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INNOVATIONS FOR SUCCESSFUL SOCIETIES

EASING THE BURDEN OF CARE: PLANNING AND BUDGETING FOR HEALTH IN VIETNAM, 2005 – 2015

SYNOPSIS

In 2005, Vietnam's legislature voted to develop a new health insurance system that would reduce most citizens' out-of-pocket health-care costs and instructed the health ministry to take steps to make care more accessible, more affordable, and more effective—especially for those who lived in remote, mountainous regions. One of the challenges was how to manage scarce resources in order to constrain soaring costs. Another was how to coordinate with provinces and local governments (districts and communes)—which controlled much of the country's health-care spending—in order to achieve national priorities, such as improved preventive care. During the next several years, the health ministry's Department of Planning and Finance worked with those subnational units to improve the financial information system, hone strategies and plans, and align activities. By 2014, Vietnam's government had more than tripled its per-capita health-care spending—to US$48.82 in 2014 from US$15.52 per capita in 2005, in current US dollars—a rate of growth that outpaced the average in both low-income and lower-middle-income countries. Although the ministry still struggled to keep patients' costs down, the share of out-of-pocket spending fell to 45% in 2015 from 67% in 2005, according to government figures.

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INTRODUCTION

In early 2005, some 20 years after introducing economic reforms that liberalized the economy, the Politburo of Vietnam's Communist Party convened to assess results—both the good news and the bad. Vietnam's economy had expanded, and its people were more prosperous. *Doi Moi*, or Renovation—the policies that had expanded the scope for the private sector—had helped more than double gross national income per capita from 1989 to 2005, thereby improving opportunities for many, though not all, of the country's nearly 84 million citizens.[1] However, the country faced a sticky challenge: how to make health care more accessible, affordable, and effective—especially for low-income citizens. Average life expectancy was 74.26 years, and infant mortality, at 19.8 per 1,000 live births, was well below the levels of most middle-income countries. But Vietnam still had to take big strides to meet the targets it sought to achieve by 2015 under the United Nations' Millennium

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Development Goals.[2] And although the country's 1992 constitution enshrined health care as a universal right, high out-of-pocket costs were putting that right out of the reach of many poorer citizens: In 2004, medical expenses pushed one in 25 non-poor Vietnamese households below the poverty line, according to one study.[3] Out-of-pocket spending accounted for 67% of Vietnam's total health-care expenditures.[4] And the government spent about 9% of its budget on health care in 2005—on a par with Brazil and South Africa but below Thailand, Colombia, and Mexico.[5]

In February 2005, the Politburo issued a resolution that sought to respond to those challenges. "Health protection and care in our country remain insufficient and weak," the policy committee announced.[6] Vietnam, it added, should reform health finance "with a view towards a rapid increase in the proportion of the public expenditure share (state budget, health insurance), and gradual declines in the form of direct out-of-pocket health spending of patients."[7] The Politburo also directed the government to pay more attention to the services people wanted—to become more sensitive to demand—and to make special efforts to identify the needs of people living in remote areas—the home of many of the country's minorities. The goal was to reform the health-care system so that care became more affordable for more people.

Duong Huy Lieu, director of the health ministry's Department of Planning and Finance, and his colleague Nam Lien would soon find themselves at the center of a major reform initiative.

THE CHALLENGE

The Politburo's commitment rallied the government to action.[8] As a first step, the legislature extended free health-care coverage to all children younger than six years of age, adding them to the pool of people already covered under compulsory insurance: schoolchildren, current and retired civil servants, the very poor, and people living in certain remote areas. That decision expanded the proportion of Vietnamese who had public health insurance coverage in 2005 to roughly 60%.[9]

Meanwhile, the health ministry convened a series of meetings to translate some of the Politburo's broad goals into a strategy that included steps to modernize and expand public hospitals, to increase the domestic production of vaccines, to invest in specialized facilities, and to revise the allocation formulas that the central government used for transferring money to provinces in order to prioritize "mountainous, remote, and disadvantaged areas." The resulting plan went to the prime minister's office for review, approval, and public release in 2006, carrying the lengthy title of Master Plan for Vietnam's Health System Development to 2010 and Vision to 2020.

The strategy sketched out a division of labor. The health ministry was responsible for implementing the action plan, coordinating across the government as needed, and reporting to the prime minister, while the planning and finance ministries were responsible for overseeing capital investments and budget allocations and working with the health ministry to direct funds to priority areas.

From their offices in the health ministry's planning and finance department, Lieu and Nam Lien began to move the program forward and began to liaise with other parts of government whose assistance they needed. Both of them were civil servants with considerable experience. Lieu had joined the ministry as secretary to the minister in 1997 before becoming director of the Department of Planning and Finance with Nam Lien as his deputy.

Given the limits on the government's resources, it was essential to use public finances in a way that delivered the greatest impact possible—and that was a difficult prospect. For one, the health sector's budgets largely represented incremental adjustments of the previous year's outlays and focused more on inputs—like numbers of hospital beds—than on programs, results, or long-term financial

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projections.[10] Prior to 2005, Vietnam's health sector lacked a process for linking policy goals to spending.

Making matters tougher still, the health ministry and the finance ministry used different digital systems to track allocations and expenditures.[11] The inconsistency made it harder to compare budget allocations with actual spending. And according to public finance specialists Phuong Anh Nguyen and Kai Kaiser, the system provided no means for recording commitments and accruals or linking purchase orders, accounts payable, expenditures, assets, and inventories.[12] Therefore, the development of a new information system was essential for improving performance.

Officials also had little capacity to assess whether money spent actually produced improved health outcomes. Such assessment would different kinds of information than conventional financial information systems provided—for example, data on changes in the incidence of specific health problems and numbers of people treated for a given disease and their posttreatment health status. As one World Bank document noted in 2003, "Vietnam lack[ed] even a basic mechanism for monitoring the actual outcomes of public spending and for feeding this information back into resource allocation decisions."[13]

Further, the health ministry only controlled a fraction of the government's total health expenditures. It had to work with Vietnam's 63 provincial-level governments (including 5 major cities), districts, and communes. Provinces received about 45% of the national budget's health-care money, transferred directly from the treasury. The districts within each province and their constituent communes received 18%, compared with the 37% that went to central government institutions responsible for health care.[14] For the most part, provinces allocated lump sums to the district- and commune-level governments below them based on such factors as number of hospital beds, patients, or health-care workers in a particular jurisdiction. The provinces were largely free to budget their health-care spending without much input from the central health ministry. Decentralization limited officials' authority to connect budgets to national priorities.

The coordination challenges did not end there. The health ministry also had to align its work with the work of the finance ministry, the planning ministry, and the social security agency—which ran Vietnam's health insurance programs—to manage the planning and budgeting process.

FRAMING A RESPONSE

The health-care team was fortunate in at least one respect. As part of a broader public administration reform project begun in 2001, Vietnam's finance ministry was already planning a series of changes to public financial management across the government. A response to the aftermath of the Asian financial crisis and the prospect of declining oil revenues, the changes sought to make the government more cost-efficient. [15] Two of the five projects the finance ministry had prioritized for reform were especially relevant to planning and budgeting in the health sector, but in 2005, officials were still discussing how to move them forward.[16]

The first was the finance ministry's plan to pilot medium-term expenditure framework (MTEF) in several ministries and provinces. Medium-term-expenditure frameworks project a government's spending over a rolling period—usually three to five years. And during the 1990s and early 2000s, an increasing number of governments had started to use that approach to help them focus on priorities.[17] Along with the ministries of education, transportation, labor, and agriculture, Vietnam's health ministry would be one of the country's first spending agencies to experiment with the practice. As part of the pilot, it would have a three-year budget ceiling and could plan how it wanted to spend its resources within that limit. The hope was that that practice would enable officials to better align their policy priorities with financial realities beyond a single

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budget year, although projected allocations might still vary if economic conditions varied from projections and revenues fell or rose to unanticipated levels. The medium-term framework supplemented the ministry's existing 5- and 10-year plans, which focused on priorities and projected expenditures.

The second change was a decision to try to eliminate inconsistencies in the government's various computerized accounting systems and to enhance capacity by installing a government-wide financial management information system. In 2003, the finance ministry secured World Bank help to create a new and better alternative.

After weighing its options, the finance ministry decided to buy a complete information system off the shelf. In 2005, it entered into a contract with Oracle-IBM for both the software and the implementation, with the aim of gradually rolling out the system across the national government—including the Ministry of Health—during the following years.[18]

Focusing other agencies and levels of government on achieving the priorities laid out in the 2006 health-care strategy also required concerted attention. The experience of responding to the Politburo's 2005 directive had created a possible model. To prepare the 2005–10 plan, the health minister had chaired a drafting committee that included the heads of his own departments as well as representatives of local governments and other parts of the national government whose activities affected public health. In support, staff members organized a series of conferences, seminars, and consultations and helped synthesize comments on the draft while also incorporating international commitments such as the Millennium Development Goals as well as targets set by Vietnam's legislature, the National Assembly. The final proposal had then gone to the minister of health, Nguyen Quoc Trieu, for his approval, before submission to the prime minister's office. The team had to further formalize the process and adapt it in order to align objectives and activity throughout the government.

GETTING DOWN TO WORK

The health ministry team began to move the agenda forward in a process that would unfold gradually during the course of 10 years. And even though the changes were under way, the legislature was still trying to find the right spending formula that would help Vietnam attain its health-care goals while also respecting budget constraints—a task that would become more urgent after the 2008 downturn in the world economy (text box 1).

Linking priorities to the budget

The first step was to get some of the new priorities into the budget so as to ensure those

Box 1. Finding a Spending Formula

Further legislation designed both to ensure health care remained a priority and to redirect spending to preventive care underscored the importance of being able to plan ahead and use the budget as a management tool. In 2008, the National Assembly enshrined into law certain gradual increases in health-care spending. Nguyen Van Tien, former vice chairman of the legislature's social affairs committee, said he and his colleagues had initially lobbied for a resolution that would commit the government to devote at least 10% of each annual budget to health care. In the end, Tien said, the social affairs committee scaled back its ambitions. Instead of 10%, the legislature committed the government to spend a higher share of the state budget on health care each year than in the previous year. (As Tien explained, boosting health care's budget share by even a tiny fraction of a percent would, technically, clear that bar.) The legislature also set targets with regard to ways the health sector could spend those resources and resolved that the government should strive to devote 30% of its health-care expenditures to preventive care instead of focusing on curative care, as it had in the past.

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priorities received the financial resources they needed. Provincial authorities and central government ministries followed similar calendars, interacting with stewards of the budget process—the finance ministry, the planning ministry, and the prime minister's office—throughout the cycle.

The process began in February of each year, when the finance ministry's budget department worked with the general departments of taxation and customs to develop a revenue forecast for the state budget of the year to come. In mid March, said Nguyen Tri Phuong, a planning specialist in the finance ministry, the department sent the draft to the finance minister, who again consulted with tax, customs, and planning officials and other stakeholders before presenting a final version to the prime minister's office for approval.

Meanwhile, the health ministry sent an outline of its annual priorities to the finance ministry's budget department. Nam Lien, who was deputy head of the health ministry's planning and finance department at the time, said the ministry also projected the costs of its proposals as it prepared for the next stage of the process.

In August, officials from the two ministries met in Hanoi to discuss the proposed health-care budget. The conversations offered health and finance officials an opportunity to review the health sector's performance during the previous fiscal year, and when the health ministry overshot or underspent its budget allocations from the year before, it would have to explain why such was the case. Nam Lien said the most frequent reasons for deviations were sudden, expensive developments, such as disease outbreaks; or health ministry overestimates of the amount of money a particular program would cost; or activities that had fallen behind schedule.

Next, the finance ministry's budget department used the revenue and expenditure estimates to develop a budget framework for the year ahead and sought to secure approval by the prime minister and the legislature by mid November. After that, the health ministry's planning and finance department had just a few weeks to allocate the funds it received—a process it completed by December 31. Nam Lien said the finance and health ministries tended to agree on spending outlines during their earlier meetings, in July and August and that the final allocation the legislature approved in November usually did not depart significantly from the budget framework the finance ministry had envisioned earlier in the year.

Piloting the MTEF

As this process moved forward, Lieu and Nam Lien also began to work with colleagues at the finance ministry on a medium-term-expenditure framework or MTEF. The health ministry was one of several ministries and provinces involved in this experiment—as part of a project supported by the World Bank. Led by the Department of Planning and Finance, the framework mapped out the health ministry's likely spending during a three-year period. (The regular five-year plans, which the government continued to construct, did not rest on multiyear projections of resources likely to be available.)

The pilot project sought to acclimate the health ministry to use of a medium-term framework—in anticipation of a broader reform of budget practices across the government through a new budget law.

The effort to generate a three-year-expenditure framework gradually moved forward but also encountered occasional obstacles, including a need for new laws to enable certain parts of the process, the difficulty of bringing four levels of government together around aspects of the plan, and lack of enthusiasm on the part of some of the staff members who had to work on the medium-term-expenditure framework in addition to handling their regular responsibilities.[19]

In the end, said Nam Lien, the ministry team did not use the framework to shape annual planning or budgeting in practice. But World Bank officials argued that the purpose of the pilot was less to have an immediate impact on financial management and more to lay the groundwork for

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an eventual transition to medium-term planning and budgeting across the government.[20] In 2017, almost a decade later, the finance ministry would once again step up its efforts to help the ministry use the frameworks more effectively.

Creating an information system

Like other central government ministries, the Ministry of Health started to adopt the new financial management information system—called TABMIS (for Treasury and Budget Management Information System) in 2010, five years after the finance ministry purchased the system—and started to train and equip its own officers to use it.

In Hanoi, finance ministry officials from a TABMIS implementation unit trained health ministry accountants in the use of the system. Provincial officials, meanwhile, convened in Hanoi, Ho Chi Minh City, and Da Nang, where they spent two to three weeks learning how to use the software before going back to their provinces and starting to use the new system there.[21]

Putting TABMIS into practice proved challenging. The health ministry had more than 140 separate internal cost centers, including special management units for certain donor-supported projects. The ministry's work also spanned many different types of activities, so it took time to develop a menu of terms that accountants could use to describe expenditures accurately and in a standardized format. There were not enough trained staff members to help enter data. And many of the ministries lacked adequate internet access or computers.

To cope with those problems, a small group of civil servants in the ministry used print reports their colleagues provided, entered the data, and monitored expenditures. The hope was to gradually delegate some of those steps to accountants in each cost center, as more and more people got trained and had adequate technology to participate.

Aligning priorities

As the effort to introduce a new information system began, it was also time to prepare a new five-year plan to cover the years 2011 through 2015, translating the priorities in Master Plan and Vision to 2020 into the next stage of the ministry's work.[22] A further round of consultation began. The International Health Partnership, which aimed to improve development cooperation in health care in order to help meet the Millennium Development Goals, facilitated some of the conversations.

When complete, the proposed text included targets in 19 categories that spanned (1) health outcomes—like maternal mortality rate and prevalence of HIV/AIDs—and (2) health inputs, such as number of physicians per 10,000 citizens. The text also provided estimates of aggregate annual budgets that the health sector would require at the central and subnational levels. "The annual budget plan relied on the five-year plan to a limited extent," said Lieu, who stepped down as director of the health ministry's Department of Planning and Finance in 2009.

Notably absent were details on how officials would implement the proposed changes.[23] Lieu said the sector's medium-term plans served as an inspiration for policy rather than as a technical road map.

One of the biggest challenges Lieu and his team expected to encounter was persuading local authorities to align their own plans with national priorities.[24] In 2011, Vietnam's subnational authorities—its 63 provincial, 713 district-level, and 11,162 commune-level governments—were responsible for 88% of the country's recurrent expenditures on health care.[25,26] Those outlays reflected a mix of local revenues and transfers

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from the central government. In the context of decentralization, it was vital to improve coordination with provinces and commune-level governments.

Subnational authorities prepared budgets separately from the health ministry. In the health sector, details of the process's early phases varied depending on how each province delegated spending responsibilities to its districts and communes. But in general, the process worked first from top to bottom—as provinces told their subordinate districts how much in transfer funding to expect and gave them other guidance—and then from the bottom up: (1) as communes developed budgets for their districts' approval, (2) as districts developed budgets for their provinces' approval, and, finally, (3) as provincial authorities passed their consolidated budget proposals on to the finance ministry.[27] Every August, representatives of the provincial governments' executive arms, known as *provincial people's councils*, met with finance ministry officials to discuss their proposals for the year ahead.[28]

Since 2004, the subnational budget process had revolved around what Vietnamese officials called *stability periods*. Stability periods were blocks of three to five years, during which the central government transferred funds to the provinces at constant per-capita rates—depending on sector—with the aim of making the annual budgeting process more predictable for the provincial authorities.[29] The health ministry developed those capitation rates, as they are known, based on provinces' historical spending patterns, health conditions, economic conditions, and emerging needs.

Once the provinces had the transfers in hand, it was up to them to decide which authorities would be responsible for spending the money. From 2004 to 2006, for instance, 17 provinces reserved local health-care spending as their own responsibility, whereas 25 others shared that role with district- and commune-level authorities, to which they transferred funds in turn.[30] Of course, provinces that delegated money to subordinate governments had to decide how to do so: some of them based such transfers on the populations of their districts and communes, whereas others used the number of hospital beds or health-care workers as the basis for allocation.[31] What provincial transfers had in common with their central government analogues was that they conveyed resources mainly through block grants.

At the end of the budget year, provincial, district, and commune-level authorities had just a few weeks to vote in their local councils to enact their budgets and, finally, to approve transfers of funds from local governments to health-care facilities.[32] That process gave the health sector and the finance ministry little ability to focus activity on priorities or to control spending. Although devolving budgetary control to provinces, communes, and other units could help make health care more responsive to citizens' needs, it had created coordination problems and necessitated new systems for managing information so that the health ministry could know whether spending actually matched allocations and plans.

The health ministry had some ways to deal with the coordination challenge that this structure created. As Nam Lien put it, "We usually conduct conferences and trainings between the health ministry and the directors of the provincial departments of health to provide guidance" around the health ministry's priorities. But as Lieu acknowledged, the health ministry couldn't enforce compliance with those guidelines. "Provinces made their own decisions regarding public health," he said.

Preventive care was one arena in which local governments often shifted responsibility to the health ministry. In 2008, the National Assembly determined that at least 30% of the health-care budget be dedicated to preventive medicine. Localities faced strong pressures to spend in other ways, however, and because the central government covered vaccinations, malaria control, and other aspects of preventive care, they sometimes decided to underspend on this priority. Nam Lien said there was insufficient

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awareness of preventive medicine, and the ministry found it hard to persuade subnational authorities to allocate support.

OVERCOMING OBSTACLES

Linking priorities to the budget gradually helped channel attention to some of the country's poorer citizens. But another problem lay ahead: containing costs proved much harder than anticipated.

At the time of the Politburo's 2005 resolution, about two-thirds of health-care spending was out of pocket, and reducing those costs was a high priority as part of the effort to expand access for the poor. Officials immediately started to review insurance options and the cost of subsidizing coverage for the country's poorest residents. Tong Thi Song Huong, former head of a provincial health department, became the leader of a new department at the health ministry dedicated to that task. Song Huong said her team began the process by looking at models used by such countries as China, Germany, Japan, South Korea, and Thailand.

Song Huong's department chose to build on Vietnam's current system by merging the existing, fragmented government insurance programs into a single system. Her team submitted draft legislation to a working group consisting of representatives of the finance ministry; the social security agency; the Ministry of Labor, Invalids, and Social Affairs; and the justice ministry. A subcommittee met to hammer out the details around premiums and subsidies. The health ministry then handed the draft to the legislature's committee on social affairs, which sent it for a vote and eventual passage into law.

The new health insurance program combined programs that already existed for the poor with those that served everyone else. The government pledged to pay insurance premiums for young children, older citizens, and the less well-off, including less-well-off ethnic minorities; and it promised to partially subsidize premiums for students and the near poor. As enrollment grew, spending would rise, but in an expanding economy, the drafters reasoned, increased outlays would be feasible—within limits.[33]

For the most part, officials managed the health insurance fund separately from the state budget, as many countries did.[34] In Vietnam's case, the social security agency, rather than the state treasury, ran the health insurance fund; and the finance ministry did not classify the fund's projected revenues or expenditures in the annual budget the legislature reviewed. The exception was the bill for insurance subsidies, which came out of the government's annual operating budget.

Each year, the social security agency worked with the finance ministry to calculate the amount the government would pay into the subsidies. When disbursed, the funds bypassed the health ministry and went directly to the social security agency's 63 provincial-level branches, which used them and the rest of the insurance pools they oversaw to pay health-care providers.

The social security agency's policies shaped the cost of care and the public expenditure on subsidies. Usually, the agency paid public hospitals through a fee-for-service system. Under fee-for-service, insurers paid providers for services after providers delivered those services. If a patient had an appendectomy, for example, hospital administrators filed a claim with the social security agency, and the agency reimbursed the hospital according to a list of fees. The difference between the cost of the treatment and the amount reimbursed by the social security agency was the responsibility of the patient.

Under that system, hospitals had an incentive to provide expensive services in order to capture the accompanying fees. Lack of rigorous guidelines regarding which treatments to provide for particular conditions meant that hospitals could get away with delivering expensive treatments to patients who had only routine complaints. Fraud was also a problem, as some hospitals fleeced the social insurance fund for services they had not in fact delivered.

The social security agency lacked the capacity to properly investigate every case of inappropriate spending. And under a government decree issued

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in 2006, many health-care facilities were allowed to use 75% of their revenues to boost staff salaries, thereby increasing the allure of charging patients for expensive services.[35] As a consequence, costs rose—and so did patients' out-of-pocket payments. Lieu said he and his team had expected to encounter that challenge when the health insurance law went into effect.

The ministry and the social security agency experimented with other ways to pay hospitals. Under a capitation system, the social security agency paid facilities based on the number of patients in each insurance class that the agency expected those facilities to treat each year. Under a diagnosis-related-group system, the agency reimbursed hospitals according to patient load across various treatment groups, yet facilities resisted introduction of the former method, and the health ministry and social security agency lacked the capacity to successfully manage the latter one. By the end of 2015, neither scheme had taken off, and fee-for-service remained the country's dominant payment mechanism.

In an attempt to make facilities' requests for payment more transparent, in 2016 the social security agency worked with three Vietnamese companies to build an online claims database and install it in health-care facilities. In theory, the database would enable the agency and the Ministry of Health to figure out where requests for reimbursement from the health insurance fund were unusually high—a first step in targeting facilities that had unreasonable spending patterns. At the end of 2017, some 98% of Vietnam's public hospitals had installed the online claims database the social security agency had developed to cut down on medical costs. But as Song Huong put it, "The main contribution of the online system is transparency," and there were no guarantees it would help lower costs for patients.

By 2017, the social health insurance fund's yearly expenditures were significantly exceeding the fund's annual revenues, according to Nguyen Minh Thao, who was then the social security agency's vice director. The agency planned to reach into its reserve funds to cover the deficit until 2020, Thao said. The health ministry and the agency considered amending the health insurance policy to expand coverage, which would increase the number of people contributing to the insurance fund, would standardize the kinds of drugs and devices permitted for specific treatments, and would tighten the social security agency's ability to review insurance claims. Nam Lien, meanwhile, suggested that the way forward was to treat more patients at lower-cost local facilities while raising premiums. The balance that officials struck among those various approaches—some of which sought to increase revenues flowing to the insurance fund and some of which aimed to control spending—would shape health-care financing in Vietnam in the years to come. Some of these decisions were still pending in 2018.

ASSESSING RESULTS

In 2015, Vietnam introduced a new state budget law. The product of years of preparation in the finance ministry, the revised law introduced medium-term-expenditure frameworks across the government, gave the legislature more power to review spending, and called for the government to release a version of each year's budget proposal to the public. All of those processes kicked off in 2017, when the new law went into effect.[36]

By experimenting with a medium-term-expenditure framework in the years after 2008, the health ministry was starting to prepare itself for that change. In theory, permanent introduction of the medium-term-expenditure framework made it easier for health sector officials to align the sector's next strategic plan with financial reality. For decades, however, officials had organized strategic plans for health care over 5- or 10-year periods—far longer than three-year medium-term-expenditure planning lasted. And by 2018, the new approach was still a work in progress.

The government-wide financial management information system, TABMIS, also continued to face hurdles. The number of reporting units within the ministry was high, said Nam Lien, and

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people authorized to use the system, who had the required skills, were still too few. The finance ministry was struggling to train sufficient numbers of health ministry officials, and as a result, it was still difficult to use the budget as a management tool.

Nevertheless, Vietnam had made some progress toward the goal the Politburo had set in 2005: Public spending on health care rose quickly over the decade, even as general government expenditures on health care as a percentage of the government's total spending did not.[37] By 2014, Vietnam's government had more than tripled the amount of money it was spending on health care—to US$48.82 per capita in 2014 from US$15.52 per capita in 2005, in current US dollars— a rate of growth that outpaced the average in both low-income and lower-middle-income countries.[38] From 2005 to 2015, the share of total health-care expenditures represented by out-of-pocket spending fell from 67% to 45%, according to government figures—a relatively high figure but one that still represented some progress.

The changing balance between public and private spending on health care reflected rising enrollment in Vietnam's public health insurance programs. The percentage of the population covered by such programs rose from 37% in 2006 to roughly 77% in 2015.[39] During the same period, the share of health-care spending covered by social insurance rose to 35% from 27%.[40]

REFLECTIONS

Officials in Vietnam's health sector enjoyed support from the highest levels of the government and the Communist Party—in particular from the Politburo. The Politburo's endorsement of progressively higher health-care spending and the rapid introduction of insurance policies that guaranteed more government subsidies cleared the way for transformation of the sector's finances.

At the same time, Vietnam faced some of the same challenges in managing health care that afflicted other countries. In particular, decentralization made it harder to focus on priorities because of the complexities associated with improving intergovernmental coordination and cooperation.

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