VSS						
	8.6 Strengthening of IT governance	MOH, VSS						
9 IT system development	9.1 Definition of each system requirement for the operational management of health insurance	MOH, VSS						
	9.2 Development of IT system and installation	MOH, VSS						
	9.3 Extension and promotion of IT system complying with the requirements	MOH, VSS						
10 Health service provision	10.1 Strengthening of referral system	MOH						
	10.2 Development of gate-keeping function at primary level	MOH						
	10.3 Strengthening of preventive medicine on NCD, especially screening, early detection and early treatment	MOH						
	10.4 Development of mechanism of drug price control	MOH						

Source: Survey Team

Figure 9-9 Proposed Roadmap to Future Development of Health Insurance System

9.2.1 Health Financing

To maintain the health insurance fund healthy, the government should take effective measurement to control total health expenditure. It may also the effective to reduce OOP expenses. At the same time, mobilization of financial sources should be considered to cover increasing health expenditure according to population growth, demography change, transition of disease structure.

Financial simulation and feasibility studies could provide effective evidences to consider each option and provide realistic projection. However, necessary data such as financial status of health insurance fund and health service providers, actual examination, and treatment service provided, as well as detailed household health expenditure are not available through the Survey.

(1) Controlling Total Health Expenditure

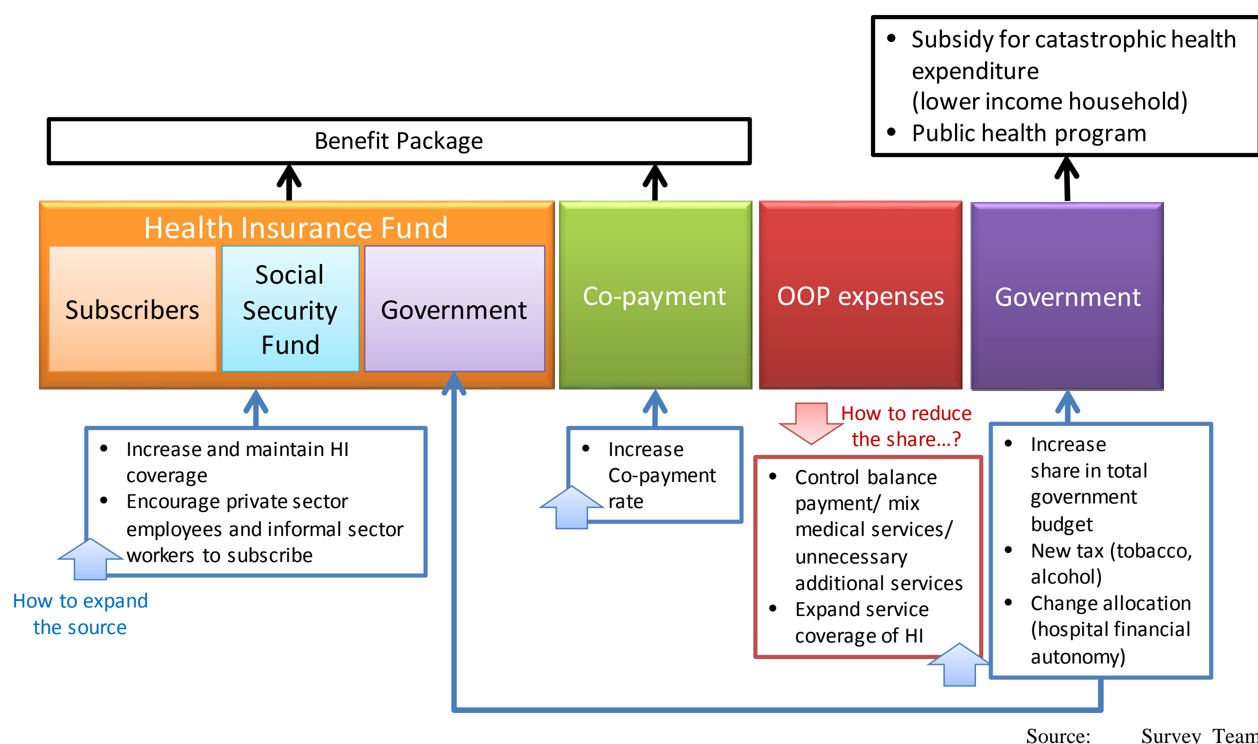
According to the Survey, unnecessary expenditure might be caused by insufficient claim examination and oversupply of medical services. Also, streamlining of drug procurement system might contribute to save expenses because it seems to be fragmented and the price could be reduced by a larger order. In addition, long-term impact of NCD should be considered.

Based on the experiences in Japan and other countries, the following could be taken into account:

- Eliminating unnecessary expenditure
  - Controlling oversupply of services by providers
    - Standard clinical practice guidelines
    - Regulating or prohibiting balance billing
  - Enhancing claiming capacity of providers
- Improving effectiveness in procedure
  - Reforming procurement and/or pricing system of drugs and medical supplies
    - Central bidding
    - Standard price list
- Controlling long-term health expenditure
  - Enhancing prevention of NCD (early diagnosis and early treatment)

(2) Improving Sustainability of Financing Sources

Figure 9-10 shows some options to ensure sustainability of health financing sources. To increase heath insurance fund revenue, high coverage should be maintained and encourage subscription of private and informal sector workers who can afford to pay the premium.



Source: Survey Team

Figure 9-10 Future Option for Sustainable Health Financing

The subscribers may oppose and stop subscribing when co-payment rate is increased. It will also cause increase in OOP expenses. Although the expansion of benefit package may be effective to decrease OOP expenses, health insurance fund may face financial difficulty.

The government budget should be expanded to provide financial support to vulnerable people and sustain public health program. According to draft health financing strategy, mobilizations of new financial resources such as tobacco tax are considered. Also, when financial autonomy of hospitals is promoted, government subsidy to central, provincial and some district hospitals could be reduced. Then, the saved budgets could be allocated for financial protection for lower income people.

9.2.2 Health Insurance Scheme

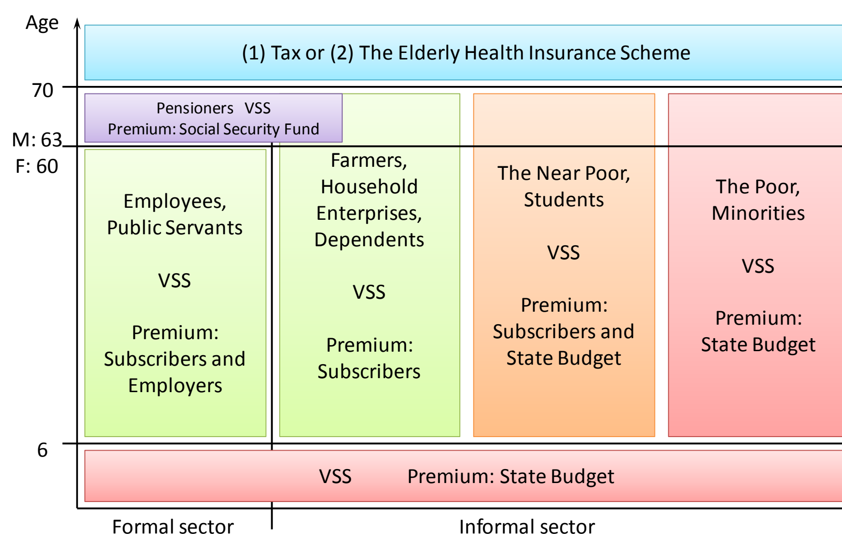
The single scheme can be managed easier and risk pool could be larger than the separated scheme. If the current single scheme would like to be maintained, the government needs to make great effort to increase the coverage of private sector employees and informal sector people to ensure revenue from premium. At the same time, the premium rate and co-payment rate should be raised to cover increasing total health expenditure according to aging and disease structure transition.

On the other hand, separate schemes for high risk group such as the elderly and the poor could be considered to ensure fairness among the subscribers, otherwise a large portion of health insurance fund may be spent by such high risk groups although the other groups contribute to a large portion of the revenue. As shown in Figure 2-5, even in 2013, expenses on health insurance fund for retirees was five times of those for workers who contributed 40% of the total revenue. When aging is progressed, such tendency will be more significant. Therefore, based on Japanese experience, a separate scheme is also suggested to consider measurement in the future in this section.

(1) Option 1: Separate Scheme for the Elderly

Considering the above situation and a possible financial crisis caused by aging, the first option of the health insurance scheme is presented in Figure 9-11.

In this option, the elderly more than 70 years old is separated. There are two options to cover their medical expenses: (1) tax-based system or (2) independent health insurance scheme like Japan. However, as mentioned above, it should be carefully studied and consider a feasibility report in order to separate the health insurance fund for the elderly. Additional sources of financing should be obtained for both two schemes since the elderly could afford to pay large amount of premium. The government budget may be a major source, and contribution from health insurance scheme for younger generation like Japan could be also considered. The different benefit package should be developed to respond their common needs. In terms of cost control, it should be only for basic services; however, it might affect on financial protection.



Source: Survey Team

Figure 9-11 Option 1 of Future Health Insurance Scheme

Because the medical cost for the elderly may generally increase because of multiple burden of having chronic diseases. In Japan, 50% of national medical expenditure is spent for people aged more than 70. As it is estimated that Viet Nam might be aged society (aging rate >14%) in the next two decades, support for the elderly should be carefully considered. Both options will require a certain scale of government budget.

Table 9-1 compares the above two options.

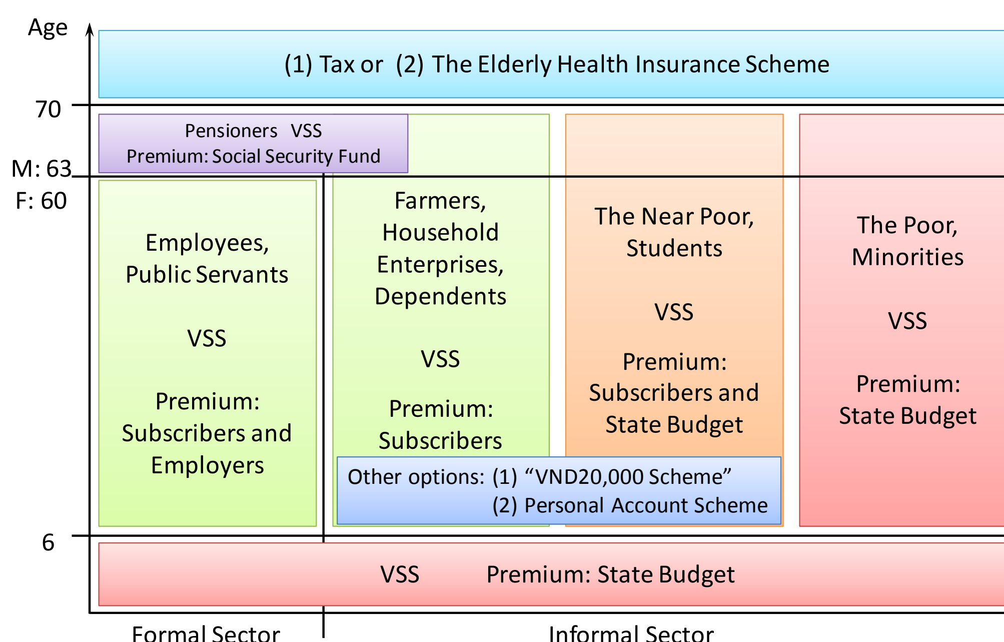
Table 9-1 Comparison of Health Insurance Scheme for the Elderly

	(1) Tax-based System	(2) Separate Scheme
Financial Source	- State budget	- State budget - Premium - Social insurance fund
Advantage	- The elderly need not to pay premium	- Financial burden of the state budget is decreased.
Risk	- The government needs to mobilize additional tax revenue - Unnecessary care seeking may increase - Oversupply of services may increase - Medical cost for the elderly may increase	- The government needs to mobilize additional tax revenue. - Adverse selection may occur - Most of the elderly do not have stable income

Source: Survey Team

(2) Option 2: Options to Attract Informal Sector People

The second option of the health insurance scheme is presented in Figure 9-12. Two options are presented to encourage informal sector people to subscribe to health insurance because they tend to prioritize other living expenditures than health insurance premium payment and they are reluctant to subscribe until they get sick.



Source: Survey Team

Figure 9-12 Option 2 of Future Health Insurance Scheme

To encourage the informal sector people to subscribe to health insurance, it may be effective to mitigate financial burden to pay the premium or save their premium for their own medical care. Table 9-2 summarizes the two options: VND 20,000 scheme could be developed in reference to Thailand (Chapter 8); and a personal account scheme is suggested based on Chinese experience. The VND 20,000 scheme is quite similar to tax-based system; however, the counter registration fee is expected to control unnecessary visit to the health facilities. The personal account might be clear for the people since they can spend as much as they have saved in their personal premium account.

However, when these schemes are introduced, management of subscribers may become complicated and work load of hospital management and social insurance institutions will be increased. Also, additional financial sources need to be mobilized.

Table 9-2 Outlines of Two Options for the Informal Sector Workers

	(1) VND 20,000* Scheme	(2) Personal Account
Outline	- Semi-tax-based system - The subscriber need not pay premium - He/she pays counter registration fee (VND 20,000) for each visit to health facility - Service provider claims medical fees to the government - Reference: 30Bahts Scheme in Thailand, Malaysia, Brunei	- The subscriber opens a personal account in Social Security Institute (or designated bank) - He/she saves the premium - The medical fees are deducted from the personal account. - The account is settled annually - Surplus can be saved in the account for future or returned to subscriber - Deficit is paid by the subscriber. If the deficit amount exceeds the designated maximum amount, a certain proportion will be subsidized by the government or social insurance fund - Reference: China
Financial source	- State budget - Registration fee for each visit	- Premium - Co-payment (to settle the deficit) - State budget or social insurance fund
Advantage	- The subscriber who has no regular/ stable income could be protected from financial burden.	- The subscribers could clearly know cash flow of their premium and medical expenses
Risk	- The government needs to mobilize additional tax revenue - Unnecessary care seeking may increase - Oversupply of services may increase - Medical cost for this category may increase	- Care seeking behavior may be unnecessarily suppressed to save the money - Account management may increase work load of social insurance institution

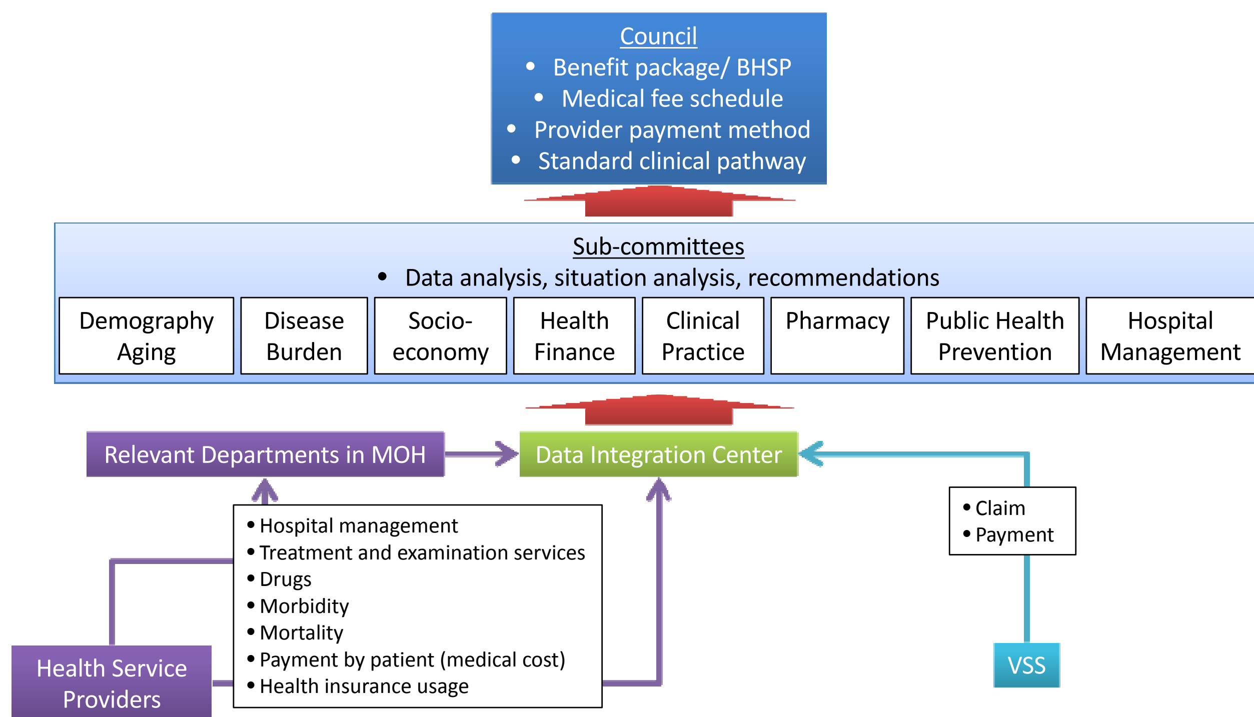
Note: * VND 20,000 (USD 0.89) was tentatively suggested referring 30 Baht (USD0.84).
Source: Survey Team

9.2.3 Management Mechanism of Health Insurance

Figure 9-13 presents proposed management mechanism. Because utilization rate of health insurance card seems to be around 70 to 80%, data on medical services and drugs should be collected directly from health service providers to grasp whole picture. The current data collection system maintained by MSA and DPF could be utilized.

The data is aggregated in a data integration center and submitted to relevant sub-committees. The sub-committees analyze the data to make recommendations on medical fee schedule, BHSP or benefit package and standard clinical pathway. Then, the council compiles those recommendations to make final decision. Since those are quite relevant to financing and health insurance system and the discussions and decisions should be made objectively and evidence-based, the council should involve not only MOH but also MOF, VSS, service providers, and academic institutions. To have proactive discussion, the council members should consider balance of each stakeholder and not exceed 20 persons. The possible stakeholders are; MOH, VSS, hospitals at all levels, academic institutions such as HSPI and universities, representative of patients, etc.

Ideally, the council should be set beyond the ministries although the secretariat is taken by MOH, because health insurance system is relevant to various sector, health policy, health finance, health service provision, human resource for health, social welfare, economy, population, drug management, etc.



Source: Survey Team

Figure 9-13 Proposed Management Mechanism

9.2.4 Provider Payment

The Ministry of Health (MOH) would like to introduce case-based payment with diagnosis related group (DRG) and has been conducting several pilots. It could be expected to reduce payment from health insurance fund. However, lessons learned from the pilot projects suggested that availability and accuracy of data are critical to develop and manage DRG efficiency and effectively. As pointed out in Chapter 5 and 6, importance of data management seems not to be important from the grass-roots to central level. Therefore, it might require more time and great effort to improve data management sufficiently to develop DRG because other measurements than case-based payment could be considered to reduce or optimize health insurance fund expenditure. As mentioned in Section 9.2.1(1), the following three options are recommended to reform provider payment method step-by-step.

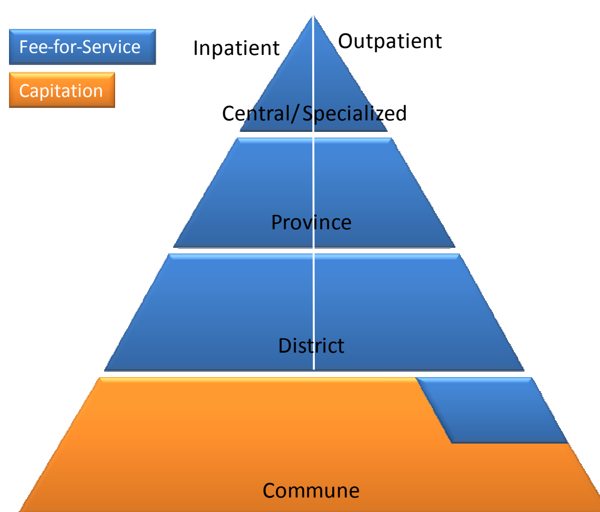
(1) Option 1: Combination of Fee-for-Service and Capitation

Figure 9-14 shows the first option of combination of provider payment method. Due to free-access within a province, district hospital should ensure enough income to provide the services according to actual demand.

If the primary health facility has appropriate gate-keeping function, commune level basically could apply capitation because, CHSs generally provide public health services, first aid, family medicine, and normal delivery. However, CHSs in hard-to-reach areas providing basic medical services may apply fee-for-service because it needs to ensure sufficient income to provide more medical services than other

CHSs in other areas. Capitation rate for such areas should be considered to be higher. In addition, sufficient budget and medical supplies should be allocated to CHSs to maintain quality of services; however, health insurance fund should be paid in accordance with appropriate capitation rate and coverage population.

On the other hand, to encourage CHSs to improve service quality, combination of government budget and existing payment method[70] (according to number of patient and fixed unit rate) may also be suggested. However, sufficient drug and medical supply, investment, O&M should be ensured by the government.



Source: Survey Team

Figure 9-14 Option 1 of Combination of Provider Payment Methods

In this option, it should be carefully considered to control over supply of services. The following options could be suggested:

- Change the budgeting system
  Because budget is set based on the previous expenditure, health service providers spend more to obtain more budgets. For example, budget may be set based on detailed cost estimate regardless of the previous expenditure.
- Standard clinical pathway
  The clinical pathway may be effective to regulate medical staff. The health insurance institution can also utilize to review claims. However, it takes time to develop all the medical procedures, train the medical staff, and revise regularly. Also, it should be introduced in pre-service education.
- Penalty for frequent over-supply
  For instance, if a health service provider repeats intentionally a certain treatment procedure, the health insurance institution terminates the contract. As income from health insurance is getting more important, it may be effective in the near future. However, the hospital that terminated the contract may require OOP payment. Also, it may be difficult to identify intentional overtreatment.

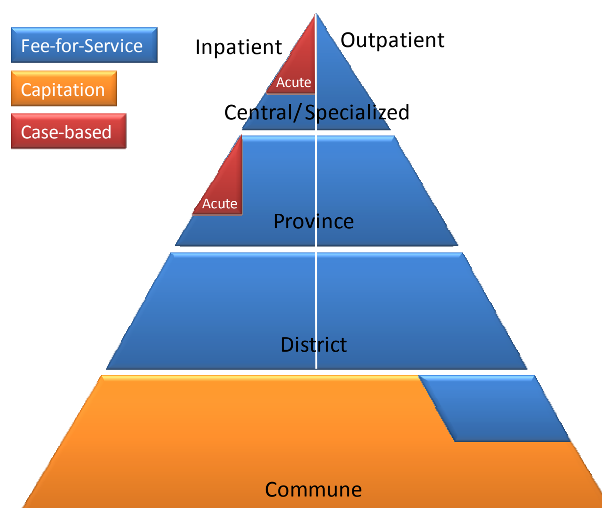
[70] According to observation of the Survey team, this method is called "capitation". It is applied in CHS to cover public service expenditure (electricity and water).

- Incentives for improvement of service quality

  Incentives such as top-up of the payment will be provided for health facilities when it improved efficiency of services and save medical cost. However, more human resources and costs may be required to evaluate the improvement and reasonable savings from medical cost.

(2) Option 2: Introducing Case-based Payment

Figure 9-15 shows the second option of combination of provider payment method. In addition to Option 1, case-based payment is introduced in inpatient services for acute diseases.



Source: Survey Team

Figure 9-15 Option 2 of Combination of Provider Payment Methods

It is easier to identify appropriate examination and treatment package as well as total cost for acute diseases than for chronic diseases. Also, it is expected to increase financial benefit by improving efficiency of service provision, for example, enhance inter-department communication to share patient information, and as a result, length of stay of inpatient will be reduced. When the following preconditions for case-based payment are fulfilled, it could be applied for acute diseases for inpatient services.

- Rigorous data collection and management to form DRG
- Capability and commitment of hospital management to increase efficiency in service provision

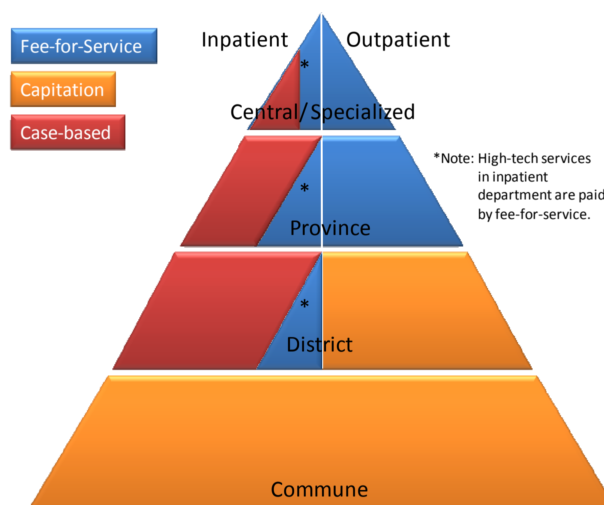
It should be started with limited diseases in hospitals with sufficient data management capacity and hospital management system. If the preconditions are fulfilled, it may be expanded to inpatient services for other acute diseases.

(3) Option 3 Combination of Three Methods

In the third option (Figure 9-16), capitation is expanded to outpatient of district hospital and case-based payment is applied to inpatient departments of all public hospitals except high-tech services.

Coverage population should be clearly defined for district hospitals and CHSs and for that, gate-keeping function of such facilities should be enhanced to improve referral system and regulate care-seeking

behavior of patients. Otherwise, some facilities might not be able to financially sustain their services since these facilities receive more patients than their coverage population.



Source: Survey Team

Figure 9-16 Option 3 of Combination of Provider Payment Methods

At the district level, patient management and accounting procedure might be more complicated because there are three payment methods in one hospital. Especially in a small size district hospital, accounting counters are not separated by inpatient and outpatient departments and accounting division seems not to have sufficient number of staff to deal with three different payment methods. Therefore, it might be difficult to apply this option without a well-established IT system and sufficient quality and quantity of human resources for accounting, claiming and patient management.

9.2.5 Benefit Package

In reviewing the benefit package, the following points need to be carefully considered and well discussed among the stakeholders:

- Accountability of health service providers and subscribers
  When the current benefit package would like to be downsized from the current wide-range of coverage into appropriate services for common diseases, it should be done with clear and reasonable criteria for health service providers and users because they may feel that they lose the benefit.
- High-cost and/or advanced medical services
  The following criteria should be established to identify range of health insurance coverage:
  - What are "high-cost medical services" and "advanced medical services"?
  - Are those really essential and appropriate to save life and/or contribute healthy life expectancy of the patient?
- Financial protection
  Financial protection for catastrophic health expenditure and impoverishment should be well considered. Either the central or local government budget may be allocated to subsidize such high-cost and necessary medical services.

- Preventive services
  Table 9-3 summarizes levels of preventive services. Those for mass population (zero and primary) should be covered by government program because it is difficult to identify costs for individuals. Secondary and tertiary levels could be covered by health insurance. Those could be effective to prevent sharp increase of treatment cost and impoverishment.

- Consistency
  The services described in the benefit package should comply to international standard such as ICD-9-CM to ensure common understanding among all the stakeholders including MOH, VSS, health service providers, etc.

Table 9-3 Levels of Preventive Services

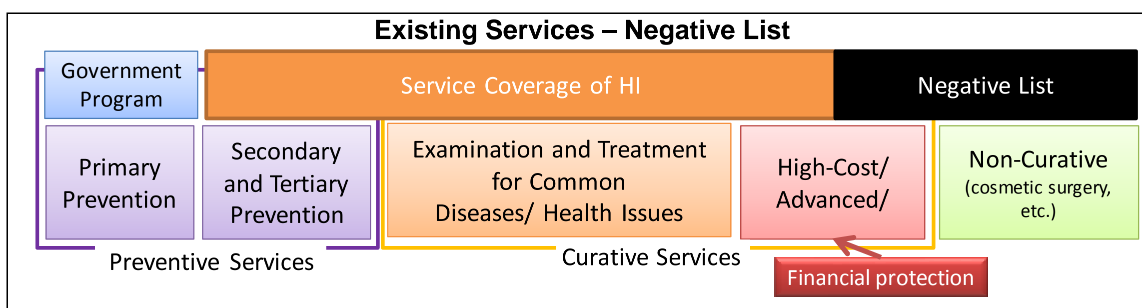
Level	Targets	Concept and Contents	Players
0. Zero Prevention	Mass Population	Advocacy at the policy level - Introducing new tax/ laws to control risk factors such as tobacco, alcohol, over-intake of high-risk foods, etc. - Developing long-term strategy, mid-term master plan, and short-term action plan	- Relevant government agencies especially leaders
1. Primary Prevention	Mass Population	Health promotion for behavior change - Public relation and health education on risk factors of NCD, injury, and traffic accident - Promotion of healthy life style (physical activities and healthy diet) and healthy environment - Immunization	- Ministry of Health - Community - Health service providers
2. Secondary Prevention	Individual	Early detection and early treatment - Mass screening of NCD - Follow-up and health education for high-risk patient - Treatment for early stage patient	- Ministry of Health - Health service providers
3. Tertiary Prevention	Individual	Rehabilitation - Guidance for a patient on diet and daily life to improve quality of life (QOL) - Physical rehabilitation to prevent severe and promote autonomous in daily life	- Ministry of Health - Health service providers - Community

Source: Survey Team

(1) Option 1: Negative List

Table 9-3, a negative list may be easy to understand for providers, subscriber, and patients and manage. The negative list includes non-curative and some advance services as well as high-cost services for less frequent diseases. It should be reviewed regularly and may be reduced considering the needs of the population, as well as capacity of health service providers and health insurance fund.

In this option, preventive services for mass population (primary) are covered by state budget as long as it is included in the government program. However, those for individuals (secondary and tertiary) need to be considered to be included.



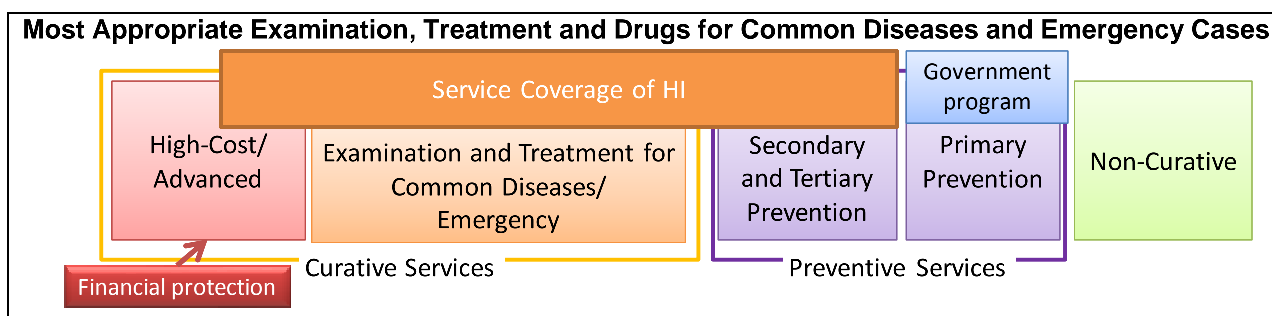
Source: Survey Team

Figure 9-17 Option 1 of Recommendation on Benefit Package

(2) Option 2: Appropriate Services for Common Needs

Figure 9-18 shows the second option. "Most appropriate" could be identified by specialists of each department. "Common diseases" could be identified as major causes of morbidity and mortality. In particular, the needs of vulnerable population (children, the elderly, etc.) should be specially considered. Preventive services and high-cost services are considered same as Option 1.

In this option, huge efforts of stakeholders may be required at the initial stage. Reliable data has to be collected to ensure representativeness of the health needs of the people and capacity of health servicce providers in the whole country. However, once the data collection mechanism is established, the service coverage or BHSP could be regularly revised based on the needs of the people, capacity of service providers, and priority in health policy implementation.



Source: Survey Team

Figure 9-18 Option 2 of Recommendation on Benefit Package

(3) Proposed Structure of BHSP/BenefitPackage

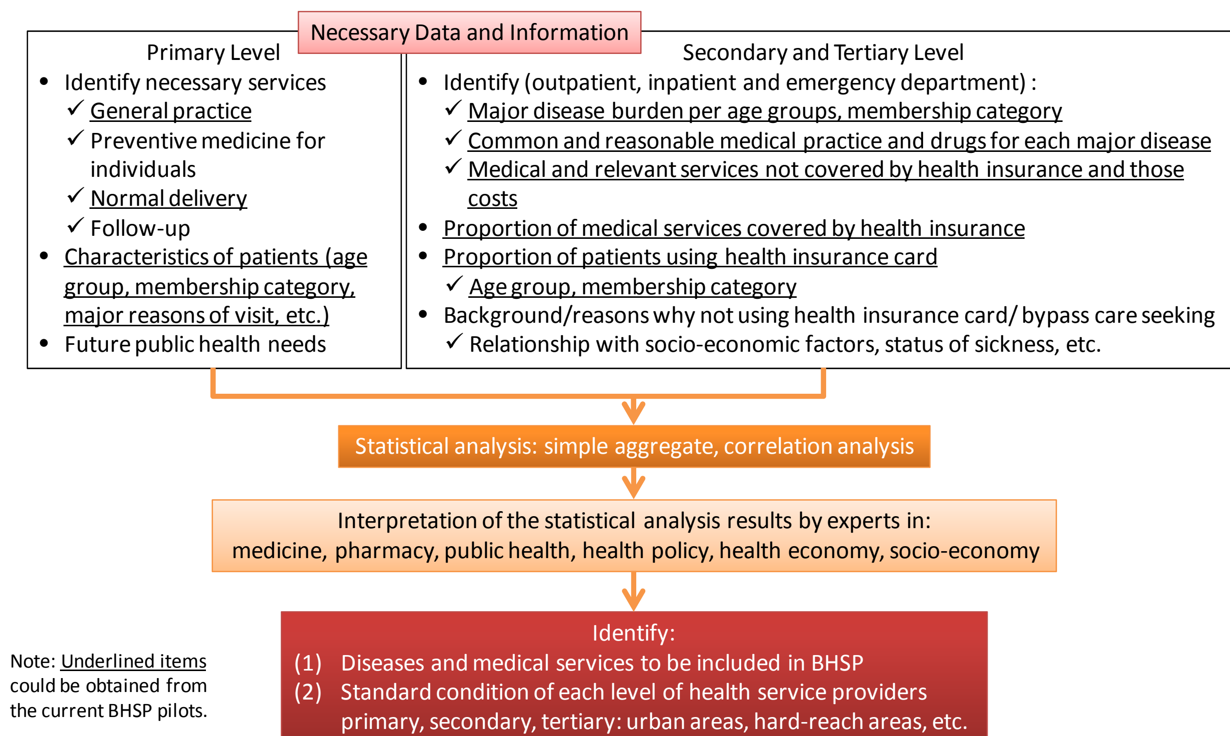
According to the above concepts, the structure of BHSP or benefit package to be covered by health insurance fund could be proposed as shown in Table 9-4. When case-based payment is applied, most of the examinations treatments and drugs might be included in DRG, and high-tech services to be covered by health insurance fund and paid by fee-for-service will be listed in Section 2.1 and 3.1. The medical fee schedule may be included when the service coding is well developed.

Table 9-4 Proposed Structure of BHSP/ Benefit Package to be Paid by Health Insurance Fund

	Chapters	Contents
BHSP	Chapter 1.Primary Level	- The following basic services to be covered by capitation payment ・ First aid ・ NCD prevention (secondary and tertiary in community) ・ Normal delivery (emergency/ hard-reach areas) ・ General practice and referral (gate-keeper)
Benefit Package	Chapter 2.Secondary Level 2.1 Inpatient 2.2 Outpatient 2.3 Emergency Department	- Most appropriate examination, treatment and drugs for common diseases * DRGs to be paid by case-based might be included if it is applied.
	Chapter 3.Tertiary Level and Specialized Hospitals 3.1 Inpatient 3.2 Outpatient 3.3 Emergency Department	- Most appropriate examination, treatment and drugs for common diseases * DRGs to be paid by case-based might be included if it is applied.
	Chapter 4.Conditions to Provide BHSP	- Staff (medical, co-medical, information management, claiming, etc.) - Equipment

Source: Survey Team

Figure 9-19 presents the flow of development or review of the benefit package/ BHSP utilizing existing data and information as much as possible.



Source: Survey Team

Figure 9-19 Flow of Benefit Package/BHSP Development/Review

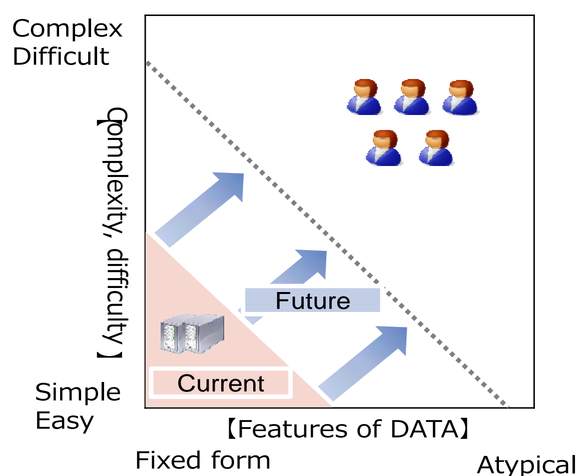
9.2.6 Information Management

Based on the above improvement of awareness and capacity on data management, fragmented information system should be integrated. Also, the relevant standards such as master code and formats need to be developed. Then, necessary data for management or health insurance system could be efficiently collected

and analyzed. Also, relevant regulation should be developed such as information security, e-document, to improve business efficiency and security protection.

(1) Development of Standards of Information Management for Health Insurance

Based on the above information management capacity, IT system could be introduced effectively. According to the Survey, IT system is applied still in simple operation with fixed formats. The complex operation which is connected across multiple departments and administrative levels has been carried out manually (Figure 9-20). In order to manage complex data by computer, standardization of information (master code, format, and rule) is essential.



Source: Survey Team

Figure 9-20 Current and Possible Implementation Range of IT System

Although MOH published the decision on the master code[71] in November 2015, the contents have not been sufficiently verified. It seems that there is a need to further review to comply with international standards such as ICD-10 and ICD-9-CM to eliminate duplication.

The revised claim format[72] should be applied in actual operation in all the public health facilities as soon as possible. At the same time, the data exchange protocol should be developed. For example, to connect systems in a hospital to each other, several protocols such as prescription data exchange, imaging data exchange, etc. are required.

The claim examination rules[73] are currently under review by VSS. In addition to existing criteria, medical viewpoints should be included to identify fraud or oversupply of examination and treatment. Also, because free access is being introduced step-by-step, accumulated claim data for a certain period (for example, three months) should be referred to all local social security institutions (Provincial Social Security (PSS) and District Social Security (DSS)) to identify doctor shopping, or inappropriate prescription and care-seeking. Such viewpoints have been introduced for a few years in Japan and it seems to be effective to

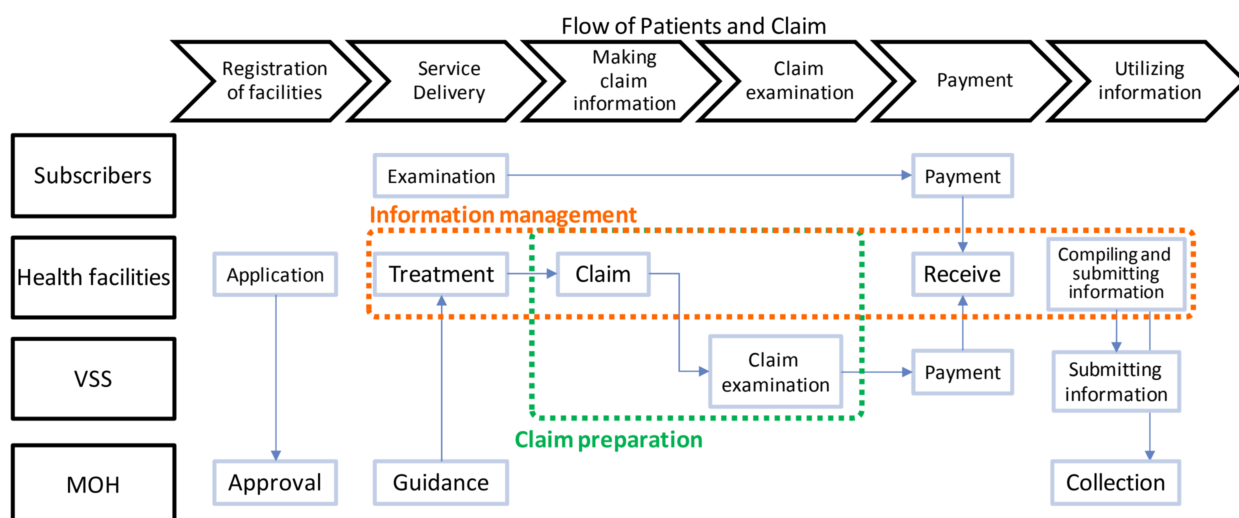
[71] 5084/BYT-BH
[72] 9324/BYT-BH
[73] 1456/QD-UD/BX-2015

control behavior of both health service providers and patients. It is also effective to prevent overdose and risk caused by multiple medications.

The above mechanism should be neutral and should involve not only MOH and VSS but also academic experts and IT vendors. For example, in Japan, an independent organization is responsible for such information standardization.

(2) Capacity Development on Information Management

In order to ensure the accuracy of data for health information, especially claim data, knowledge on both medical and IT fields are essential. As shown in Figure 9-21, a person in-charge of information management should have an overview from the start of treatment to receipt of payment from the health insurance fund and the data flow. The personnel should also be responsible for compiling hospital management information and reporting to regulatory authority (MOH/ DOH). The other personnel should focus on accurate claim preparation and response to claim examination by the social security institution.



Source: Survey Team

Figure 9-21 Conceptual Diagram of Information Management and Health Insurance Claim of the Hospital

According to the Survey, the accounting department/division is responsible for such tasks; therefore, its function could be expanded and strengthen the relevant capacity. At the same time, the general planning department should enhance information management capacity to deal with all the relevant hospital management information.

To ensure sustainability and continuous improvement in each health facility, it is recommended to develop an accreditation system for such information management in future. Regarding claim data, in Japan, a medical care information management officer and a patient billing/ health insurance claiming officer are licensed by independent organizations. Health facilities with a certain number of licensed personnel could be top up the payment from health insurance fund because those are making an effort to improve data accuracy.

(3) Strengthening of IT Governance

To enhance IT governance, the capacity of both central and local agencies, MOH, DOH, and the social security institutions should be developed to regulate the information management by having an effective IT and security protection. In particular, the IT department of MOH and VSS has a role on operational environment development for promoting the modernization and executing the requirement definition in installation of IT system to health insurance system operation.

At the local and operational level (DOH, P/DSS and hospitals), there should be a personnel that would supervise the entire information management that could be designated as Chief Information Officer (CIO). It could be assigned in the general planning department close cooperation with the IT department. Table 9-5 summarizes expected functions of CIO and the IT department to improve IT governance in local health administration and health facility.

Table 9-5 Expected Functions of CIO and IT Department to Improve IT Governance

	CIO	IT Department
Mission	IT governance	IT operational management
Expected Functions	- Incorporate a business goal and plan into goal and strategy of IT development - Prioritization of IT projects according to expected outcomes and resources (IT portfolio management) - Allocation of necessary resources for IT development - Risk management - Monitoring and evaluation of IT development	- Development of IT strategy and plan according to the organizational strategy - Human resource management - Project management - Operation management incident-management, problem management - Reporting process, progress, and achievements to the management team

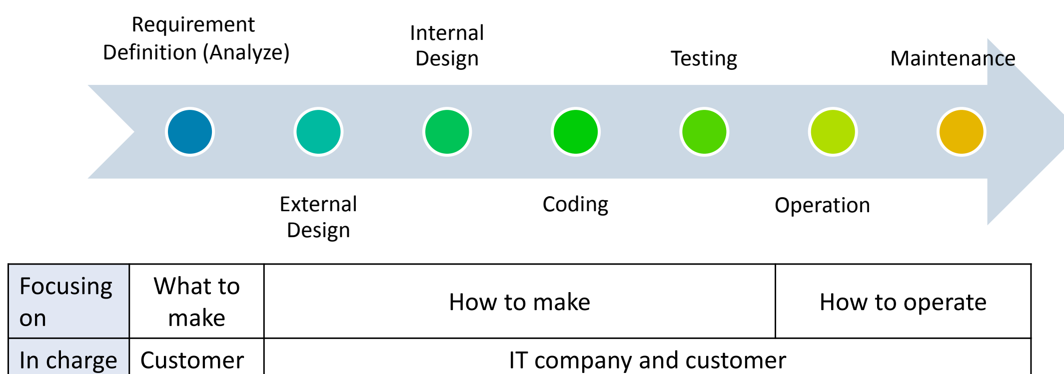
Source: Survey Team

9.2.7 IT System

Because health insurance business is composed by various factors and therefore complex (multiple stakeholders, a lot of information, complex management items, constraints), the administrators in MOH and VSS should understand the overall picture, contents of each task flow and relationship of those tasks, and issues that are occurring on the business prior to entrusting IT development to vendors. The Survey Team observed that some pilots had not been successfully implemented because the terms of reference (TOR) of the IT pilots was developed by a vendor and the administrators did not understand the overall picture of relevant works.

(1) Requirement Definition by the Customer/ User of the System

The requirement definition is one of the important phases in the IT system development process as shown in Figure 9-22.



Focusing on	What to make	How to make	How to operate
In charge	Customer	IT company and customer	

Source: Survey Team

Figure 9-22 IT System Development Phase

It should be done prior to actual design and coding. In this phase, it is necessary to clarify the function and performance of the IT system based on the requirement of users. Outcomes of this phase were summarized in the requirements definition document. It is emphasized that the requirement definition phase should be led by the customer especially the IT department who well understands the business procedure and the organization structure, not by other IT companies.

(2) Extension and Promotion of the IT System

In order to accelerate IT installation to health facilities, financial support from the state budget should be considered to procure hardware and software especially at the initial stage. In addition, incentives for health facilities which have developed IT system could be effective to motivate health facilities and local administrations. For example, the payment from health insurance fund could be topped up in accordance with the level of IT system development.

Chapter 10 Recommendation on Future Cooperation

Among the prioritized actions in Chapter 9, the Survey Team suggested five components as shown in Table 10-1 for JICA's technical cooperation for the next five years. Those were considered based on situational analysis made in Chapters 2 to 7 and information on technical cooperation resources in Japan and other countries described in Chapter 8. At the same time, as budgetary support is considered in the Health Sector Five-Year Plan 2016-2020 (Table 3-4), a development policy loan (DPL) is also suggested in this chapter.

Table 10-1 Proposed Components for JICA's Technical Cooperation

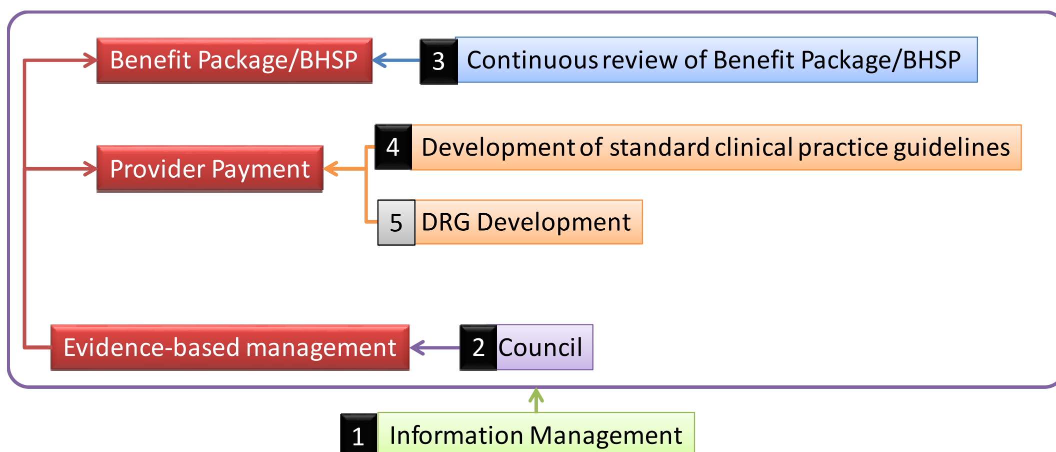
	Components	*	Proposed Available Resources
1	Improvement of data entry and management capacity of accounting, claiming and clinical staff	8.1	Accumulated experiences of JICA's technical cooperation on health information management Experiences and resources of the Project for Strengthening Medical Service in Northwest Provinces (JICA).
2	Capacity development of the council/ sub-committee to manage benefit package, medical fee schedule and provider payment method	3.2	Experiences in establishing the Central Social Insurance Medical Council (CSIMC) of Japan and its TOR, function, and actual operation.
3	Continuous review of BHSP to be paid by the health insurance fund	4.3	Roles, functions and tasks of CSIMC, its technical working groups, and concerned agencies to revise the benefit package and medical fee schedule. Methodology and procedure to collect and analyze necessary data.
4	Development of standard clinical practice guidelines to be covered by health insurance	4.4	Experiences in developing and revising standard clinical guidelines by academic societies
5	Development of DRGs	6.3	Partnership Project for Global Health and Universal Health Coverage (JICA)

Note: *=Numbers in proposed roadmap (Figure 9-9)

Source: Survey Team

10.1 Technical Cooperation

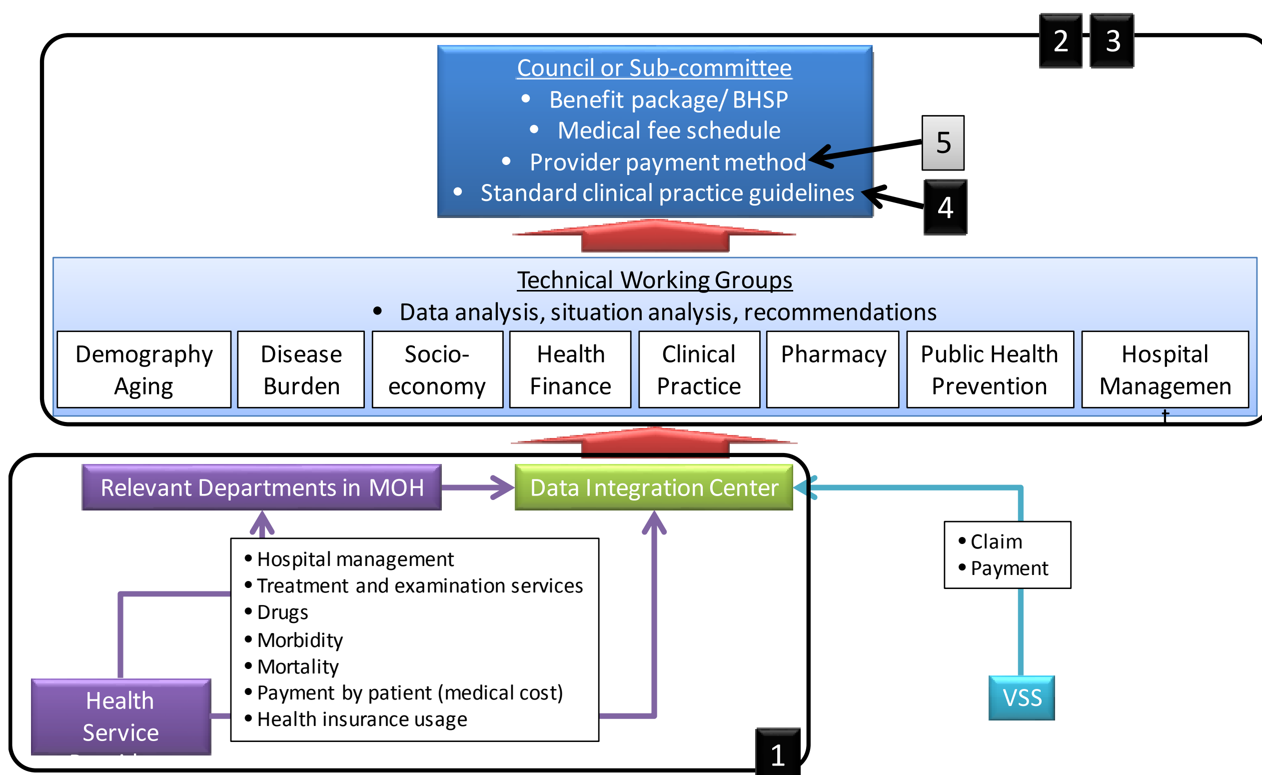
As mentioned above, five components are suggested for technical cooperation. When the draft BHSP is presented, the project may undertake a trial cycle of evidence-based review and discussions on policy guidance to optimize it. For the evidence-based review, management of provider payment and data collection should be implemented appropriately. Therefore, the project should include three factors; Benefit Package/BHSP, provider payment and evidence-based management. As shown in Figure 10-1, Component 3 will assist in the Benefit Package/BHSP development and continuous review, Components 4 and 5 may contribute in the improvement of provider payment mechanism. Component 2 may assist in strengthening evidence-based management of BHSP or benefit package and provider payment method, while Component 5 will assist to strengthen information management capacity, which is basic and essential factor for evidence-based management. Therefore, these components are mutually relevant to develop the health insurance system.



Source: Survey Team

Figure 10-1 Proposed Components for JICA's Technical Cooperation

Figure 10-2 presents the targets of each component. Components 2 to 5 need to work with a council and its technical working groups. Component 1 is for the operational level to improve quality of data.



Source: Survey Team

Figure 10-2 Targets of Each Component

10.1.1 Preconditions for Technical Cooperation Project

However, during the Survey, clear decision to establish the council has not been made. Also, clear consensus on the concept of the Benefit Package/BHSP has not been obtained among the stakeholders. Therefore, the following preconditions (Table 10-2) should be fulfilled to design the above technical cooperation project, because the suggested components will be relevant to the council and the Benefit

Package/BHSP. Even in Component 1 (information management), necessary data to manage the Benefit Package/BHSP and provider payment should be identified by the council.

In addition, because the Benefit Package/BHSP is relevant to various factors such as medical services, drugs, medical supplies, service prices, as well as financial status of hospitals and health insurance fund, cross-sectoral/inter-agency collaboration should be ensured. The Survey Team found out that collaboration between MOH and VSS seems not practically well functioning. Also, as mentioned in the Health Sector Five-Year Plan 2016-2020, relevant circulars are not consistent and coordinated with each other. It means concerned departments under MOH are not well coordinated with each other and the leadership may still be weak to make all stakeholders aim at the same direction for continuous improvement of health insurance system to respond to people's needs.

Table 10-2 Preconditions for JICA's Technical Cooperation

- Establishment of an organization for continuous improvement of the benefit package or BHSP
  - Although the decision on the National Council on Health Insurance Policy has been issued, the concrete tasks, roles, responsibilities, authorities and official recognition seem not to be defined. To develop BHSP or review the health insurance benefit package and well maintain continuously, an organization to be involved in continuously improvement of the package will be important. Therefore, the clear consensus should be announced by an official document, such as a circular.
  - If one of the sub-council will take care of it, terms of reference (TOR) including list of concerned departments or divisions and technical working group members should be prepared to start actual work.
- The Benefit Package/ BHSP
  - To issue a circular on the clear and concrete definition and objectives of BHSP, and direction/ strategy to continuous review of the benefit package/ BHSP
- Cross-sectoral/ Inter-agency collaboration
  - To ensure proactive involvement or cooperation of VSS and the Ministry of Finance
  - To ensure strong commitment of all concerned departments of MOH (Department of Planning and Finance (DPF), Department of Health Insurance (DHI), and Medical Service Administration (MSA)) and organizations in the pilot provinces (People's Committee, DOH, PSS, and health facilities)

Source: Survey Team

10.1.2 Outline of the Proposed Components

(1) Component 1: Information Management

Component 1 for information management has two sub-components. The first one aims to improve quality of data entered in daily operation (Table 10-3). Although the accuracy and timeliness of data submission is essential for evidence-based decision making, it was not well recognized among stakeholders. Through Component 1-1, firstly, concerned departments of MOH are expected to understand the importance of appropriate data management and it will be expanded to the personnel at the operational level.

Table 10-3 Component 1-1: Improvement of Data Quality at the Operational Level

<table>
<tr><th>Item</th><th colspan="3">Contents</th></tr>
<tr><td>Background</td><td colspan="3">- In general, importance of data accuracy and data management are not well recognized from central to grass roots level.
- Health service providers do not enter accurate data on examination, treatment, prescription and health insurance claim.
- Policies and regulations are not developed based on appropriate evidences.</td></tr>
<tr><td>Objectives</td><td colspan="3">- To ensure data accuracy in health facilities
- To strengthen capacity of staff in charge of data entry and management
- To develop national standard on the Hospital Information System (HIS)</td></tr>
<tr><td>Stakeholders</td><td colspan="3">- MOH (DPF (Statistics Division), MSA, IT Department)
- Hospitals (General Planning Department (GPD), nurses, and staff entering data in their daily work)</td></tr>
<tr><td rowspan="6">Activities</td><td></td><td>MOH</td><td>Hospitals</td></tr>
<tr><td>To assist in developing a roadmap and action plan to improve data quality in health facilities</td><td>○</td><td></td></tr>
<tr><td>To assist in developing criteria of human resources for data management</td><td>○</td><td></td></tr>
<tr><td>To assist in developing training program and materials on data accuracy</td><td>○</td><td>○</td></tr>
<tr><td>To assist in providing the trainings (general planning department, accounting department, etc.)</td><td>○</td><td>○</td></tr>
<tr><td>To jointly study on the current situation of HIS and identify necessary standard</td><td>○</td><td>○</td></tr>
</table>

Source: Survey Team

The second sub-component is to assist in the establishment of integrated data management system. As shown in Figure 10-2, various data relevant to medical services, payment, health status, and hospital management are to be collected and integrated to provide evidences to make appropriate decisions on health insurance system. In Component 1-2 (Table 10-4), the framework of data integration will be discussed and outlined through collaboration among stakeholders. Through this process, clear responsibility, leadership and implementing structure should be identified.

Table 10-4 Component 1-2: Capacity Development on Data Integration

Item	Contents
Background	- Necessary data to manage health insurance system are fragmented among the departments of MOH, health service providers and VSS/PSS. - Benefit package and provider payment are not managed based on appropriate policy evidences.
Objectives	- To develop data collection, management and aggregation to prepare appropriate policy evidence for the council/sub-council - To strengthen awareness and capacity of MOH officers on data management for policy evidence - To develop national standard of data management system, i.e., health management information system (HMIS), etc.
Stakeholders	- MOH (DPF (Statistics Division), MSA, IT Department) - VSS (Health Insurance Implementation Department)
Activities	a) To assist in developing a roadmap and action plan to establish a data integration center b) To assist in developing a routine data collection system and protocol for the technical working groups under the council/sub-council c) To assist in developing the training program and materials on data management d) To assist in providing a training for the data integration center staff and MOH concerned personnel e) To seek collaboration with DHIS operated by MSA f) To assist in developing national standard for data management system (PC, software, etc.) g) To jointly study the current situation of data management system, and identify necessary function and standard

Source: Survey Team

(2) Component 2: Capacity Development of the Council

Through Component 2 (Table 10-5), a council to manage health insurance system including the benefit package and provider payment mechanism, NACHIP, should be strengthened its capacity together with sub-committees. At the same time, concerned departments of MOH will strengthen necessary capacity to provide information to the council. The council will develop capacity to build consensus among various stakeholders and advocate relevant decisions based on evidences.

The above mechanism might be innovative for Viet Nam. To coordinate among various stakeholders that have different intention and interest, the secretariat should be neutral. Also, the secretariat should coordinate and compile the various evidences required to manage the health insurance system. It may need a certain work load. Considering the above, competency of the head and staff of the council should be carefully discussed.

Table 10-5 Component 2: Capacity Development of the Council to manage the Benefit Package/BHSP and Provider Payment Mechanism

Item	Contents
Background	- Health insurance benefit package and provider payment methods are not managed sufficiently.
Objectives	- To establish a cross-sectoral cooperation and coordination mechanism to manage health insurance system - To strengthen the above mechanism
Stakeholders	- MOH (DPF, DHI, MSA, Administration of Drug Management, Medical Equipment and Infrastructure Department, Administration of Preventive Medicine, etc.) - VSS (Health Insurance Implementation Department) - Ministry of Finance (MOF), Ministry of Planning and Investment (MPI) - Academic institutions
Activities	a) To assist in drafting the terms of reference (TOR) of the council and the technical working groups, including membership, mission, objectives, function, activities, etc. b) To assist in consensus building among the stakeholders such as relevant departments of MOH, VSS, health service providers, academic institutions, etc. c) To clarify roles and functions of the secretariat and establish competencies of the head and staff to be assigned to the secretariat. d) To assist in identifying necessary routine data to review the benefit package/ BHSP. e) To design the survey to collect and analyze the above data in cooperation with academic institutions. f) To assist in capacity development of the technical working groups on data analysis and interpretation, as well as situational analysis. g) To assist in capacity development of the council to make policy recommendations to decision makers.

Source: Survey Team

(3) Component 3: Continuous Improvement of Benefit Package/BHSP

Component 3 is for continuous improvement of Benefit Package/BHSP.

As shown in Table 10-6, technical working group will be formed to draft BHSP referring to available data. The methodology described in Section 9.2.5 may be referred. Because it seems to be difficult to conduct a pilot on the draft, several consultation meetings will be held to obtain inputs and opinions from stakeholders such as hospitals, patients, local governments, etc.

Table 10-6 Component 3: Continuous Improvement of Benefit Package/BHSP

Item	Contents
Background	- The current wide-range of benefit package may be critical on sustainability of health insurance fund. - The existing lists of services to be covered by the health insurance (Circular 43 and 37) are not standardized.
Objectives	- To develop a clear list of services to be covered by health insurance
Stakeholders (TWG members)	- MOH (DPF, DHI, MSA), chief doctors in the hospitals, academic personnel, Health Strategy and Policy Institute (HSPI), VSS, etc.
Activities	a) To facilitate to form the technical working group (TWG). b) To provide trainings on health insurance system and appropriate benefit package. c) To facilitate the TWG to discuss concepts and contents of the health insurance benefit package referring to HFG data. d) To assist TWG to draft the health insurance benefit package. e) Integrating the existing lists. f) Matching with the international standards such as ICD9-CM, ICHI, etc. g) To assist TWG to consult with stakeholders on the draft. h) To assist TWG to finalize the draft to be submitted to the national assembly.

Source: Survey Team

(4) Component 4: Development of Standard Clinical Practice Guidelines

Standard clinical practice guidelines to be covered by health insurance could be effective to improve quality of medical services, control oversupply, and enhance claim examination from medical viewpoints. In Component 4 (Table 10-7), the guidelines for major diseases could be developed. It could be reflected to pre-service education to expand proper understanding among health service providers.

Table 10-7 Component 4: Development of Standard Clinical Practice Guidelines

Item	Contents
Background	- Oversupply of the treatment and examination services may cause unnecessary expenses of health insurance fund and financial burden of patients. - VSS/PSS cannot control oversupply because they cannot identify unnecessary services.
Objectives	- To develop the standard clinical guidelines to be covered by health insurance fund - To improve efficiency and effectiveness of claim examination - To control oversupply to reduce financial burden of patients and health insurance fund
Stakeholders (TWG members)	- MOH (MSA, DPF, DHI), chief doctors in the hospitals, academic personnel, Health Strategy and Policy Institute (HSPI), VSS, etc.
Activities	a) To facilitation in forming the technical working group (TWG) b) To provide trainings on standard clinical practice guidelines c) To identify diseases/ symptoms to develop the standard clinical practice guidelines d) To assist in developing the guidelines e) To assist trial in some pilot hospitals to verify effectiveness on patient services, claim examination, total medical cost, OOP and payment from health insurance fund

Source: Survey Team

(5) Component 5: DRG Development

Regarding technical assistance for DRG development, MOH has been cooperating with the Thai government through participating in training and technical assistance for the pilot project. Meanwhile, Japan does not have the appropriate technical resources on development of DRG. The Survey Team would like to suggest to seek an opportunity to have another technical cooperation through a JICA project to be implemented under partnership with the Thai government.

10.1.3 Training in Japan and Third Country

(1) Training in Japan

During the study tour in Japan as an activity of 'Basic Information Survey for BHSP and Provider Payment Mechanism in Viet Nam', the Survey Team identified several training needs for the future. The study tour in Japan was conducted from 15 May to 24 May 2016 (Please refer the contents in the Chapter 1). Fourteen participants came from MOH, DOH of the two provinces and related organization such as MOF and VSS. Participants were from deputy department director to officer classes. Therefore, the level of understanding of social insurance system was different. Since the training in Japan was designed to cover all the contents such as overview of social security system including public health insurance with respective stakeholders such as the Ministry of Health, Labour and Welfare, several insurers such as Japan Health Insurance Association (kyokai kenpo), National Federation of Health Insurance Association, Health Insurance Claims Review and Reimbursement Services. Participants also visited the local government of Saku City, Nagano Prefecture, Saku Central Hospital and Kitaaiki Clinics.

All participants understood that it is not only the health insurance system has to be properly established but also proper health service mechanism has to be put in place to guarantees quality health care and easy access for the people.

For this reason, the Survey Team proposes the following training program to strengthening the Vietnamese health insurance system.

Table 10-8 Examples of Future Training in Japan

Name of Program	Contents	Target	Duration
Strengthening Capacity of Policy Making	1. Concept Setting 2. Role of bureaucrats 3. Policy Formation 4. Information Collection, etc	Director class officials (MOH, MOF)	2 weeks
Role of Central Social Insurance Medical Council	1. Function of the Secretariat 2. Importance of statistical data and proper analysis 3. Schedule setting consensus building, etc	Middle class officials (MOH)	1 week
Extension of Coverage	1. Knowing the present situation of Vietnam 2. Application 3. Collaboration of educational institutions, etc	Middle class official (VSS)	1 week
Collection of Premium	1. Collection of premium 2. Analyzing existing organization and possibility of collaboration 3. Training of community health workers, etc	Middle class official (VSS, PSS, DOH)	1 week
Concept of DPC	1. Concept of DPC 2. Formulation of DPC 3. Conducting pilots with medical institutions 4. Modification of contents through the information provided by pilot medical institutions, etc.	Middle class officials (MOH, medical universities)	2 weeks

Source: Survey Team

(2) Training in Third Country

Given the situation of the ASEAN countries, namely: Thailand, Indonesia, the Philippines, Cambodia, Lao PDR, and Malaysia, were considered, and only Thailand can be considered as reference for the Vietnamese health insurance system in terms of level of coverage (UHC), medical fee payment system (Capitation,

Fee-for-Service, DRG), methodology of coverage for informal sectors, and function of service providers and budget arrangement, In addition, medical cost of the elderly is a future challenge for the health insurance system in Vietnam, a project by JICA called the Project of Long-Term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP) is worthy to visit and understand the concept and operation of the project.

For this reason, the training in third country is recommended to be conducted in Thailand with the following subjects:

- Extension of coverage to informal sector (budget allocation, involvement of local government and service providers, defining medical service package and negative list);
- Preparing for the aging and aged society and examining the possibility of care service for the elderly under health insurance or necessity of separate system;
- Collection of data for policy design and function of research institutes;
- Collection of premium (actions and challenges) by SSO;
- Method of controlling the quality health care;
- Development of DRG (need to examine whether it is applicable for Vietnam); and
- Joint training with CAP-UHC in Thailand.

Trainings could be arranged with National Health Security Office (NHSO), Social Security Office (SSO) and the Ministry of Public Health of Thailand.

10.2 Development Policy Loan

To respond to the Health Sector Five-Year Plan 2016-2020 mentioning a shift from project loan to budget support loan, a development policy loan (DPL) might be suggested. JICA has provided it to Kenya for strengthening the health insurance system, especially to support the poor. Although the possible scope has not been identified, DPL might exert the effort to further develop the health insurance system and achieve universal health coverage (UHC).

DPL is to be disbursed in accordance with the achievements of policy development actions defined in a policy matrix. The draft policy matrix is suggested as shown in Table 10-9 based on the results of the Survey and the following criteria:

- The actions are essential or important to:
  - Draw an overall picture of health insurance system as part of national health financing strategy;
  - Ensure financial resources to achieve UHC;
  - Present clear and simple benefit package and medical fee schedule for all stakeholders;
  - Control overuses of unnecessary high-cost medical services;
  - Make decision based on reliable evidences; and
  - Improve overcrowding in the central/provincial hospitals.
- Progress of the actions could be monitored and controlled by MOH.

The actions on health insurance are relevant to other important stakeholders such as MOF and VSS.

Table 10-9 Proposed Draft Policy Matrix

Category	Expected Impact	First Tranche (Sep. 2017)	Second Tranche (Sep. 2019)	Monitoring Indicators			Responsibility
				Baseline	Target	Source of verification	
Policy	Whole picture of health financing including health insurance system is established.	Health financing strategy is developed.		draft	Jul. 2017	An approved strategy	MOH-DPF, MOF
		Mid-term plan and action plan on health financing are developed.		n.a.	Sep. 2017	An approved plan	MOH-DPF
			Financial simulation of health care expenditure and the health insurance fund are reported to the stakeholders.	n.a.	Sep. 2019	An approved report on the financial simulation	MOH-DPF, VSS
Financing	Financial resources for UHC are ensured.	New tax revenue from tobacco and alcohol are allocated for financial protection for the vulnerable people.		n.a.	Sep. 2017	Financial report of MOH	MOH-DPF MOF
Management of benefit package, medical fee schedule and provider payment method	The benefit package of health insurance is optimized.	A council/sub-council commenced its activity to develop and manage the benefit package and medical fee schedule.		Decision of establishment	Jul. 2017	Minutes of meetings	MOH-DHI
		Technical working group to develop/review the benefit package/BHSP is established.		n.a.	Mar. 2017	An approved TOR, work plan and minutes of meeting	MOH-DHI
	Appropriate provider payment methods are applied.	Outputs and lessons learned of pilot projects on provider payment method (capitation and DRG) are integrated and analyzed.		fragmented pilots	Sep. 2019	A report on the analysis	MOH-DPF
	Evidence-based decision making is made on the benefit package/BHSP and medical fee schedule.		The council/sub-council or the technical working group identifies necessary data for management of benefit package and medical fee schedule.	n.a.	Sep. 2017	A list of necessary data	MOH-DHI
Benefit package and medical fee schedule	A comprehensive benefit package of the health insurance is developed.	Lists of medical examination and treatment, drugs and medical materials to be provided in each level of health facility are integrated into one benefit package.		fragmented lists	Sep. 2017	An integrated list of medical services, drugs, medical materials (benefit package)	MOH-MSA MOH-DPF

Category	Expected Impact	First Tranche (Sep. 2017)	Second Tranche (Sep. 2019)	Monitoring Indicators			Responsibility
				Baseline	Target	Source of verification	
			Medical fee schedule is integrated into the benefit package or BHSP		Sep. 2019	A benefit package with medical fee schedule	MOH-DPF
			Draft circular on BHSP or revised benefit package to be paid by health insurance fund is developed.	n.a.	Sep. 2019	A draft circular on BSHP or revised benefit package	MOH-DPF
	Overuse of high-cost services is controlled.	Legal documents on criteria of high-cost/ advanced medical services to be covered by health insurance are developed.		n.a.	Sep. 2017	Approved criteria of high-cost/ advanced medical services to be covered by health insurance	MOH-DPF
			Legal documents on standard clinical practice guidelines for major diseases to be covered by the health insurance fund are developed.	n.a.	Sep. 2019	Approved guidelines of major diseases	MOH-MSA
Information management	Necessary standards are developed to apply IT to health insurance claim and examination.	Standards of information management for health insurance: master code and claim format are improved.		existing codes and formats	Dec. 2017	Revised mater code and claim format	MOH-DHI
			Standards of information management for health insurance: claim examination rule are developed.	existing rules	Sep. 2019	Revised claim examination rule	MOH-DHI, VSS
	Accurate data is submitted in timely manner.	A manual to enter accurate data in timely manner for accounting, claiming and clinical staff are developed.		n.a.	Dec. 2017	The manual	MOH-DHI
	Stakeholders utilize data to make decision and develop action plan.		Mechanism for integration of necessary data for management of health insurance system is developed.	n.a.	Sep. 2019	Legal document on establishment of a health insurance data integration center	MOH-DHI, VSS

Category	Expected Impact	First Tranche (Sep. 2017)	Second Tranche (Sep. 2019)	Monitoring Indicators			Responsibility
				Baseline	Target	Source of verification	
Service delivery	Referral system is strengthened.	A legal document on gate-keeping function of CHSs or family doctor is developed.		n.a.	Sep. 2017	An approved circular on gate-keeping function	MOH-MSA

Source: Survey Team

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APPENDICES

Appendix 1: Itinerary and Photos of Field Survey
Appendix 2: Program and Record of the First Workshop
Appendix 3: Program, Participants and Photos of Study Tour in Japan
Appendix 4: Summary of the Amendment of Health Insurance Law

Appendix 1: Itinerary and Photos of Field Survey

Itinerary of Field Survey
(1) First Field Survey

Date			Itinerary	
Nov	25	Wed	Arrived inHanoi (Nagai, Nishimagi)	
			Ministry of Health (MOH) – Department of Planning and Finance (DPF): Dr. Tham Chi Dung	
	26	Thu	JICA Viet Nam Office, Ms. Sadamoto, Ms. Hoa	
			Arrived inHanoi (Arima), Nippon Koei Viet Nam	
	27	Fri	NTT Data Vietnam	
	28	Sat	Reporting	
	29	Sun	Arrived inHanoi (Sasada, Sato), Team Meeting	
	30	Mon	USAID-Health Finance and Governance Project (HFG) (Abt Associates) Diu Nguyen, MPH, Communication and M&E Program Officer, Health Finance & Governance Project	
Dec	01	Tue	Pre-meeting for the workshop on social insurance database, the World Bank	
			MOH - Department of Health Insurance (DHI): Dr. Tong Thi Song Huong – Director	
	02	Wed	Team meeting	
	03	Thu	LuxDev (the Luxembourg Agency for Development Cooperation) Mr. Raja Chowdhry, Senior Technical Advisor and Ms. Yen Pham	
	04	Fri	Hanoi Economic University (IPPM): Prof. Giang Thanh Long	
			DPF, Dr.Dung	
			LuxDev: PIC for performance based financing	
			Health Strategy Policy Institute (HSPI): Dr. Oanh- Director	
	05	Sat	Reporting	
	06	Sun	Team Meeting	
	07	Mon	WHO, Dr. Ngyen Kim Phuong, National Professional Officer, Health Financing	
	08	Tue	Leave for Japan (Nagai)	
			MOH – Administration of Health Information Technology Mr. Pham Xuan Viet, PhD – Deputy Director	
	09	Wed	Vietnam Social Security (VSS) –Department of International Cooperation -Board of health insurance policies -Department of collection -IT Center -Multi-line payment center north	
			VNPT Mr. Nguyen Quoc Cuong, Director, Information Technology and Value Added Services Department	
	10	Thu	Vietnam Academy of Social Sciences (VASS) Dr Tran Thi Minh Thi, Deputy Director, Research Institute for Family and Gender	
	11	Fri	FPT Information System: Ms. Mai Do Thi Ngoc, Director of Business Assurance Center	
			The World Bank: Ms. Nga Nguyet Nguyen	
	12	Sat	Reporting	
	13	Sun	Leave for Gia Lai (Sasada, Sato, Arima)	
			Arrive in Hanoi (Nagai)	
	14	Mon	Reporting	Gia Lai (Sasada, Sato, Arima)
	15	Tue	Reporting	
	16	Wed	Hoa Binh (Nagai, Onishi, Nishimagi)	
	17	Thu		Arrive in Hanoi (Sasada, Sato, Arima)
	18	Fri		The World Bank: Dr. Dao Lan Huong
	19	Sat	Reporting	
	20	Sun	Reporting	
	21	Mon	DPF, Dr. Dung	

Date			Itinerary
			JICA Viet Nam Office
	22	Tue	WHO: Dr. Socorro Escalante / Ms. Nguen Thi Kim Phuong
			Preparation Meeting for NHC Workshop
	23	Wed	Reporting
	24	Thu	Leave for Japan (Sasada)
			BAOVIET INSURANCE CORPORATION Mr. Do Hoang Phuong, Health and PA Division
	25	Fri	Preparation Meeting on National Council for Health Insurance Policy, MOH
	26	Sat	Leave for Japan (Sato, Arima and Nishimagi)
	27	Sun	Reporting
	28	Mon	Leave for Japan (Nagai, Onishi)

(2) Second Field Survey

Date			Itinerary	
Jan	30	Sat	Arrive in Hanoi (Onishi, Uehara)	
	31	Sun	Team Meeting	
Feb	01	Mon	JICA Viet Nam: Ms. Sadamoto, Ms. Hoa	
	02	Tue	DPF, Dr. Dung HFG, Mr. Nazzareno Todini, Chief of Party, Health Finance & Governance Project	
	03	Wed	HSPI: Dr. Oanh- Director	
			Leave for Bangkok, Thailand (Onishi)	
	04	Thu	National Health Security Office, Thailand	
	05	Fri	Social Security Office, Thailand	
	06	Sat	Leave for Tokyo (Onishi)	
			Move to another JICA project from Feb 7 (Uehara)	
	16	Tue	Arrive in Hanoi (Arima)	
	17	Wed	Arrivel in Hanoi (Onishi, Nishimagi)	
	18	Thu	DPF, Dr. Dung	
	19	Fri	MOH-Department of International Cooperation: Mr. Do Dang An	
	20	Sat	Reporting	
	21	Sun	Arrive in Hanoi (Nagai, Sato)	
	22	Mon	Arrive in Hanoi (Uehara)	
			JICA Viet Nam Office	
	23	Tue	Hanoi Medical University-Department of Health Economics: Dr. Pham Huy Tuan Kiet	
			DPF	
	24	Wed	Reporting	
	25	Thu	DPF, Dr. Dung	
	26	Fri	Health Finance Technical Group Meeting, MOH	
	27	Sat	Reporting	
	28	Sun	Reporting	
	29	Mon	DPF, Health Statistics Division, Ms. Hang	
			JICA Viet Nam	
Mar	1	Tue	The First Workshop	
			Arrive in Hanoi (Sasada)	
	2	Wed	Leave for Japan (Arima)	
			Leave for Binh Dinh province (Nagai, Sato, Nishimagi)	
			Leave for Japan (Uehara)	
			Vietnam Health Economics Association	
			HSPI -Capitation Pilot	
	3	Thu	Leave for Japan (Onishi)	Binh Dinh (Nagai, Sato, Nishimagi)
			EU-Health Facility Program (HF)	
	4	Fri	Reporting	
	5	Sat	Team Meeting	

Date			Itinerary
			Arrive in Hanoi (Arima)
	6	Sun	Leave for Japan (Sasada)
			Arrive in Hanoi (Onishi)
	7	Mon	VSS: Department of Health Insurance Policy Implementation/ Department of International Cooperation
			VSS: IT Center
	8	Tue	WHO
			Leave for Dong Thap Province (Onishi, Arima, Nishimagi)
	9	Wed	Leave for Japan (Nagai)
			Dong Thap (Onishi, Arima, Nishimagi)
	10	Thu	
	11	Fri	
	12	Sat	Arrive in Hanoi (Onishi, Arima, Nishimagi)
	13	Sun	Leave for Japan (Onishi)
	14	Mon	Arrive in Hanoi (Nagai)
			Meeting "Survey and development of statistic and automatic review system for the pilot project of DRG payment method by Ministry of Economy, Trade and Industry (METI)"
	15	Tue	Consultation Workshop on Health Financing TWG (Nagai, Sato)
	16	Wed	Reporting
	17	Thu	MOH-Medical Service Administration (MSA), Dr. Son
	18	Fri	DHI, Ms. Nu Anh
	19	Sat	Reporting
	20	Sun	Reporting
	21	Mon	Reporting
	22	Tue	DPF: Dr. Cong, Dr. Anh, Dr. Dung
			JICA Viet Nam Office
	23	Wed	Leave for Japan (Nagai, Sato)
	24	Thu	Reporting
	25	Fri	Leave for Japan (Nishimagi)
	26	Sat	Reporting
	27	Sun	Reporting
	28	Mon	Arrive in Hanoi (Onishi)
	29	Tue	Leave for Binh Dinh (Onishi, Arima)
	30	Wed	Binh Dinh: PSS, DSS, Hospitals
	31	Thu	Binh Dinh: PSS, DSS, Hospitals
Apr	1	Fri	Leave for Japan (Onishi, Arima)

(3) Third Field Survey

Date			Itinerary
Apr	19	Tue	Arrive in Hanoi (Arima)
	20	Wed	Arrive in Hanoi (Nagai, Sato)
	21	Thu	BHSP Workshop
	22	Fri	BHSP Workshop
			DPF
	23	Sat	Arrive in Hanoi (Onishi, Nishimagi)
	24	Sun	Team Meeting
	25	Mon	Reporting
	26	Tue	Leave for Tokyo (Nagai, Sato, Arima)
	27	Wed	Leave for Tokyo (Nishimagi)
	28	Thu	Reporting
	29	Fri	Hanoi Economic University (IPPM): Prof. Giang Thanh Long
	30	Sat	Leave for Tokyo (Onishi)

(4) Fourth Field Survey

Date			Itinerary
May	29	Sun	Arrive in Hanoi (Onishi, Sato, Nishimagi)
	30	Mon	Binh Dinh (Onishi, Sato, Nishimagi)
	31	Tue	
Jun	1	Wed	Arrive in Hanoi (Nagai)
	2	Thu	Arrive in Hanoi (Arima)
	3	Fri	NTT Data Vietnam
	4	Sat	Team Meeting
	5	Sun	Reporting
	6	Mon	VSS
	7	Tue	DPF
			Bach Mai Hospital
			Meeting with Vice- Minister
	8	Wed	JICA Vietnam Office
	9	Thu	Reporting
	10	Fri	Leave for Tokyo (Nagai, Onishi, Sato, Arima, Nishimagi)

(5) Fifth Field Survey

Date			Itinerary
Aug	29	Mon	Arrive in Hanoi (Nagai, Onishi, Sato), JICA Viet Nam
	30	Tue	WHO
	31	Wed	Workshop on National Council for Health Insurance Policy, MOH
Sep	1	Thu	HSPI
	2	Fri	DPF, DHI
	3	Sat	Leave for Tokyo (Nagai)
	4	Sun	Reporting
	5	Mon	DPF, DHI
	6	Tue	DHI
	7	Wed	DPF, DHI
	8	Thu	DPF, DHI
	9	Fri	DHI (Director)
	10	Sat	Leave for Tokyo (Sato)
	11	Sun	Reporting
	12	Mon	Reporting
	13	Tue	DHI
	14	Wed	DHI
	15	Thu	DHI
	16	Fri	Workshop on Capitaion (DPF & EU)
	17	Sat	Reporting
	18	Sun	Reporting
	19	Mon	Reporting
	20	Tue	EU EPOS Project, DPF
	21	Wed	DHI
	22	Thu	DHI, Leave for Tokyo (Onishi)
Oct	17	Mon	Arrive at Hanoi (Onishi)
	18	Tue	Arrive at Hanoi (Sato)
	19	Wed	DPF
	20	Thu	DHI, JICA Viet Nam Office
	21	Fri	DPF, DHI
	22	Sat	Leave for Tokyo (Sato)
	23	Sun	Reporgting
	24	Mon	DPF, DHI

Date			Itinerary
	25	Tue	DPF, DHI
	26	Wed	DPF, DHI
	27	Thu	DPF, DHI
	28	Fri	DPF, DHI
	29	Sat	Leave for Tokyo (Onishi)
	30	Sun	
	31	Mon	Arrive at Hanoi (Nagai), JICA Viet Nam
Nov.	1	Tue	Workshop on Preliminary Results of Actuarial Analysis for BHSP, MOH-HFG
	2	Wed	VSS
	3	Thu	Leave for Tokyo
Dec.	21	Wed	Arrive at Hanoi (Onishi)
	22	Thu	DPF
	23	Fri	DPF, DHI
	24	Sat	Reporting
	25	Sun	Reporting
	26	Mon	DHI
	27	Tue	JICA Senior Advisor for MOH, Leave for Tokyo (Onishi)
Feb.	6	Mon	Arrive in Hanoi (Onishi)
	7	Tue	DPF
	8	Wed	Informal Donor Meeting
	9	Thu	DHI, WHO
	10	Fri	EU, World Bank
	11	Sat	Reporting
	12	Sun	Reporting
	13	Mon	HSPI
	14	Tue	EU-HF, DHI, DPF
	15	Wed	VSS
	16	Thu	Arrive in Hanoi (Nagai), DHI and VSS, Health Insurance Policy Implementation Dept.
	17	Fri	Leave for Tokyo (Onishi)
	18	Sat	Reporting
	19	Sun	Reporting
	20	Mon	HSPI
	21	Tue	Leave for Tokyo (Nagai)

Photos of Field Survey

Interview with DOH in Hoa Binh

Interview with Provincial Hospital in Hoa Binh

Provincial Hospital in Gia Lai

Preparation Meeting on National Council for Health Insurance Policy, MOH

Interview with National Health Security Office in Thailand

Interview with Social Security Office in Thailand

Workshop1 in Hanoi in March 1, 2016
– Opening Speech by MOH

Workshop 1 in Hanoi on 1 March, 2016
– Presentation by JICA Survey Team

Interview with Provincial People's Committee
in Binh Dinh

District Hospital in Binh Dinh

Interview with DOH in Dong Thap

Interview with ProvincialHospital in Dong Thap

Interview with Provincial Hospital,
Binh Dinh Province

An Nhon District Social Security,
Binh Dinh Province

Interview with Bach Mai Hospital

Meeting with DPF, MOH

Meeting with Vice-Minister, MOH

Meeting with Vice-Minister, MOH

Appendix 2: Program and Record of the First Workshop

Date: 8:30-13:30, March 1st, 2016

Venue: Pullman Hotel, Hanoi

Chaired by: Dr. Pham Le Tuan, Vice Minister, MOH
Mr. Nguyen Minh Thao, Deputy General Director, VSS
Mr. Chikahiro Masuda, Senior Representative, JICA Vietnam

Objectives:

1. To present preliminary results and findings of the Survey
2. To provide outlines of Japanese medical insurance and medical fee payment system, and the function of Central Social Insurance Medical Council which could be useful for Viet Nam to consider the National Council for Health Insurance Policy

1. Opening Remarks

1) Dr. Pham Le Tuan, Vice Minister, MOH

The Resolution No.68/2013/QH13 and Law No/46/2014/QH13 of the National Assembly, specified requirements to increase the coverage of health insurance, to take measures to ensure the quality of medical services, to ensure the sustainability of health insurance fund and to reduce out-of pocket payments. In accordance with them, MOH and stakeholders are to develop and issue a circular on basic health service package (BHSP) covered by the health insurance by 2018. MOH has been implementing activities for developing BHSP in close collaboration with relevant stakeholders such as Luxembourg Agency for Development Cooperation and HFG-USAID. As for payment mechanism, we have promoted activities to strengthen data collection, which is necessary for establishing BHSP and proper payment mechanism. MOH has worked closely with VSS and stakeholders, and tried different payment methods such as capitation and DRG. We are pleased to work with JICA for developing BHSP and provider payment method for achieving UHC in Vietnam.

2) Mr. Nguyen Minh Thao, Deputy General Director, VSS

Development of BHSP is in accordance with social policies to be implemented by 2020, which articulated in Resolution No.15-NQ-TW. The amendment of the Health Insurance Law also articulated the development of BHSP. In developing BHSP, the following points need to be considered; 1) scope of BHSP (e.g who is covered? which services? How much is covered? What are the “basic services”?), 2) the service providing capacity of health facilities, 3) distribution of budget to each level, 4) provider payment mechanism, 5) examination of high-frequency technical service.

3) Mr. Chikahiro Masuda, Senior Representative, JICA Vietnam

I would like to express our sincere thanks to Dr. Pham Le Tuan, Vice Minister, MOH and Mr. Nguyen Minh Thao, Deputy General Director, VSS and stakeholders attending this workshop. JICA has been providing comprehensive support to health system in Vietnam over 20 years particularly to three top referral hospitals. We are currently extending our further cooperation to provincial hospitals. Health financing is a new area for JICA cooperation and we started the basic information survey. The purpose of the survey is to collect a wide range of information of the current situation regarding BHSP and provider payment mechanism. We

will analyze and utilize the collected information for our future cooperation of strengthening and management of BHSP and provider payment mechanism. In this workshop, our consulting team will share the preliminary findings with recommendation and Dr. Tanimura from Ministry of Health, Labour and Welfare (MHLW) will introduce the Japanese medical insurance system and function of Central Social Medical Insurance Council. Needless to say, Japanese system is different from yours, but experience of Japan for more than 50 years of UHC and lessons learned will be useful for health care system in Vietnam. Let me take this opportunity to express our sincere gratitude to Vice Minister Dr. Pham Le Tuan, colleagues of MOH especially DPF and all participants for your kind support for the survey team.

2. Presentation

1) Outline of the Survey and Preliminary Findings, by Ms. Keiko Nagai, Leader of JICA Survey Team
2) Japanese Medical Insurance and Medical Fee Payment System, and the Function of Central Social Insurance Medical Council, by Mr. Hironari Onishi, JICA Survey Team
3) Basic Concept of Medical Fee Schedule and its Policy Use, by Dr. Tadayuki Tanimura, Ministry of Health, Labour and Welfare, Japan

3. Discussion

- HFG－USAID
  - Balance of Health Insurance Fund (2016 estimates): Need to clarify “expenditure will be higher than revenue”.
    ⇒Please give source of reference. (VSS)
    ⇒Survey team used the information from web site of VSS. (Ms. Nagai)

  - OOP: Better to check the latest National Health Account to get the latest figure.
    ⇒OOP is gradually decreasing from 48% to 43% (2014)(VSS).
- VSS
  - Medical fee schedule in Japan: Want to know there is any difference in medical fee between the elderly population and other groups.
    ⇒There is no difference. But copayment rate is different according to each category.
    Copayment for people under 6 depends on each local government. Some local government pay for copayment amount for children and their medical fee is free of charge.
- World Bank
  - OOP: According to MOH in Joint Annual Health Review, OOP is in the declining trend and has gone back up towards 50%. It is not productive to discuss on this particular issue as it is an estimated figure. In fact, patients often need to pay drag cost which is not covered by public health insurance.
  - Need to redefine BHSP, which can contribute to improving UHC in Vietnam. BHSP needs to be elaborated for example based on policy priority and can be developed to improve the balance of Health Insurance Fund. It also needs more clarity in terms of the benefit of the health insurance that people have more confidence about what health services are paid for by analyzing additional costs (e.g. copayment rate is not only thing people has to spend).

- Need to be sure that services of BHSP are in line with the health needs of grass-roots level and change of disease trend. HSPI is going to take this angle in their recommendation for BHSP, which is very much in line with MOH strategy.
- List of health services (currently 17,000 different services) needs to be simplified by ensuring they are according to ICD or procedure classification system. It needs to avoid duplication and make it understandable to providers what is included and not included.
- Challenge of UHC in Vietnam based on MOH priority: it is better to take account of the existing research and recommendation (e.g. HSPI, HFG's work). Those will direct the technical assistance of JICA.

➢ HSPI
  - The survey team takes comprehensive approach on BHSP. As MOH is responsible for developing BHSP by 2018, and we need to have specific assessment from Japanese side on service provider and clarify what is necessary or unnecessary in BHSP based on the Japanese experiences.
  - Regarding medical fee, we would like to learn about the system in Japan in order to control the cost effectively. We cannot change from fee-for-service to capitation, DRG immediately. We would like to have recommendation to identify reasonable and acceptable payment system for health providers based on Japanese experiences. We also would like to know how to utilize data of VSS.

➢ EU
  - "Paradigm shift" will be required for health financing system in Vietnam. Currently, primarily focus is on treatment. But, it needs more focus on prevention and promotion in order to reduce morbidity. Most of leading causes for morbidity and mortality in Vietnam (e.g. communicable diseases, respiratory diseases, digestive diseases) are preventable. Financial resource can be saved for treatment if fund is allocated to prevention. Therefore, BHSP should include prevention activities.
  - It also needs to think about increasing contribution rate and increasing collection in informal sector. In another emerging countries which GDP is same as Vietnam, the average contribution rate is around 10%. About 40 – 45% of companies which belong to informal sector usually doesn't pay contribution.
  - In general, in developing BHSP, it needs 1) to focus on prevention and promotion, 2) to develop standards to focus on quality and accreditation in health care services, 3) to strengthen ICT for administration and management, 4) to consider provider payment mechanism. All these issues are supposed to be looked together in terms of provider payment mechanism by taking account of compatibility of each method.

➢ DPF-MOH
  - DPF has provided valuable information for the survey team since the survey started. We are focusing on BHSP, which could be part of the process toward UHC, and improvement of provider payment mechanism. We would like to confirm the direction of JICA's cooperation (UHC or BHSP?).
  - As for BHSP, I suggest that JICA use the data LuxDev and HFG have already collected in order to avoid duplication.

- Other countries establish BHSP from the criteria including access, infrastructure, quality of service, efficiency, affordability. In developing BHSP in Vietnam, we would like to have JICA's opinion whether the criteria can be applied to Vietnam.
- Detailed explanations on provider payment mechanism in Vietnam will be required and we would like to know how JICA will support the provider payment mechanism. For IT system, we have already foundation that Viettel and FPT supported, and we need software supporting payment operation. It is expected that JICA will support IT system to improve provider payment mechanism and avoid overlap with other support.

➢ DOHI-MOH
- In order to understand the high OOP, more detailed research will be required (e.g. how much OOP costs are borne by insured people).
- We would like to have further information about the role and function of Central Social Insurance Medical Council of Japan. How the council formulate consensus on medical fee schedule which is uniform in whole country. And I would like to know the intervention procedure to each stakeholder.
- Want to clarify how "free-access" functions in Japan. Patients can go/be transferred to any hospitals?

➢ Luxembourg Agency for Development Cooperation
- Appreciate JICA for organizing meeting and sharing the results of the survey. This is learning survey for the team and it showed JICA would like to join the support BHSP development.
- The comments from World Bank reminded me of the observation in its report in 2014("Moving toward Universal Coverage of Social Insurance in Vietnam"). We have to move away from learning process. All the data and documents concerning 17,000 services should be sent to JICA and lots of resources including discussions and consultations among MOH, international organization and other relevant agencies would provide more insights.

➢ VSS
- Controlling drug costs is very important issue in Vietnam. We would like to know the policy incentive to encourage generic drug in Japan.
  ⇒Dr. Tanimura from MHLW explained about Diagnostic Procedure Combination (DPC) system in Japan, which is similar to the DRG and linked with a reimbursement system for acute care hospitals. DPC has indicators (e.g. diseases, treatment) for basic fees and additional points are also calculated which depend on how hospital contributes to local health care services. Additional points include several indicators to rate hospital's initiative for local health care and use rate of generic drugs is incorporated into indicators. Hospitals with high use rate of generic drugs can receive additional points on DPC prices, which become new incentive for hospitals.

7. Closing Remarks

➢ Mr. Masuda, JICA

We were pleased to see many people gathered here today and to have active discussion, comments and recommendations, which are very useful for considering our further cooperation.

I found three points to be highlighted in this workshop; 1) BHSP should be considered under overall umbrella of health system, especially health financing strategy. BHSP is not single solution to solve all

problems in health system, 2) there are many actors in health financing in Vietnam including MOH and its relevant departments, VSS, MOF, hospitals, relevant organizations and partners. Full cooperation among stakeholders is important. Sharing of accurate data is also indispensable, 3) we need consensus on what is BHSP. It is right time to establish appropriate system for the health insurance considering emerging issues such as the change of demography.

Hope today's workshop is valuable to everyone and I am very happy to continuously discuss on establishment of BHSP. Thank you very much.

- Dr.Tuan, MOH

We would like to express our sincere appreciation to JICA and the survey team for sharing the preliminary findings and recommendation. We also thank all the participants for comments and discussions, which would be valuable inputs for developing BHSP.

BHSP should be in line with UHC. We need to consider how BHSP can contribute to achieving UHC and how to solve the weak points the survey team pointed out. Inter-sectoral coordination and support from donors are very important for UHC in Vietnam. Clear concept for BHSP is also required. We need to minimize 17,000 technical service lists in accordance with ICD9-CM.

MOH need to finalize BHSP by the end of 2017, and we would like to take account of relevant Japanese policy and system, which can be applied to Vietnam.

Again, we would like to express our gratitude to all of you.

End

Attendance List

No.	Full name	Organization
1	Pham Le Tuan	MOH
2	Nguyen Minh Thao	VSS
3	Le Thanh Cong	DPF - MOH
4	Duong Duc Thien	DPF - MOH
5	Cao Ngoc Anh	DPF - MOH
6	Tham Thi Dung	DPF - MOH
7	Dang Trung Ha	DPF - MOH
8	Nguyen Nam Khanh	DPF - MOH
9	Le Nguyen Bang	IT Dept. MOH
10	Nguyen Duc Thang	MSA
11	Luong Bao Khanh	MSA
12	Tran Thi Dieu Trinh	IT Dept. MOH
13	Nguyen Nhien	MOH Office
14	Nguyen Sao Mai	MOH Office
15	Luu Thi Lien	Hanoi DOH
16	Vu Thi Sinh	Finance Dept. Hanoi DOH
17	Nguyen Thi Thu Hien	Hoa Binh DOH
18	Le Van Kham	VSS
19	Vu Ha Thu	VSS
20	Nguyen Thi Hai Nhu	VSS
21	Dang thi Hue	VSS
22	Doan Tuong Van	IC Dept. VSS
23	Nguyen Phuc Khoat	PSS Vietnam
24	Le Cong Minh Duc	PSS Vietnam
25	Nguyen Thi Hong Van	PSS Vietnam
26	Ngo Thu Ha	PSS Vietnam
27	Pham Minh Thanh	Social Science Dept. - PSS VN
28	Tran Thi Hong Van	HN VSS
29	Nguyen Ngoc Son	Hoa Binh VSS
30	Doan Duc Thang	Hoa Binh VSS
31	Nguyen Khanh Phuong	HSPI
32	Hoang Thu Thuy	HSPI - MOH
33	Vu Duc Long	VAAC
34	Do Thi Nhan	VAAC
35	Duong Thuy Anh	VAAC
36	Dejan Ostojic	EU Health Facility
37	Nguyen Thuy Huong	EU Health Facility
38	Kari Hurt	WB

No.	Full name	Organization
39	Dam Duy Lam	HFG pjt
40	Naz Todini	HFG pjt
41	Raja Chowdhry	LuxDev
42	Dinh Thanh Hang	ADB Consultant
43	Pham Thi Yen	VIE/27 pjt
44	Yoko Tsuruya	Embassy of Japan
45	Doi Masahiko	NCGHM
46	Tadayuki Tanimura	MHLW Japan
47	Chikahiro Masuda	JICA Viet Nam
48	Hirotsun Aiga	JICA HQ
49	Emiko Nishikawa	JICA HQ
50	Nguyen Hai Van	NTT Data
51	Dao Thanh Hai	Economy Times
52	Do Kha Thoa	Vietnam Communist Party Newspaper
53	Nguyen Mai Hoan	People TV
54	Nguyen Ngoc Tuan	People TV
55	Phan Thanh Quy	People Newspaper
56	Luong Ngoc Thao	VSS newspaper
57	Kieu Mai Phuong	
58	Duong Duc Thien	

Basic Information Survey for BHSP and Provider Payment Mechanism in Viet Nam

Outline of the Survey and Preliminary Findings

01 March 2016, Hanoi, Viet Nam

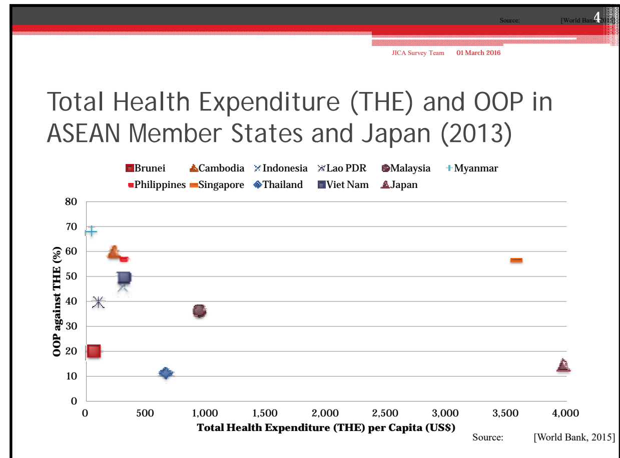
Japan International Cooperation Agency (JICA)
KRI International Corp.

Contents

1. Background
2. Objectives
3. Methodology
4. Preliminary Findings
5. Preliminary Recommendations
6. The Way Forward

1. Background of the Survey

Total Health Expenditure (THE) and OOP in ASEAN Member States and Japan (2013)

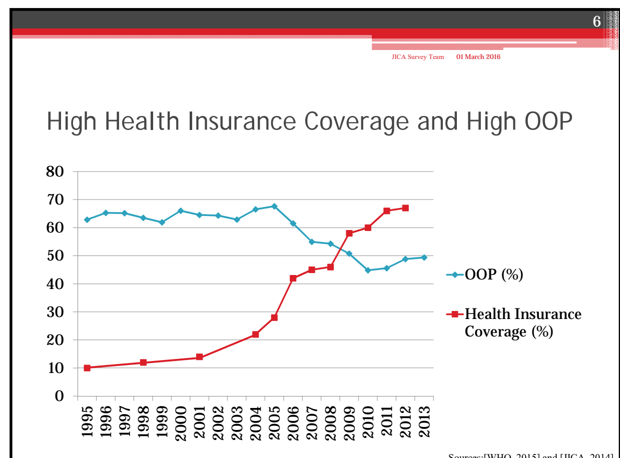


Source: [World Bank, 2015]

Health Insurance in Other ASEAN Countries

Country	Viet Nam	Thailand	Philippines	Indonesia
Population	87million	65.5million	94million	250million
Public Service	a) Social Health Insurance (SHI) b) Contributions c) 2.3million	a) Civil Servant Medical Benefit Scheme (CSMBS) b) No contributions c) 5.9million	a) PhilHealth - Employee program b) Contributions c) 5.94million	a) National Health Insurance (JKN) b) Contributions (Government contributions for the poor) c) 152million *To be applied for all the nationals by 1 January 2019.
Formal Sector	a) SHI b) Contributions c) 6.6million	a) Social Security Service (SSS) b) Contributions c) 9million	a) PhilHealth- Employee program b) Contributions c) 17.79million	
Informal Sector	a) SHI b) Contributions c) 46million	a) Universal Coverage (UC) b) No contributions c) 47million a) Voluntary SSS b) Contributions c) 1.65million	a) PhilHealth – program for the poor b) No contributions c) 38.94million	
Coverage	63.71%	Nearly 100%	82%	n.a.
Service providing system	Public	Public	Private	Public
OOP/THE	49.41%	11.27%	56.67%	45.81%

High Health Insurance Coverage and High OOP



Sources:[WHO, 2015] and [JICA, 2014]

The insured includes subscribers and non-subscribers.

Challenges for UHC in Viet Nam

Demand Side	Supply Side
• High Out-of-Pocket (OOP) expenses • The informal sector, who is difficult to be identified and to be covered by health insurance, accounts for 80% of the population • Low utilization of services by the insured	• Low quality of public health services • Referral system does not work well • Too broad benefit package • Payment mechanism induces over-supply • Number of registered facilities is limited

2. Objectives of the Survey

Objectives (Modified)

1. **To sort out the preconditions of the technical cooperation project**
   - To draw the needs for technical cooperation on develo0pment and management of BHSP and any other factors to contribute to UHC in Viet Nam.
   - To study cooperation resources both in Japan and other Association of Southeast Asian Nations (ASEAN) member states.
2. **To make recommendations to enhance BHSP development, planning of the pilot project, and other necessary management mechanism for health insurance system**
   - To collect information on the latest situation of BHSP drafting, concept, implementation plan of the pilot, availability of necessary data for further data analysis, and other relevant factors to management of the benefit package and medical fees.
   - To make recommendations based on the above situation analysis.
3. **To make recommendations on policy development of MOH**
   - To analyze the current situation of policy and its implementation on health insurance and UHC, then identify challenges and priority issues.
   - To identify cooperation resources in Japan to contribute to the issues.
   - To propose mid-/long-term policy matrix or roadmap based on the above analyses.

Derivable

- Inception Report: December 2015
  - Outline and methodology
  - Survey plan
- Progress Report: January 2016
  - Preliminary findings
- Interim Report: March 2016
  - Situation analysis
  - Draft recommendations
- Final Report: July 2016
  - All the survey results
  - Recommendations

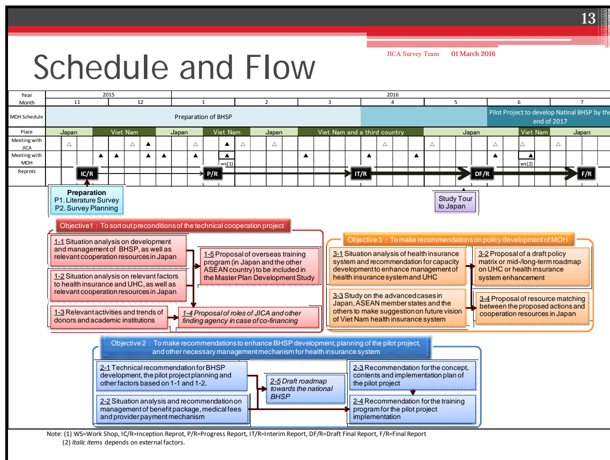
3. Methodology

Period and the Team

- Period:
  Nov. 2015 to Jul. 2016
- Reports
  - Jan. 2016: Progress
  - Mar. 2016: Interim
  - Jun. 2016: Draft final
  - Jul. 2016: Final
- Workshops
  - Mar. 2016
  - May 2016
- Study tour
  - May 2016 (Japan)

- Team:

Name	Task/ Expertise
Keiko Nagai, MMedSc.	Team Leader/ Epidemiology, health policy
Shiho Sasada, MPH	Health Finance/ Health economics
Hironari Onishi, MSc.	UHC/ Social security
Junko Sato, MPH	UHC/ Health policy
Izuru Arima	Health ICT/ ICT for social security
Shino Nishimagi, MA	Health Policy/ Social study
Ai Uehara, MA	Workshop and Training/ Social study



Methodology

- Document research
  - Reports, statistics, legislations, research papers, etc.
- Interviews
  - Hanoi: ministries, government agencies, donors, NGOs, private sector
  - Province/District: local government agencies, hospitals, CHSs
- Direct observation
  - Health facilities, social security (SS)

4. Preliminary Findings

Conceptualizing UHC

Total health expenditure
Reduce cost sharing and fees
Include other services
Direct costs: proportion of the costs covered
Extend to non-covered
Current pooled funds
Population: who is covered?
Services: which services are covered?
Quality
Equity

1. **Population coverage** ("breadth")
2. **Financial coverage** ("height")
3. **Service coverage** ("depth")

+ **Quality**
+ **Equity**

Reference: Presentation by Ajay Tandon and Christoph Kurowski, February 2016

Basis of UHC

- Consensus of stakeholders: health, finance, welfare/ Hospital, Insurer, Subscriber/ ...
- Health financing strategy
- Strategy on development of human resource for health
- Stable service providing system

UHC Cube in Viet Nam

Financial Coverage

- High OOP
- Low HI utilization (urban area)

- Low co-payment rate

- Aging
- Increase of NCD
- Increase of medical fee
- Increase of financial burden of health insurance fund/ state budget

- Decline medical services covered by health insurance

Service Coverage

- Supply side:
  - ✓ Human resources
  - ✓ Equipments
  - ✓ Drugs
- Demand side:
  - ✓ Access in remote areas

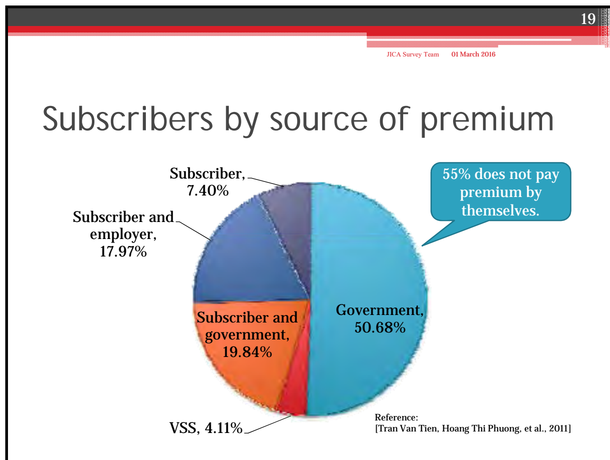
Population coverage

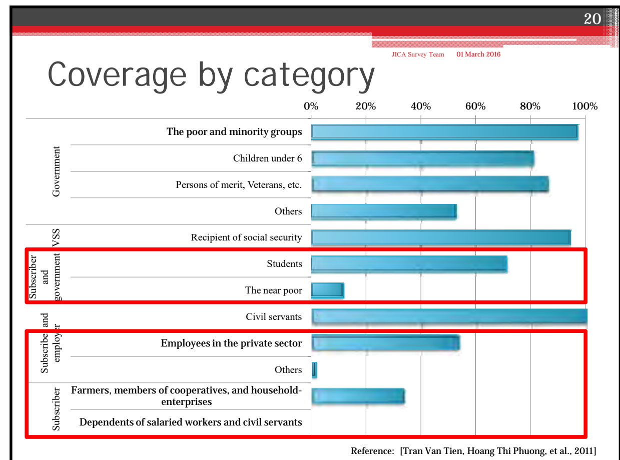
- Overall HI coverage: >70%)

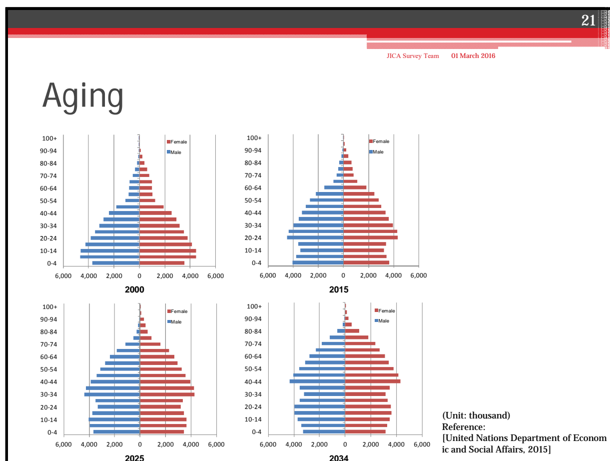
- Informal sector, SME (subscription, premium payment)

4-1. Population

- Coverage vary among categories.
  - Informal sector
    - Private sector employees
    - Dependents ⇒ Household Subscription
    - Farmers
    - The near poor
- Aging
  - Multiple NCD burden
    ⇒ increase of medical expenses
  - Decrease income ⇒ Decrease of premium revenue

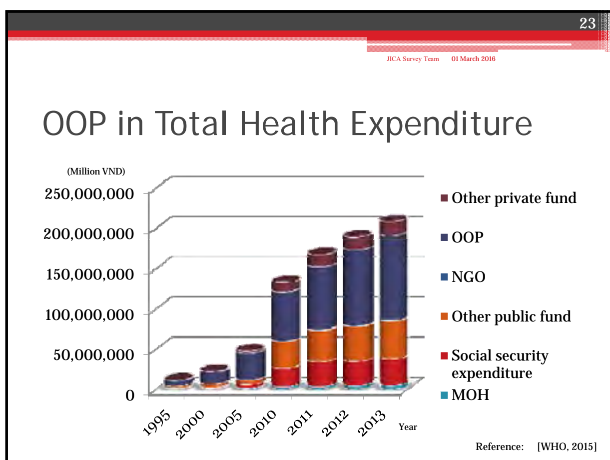


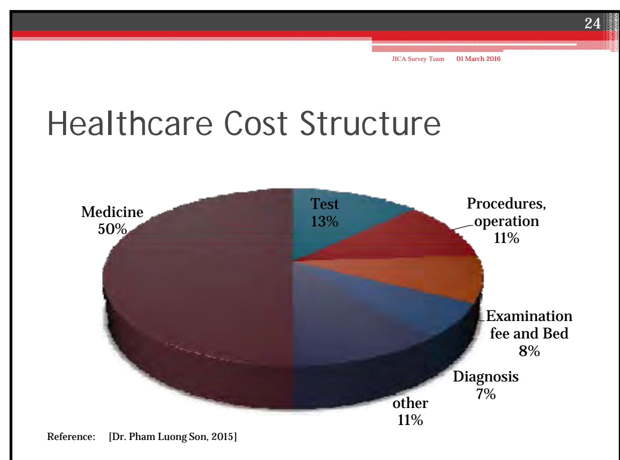




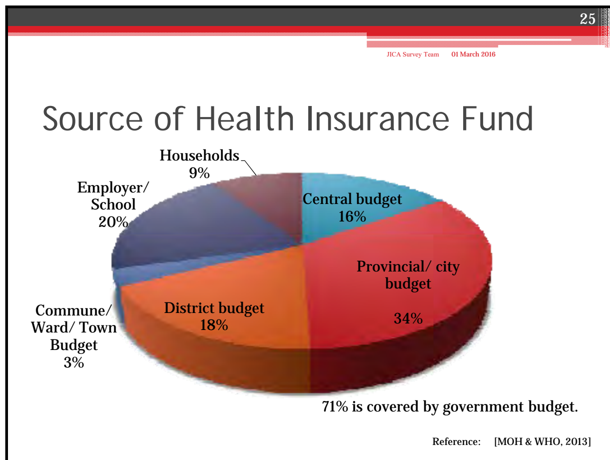
4-2. Finance

- Increase of total health expenditure
  ⇒ Increase of OOP expenses
- Expenses for drugs
  - Procurement system
  - Stock-out in health facilities
- Source of Health Insurance Fund
  - 70% is from the government.
- Balance of Health Insurance Fund
  - Increase of medical fee
  - Increase of utilization..?





Source of Health Insurance Fund



71% is covered by government budget.

Reference: [MOH & WHO, 2013]

Balance of Health Insurance Fund
(2016 estimates)

Revenue		Expenditure	
Social insurance	158,443 billion	Social insurance spending from social security funds	110,121 billion
Health insurance	66,288 billion	Examination and treatment of health insurance	72,700 billion
Unemployment insurance	10,363 billion	Unemployment insurance regime	7,371 billion
Profits from financial investments	34,200 billion	Administrative costs	9,855 billion
TOTAL	**269,294 billion**	**TOTAL**	**200,047 billion**

4-3. Service

- Supply side
  - High cost services (hematology, plastic and cosmetic surgery, etc.)
  - Insufficient human resources and equipment to provide HI covered services
  - Over treatment/ examination
- Demand side
  - Difficulty in access (remote areas)
  - Low utilization of HI (urban areas)
- Impacts of exclusion some HI covered services..?

VSS-contracted Healthcare Facilities (2014)

Category		Total (2013) a)	Contracted (2014) b)	
Type of Facilities	Public	*1	1,687	n.a.
	Non-public	*1	424	n.a.
Level of Facilities	Central	46	52	*2
	Province	447	619	*2
	District	1,214	1,173	96.6% *3
	Commune	11,033	267	2.4% *3
	(Private)	155	*1	*2
		13,680	**2,111**	**15.4%**

Source: a) Health Statistics Yearbook 2013, b) [Dr. Pham Luong Son, 2015]

*1: Definition of "non-public" (source b)) and "private" (source a)) seems to be different.
*2: As contracted facilities might include private establishments, proportion could not be calculated.
*3: The proportion is based on the assumption that all the facilities are public establishment.

4-4. Governance

- Policy
  - Fragmented policy targets
  - Luck of evidence for policy making
- Implementation
  - Time-lag to practical understanding and actual implementation
  - Inefficiency in daily works
- Inter-sectoral coordination
  - UHC needs multispectral approach.

History of Health Insurance System

Year	Policy concept	
1986	New financing mechanisms for health care	Economic reform led by the Doi Moi policy • Introduction of health insurance scheme • Liberalization of healthcare and pharmaceutical markets • Introduction of user fees in public health facilities
1992		Decree No. 299/1992/HDBT Establishment of compulsory health insurance scheme •Compulsory group includes: civil servants, employees in companies with ten or more employees, pensioners, social assistance recipients, employees in foreign companies
1998	Unified health insurance system/health insurance fund	Decree No. 58/1998/ND-CP • Integration of each provincial health insurance fund into a single national fund • Expansion of the insurance coverage
2005	Compulsory and voluntary health insurance	Decree No. 63/2005/ND-CP • Coverage of the poor supported by the government Law on Education, Healthcare, and Protection of Children also provides free access to medical treatment for children under six years old
2009	Universal health insurance	Law on Health Insurance (No. 25/2008/QH12) • Legislation of health insurance scheme which had been administered by ministerial decrees • Ensuring the coverage of the poor, the elderly, and children under six years old by full government support • Provision of partial government support to the near poor and students
2014	Compulsory universal health insurance	Law on Amendments to the Law on Health Insurance (No. 46/2014/QH13) • Compulsory participation in health insurance scheme • Participation by household • Expansion of benefit levels • Development of Basic Health Service Package

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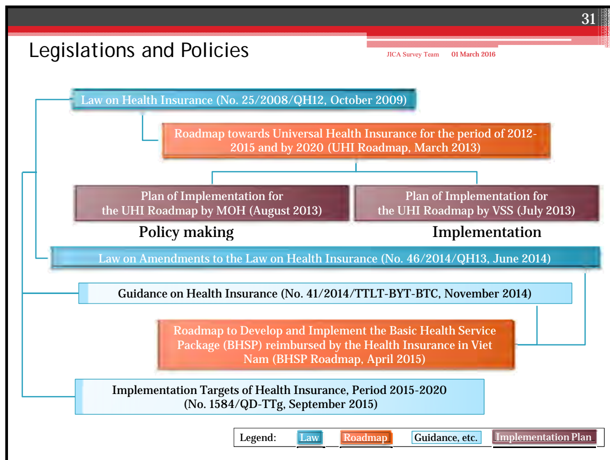
Legislations and Policies



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Relevant Policy Targets

- Roadmap towards Universal Health Insurance for the Period of 2012-2015 and by 2020 (2013)
  - Health insurance coverage: 80% by 2020
  - Proportion of OOP to THE: 40% by 2020
  - Improvement of insured medical services
- Amendments to the Law on Health Insurance (2014)
  - Progumulation of "BHSP covered by health insurance fund": by 2018

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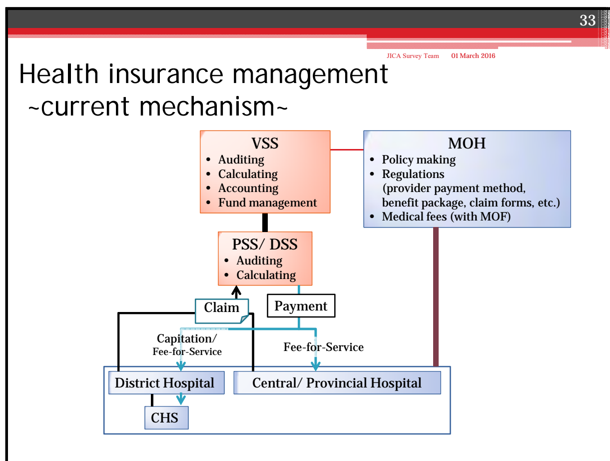
Health insurance management ~current mechanism~



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- Data is processed manually.
- Each hospital introduce each software.
- Each work use each software without linkage.

Fraud, mistake, or waste might not be sufficiently checked..?

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5. Preliminary Recommendations

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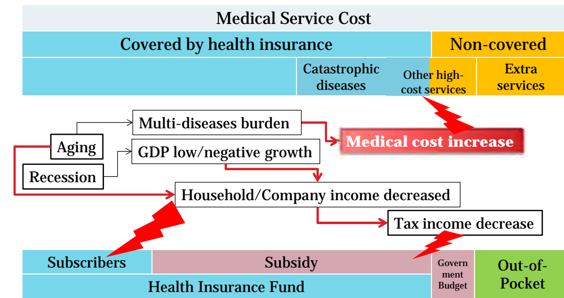
Toward UHC… (1)

1. Population
   - Increase enrollment of informal sector
     - Increase awareness of benefit and provision for the future
     - Make health insurance attractive (transparency, effectiveness, etc.)
2. Finance
   - Strategy to reduce OOP expenses
     - Drug price..?
     - Hidden OOP
   - Financial protection for catastrophic cases
   - Ensure premium collection
   - Strategy for "healthy health insurance fund"
     - Provider payment method
     - Medical fee schedule
     - Co-payment

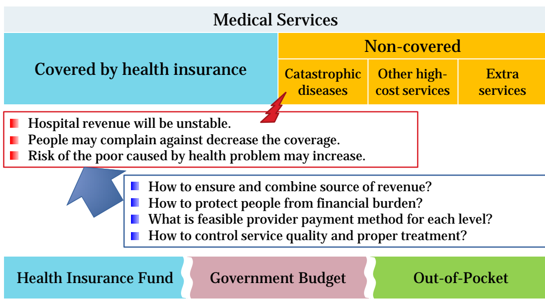
Toward UHC... (2)

3. Service
   - Benefit package of health insurance
     - Clear and reasonable criteria
   - Stable and quality service providing system
     - Facility standard (ex. accreditation)
     - Standard clinical pathway
     - Human resource development
4. Governance
   - Umbrella of multispectral policy targets
     - Health financing strategy, etc...
     - Inter-sectoral coordination (finance – health policy/priority – socioeconomic situation)
   - Evidence
     - Data accuracy
     - Efficient data management
   - Continuous and evidence-based improvement mechanism
     - Flexible modification response to socioeconomic change

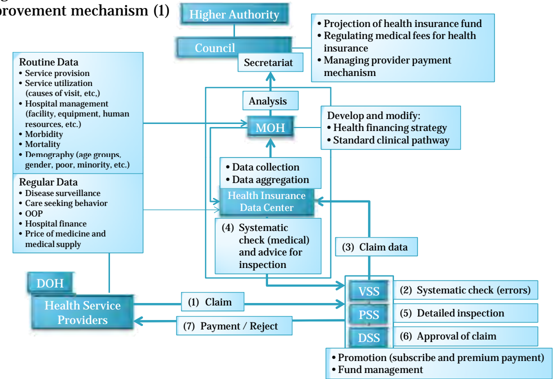
For Healthy Health Financing...



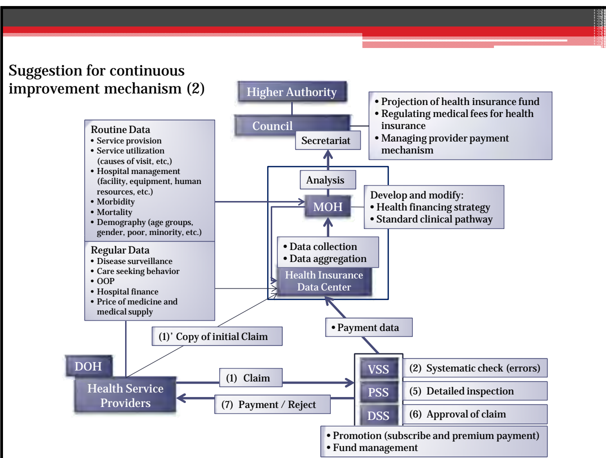
For Healthy Health Financing...



Suggestion for continuous improvement mechanism (1)



Suggestion for continuous improvement mechanism (2)



6. The Way Forward of the Survey

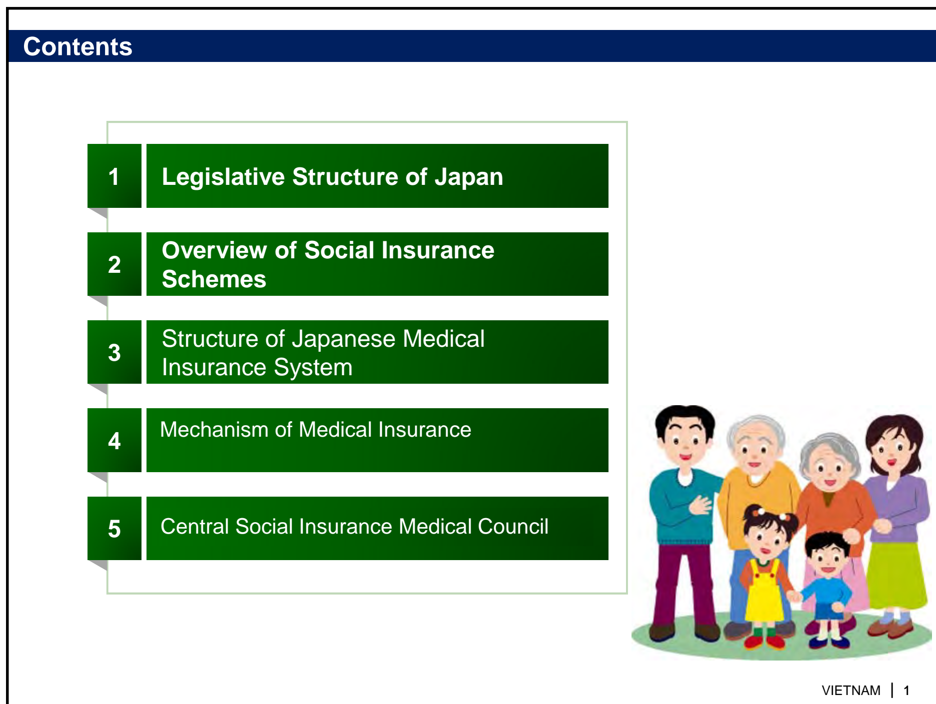
Challenges in the Survey

- The latest data on health insurance
  - Coverage by category
  - Structure of revenue and expenditure of health insurance fund
  - HI utilization rate by age group, category, area, etc.
  - Average premium amount by category
  - Medical fee schedule of each province
  - Statistics of provider payment method
  - Statistics of contracted health facility
- Financial status of health facility
  - Structure of revenue and expenditure
  - Difficulty in financial management
- Roles, functions and relationships of stakeholders
  - Departments in MOH/ VSS
  - Councils under MOH
  - Other relevant ministries (MOF, MPI...)

Thank you!!

Xin Cảm ơn!!

VIETNAM
Japanese Medical Insurance and Medical Fee Payment System, and the Function of Central Social Insurance Medical Council
December 2015


Contents
1 Legislative Structure of Japan
2 Overview of Social Insurance Schemes
3 Structure of Japanese Medical Insurance System
4 Mechanism of Medical Insurance
5 Central Social Insurance Medical Council
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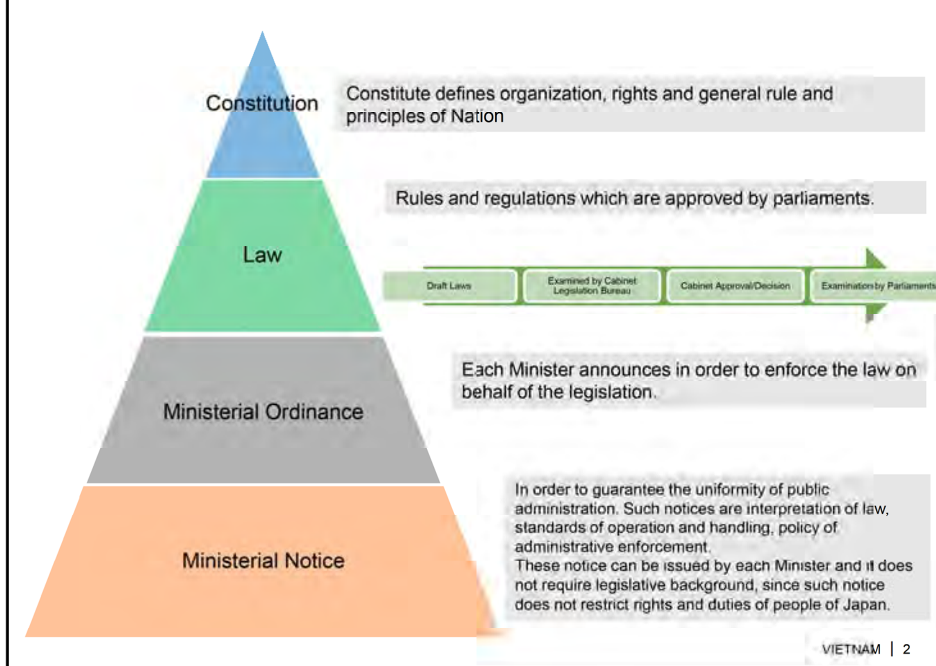

2. Overview of Social Insurance System in Japan

Social Insurance Schemes in Japan consists of 4 schemes and Long-term care insurance

Scheme	Overview of each scheme
Pension	All residents aged between 20 and 60 are required to join National Pension. Pensionable age: 65 Disability Pension and Survivors' Pension are also provided if conditions meet.
Medical Insurance	All residents are required to join. Benefits in kind is essential, but some cases, benefits in cash are applicable.
Unemployment Insurance	In principle, in case any employed persons lose their jobs, benefit will be paid on having training course. In case of dismissal or bankruptcy, benefit will be paid for 330 days max.
Work Injury Insurance	All workplaces are required to join. Benefits are paid to workers in case there is work injury. (Benefits can be in kind or cash)

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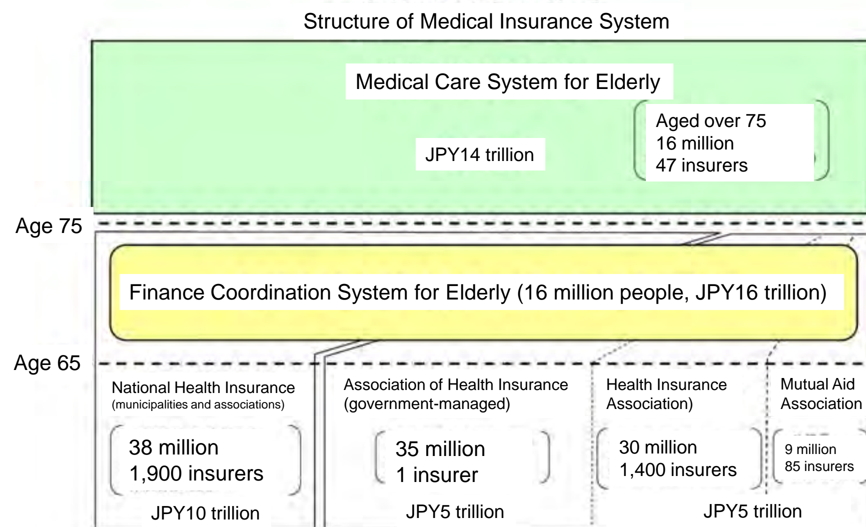
Basic Policy on medical insurance system and the medical fee system
(Cabinet Decision on March 28, 2003) Related Part

［Basic Policy］
Based on advance of fewer birth rate, change in disease structure and progress of medical technology, while ensuring the necessary and adequate medical care standard, from the patient's point of view, revision of medical fee payment will be reviewed.
It is necessary to ensure easy-to-understand system and clarify the standards and measures relating to the evaluation of the medical fee system

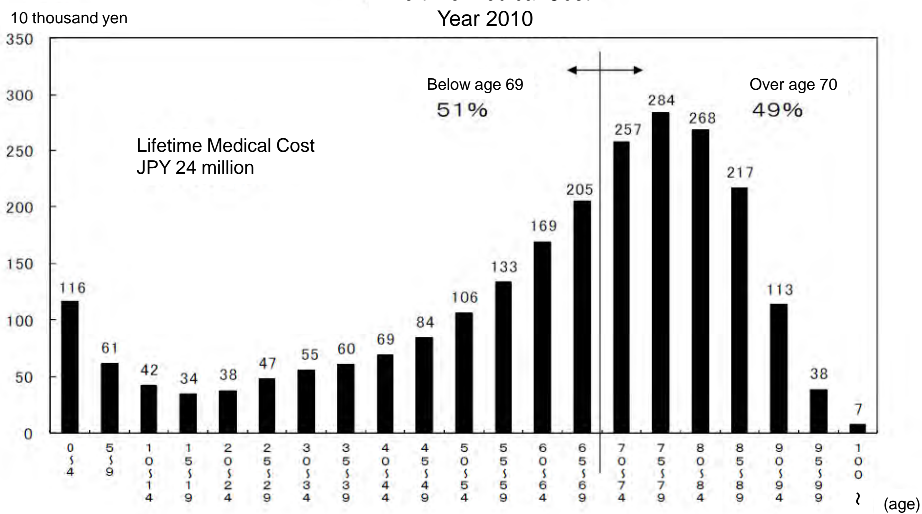
［Basic Direction］
Revision process will take the following ideas into consideration:
① Proper evaluation of medical technology (identifying doctor fee element)
② Overall evaluation which reflects the cost and function of medical institutions appropriately (Hospital fee element)
③ Focus on the patient's point of view

3. Structure of Medical Insurance System



Comparison of Respective Health Insurance Schemes

	National Health Insurance	Government-Managed Health Insurance	Health Insurance Association	Mutual Aid Association	Health Insurance for the aged 75 and over
Number of Insures (As of March 2013)	1,717	1	1,431	85	47
Number of Insured (As of March 2013)	35 million	35 million	30 million	9million	15million
Agerage Age (2013)	50.4	36.4	34.3	33.3	82.0
Percentage of aged 65-74	32.5%	5.0%	2.6%	1.4%	2.6%
Amount Medical Expense per insured (2013)	316,000 yen	161,000 yen	144,000 yen	148,000yen	919,000yen
Agerage income amount per insured	830,000 yen	1,370,000yen	2,000,000yen	2,300,000yen	800,000yen
Average premium amount per insured	83,000 yen	105,000yen	106,000 yen	126,000yen	67,000yen
Percentage of insurance premium	9.9%	7.6%	5.3%	5.5%	8.4%
Subsidy by government	50% of total cost	16.4% of total cost	None (but the support the aged over 75)	None	50% of total cost
Amount of government subsidy	3,500 billion yen	1240 billion yen	27 billion yen	None	6,823 billion yen



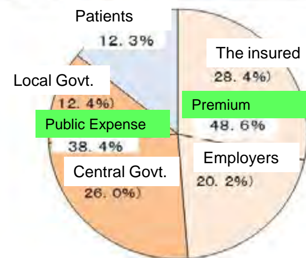
Significance of Japanese Medical Insurance System

- **Under the concept or Universal Health Coverage for all, Japan has achieved highest level of life expectancy and highest level of medical care.**
- **Coping with fewer birth rate and fluctuation of socio-economic environment, the Government declare to maintain public medical insurance System.**

【 Characteristic of Japanese UHC 】

1. Cover all citizen by public health insurance
2. Freely choose medical institutions (Free Access)
3. Low premium but high level medical service
4. SHI is a basic concept, but national subsidy is provided to maintain UHC

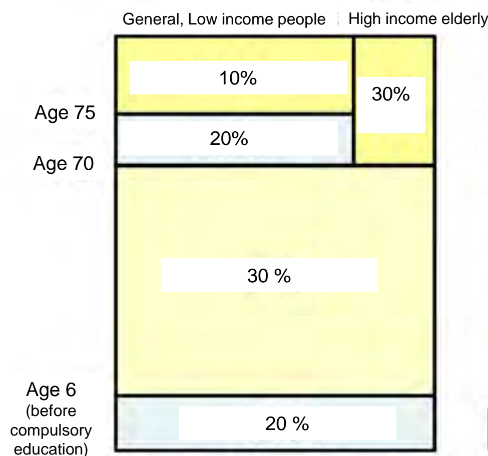
Burden structure of national medical cost (2011)



4. Mechanism of Medical Insurance System

Burden on Medical Fee by Patients

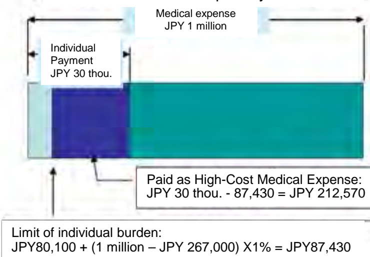
Ratio of patient burden



※ High-cost Medical Care Scheme

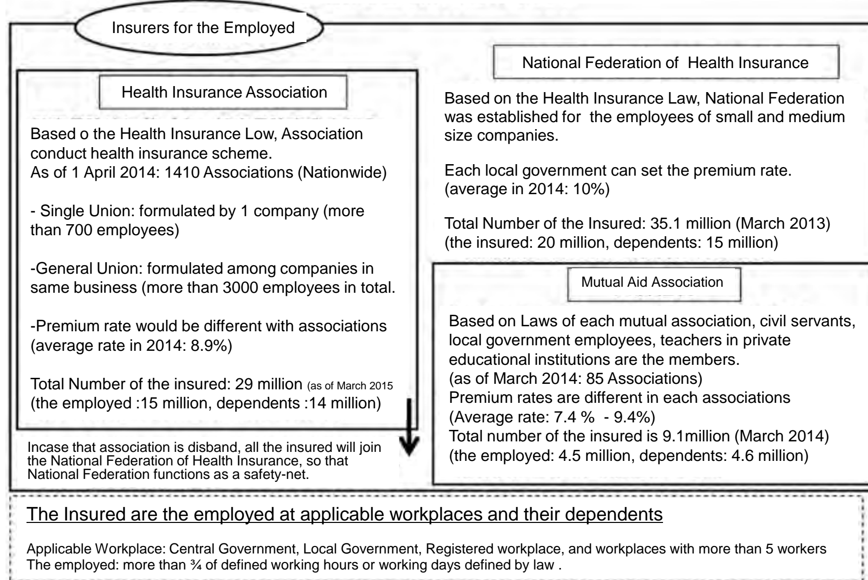
If the medical expenses (by individual has exceeded the ceiling, the amount beyond the ceiling will be paid by the system.

< Ex. Case of 30% to be paid by the insured >



4. Mechanism of Medical Insurance System

Overview of the Insurers for the Employed



The Insured are the employed at applicable workplaces and their dependents

Applicable Workplace: Central Government, Local Government, Registered workplace, and workplaces with more than 5 workers
The employed: more than ¾ of defined working hours or working days defined by law .

Medical Fee Payment System

(1) Mechanism of Medical Fee Payment

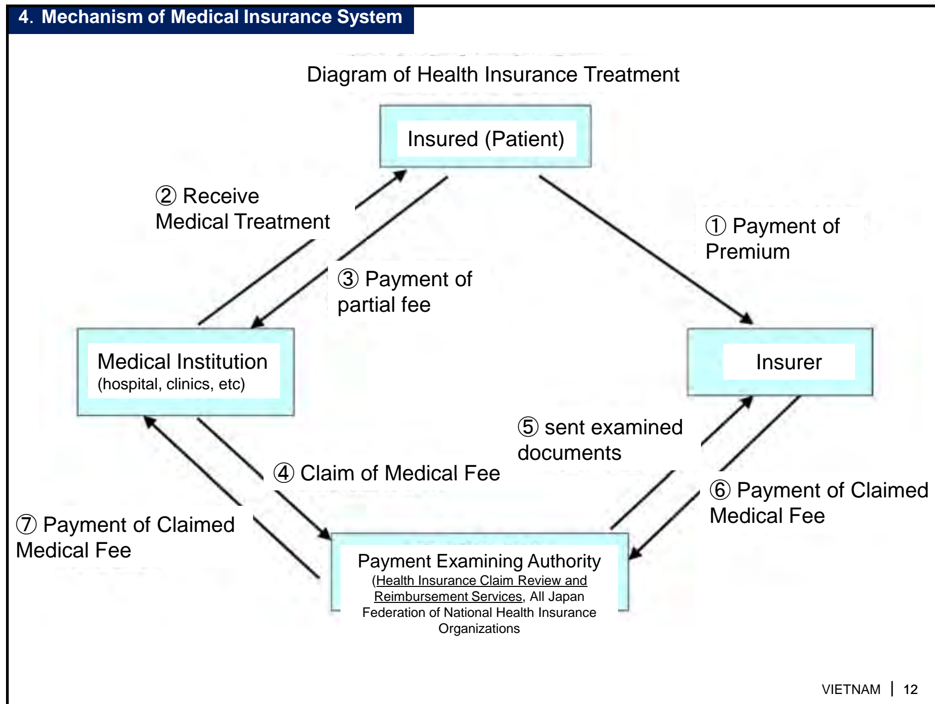
○ Medical Fee Payment is the reward paid by the insurers against medical services by medical institutions and pharmacies

○ Minister of Health, Labour and Welfare determines based on the discussion of Central Social Insurance Medical Fee Council.

(2) Contents of Medical Fee

Medical Fee
- Assessment of Medical Tec. And Services
- Assessment of price of goods (Drug prices are fixed by Drug Price Standard)

○ Point table defines each medical services with point (1 point =10 yen)
○ There are three kind of table for Medical Treatment, Dentist Treatment, and drugs.



Present condition of Japanese Mechanism

① Patient can visit any medical institutions and quality of doctors and services are guaranteed.
② There are 177,769 medical institutions (Hospital: 8540, Dental Clinic: 68,701, Clinic: 100,528) (as of 2013)
③ There are 303,268 doctors, 102,552 dentists, and 280, 052 pharmacists. (As of 2012)

Majority of medical care treatments are provided private hospitals and clinics since the Government considered that accessibility of medical care is essential for the people and it is the responsibility of the Government.

Public health providers had limited capacity to provide such services due to capacity of infrastructure and human resources.

What is Health Insurance Claim Review and Reimbursement Services?

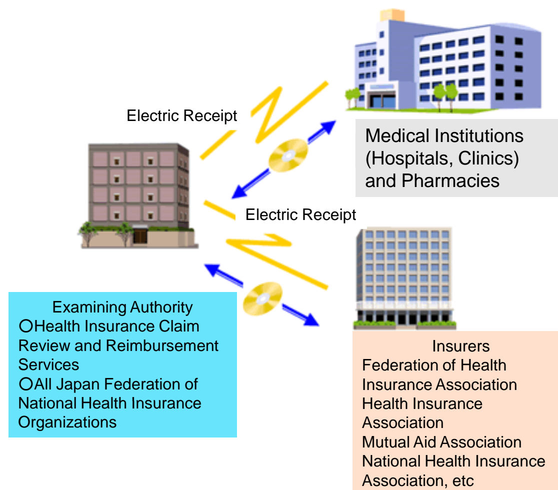
HICRRS is established based on the Law of Health Insurance Claim Review and Reimbursement Services (July 1948) and it is a private entity.
The is not for profit and it does not have the Capital and Equity. And its business plan and budge are required the approval by the Minister, Health Labour and Welfare.

Mission
We support the Medical Insurance System as the specialized organization on medical fee payment through 'appropriate examination' and 'Prompt Payment'.

5 Promises of HICRRS

1. Quality service will be provided through IT
2. As a private entity, we operate effectively with cost-conscious
3. Unified services are provided nationwide
4. Through legal compliance, we do provide fair operation
5. We promote information disclosure, and fulfill the accountability

Overview of Medical Fee System



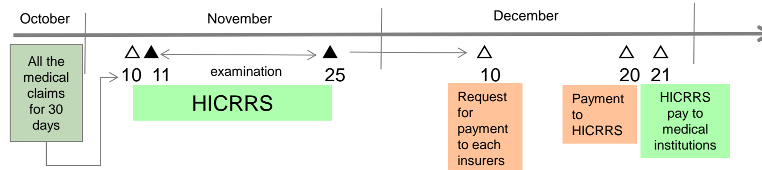
Receipt Computerized Processing System is the system that all medical institutions and pharmacies can submit their medical fee claim documents with electric receipts or electric media and the examining authority will check and examine the contents and their appropriateness and submit the designated insurers. The system aims to establish prompt claim processing and reduction of claim volume through unified system among medical institutions, pharmacies, examining authority and insurers

Number of receipt processing is 150 million per month

Advantage of Receipt Computerized Processing System

① Insurers focus on collection of premium and payment to the medical institutions.
② Insurers can reduce the cost for claim examination by outsourcing and they can process balk volume of data (100% examination).
③ The system can automatically reject incorrect receipts (claim) and branch offices of HICRRS will examine manually such incorrect receipts (mostly by doctors).
④ Claim examining authority uses functions as a gate keeper against fraud claims by using IT technology. Most of claims are checked by electric basis. And administration cost is reduced.
⑤ Claim examining authority is separated from insurers in order to avoid fraud.
⑥ Insurers could increase the surplus by demanding the processing charge by examining authority.

⑥ Payment term is fixed. (Health Insurance Claim Review and Reimbursement Services (79 million claims per month), All Japan Federation of National Health Insurance Organizations)
(Claims from 1st to 30th of each month) submit to (HICRRS) by 10th of next month, HICRRS examine from 11th till 25th of next month, and request insurers to pay the insurance payment by 10th of the following month, and insurers will pay by 20th of the following month to HICRRS and HICRRS will pay 21th of the following month to medical institutions.



Examination

Examination means that respective medical treatments by medical institutions are followed the rules and regulations, point table and related ministerial notices).
The following items must be examined:

(1) Confirmation of the specified contents
Confirmation of erroneously omit and insurance number

(2) Confirmation of medical intervention
Name of intervention, Points, Number of times, Medical propriety, Calculation requirements, etc.

(3) Confirmation of Drugs
Confirmation of Name of the drugs, Price, Adaptation, Usage, Dosage, Medical propriety, etc.

(4) Confirmation of Medical Materials
Confirmation of Name of medical materials, Price, Usage, Dosage, Medical propriety, etc

Examination (2)

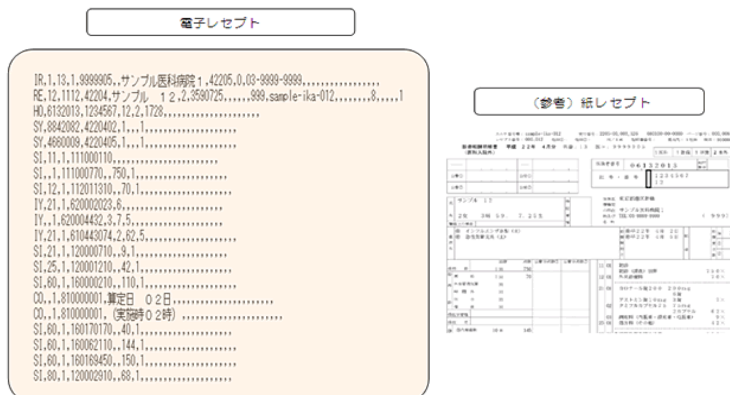
Determination of the examination is done by the Examination Committee that has been established in each branch of HICRRS in 47 prefectures. The Examination Committee consists of a professional group of doctors, dentists and pharmacists together with representatives of health insurance associations, medical institutions and academic experts. The same number of representatives of each group and a tripartite structure are guaranteed for fairness.

Also, any expensive receipts (more than 400,000 points =JPY4,000,000) will be check by the Special Examination Committee.

Total number of Examiner in Japan: 4,700

- Number of medical institutions using electric receipts: 220,000 institutions
- Number of processing receipt per official of HICRRS: 18,000/year
- Standard Examination by Examination Committee: 7 days / month
- Amount of valuation (Reject): 55 billion yen / year
  Rejection rare: 0.259%

Sample of Electric Receipt



5. Central Social Insurance Medical Council

[Responsibilities]

○ The Central Social Insurance Medical Council ("CSIMC" or the "Council") has the powers to make discussions and give advice in response to the Minister of Health, Labour and Welfare's request for advice, as well as to submit recommendations to the Minister of Health, Labour and Welfare, with respect to the revision of medical fee points and other relevant matters.

[Tripartite Structure]

○ The Council adopts the so-called "tripartite structure" in which payer-side members and medical institution-side members have discussions as the both parties of insurance contracts, and public-interest members act as coordinators between the both parties. The term of office of each member is 2 years (up to 3 successive 2-year terms, i.e., 6 years).

(1) Payer-side members (representatives of insurers and insureds): 7
(2) Medical institution-side members (representatives of physicians, dentists and pharmacists: 7
(3) Representatives of public interest: 6 (subject to the Diet's approval)

○ A Chairperson will be elected by members from among the representatives of public interest.
○ Members representing the public interest of the Council will discuss the schedule and agendas of the meeting and other matters regarding the administration of the Council, and the payer-side members and the medical institution-side members will respect results of such discussions.

[Deliberations about Specialized Issues]

○ The Minister of Health, Labour and Welfare may designate up to 10 expert members (as appointed by the Minister) whenever he/she deems necessary to discuss specialized issues.

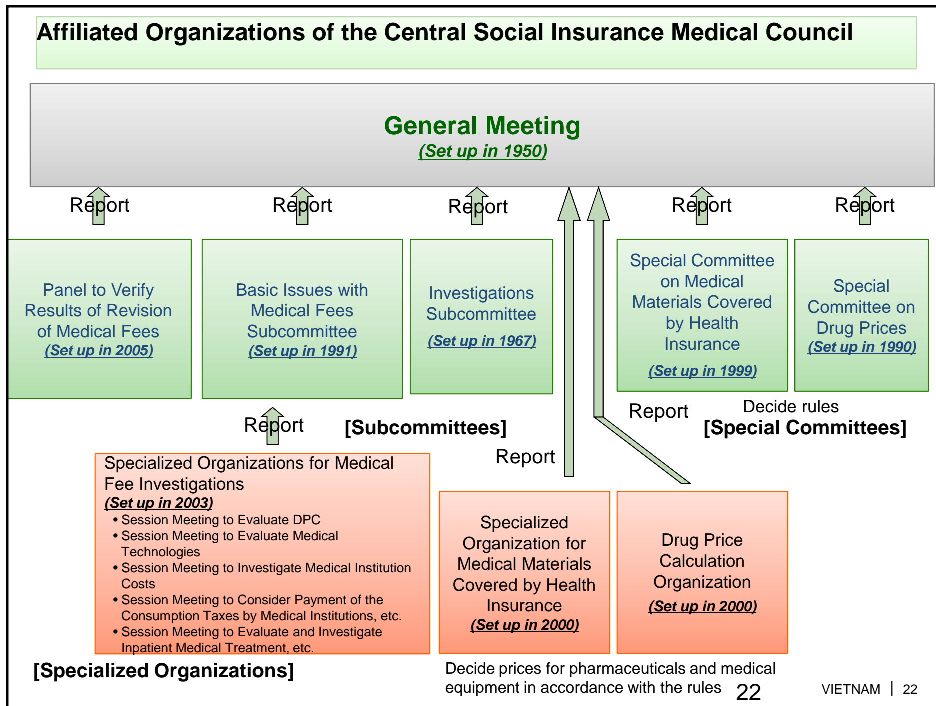
History of CSIMC

○Japanese medical insurance system was established in 1927 and medical fee has been fixed by the Government up to now.
However, when the Health Insurance Law was introduced the medical fee was defined under the agreement between insurers and service providers.

○In 1943, the system was changed that Japan Medical Institution, Federation of Health Insurance Association and National Health Insurance Association discuss about the fee and Minister of Health and Welfare approves the fee, and in 1944 the system again transformed to 'Social Insurance Medical Fee formulation Council' by adding academic experts.

○And further, in 1950 Central Social Insurance Medical Fee Council was established by merging 'Social Insurance Medical Care Council' which is a advisory and supervisory body in health insurance treatment and 'Social insurance Medical fee formulation Council'.

Although CSIMEC was created, there was no clear calculation rules, and therefore actual revision policy was determined by representatives of interested groups such as Japan Medical Association.
For this reason, revision rate was decided by the discussion among MPs associated with Health and Welfare groups for a while.



Surveys/Investigations Contributing to the Revision of Medical Fees

Controlling/conducting entities	Description of survey/investigation	Outline
Statistics and Information Department	Survey of Medical Care Activities in Public Health Insurance	Survey on the times, points, etc. of medical care activities
Medical Economics Division, Health Insurance Bureau/prefectural health, labor and welfare bureau	Report on notifications of health care facility standards	Status of notifications of health care facility standards subject to medical fee items
Panel to Verify Results of Revision of Medical Fees, CSIMC/Medical Economics Division, Health Insurance Bureau	Investigations by the Panel	Investigations into the items that were decided by the CSIMC to be verified at the time of the revision of medical fees
CSIMC/Medical Economics Division, Health Insurance Bureau	Survey on Economic Conditions in Heath Care (Survey on Health Care Facilities)	Survey on how medical institutions are actually managed
Medical Economics Division, Health Insurance Bureau	DPC (diagnostic procedure combination) data	Medical practice data when DPC is used
General Affairs Division, Health Insurance Bureau	National Database	All data on medical care activities in electronic receipts
Economic Affairs Division, Health Policy Bureau	Survey on prevailing prices for drugs and medical materials	Prices at which medical institutions actually purchase drugs and medical materials
Actuarial Research Division, Health Insurance Bureau	Survey on the trend of medical care expenditures	Whole medical care expenditures computed from receipts

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Survey of Medical Care Activities in Public Health Insurance

1. Purpose of the Survey
   The purpose of the survey is to obtain fundamental materials necessary for the medical insurance administration by clarifying the **details of medical care activities, conditions of injuries and diseases**, details of pharmacy dispensing, and status of use of drugs, all involving recipients of medical benefits under the national health insurance coverages.

2. Subjects of the Survey
   The survey covered the health insurance claims of medical/dental fees and dispensing fees under the health insurance systems submitted by health insurance-covered medical institutions and pharmacies across the country to, and assessed and approved by prefectural branches of the Health Insurance Claims Review & Reimbursement Services and the Federations of National Health Insurance Organizations. For medical hospitals, medical clinics, dental clinics and health insurance-covered pharmacies, the subjects of the survey were all health insurance claims of medical/dental fees and dispensing fees stored in the NDB (National Database of Health Insurance Claim Information and Specified Medical Checkups). For dental clinics, the objects of the survey were the health insurance claims of dental fees (including those stored in the NDB) which were extracted using a two-stage stratified random sampling with insured medical care institutions covered as the primary sampling unit out of the whole insured medical care institutions, and health insurance claims of dental fees as the secondary sampling unit.

3. Survey Items
   Health insurance claims of medical/dental fees: Age, name of disease, actual number of days of medical care, points and times by medical care activity, and use of drugs (name and dose of drug, etc.), etc.
   Health insurance claims of dispensing fees: Age, number of prescriptions accepted, points and times by dispensing activity, and use of drugs (name and dose of drugs, etc.), etc.

4. Survey Period: Assessed in June each year

5. Survey Method
   Conducted by the prefectural branches of the Health Insurance Claims Review & Reimbursement Services and the Federations of National Health Insurance Organizations by extracting claims from the health insurance claims of health insurance-covered medical institutions using a sampling rate prescribed separately, and sending copies of the extracted claims to the Ministry of Health, Labour and Welfare.
   Tabulated claims of medical/dental fees and dispensing fees from the NDB.

Status of Notifications of Major Health Care Facility Standards

- The following summarizes the status of notifications by major medical institutions required to notify their health care facility standards for the purpose of calculating medical fees as of July 1 each year.
- The Medical Economics Division compiled the data submitted to the prefectural health, labor and welfare bureau by medical institutions.

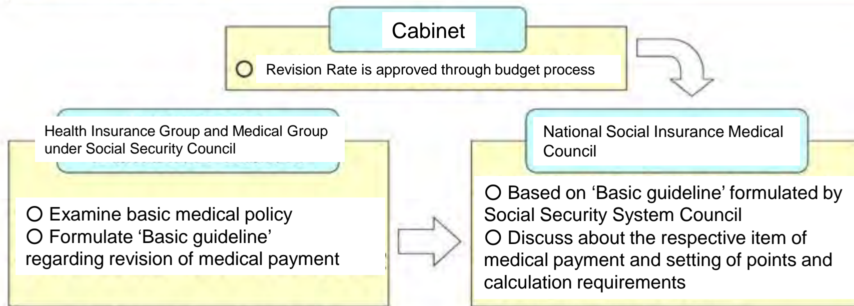
Example: Status of notification of the basic fees for hospitalization

	Summary of the Health Care Facility Standards	Number of the Medical Institutions that Submitted the Notifications (Upper column: Number of medical institutions/Middle column: Number of hospital wards/Lower column: Number of hospital beds)		
		2007	2008	2009
Basic fees for hospitalization in general ward	• Real nurse assignment and nurse-to-patient staffing ratios in the general wards are divided from 7:1 to 15:1, depending on average number of hospitalization days	5,534 16,038 715,413	5,437 15,207 700,358	5,425 14,989 690,884
Basic fees for hospitalization in long-term care ward	• Divided depending on the medical care or other category in the long-term care wards	3,708 5,749 209,968	3,650 4,992 211,592	3,560 4,933 212,638
Basic fees for hospitalization in tuberculosis ward	• Real nurse assignment and nurse-to-patient staffing ratios in the tuberculosis wards are divided from 7:1 to 20:1, depending on average number of hospitalization days	236 265 9,220	225 240 8,177	205 232 7,850
Basic fees for hospitalization in psychiatric ward	• Real nurse assignment and nurse-to-patient staffing ratios in the psychiatric wards are divided from 10:1 to 20:1, depending on average number of hospitalization day	1,381 3,600 197,812	1,335 3,362 188,796	1,344 3,289 184,873

Flow of Medical Fee Revision Process

Revision of medical fee is based on the following guidelines:

1. Through the budget formulation process, the revision rate approved by the Cabinet as the pre-condition,
2. Based on 'Basic Guideline' formulated by Health Insurance Group and Medical Group under Social Security System Council
3. National Social Insurance Medical Council conducts examination of setting of concrete medical payment points



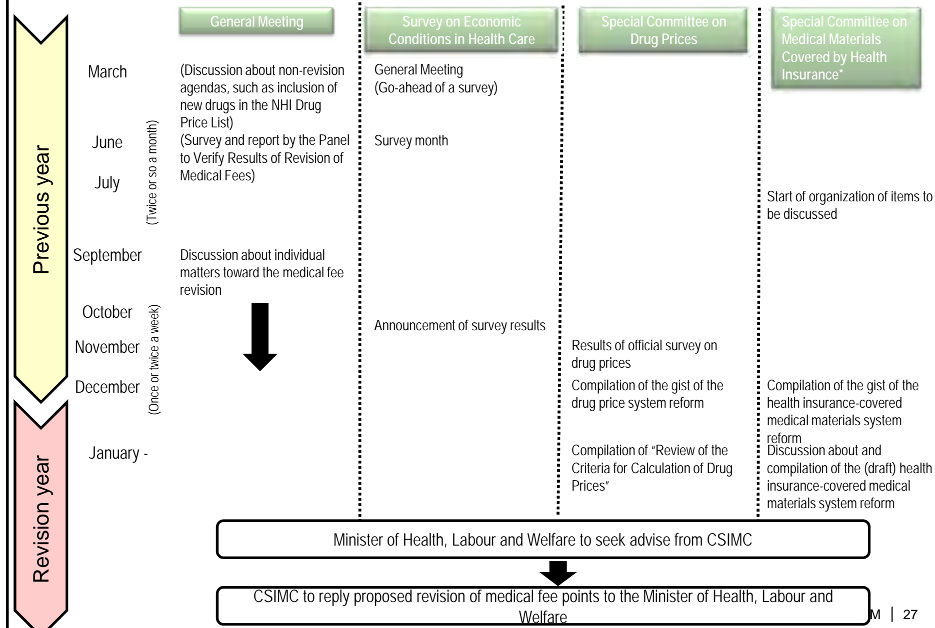
Members of National Social Insurance Medical Council

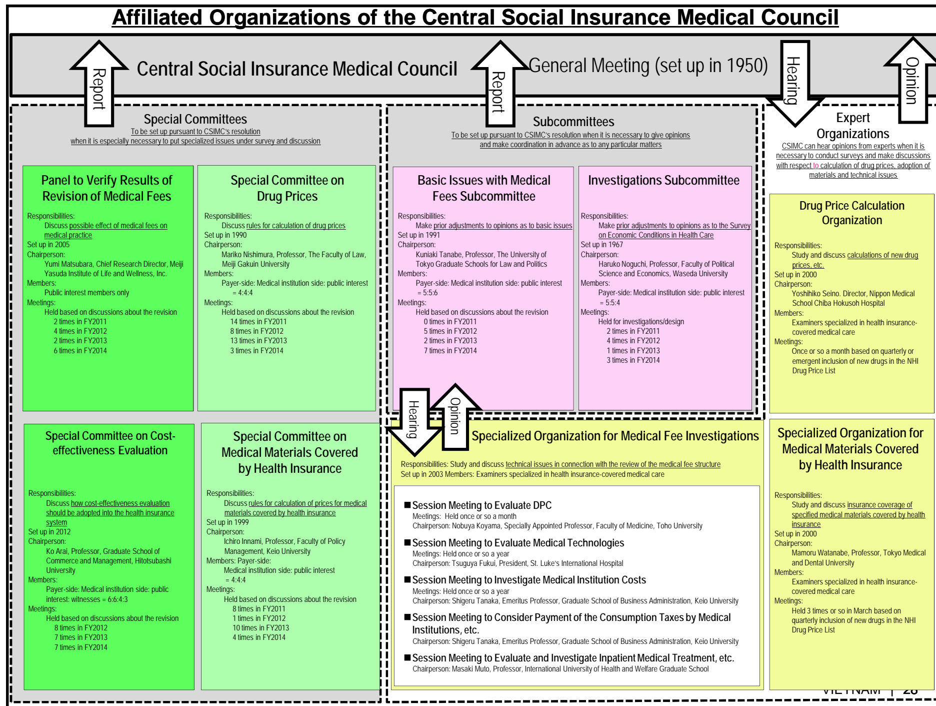
① 7 Members from payment side (representatives of insurers and the insured

② 7 Members from medical institutions (representatives of doctors, dentists and pharmacists

③ 7 Member from public (need to be approved by the Parliament)

Major Schedule for Medical Fee Revision





Councils, Advisory Groups and Study Groups (Ministry of Health, Labour and Welfare

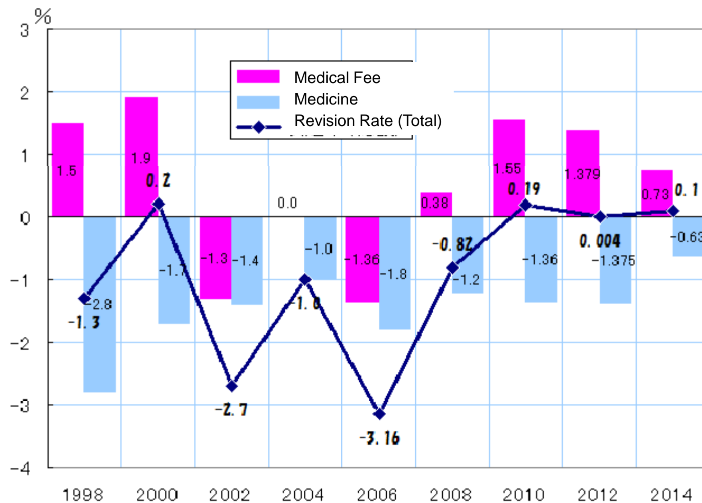
- Social Security Council
  - Medical Sub-group
  - Statistics Sub-group
  - Long-term Care Benefit Su-group
  - Welfare Group
  - Social Assistance Group
  - Population Group
  - Health Insurance Group
  - Health Insurance Sub-group(Massage, Acupuncture, etc)
  - Child-Affairs Group (many sub-groups)
  - Medical Care Group
  - Pension Actuary Group
  - Pension Group (many sub-group)
  - Corporate Pension Group
  - Working Group on Short-tem Workers
  - Group on the Disabled
  - Long-tem care Group
  - Working group on fewer birth rate (several groups)
  - Working group for elderly aged over 75
  - and more……

Factor Analysis on increase of medical cost (very summarized example)

	2008	2009	2010	2011	2012	2013	2014
Increase rate of Medical Cost ①	2.0%	3.4%	3.9%	3.1%	1.6%	2.2%	1.8%
Revision of Medical Fee②	-0.82%		0.19%		0.004%		**0.10%**
Population increase rate ③	-0.1%	-0.1%	0%	-0.2%	-0.2%	-0.2%	-0.2%
Impact from Ageing ④	1.3%	1.4%	1.6%	1.2%	1.4%	1.3%	1.2%
Others (①−②−③−④) -Higher Medical tech. -Burden on Patients	1.5%	2.2%	2.1%	2.1%	0.4%	1.1%	0.6%

MHLW analyze that approx. 1.6% of medical cost increased due to ageing related indicators.

Transition of medical fee revision rate



Source: Sankei and Mainichi Newspapers

BASIC CONCEPT OF MEDICAL FEE SCHEDULE AND ITS POLICY USE

TADAYUKI TANIMURA, HEALTH POLICY BUREAU, MINISTRY OF HEALTH, LABOUR AND WELFARE, JAPAN

BASIC CONCEPT ON MEDICAL SERVICES IN THE PUBLIC HEALTH INSURANCE

- Medical service coverage and prices are determined by Health Minister based on the report by Central Social Medical Insurance Council (CSMIC)
  - **Service coverage** by insurance **need to be deliberated and optimized** as the public health insurance system is sustained using national budget and premium as financial resources.
  - **Efficacy and safety** of medical services provided **need to be assured** as they may directly affect patients' lives. However, there is limitations for patients to judging what medical services to take by themselves as medical services contain highly specialized ones.
  - The CSMIC is the place where service coverage and prices are deliberated

Ministry of Health, Labour and Welfare, Japan

CHARACTERISTICS AND FUNCTIONS OF MEDICAL FEE SCHEDULE

- CHARACTERISTICS
  - To determine service coverage (contents) by insurance
  - To determine the price of services
- FUNCTIONS
  - The income source for clinics and hospitals
  - The incentive for behaviors of healthcare providers

Ministry of Health, Labour and Welfare, Japan

EXAMPLE OF INCENTIVE 1 : PROMOTING GENERIC DRUG USE

- Low rate of generic drug use in Japan
- Goal : 80% of share in the end of 2020
- Incentive for hospitals and pharmacies to prescribing generic drugs, with other supportive policies
  - Incentive for hospitals according to rates of generic use
  - Incentive for pharmacies that achieve certain target rate

Rates of generic drug use (2013.10-2014.9)

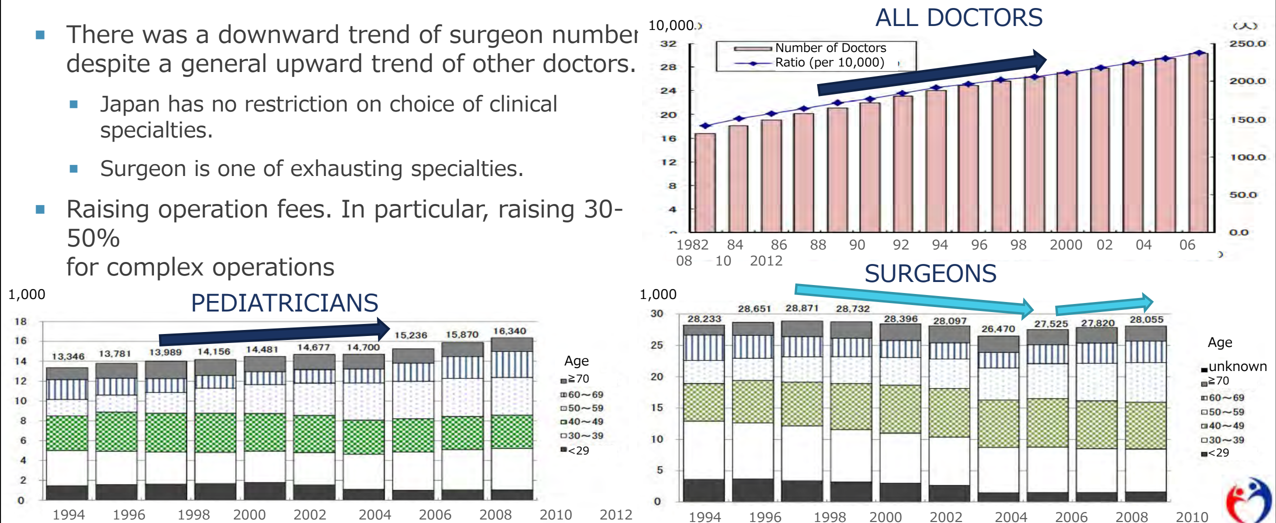
Japan	US	Germany	UK	Italy	France	Spain
49%	92%	83%	73%	57%	64%	65%

Rate of generic drug use in Japan

Ministry of Health, Labour and Welfare, Japan

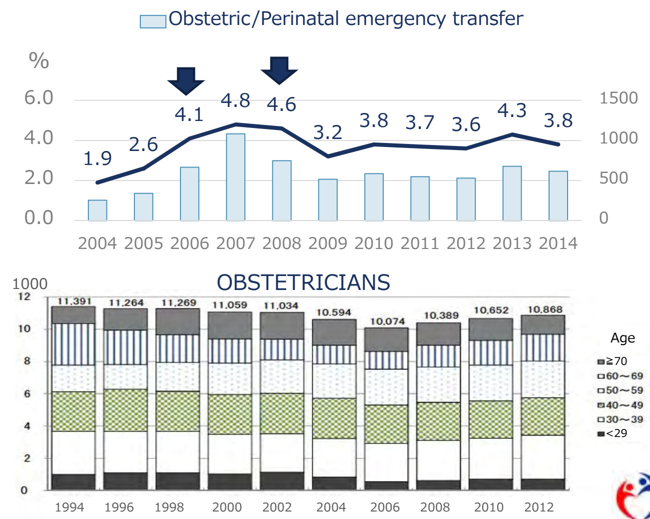
EXAMPLE OF INCENTIVE 2 :
RESPONSE TO SURGEON REDUCTION

- There was a downward trend of surgeon number despite a general upward trend of other doctors.
  - Japan has no restriction on choice of clinical specialties.
  - Surgeon is one of exhausting specialties.
- Raising operation fees. In particular, raising 30-50%
  for complex operations



EXAMPLE OF INCENTIVE 3 :
STRENGTHENING PERINATAL CARE CAPACITY

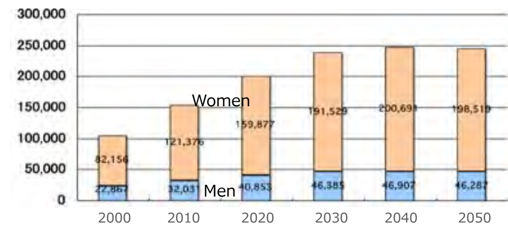
- Cases of declining requests of obstetric/perinatal emergency transfer were recognized as social problem around 2006 and 2007. These were mainly due to cases being beyond physical or technical capacity.
- The following incentives were newly established:
  - Incentive for taking care of high-risk pregnancies in 2006
  - Incentive for accepting perinatal emergency cases in 2008
  - Raising the medical fee for NICU (neonatal intensive care unit) in 2008
- Emergency transfer rules at prefectural level were developed around 2010



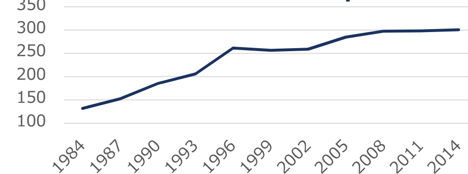
EXAMPLE OF INCENTIVE 4 :
STRENGTHENING REFERRAL SYSTEM

- Patients tend to gather at large/tertiary/advanced hospitals due to free access or their function of acute-phase care. Functional differentiation, particularly reverse referral(smooth discharge), is being promoted to utilize hospitals efficiently.
- The incentives and disincentive for its purpose are:
  - Incentive for following clinical pathways(process maps) such as for femoral neck fracture, brain attack or cancer treatment.
  - Incentive for high reverse referral rate at local-government-designated hospitals
  - Incentive for coordination of discharge/charging hospitals
  - Extra fee for going large hospitals without referral etc.

Projected number of patients of femoral neck fracture



(1,000) **Number of cancer patients**



Appendix 3: Program, Participants and Photos of Study Tour in Japan

3-1: Program of Study Tour in Japan

Date	Time	Activities
2016/5/15	-	Arrive in Tokyo
	17 :30-18 :30	**Orientation** Survey Team explaned the folloing points. ・ Objectives of Study Tour program ・ Contents to be learned ・ Requirement for participants ・ Presentation in the final session of the program ・ Logistic guide
2016/5/16	9 :30-10 :00	**Courtesy Call in JICA** Participants visited JICA and to exchage greetings. Participants from JICA : Health Development Department -Mr. Watanabe, Mr. Yoshida, Ms. Nishimura, Ms. Sakurai, Mr. Ushio Southeast Asia and Pacific Department- Ms. Yamazaki
	10 :10-12 :10	**Lecture by Prof. Hiroi from Kyoto University** Prof. Hiroi had the lecture about intordustion of socialsecurity and medical insurance. The points of lecture is as below: ・ Points of Social Security ・ Characteristic of Social Security in Japan ・ Characteristic of Medical Insurance in Japan ・ History of Social Security and Medical Insurance in Japan ・ Problem to be sold
	13 :30-16 :00	**Lecture by the Ministry of Health, Labour and Welfare** Dr. Tanimura explained the health system and health insurance system in Japan. The points of lecture is as below: ・ History of medical insurance system ・ Outline and characteristics of the system ・ Challeges of the present system and possible policy interventions toward improvement ・ Lessons learned ・ Medical service chain ・ Realignment wih private insurance
2016/5/17	10 :00-11 :30	**Lecture by the Helth Insurance Claim Review and Reimbursement Services** Participants visited the Health Insurance Claime Review and Reimbursement Serivices and had a seccion regarding the followings. ・ Medical service fee in Japan ・ Position and Structure of Health Insurance Claims Review and Reimbursement Services ・ Digitization of Medical Fee Claims ・ Review of Electronic Medical Fee Claims
	13 :30-16 :00	**Lecture by the Ministry of Health, Labour, and Welfare** Dr. Tanimura gave the lecture about payment system of medical insurance and the central social insurance medical council in Japan. ・ Outline of medical payment system ・ Histry and characteristic of medical payment system ・ Management of advanced medical treatment ・ History of central social insurance medical council ・ Procedures on revising price of medical payment
2016/5/18	10 :00-12 :00	**Lecture by the Japan Health Insurance Association** Participants visited the Japan Health Insurance Association and had a seccion regarding the followings. ・ Outline and role of the Association ・ Financial situation of the Assosiation ・ Efforts of Medical care expenditure regulation
	13 :30-15 :30	**Lecture by the Health Insurance Society** Participants had a seccion by the Health Insurance Society regarding the followings. ・ History of the public health insurance for the whole nation

Date	Time	Activities
		・ Situation of medical insurance system ・ Outlin and role of Health Insurance Society ・ Finacial condition and problems of Health Insurance Society ・ Activities of Health Insurance Society
2016/5/19	9 :30-11 :30	Transfer (Tokyo – Sakudaira)
	13 :30-16 :00	**Lecture by Saku City** 1. Activities of health care ・ Introduction of Saku city ・ Health life expectancy in Saku city ・ Development of health activities ・ Challenges and activities on promotion of admission to health insurance and imposition 2. National health insurance service in Saku City ・ Financial condition
2016/5/20	9 :30-11 :30	**Lecture by Saku Central Hospital** 1. Lecture by Dr. Izawa ・ Introduction of Saku Central Hospital ・ History of health care in Saku area 2. Lecture about medical IT system in Saku Central Hospital ・ How to claim for medical fee
	13 :00-14 :50	**Lecture by Sakuho Town** ・ Intoroduction of Sakuho Town ・ History and outline of health activities for decreasing medical care expenditure
	15 :30-17 :00	**Lecture and Site Visit to Kitaaiki Village Clinic** ・ Health care activities and management by Dr. Matsuhashi ・ Condition of Kitaaiki Village
2016/5/21	10 :00-12 :00	Transfer (Sakudaira – Tokyo)
2016/5/22	-	Preparation of groupe presetation
2016/5/23	9 :30-12 :30	**Lecture by Prof. Shimazaki from National Graduate Institute for Porlicy Studies** ・ Characteristic of public health insurance for the whole nation and the way to achive UHC ・ Explanation of essence and process of public health insurance for the whole nation in Japan ・ Political implication of public health insurance for the whole nation in Japan
	13 :30-16 :30	**Wrap up session of training** ・ Presentations
2016/524	-	Departure for Hanoi

3-2: The List of Participants of Study Tour in Japan

No.	Name	Title
1	Mr. CAO Ngoc Anh	Head of Provider payment method management Division, DPF, MoH
2	Mr. THAM Chi Dung	Deputy head of Provider payment method management Division, DPF, MoH
3	Ms. PHAM Thi Minh Nga	Deputy head of State financing, DPF, MoH
4	Mr. DANG Trung Ha	Officer, Provider payment method management Division, DPF, MoH
5	Ms. NGUYEN Sao Mai	Officer, Provider payment method management Division, DPF, MoH
6	Mr. DANG Hong Nam	Deputy head of Health insurance Department, MoH
7	Mr. LUONG Bao Khanh	Administration of Medical Service Management, MoH
8	Ms. PHAM Hong Thuy	Vietnam Administration of HIV/AIDS Control, MoH
9	Ms. NGUYEN Thi Thanh Ha	Department of Health insurance policy, Vietnam Social Security
10	Ms. NGUYEN Thi Huong	Vice Head, Department of Price Management, Ministry of Finance
11	Ms. HOANG Thu Thuy	Deputy head of Public health Department, Health Strategy and Policy Institute
12	Ms. LUU Thi Lien	Deputy manager of Department of Health in Hanoi
13	Ms. NGUYEN Thi Thu Ha	Deputy head of Finance and Accounting Unit, Department of Health in Hoa Binh province
14	Mr. DINH Ha Nam	Deputy manager of Department of Health in Gia Lai province

3-3: Template of Report on Training in Japan

(Tokyo and Saku, 15-24 May 2016)

Name:

Organization:

Position:

Email (in block letter)

1. Training Schedule
2. List of Persons met
3. Information you obtained from each organization

(1) Ministry of Health, Labour and Welfare

(2) National Federation of Health Insurance Societies

(3) Health Insurance Claims Review & Reimbursement Services

(4) Japan Health Insurance Association

(5) Saku City

(6) Sakuho Town

(7) Saku Central Hospital

(8) Kitaaiki Village Clinic

(9) Professor Yoshinori Hiroi, Kyoto University

(10) Professor Kenji Shimazaki, GRIPS

4. Your objectives before the participating of the training
5. How much have you achieved your objectives through the training program?
6. What have you studied from the Medical Insurance System in Japan?
7. Are there any points which may be introduced to the Health Insurance System in Viet Nam?
8. Are there any points which will not be introduced to the Health Insurance System in Viet Nam?
9. Overall evaluation of the training program
10. Additional questions or requests if any (to be answered)

3-4: Photos of Study Tour in Japan

Orientation on May 15

Courtesy Call on JICA on May 16

Lecture by Prof Hiroi on May 16

Lecture by Dr. Tanimura from Ministry of Health, Labour and Welfare on May 16

Lecture by Review System of Medical Fee Claims in Japanese Health Insurance on May 17

Lecture by Review System of Medical Fee Claims in Japanese Health Insurance on May 17

Lecture by Japan Health Insurance Association Head Office on May 18

Lecture by National Federation of Health Insurance Societies on May 18

Lecture by Saku City on May 19

Lecture by Dr. Izawa from Saku Central Hospital on May 20

Visit the reception of Saku Central Hospital on May 20

Lecture by Sakuho Town on May 20

Visit Kitaaiki village clinic on May 20

Lecture by Prof. Shimazaki from National Graduate Institute for Policy Studies on May 23

Presentation in Lap Up Session on May 23

Lap Up Session on May 23

3-5: Itinerary and Participants of Study Tour in Japan on Health Insurance Claims Review & Reimbursement Services

<table>
<tr><th>Date</th><th>Itinerary</th></tr>
<tr><td rowspan="3">Tue, 22 Nov.</td><td>Arrive in Tokyo</td></tr>
<tr><td>JICA Headquarters</td></tr>
<tr><td>Ministry of Health, Labour and Welfare
• Overview of medical security system and insured medical services in Japan
• Overview of medical fee claim, examination and payment flow, and prevention and measurements against illegal and improper claims
• Overview of revising of medical fee schedule
• Overview, roles and responsibility of the Central Social and Medical Insurance Committee</td></tr>
<tr><td rowspan="2">Wed, 23 Nov.</td><td>Health Insurance Claims Review & Reimbursement Services (HICRRS), Headquarters
• Overview and mission of HICRRS
• Overview of claim examination and IT
• Measurements for illegal and improper claims</td></tr>
<tr><td>HICRRS, Tokyo Brunch
• Examples of claim examination</td></tr>
<tr><td>Thu, 24 Nov.</td><td>All-Japan Federation of National Health Insurance Organizations (NHIO)
• Overview and mission of NIHO
• Overview of claim examination and IT
• Measurements for illegal and improper claims</td></tr>
<tr><td>Fri, 25 Nov.</td><td>IT company</td></tr>
<tr><td>Sat, 26 Nov.</td><td>Reporting</td></tr>
<tr><td>Sun, 27 Nov.</td><td>Leave for Hanoi</td></tr>
</table>

No	Name	Position	Organization
1	Mr. Pham Luong Son	Deputy Director General	Vietnam Social Securiry (VSS)
2	Mr. Le Hong Huyen	Director of Social Department	Central Economics Commission
3	Mr. Đặng Nguyen Binh	Deputy Director of Department IV	Central Organization Commission
4	Mr. Trần Đức Long	Director	Inspection and Auditing Department, VSS
5	Mr. Do Van Khoan	Director	Northern Center for Medical Review and Tertiary Care Payment, VSS
6	Mr. Nguyễn Kim Chiến	Staff	Information Technology Center, VSS
7	Mr. Le Xuan Ky	Deputy Director	Organization and Personnel Department, VSS
8	Mr. Duong Tuan Duc	Deputy Director	Health Insurance Implementation Department
9	Ms. Dang Thi Thanh Ha	Deputy Director	Ninh Binh Social Security Office
10	Trần Thị Thu Trà	Deputy Director	International Cooperation Department, VSS
10	Mr. Lê Nguyên Bồng	Deputy Director	Information Technology Center, VSS
12	Ms. Nguyen Thi Thu Trang	Staff	Project Management and General Affairs Division, International Cooperation Department, VSS

Appendix 4: Summary of the Amendment of Health Insurance Law

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
1	Governing Scope and Subjects of Application	-
2	Interpretation of Terms	・ Health Insurance is a compulsory scheme implemented by the State for non-profit purposes. ・ All household members included in the family registers or temporary residence book shall be insured. ・ "Basic health service package (BHSP) covered by health insurance fund" is added.
3	Health Insurance Principles	・ It is clearly specified that the basis of premium are monthly salaries, retirement pensions, allowance, or base salaries. ・ The benefit levels depend on groups of the insured and the period of premium payment, in addition to seriousness of sickness.
4	State Policies on Health Insurance	-
5	State Management Agencies in charge of Health Insurance	-
6	The Ministry of Health's Responsibilities for Health Insurance	・ MOH shall promulgate regulations on technical procedures and guidance of medical examination, treatment and referral, in addition to formulating policies and laws, organizing service providing systems. ・ Also, MOH shall promulgate BHSP covered by health insurance fund.
7	The Finance Ministry's Responsibilities for Health Insurance	Responsibilities of MOLISA, MOET, MOND and MOPS are added to instruct and determination and administration of the insured. ・ MOLISA (Ministry of Labor, War Invalids and Social Affairs) shall take care of the following insured groups; persons with meritorious services and war veterans and their family as well as their relatives, children under 6, pensioners of social protection pensions, and the poor and groups in socio-economic difficulties. ・ MOET (Ministry of Education and Training) shall take care of students and foreign student granted by the Vietnam Government. Also, MOET shall provide primary health care in the school in cooperation with MOH. ・ Ministry of National Defense (MOND) and Ministry of Public Security (MOPS) shall take care of commissioned officers, solders, police officers, police students, public security officers, as well as their relatives. Also, those shall cooperate for contracting between the medical facilities under those jurisdiction and VSS.
8	Responsibilities of People's Committees at All Levels for Health Insurance	・ The People's Committee from central to provincial levels shall be responsible for instructing of the local SS and administration on the use of annual surplus of the health insurance fund. ・ The People's Committee of communes, wards and towns shall prepare the list of target groups except the employees, persons with meritorious services and war veterans, and students. Also, it shall request health insurance card and birth certificate for the children under 6.

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
9	Health Insurance Institutions	-
10	Audit of the Health Insurance Fund	-
11	Prohibited Acts	-
12	The Insured	See the table below.
13	Health Insurance Premium Rates and Responsibilities to Pay Health Insurance Premium	See the table below.
14	Salaries, Remuneration, Allowances Serving as a Basis for Health Insurance Premium Payment	The monthly salary as a basis of the premium amount shall not exceed 20 times of the minimum wage.
15	Method of Payment of Health Insurance Premium	See the table below.
16	Health Insurance Card	The effective dates are clearly determined. ・ Upon the first payment ・ New card: upon the expiry of the pervious health insurance ・ When the premium was not paid for more than 3 months in a year, 30 days after resume the payment. ・ When a preschool child become 6 before his/her school year, it is effective until 30 September in such year. ・ The health insurance organization shall provide the sample of health insurance card after reaching consensus of MOH.
17	Grant of Health Insurance Cards	・ Responsibility to identify people to be insured is clearly mentioned. ➢ Employees – employers ➢ Students and foreign students granted by the State – Education/Training institutions under MOE. ➢ Officers under MOND/MOPS – MOND/ MOPS ➢ The others – the People's committee at commune level ・ The health insurance organizations shall issue the cards within 10 working days after receipt of the completed applications.
18	Re-grant of Health Insurance Cards	・ The insured shall be eligible during the re-issuance process. ・ The fees for the re-issuance shall be prescribed by MOF (Ministry of Finance), not MOH. ・ The fees shall not be required when the re-issuance is caused by failure of the social insurance organizations.
19	Exchange of Health Insurance Cards	-

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
20	Revocation, Seizure of Health Insurance Cards	· Concurrent issuance shall also be revoked.
21	Scope of Health insurance Benefits	· Medical examinations for early detection of some diseases were annulled. · The Minister of Health shall be responsible for providing list of medical services, drugs and supplies to be covered by health insurance, and scope of benefits.
22	Levels of Health Insurance Benefits	· Benefit levels are concretely determined. See the table below for the level for each group. · 100% shall be covered in CHS within the prescribed amount by the Government.6 times of minimum wage at the registered hospital. · 100% shall be covered for the insured who had paid premium at least 5 years and spend more than · The benefit levels in non-registered health facilities without official procedures are as follows: ➢ Central hospital: 40% of inpatient treatment costs ➢ Provincial hospital: 60% of inpatient treatment costs until 31 Dec. 2020; 100% from 01 Jan. 2021. ➢ District hospital: 70% of examination and treatment costs until 31 Dec. 2015; 100% from 01 Jan. 2016. · District and commune levels are free-access within the province from 01 Jan. 2016. · Provincial level is free-access within the nation from 01 Jan. 2021.
23	Cases not eligible for Health Insurance Benefits	Suicide, poisoning, visual disturbance of children, and are covered by health insurance.
24	Health insurance-covered Medical Care Providers	Private providers could be covered medical facilities when those contract with the health insurance organizations.
25	Contracts on Health Insurance-covered Medical Care	· Concrete criteria are set to be a covered medical facility. · MOH shall cooperate with MOF to provide a sample contract.
26	Registration for Health Insurance-covered Medical Care services	-
27	Treatment-line Transfer	-
28	Procedures for Health Insurance-covered Medical Care	-
29	Health Insurance Assessment	-
30	Methods of Payment of Costs of Insured Medical Care	Explanation of capitation is modified.

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
31	Payment of Costs of Health Insurance-covered Medical Care	· Conditions for direct reimbursement for the insured are modified. ➢ Use a non-covered medical facility ➢ The process is failed to the regulation. ➢ Other special cases prescribed by MOH · MOH and MOH shall regulate unified medical service fees covered by health insurance for each level.
32	Advancement, Payment, Settlement of Costs of Health Insurance-covered Medical Care	· The health insurance organization shall make advance payment of 80% of the settled amount of the previous quarter within 5 working days from the receipt of the financial statement. · The initial advance payment shall be made 80% of estimated amount by the health insurance organization. · When the quarterly claim amount exceeds the budget, the medical facility shall send a report to VSS. · Health facilities shall submit monthly claim by 15 of next month, quarterly financial statement by 15 of the first month of next quarter. · The health insurance organizations shall notify the verification result within 30 days from the receipt of the quarterly financial statement, and make payment within 10 days from the notification. · Annual accounting report and handling of surplus shall be made by 10 Jan. every year. · The direct payment to the insurer shall be made within 40 days from the receipt of the request.
33	Sources for Setting Up the Health Insurance Fund	-
34	Management of the Health Insurance Fund	Management mechanism is not clearly mentioned. The Vietnam Social Insurance Management Board shall administer the health insurance fund.
35	Use of the Health Insurance Fund	· Allocation and use of the health insurance fund are defined with figures. ➢ 90% of premium – medical examination and treatment ➢ 10% of premium – administration cost and reserve fund (at least 0.05%) · Contingency shall be allocated according to the decision of the board. · Surplus at provincial level until 31 Dec. 2020 ➢ 80% shall be allocated to reserve fund. It shall be allocated within 12 months from the VSS's auditing of the financial statement. ➢ 20% shall be allocated according to priority: to expand services for the poor and socially vulnerable such as improvement of district hospitals. ➢ The allocation of the above 20% shall be made upon approval of VSS within a month from the auditing. · From 01 Jan. 2021, the 20% shall be allocated to the reserve fund. · The annual deficit shall be made up by the reserve fund of VSS.

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
36	Rights of the Insured	The insurers can choose any health insurance organizations to pay premium and any covered medical providers.
37	Responsibilities of the Insured	-
38	Rights of Organizations and Individuals Paying Health Insurance Premiums	-
39	Responsibilities of Organizations and Individuals Paying Health Insurance Premiums	-
40	Rights of Health Insurance Institutions	-
41	Responsibilities of Health Insurance Institutions	More concretely defined such as promotion of subscription and premium payment, management of the insured, and store and manage the data (i.e., use of IT, development of database).
42	Rights of Health Insurance-covered Medical Care Providers	More concretely defined such as providing medical record to the health insurance organizations, maintain validity and accuracy of the data, and providing medical certificate to the insured.
43	Responsibilities of Health Insurance-covered Medical Care Providers	-
44	Rights of Organizations Representing Employees and Those Representing Employers	-
45	Duties of Organizations Representing Employees and Those Representing Employers	More concretely defined responsibilities of the representatives of employers and employees to supervise the implementation of the law.
46	Health Insurance Inspectorate	-
47	Complaint, Denunciation on Health Insurance	-
48	Health Insurance Disputes	-
49	Handling of Violations	More concretely defined "violation" and the case of employers who fail to their duties is added The unpaid premiums and the interests shall be paid in twice of the amount. When it is still not paid, the State Treasuries shall deduct from its deposit account.

Ar.	25/2008/QH12	Points of Amendment in 46/2014/QH13
50	Transitional Provisions	-
51	Effect	-
52	Implementation Detailing and Guidance	-

Article 12 (Eligibility), Article 13 (Premium Rate), Article 15 (Premium Payment), Article 22 (Level of Benefit)

Source of Premium	Sub-Group[1]	Resp.	Premium		Benefit Level
			Rate[2]	Method	
Employers and employees	· Employees indefinite or at least 3-month full-time contracts · Salaried business · Managers · Officials and civil servants		6% of monthly salary (4% - employers, 2% - employees)	Monthly	80%
	· Part-time officers in communes, wards and towns		6% of minimum wage (4% - communes/wards/towns, 2% - the officers)	Monthly	80%
Social insurance organizations	· Pensioners (retirement and disability)		6% of the allowance	-	95%
	· Pensioners (worker's compensation, long-term treatment, old-age (≧80)		6% of minimum wage	-	95%
	· Social security recipients		6% of minimum wage	-	95%
	· Unemployment insurance recipients		6% of minimum wage	-	95%
State budget	· Commissioned officers, solders, police officers, public security officers, those students, and their relatives	MOND /MOPS	6% of monthly salary	Quarterly	100% + health insurance fund (and state budget) for non-covered services/items
	· State pension recipients	MOLISA	6% of minimum wage	Quarterly	100% + health insurance fund for non-covered services/items
	· Persons meritorious services and war veterans, and families	MOLISA	6% of minimum wage	Quarterly	100% + health insurance fund for non-covered services/items
	· Relatives of persons meritorious services and war veterans	MOLISA	6% of minimum wage	Quarterly	95%
	· Incumbent deputies of National Assembly or People's Councils at all levels		6% of minimum wage	Quarterly	80%
	· Children under 6 (pre-school)	MOLISA	6% of minimum wage	Quarterly	100% + health insurance fund for non-covered services/items
	· Social protection pension recipients	MOLISA	6% of minimum wage	Quarterly	100% + health insurance fund for non-covered services/items

Source of Premium	Sub-Group[1]	Resp.	Premium		Benefit Level
			Rate[2]	Method	
	• Poor household and other groups in socio-economic difficulties, islands	MOLISA	6% of minimum wage	Quarterly	100% + health insurance fund for non-covered services/items
	• Legal organ donors		6% of minimum wage	Quarterly	80%
Scholarship provider	• Foreign students granted by the state budget	MOET	6% of minimum wage	Quarterly	80%
State budget and the insurers	• Near-poor household		6% of minimum wage (partially paid by the state budget)	Quarterly (state budget)	95%
	• Students	MOET			80%
Head of household	• Other household		6% of minimum wage	Agriculture, forestry, fishery and self-enterprises – quarterly or bi-annually	80%
	• Other household members		1 - 6% of minimum wage 2 - 4.2% (70%) 3 - 3.6% (60%) 4 - 3% (50%) 5 and more - 2.4% (40%)		80%

Note:

1. When the individual is concurrently eligible more than one group, the earlier clause shall be applied. For example, a 4-year-old child living with his/her parents working in agriculture sector and not the poor, he/she are eligible as “children under 6”.
2. When an employee works for more than one employer, higher salary shall be a basis of the premium amount.