HEALTH EQUITY AND FINANCIAL PROTECTION IN ASIA

POLICY BRIEF

CHALLENGES TO REACHING UNIVERSAL HEALTH COVERAGE IN VIETNAM

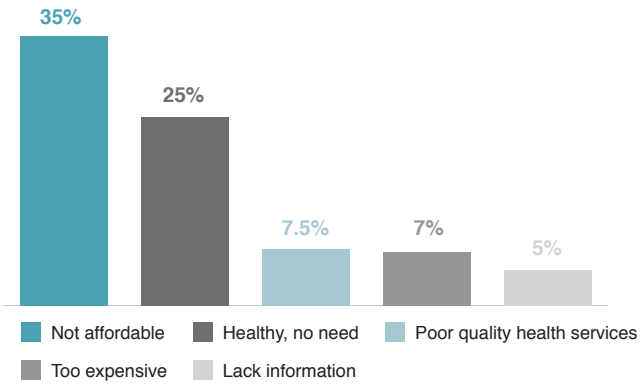
Like many other countries, Vietnam is striving to achieve universal health coverage (UHC) in the context of an evolving health system. This policy brief summarises HEFPA's research into the viability of extending coverage and constraints on the achievement of this goal.

Q HOW MIGHT VIETNAM REACH UHC IN A SUSTAINABLE FASHION?

Extending social health insurance from coverage mainly of civil servants and formal sector workers to the rest of the population in Vietnam has been pursued by fully subsidising the poor and young children (<6 years). This has contributed to around two-thirds of the population now being covered. Reaching the remaining third dependent on informal sector employment is a major challenge. Despite a premium subsidy of 70 per cent offered to the near-poor, coverage remains very low. HEFPA conducted an experiment designed to establish the extent to which insurance uptake is impeded by affordability, as opposed to a lack of information on the benefits of coverage.

Two other studies reveal potential threats to the universal coverage agenda from seemingly unrelated health system reforms. One assesses whether replacing fee-for-service with capitation payment of providers of insured services results in reduced provision to the insured compensating overprovision of services to the uninsured. The other study suggests that granting hospitals operational autonomy increases their activity but can result in over-servicing of patients and higher out-of-pocket payments.

REASONS REPORTED FOR NOT ENROLLING IN SOCIAL HEALTH INSURANCE



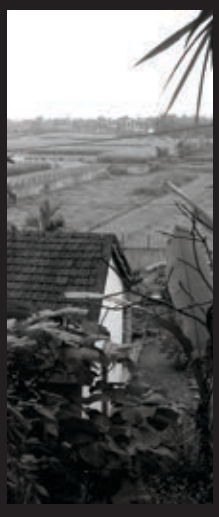
Q DOES A PREMIUM DISCOUNT INCREASE ENROLMENT?

Affordability is the most obvious deterrent to insurance enrolment. Indeed, it was the reason most frequently given by uninsured participants in the HEFPA study for not taking out cover. Other reasons given included low perceived need, poor quality-insured services and not knowing where to buy insurance.

If households lacking experience of insurance products do not fully understand the concept of insurance, nor appreciate its potential benefits, then lowering its cost will be ineffective in raising participation. A randomised experiment was therefore carried out to provide evidence on the relative responsiveness of enrolment to a 25 per cent premium subsidy and to the provision of information through a leaflet explaining both the operation of the insurance scheme and the benefits of the coverage offered.[1]

HOW THE EXPERIMENT WAS CONDUCTED

The experiment randomly assigned roughly 2,600 households in two districts of Ha Nam province, not eligible for premium subsidies offered to the poor and near-poor, into four groups: information only, subsidy only, subsidy plus information, and control. Households assigned to the two subsidy groups received entitlement to a 25 per cent reduction in the premium. The two information groups received a leaflet explaining the system and benefits of the health insurance. Enrolment was recorded continuously, and a follow-up survey conducted after one year.



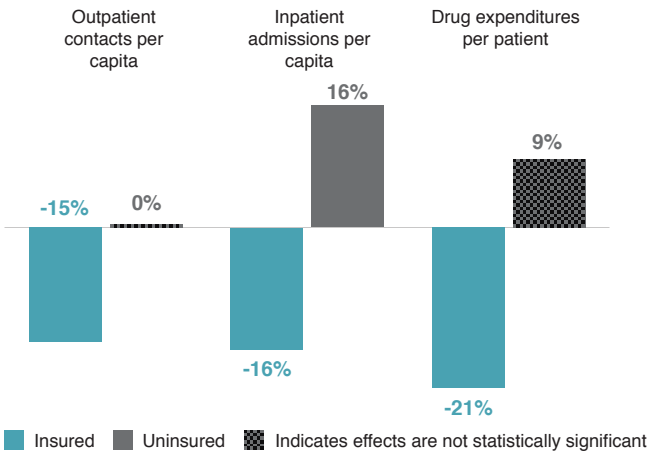
ENROLMENT INCENTIVES: FINDINGS

The 25 per cent subsidy and the provision of information had no significant impact on enrolment, irrespective of whether the two were offered in isolation or in combination. In part, this may be attributable to a small sample size. The likelihood of enrolment was higher in the groups offered the subsidy, but the difference did not reach statistical significance. However, a significant increase in enrolment was found among those reporting poor health that were offered both the subsidy and information. This may be indicative of adverse selection in the response to the incentives by those most likely to claim. In the full sample, despite the offer of a 25 per cent subsidy, coverage remained well below 10 per cent.

ENROLMENT INCENTIVES: POLICY IMPLICATIONS

The most plausible explanation for the lack of impact of the above strategies on enrolment is the low perceived benefits of health insurance, arising from observed high out-of-pocket spending and low quality of care received by the insured. The difficulty of overcoming these obstacles does not appear to be appreciated by central and provincial level officials, who were optimistic about the potential impact of the subsidy and information provision prior to the experiment. Scepticism voiced by district and commune officials, who are directly involved in the day-to-day operations, proved to be better founded. Policy makers should perhaps turn more to officials on the ground for ideas of future changes that would be more effective in encouraging enrolment. These might include better quality and value of the medical services covered by insurance, reduced out-of-pocket spending of those covered and possibly even larger subsidies to make health insurance more affordable. Of course, this combination would require a very substantial increase in government funding of social insurance.

PERCENTAGE CHANGE IN HEALTHCARE USE AND OUT-OF-POCKET DRUG EXPENDITURES DUE TO HOSPITAL CAPITATION



Q WHAT IS THE IMPACT OF CAPITATION ON COST AND OOP?

Setting appropriate provider incentives is an essential component of any social health insurance aiming to achieve efficiency, quality of care and financial protection. Vietnam has begun to move away from fee-for-service towards capitation payment of district hospitals treating patients. The uninsured continue to pay on a fee-for-service basis. HEFPA evaluated the impact of capitation on efficiency, quality and equity.[2]

Under the new payment policy, a capitation fund is allocated to each district hospital based on the size and composition of the social health insurance members in the locality it serves. These facilities play a fundholding role; they are responsible for reimbursing the cost of services used by the insured at provincial and central hospitals. This policy puts strong pressure on the district hospitals to cut costs while providing no immediate incentives to improve quality of care. The capitation scheme started in a small number of district hospitals in 2006 and is currently being scaled up rapidly, set to include all district hospitals by 2015.

HOSPITAL CAPITATION PAYMENTS: FINDINGS

Capitation resulted in a 5 per cent reduction in total recurrent expenditures for a given volume of care, while drug expenditure on both the insured and uninsured was cut by nearly 8 per cent. There was no significant effect on clinical outcomes (deaths and adverse events). Among the insured, outpatient contacts per capita were reduced by 15 per cent and inpatient admissions cut by 16 per cent. The latter, however, was offset by a 16 per cent increase in admissions of the uninsured. Drug expenditure per insured patient was reduced by 21 per cent.

HOSPITAL CAPITATION PAYMENTS: POLICY IMPLICATIONS

Capitation appears to induce cost savings without negatively affecting clinical outcomes. Hospitals respond to harder budget caps from the insurance fund by reducing the intensity of service provision to insured patients, but compensate by increasing intensity and revenues from uninsured patients. Policy makers need to be alert to potential unintended consequences of changes in provider incentives. Capitation payment can contribute to controlling costs for the insurance fund, thus relieving budgetary pressure, but it may also increase out-of-pocket spending and threaten the affordability of care for those remaining uninsured.

HOW THE FINDINGS WERE OBTAINED

Staggered implementation of both the capitation and autonomisation policies enables the effect of each to be identified, principally by comparing changes in costs and outcomes that occur in hospitals where a policy is introduced to changes in hospitals that continue to be paid for and managed as before. This difference-in-differences strategy eliminates variance in costs and outcomes related to disparity between hospitals, as well as those arising from general changes in the health system that would influence outcomes regardless of whether or not a reimbursement or management control policy is implemented.

Data are from an annual (2003-11) hospital survey conducted by the Ministry of Health.

Q HOSPITAL AUTONOMY: EFFICIENCY AT THE EXPENSE OF FINANCIAL RISK TO HOUSEHOLDS?

Financial and operational autonomy of public hospitals in Vietnam has been increased in an effort to raise efficiency. The decision-making power of hospital staff and managers has been strengthened, and their scope to benefit from surpluses extended. Hospitals have become less reliant on budget allocations and more dependent on user fees and income from the social health insurance agency. Parallel reforms have sought to protect the poor by subsidising their enrolment in the social health insurance scheme, rather than asking hospitals to grant them unreimbursed exemptions.

The HEFPA evaluation provides evidence on the extent to which autonomisation has achieved efficiency objectives without jeopardising UHC goals.[3]

AUTONOMISATION: FINDINGS

Autonomisation slightly increased hospital admissions and outpatient visits, but had no effects on bed stocks, or bed-occupancy rates. There is some evidence that the policy led to higher household out-of-pocket spending on hospital care, as well as higher spending per treatment episode. Autonomy did not affect in-hospital death rates or adverse events, but in lower-level hospitals it did lead to a more intensive style of care, with more lab tests and imaging per case.

AUTONOMISATION: POLICY IMPLICATIONS

Greater hospital autonomy appears to have brought little gains in efficiency, and yet has raised household out-of-pocket spending and so threatened the financial protection goal of UHC. Looking forward, incentives need to be tuned more finely to ensure that hospitals operate in a way that is consistent with the affordability, access and quality of care, and not only with maintaining their bottom line.

REFERENCES

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[2] Nguyen HTH, Bales S, Wagstaff A, Dao H, 'Getting Incentives Right: An Impact Evaluation of a District Hospital Capitation Payment Scheme in Vietnam', Policy Research Working Paper 6709, The World Bank (see also *HEFPA Working Paper 17*, Erasmus University Rotterdam).

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PROJECT IDENTITY

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- **World Bank Development Research Group** http://econ.worldbank.org/

FURTHER INFORMATION

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