



INNOVATIONS FOR SUCCESSFUL SOCIETIES

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

SYNOPSIS

In 2005, Vietnam’s legislature voted to develop a new health insurance system that would reduce out-of-pocket healthcare costs for most citizens 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 challenge was how to manage scarce resources in order to constrain soaring costs. Another was how to coordinate with provinces and local governments, which controlled much of the country’s health budget, in order to achieve national priorities, such as improved preventive care. Over the next several years, the health ministry’s department of planning and finance worked with other parts of government to improve the financial information system, hone strategies and plans, and align activities across levels of government. By 2014, Vietnam’s government had more than tripled the amount of money it spent on health, to \$48.82 per capita in 2014 from \$15.52 per capita in 2005, in current U.S. 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 costs down for patients, the share of out-of-pocket spending fell from 67% to 45%, according to official figures.

ISS staff members drafted this case study based on interviews conducted in Hanoi, Vietnam by Simon Engler and Huong Dang in May, June, and August 2018. This case is still in draft form.

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. On the one hand, Vietnam’s economy had expanded, and its people were more prosperous. *Doi Moi*, or “Renovation”—the policies that expanded the scope for the private sector—had helped more than double gross national income per capita between 1989 and 2005, improving the opportunities of 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 1000 live births, was well below the level 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 UN’s Millennium Development Goals.² And although the country’s

1992 constitution enshrined healthcare 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

Government spending on health accounted for a much smaller share of the government budget than it did in comparable countries in 2005, while out-of-pocket spending accounted for 67 percent of Vietnam's total health expenditures.⁴

In February, the Politburo issued a resolution that sought to respond to these challenges. "Health protection and care in our country remains insufficient and weak," the Politburo announced.⁵ 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."⁶ The Politburo also directed the government to pay more attention to the services people wanted—to be more sensitive to demand—and to make special efforts to identify the needs of people living in more remote areas, home to many of the country's minorities. The goal was to reform the health system so that care became more affordable for more people.

Duong Huy Lieu, the 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.⁷ As a first step, the legislature extended free health care coverage to all children younger than six, 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. This decision expanded the proportion of Vietnamese who had public health

insurance coverage in 2005 to roughly 60 percent.⁸

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; increase the domestic production of vaccines; invest in specialized facilities; and revise the allocation formulas that the central government used to transfer money to provinces in order to prioritize "mountainous, remote, and disadvantaged areas."⁹ The resulting plan went to the prime minister's office for review, approval, and public release in 2006. It carried the lengthy title, "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 liaise with the other parts of government whose assistance they needed. Both men 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, focused more on inputs—like numbers of hospital beds—than on programs, results, or long-term financial projections.¹⁰ Prior to 2005, Vietnam's health

sector lacked a process for linking policy goals to spending. Lieu and Nam Lien would have to find a way to use the budget to meet the new priorities.

Making matters tougher still, the health ministry and the finance ministry used different digital systems to track allocations and expenditure.¹¹ The inconsistency made it harder to compare budget allocations, which were registered at the finance ministry, with actual spending, which was registered at the health ministry. Comparing allocations to spending was one way to improve performance over time. Developing a new information system was one part of building this capacity.

Officials also had little capacity to assess whether money spent actually produced results. This required a different type of information than conventional financial information systems provided—for example, data on changes in the incidence of specific health problems, or numbers of people treated for a given disease and their post-treatment 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.”¹² (Many comparable countries also lacked this capacity at this time.)

Further, the health ministry was just part of the picture: it had to work with Vietnam’s 63 provincial-level governments (including 5 major cities), as well as 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. Provinces received about 45% of the national budget’s health money, and districts and communes received 18%, compared to the 37% that went to the central government.¹³ For the most part, provinces allocated lump sums to the district- and commune-level governments below them based on such factors as the number of hospital beds, patients, or health workers in a particular jurisdiction. They were largely free to budget their health spending without much input

from the central health ministry. This arrangement limited officials’ abilities connect budgets to national priorities.

FRAMING A RESPONSE

The health 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.¹⁴ Two of the five projects that the finance ministry had prioritized for reform were especially relevant to planning and budgeting in the health sector; in 2005, officials were still discussing how to move them forward.¹⁵

The first was the finance ministry’s plan to pilot medium-term expenditures in several ministries and provinces. Medium-term expenditure frameworks project a government’s spending over a rolling period, usually of between three and five years. Over the course of the 1990s and early 2000s, an increasing number of governments had started to use this approach to help them focus on their priorities.¹⁶ Along with the education, transportation, and labor and agriculture ministries, the health ministry would be one of the first spending agencies in Vietnam to experiment with the practice. As part of the pilot, it would receive a three-year budget ceiling and could plan how it wanted to spend its resources within that limit. The hope was that this practice would allow officials to better align their policy priorities with financial realities beyond a single budget year, though projected allocations might still vary if economic conditions departed from projections and revenues fell or rose to unanticipated levels. The medium-term framework supplemented the ministry’s existing five- and ten-year plans, which focused on priorities and projected expenditures.

The second change was a decision to try to eliminate the inconsistencies in the government’s

various computerized accounting systems by installing a government-wide financial management information system. After weighing its options, the finance ministry decided to buy a complete information system (IFMIS) off the shelf. In 2005, it procured a turnkey system from IBM, with the aim of gradually rolling it out across the national government, including the ministry of health, over the following years.¹⁷

Focusing other agencies and levels of government on achieving the priorities laid out in the 2006 health strategy also required concerted attention. The experience of responding to the Politburo's 2005 directive had created a possible model. To prepare the 2005-2010 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, and targets set by 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 needed to formalize this process further and adapt it to

help align objectives and activity throughout the government.

GETTING DOWN TO WORK

The health ministry team began to move this agenda forward in a process that would unfold gradually over the course of ten years. While these changes were underway, the legislature tried to find the right spending formula to help Vietnam attain its health goals while also respecting budget constraints, a task that would become more urgent after the 2008 downturn in the world economy. (See text box 1.)

Linking priorities to the budget

The first step was to get some of the new priorities into the budget, to ensure they received the financial resources they needed. The annual budget process ran from January through December each year.¹⁸ Provincial authorities and central-government ministries followed similar calendars, interacting with the 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, 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 in the year to come. In mid-March,

Box 1. Finding a Spending Formula

Further legislation designed 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 passed a resolution enshrining gradual increases in health spending in law. Nguyen Van Tien, the former vice chairman of the legislature's social affairs committee, said that he and his colleagues initially lobbied for a resolution that would commit the government to devote at least ten percent of each annual budget to healthcare. In the end, Tien said, the social affairs committee scaled back its ambitions. Instead of ten percent, the legislature committed the government to spend a higher share of the state budget on health each year than in the previous year. (As Tien explained, boosting health's share of the budget by even a tiny fraction of a percent would technically clear this bar.) The legislature also set targets for how the health sector could spend these resources and resolved that the government should strive to devote 30 percent of its health expenditures to preventive care, instead of focusing on curative care as it had in the past.

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 the 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 budget. These conversations offered health and finance officials an opportunity to review the health sector's performance during the previous fiscal year. When the health ministry overshot or underspent its budget allocations from the year before, Nam Lien said, it would have to explain why that was the case. He added that the most frequent reasons for deviations were sudden, expensive developments, such as disease outbreaks; health ministry overestimates of the amount of money a particular program would cost; or activities that were 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 the approval of 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 that it completed by December 31. Nam Lien said that the finance and health ministry tended to agree on the outlines of spending during their earlier meetings, in July and August, and that the final allocation that the legislature approved in November usually did not depart significantly from the budget framework that 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. The health ministry was one of several ministries and provinces to experiment with a medium-term expenditure framework, 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 over a three-year period.

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

The effort to generate three- to five-year expenditure frameworks gradually moved forward but also encountered occasional obstacles, including the need for new laws to enable some parts of the process, the difficulty of bringing four levels of government together around aspects of the plan, and lack of enthusiasm among some of the staff members who had to work on the MTEF while 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 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. 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 between two and 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 over 140 separate internal cost centers, including special management units for some donor-supported projects. Its work also spanned many different types of activities, so developing a menu of terms accountants could use to describe expenditures accurately, and in a standardized format, took time. There were not enough trained staff members to help enter data. Further, the ministries many units did not all have adequate internet access or computers.

To cope with these problems, a small group of civil servants in the ministry used print reports their colleagues provided, entered the data, and monitored expenditure. The hope was to gradually delegate some of these steps to accountants in each cost center, as more people were 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 from 2011 through 2015, translating the priorities in Master Plan and Vision 2020 into the next stage of the department's work.²² A further round of consultation began. The International Health Partnership +, which aimed to improve development cooperation in health in order to help meet the Millennium Development Goals, facilitated some of the conversations.

When complete, the proposed text included some hard targets in 19 categories, spanning both health outcomes, like the maternal mortality rate and the prevalence of HIV/AIDs, and inputs, such as the number of doctors per 10,000 citizens. It 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 how officials would implement proposed changes.²³ Lieu said that the sector's medium-term plans served as an inspiration for policy rather than as a technical roadmap.

One of the biggest challenges Lieu and his team expected to encounter was getting 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 percent of the state's recurrent expenditures on health.^{25 26} Those outlays reflected a mix of local revenues and transfers 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, the details of the process' early phases varied, depending on how each province delegated spending responsibilities to its subordinate 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, as communes developed budgets for their districts' approval, as districts developed budgets for their provinces' approval, and, finally, as provincial authorities passed on their consolidated budget proposals to the finance ministry.²⁷ Each August, the representatives of the provincial government's executive arms, known as the 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. These were blocks of between three and five years during which the central government transferred funds to the provinces at constant per-capita rates, depending on the sector, with the aim of making the annual budgeting process more predictable for provincial authorities.²⁹ The health ministry developed those capitation rates, as they were 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 them. Between 2004 and 2006, for instance, 17 provinces reserved local health spending as their sole 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 based the transfers on the population rates in their districts and communes, while others looked to such measures as the number of hospital beds or health workers.³¹ What provincial transfers had in common with their central-government analogues was that they largely depended on block grants rather than on the expected costs of particular health-sector programs.

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 the transfer of funds from local governments to health facilities.³²

This process gave the health sector and 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 citizen 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 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 had determined that at least 30% of the health budget should go 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 that there was insufficient 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 lurked around the corner. Containing costs proved much harder than anticipated.

At the time of the Politburo's 2005 resolution, about 67% of health spending was out-of-pocket. Reducing these 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 these for the country's poorest residents. Tong Thi Song Huong, the former head of a provincial health department, became the leader of a new department at the health ministry dedicated to this task. Song Huong said that her team began

the process by looking at models from such countries as China, Germany, Japan, South Korea, and Thailand.

Song Huong's department chose to build on Vietnam's merge existing government programs into a single system. Her team submitted draft legislation to a working group comprising 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 the provisions that already existed for the poor with those that served everyone else. The government pledged to pay the premiums for young children, the elderly, and the poor, 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 that 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 break down 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 that the government would pay into those subsidies. When disbursed, these 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 healthcare providers.

The social-security agency's policies shaped the cost of care and 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 to 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 this system, hospitals had an incentive to provide expensive services in order to secure the accompanying fees—a common challenge with this provider-payment mechanism. A lack of rigorous guidelines regarding which treatments to provide in responses to particular conditions meant that hospitals got away with delivering expensive treatments to patients with routine complaints. Fraud was also a problem, as some hospitals fleeced the social insurance fund for services that they did not in fact deliver.

The social-security agency lacked the capacity to properly investigate every possible case of inappropriate spending. And under a government decree issued in 2006, many health facilities were allowed to use 75 percent of their revenues to boost staff salaries, increasing the allure of charging patients for expensive services.³⁵ As costs rose, so did out-of-pocket payments.

Lieu, who stepped down as head of the health ministry's planning and finance department in 2009, said that he and his team had expected to encounter this challenge when the health insurance law went into effect.

The ministry and the social-security agency experimented with other ways to pay hospitals in response. Under one system, known as capitation, 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 another, known as the

diagnosis-related group system, the agency reimbursed hospitals according to the patient load across various treatment groups. Yet facilities resisted the 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 facilities. In theory, the database would allow 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 with unreasonable spending patterns. At the end of 2017, some 98 percent of Vietnam's public hospitals had installed the online claims database that 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 that it would help lower costs for patients.

By 2017, the social health insurance fund's yearly expenditures significantly exceeded its yearly revenues, according to Nguyen Minh Thao, who was then the social security agency's vice director. The social-security agency planned to reach into its reserve funds to cover the deficit until 2020, Thao said. The health ministry and social-security agency considered amending the health insurance policy so as to expand coverage, thus increasing the number of people contributing to the insurance fund; standardize the kinds of drugs and devices permitted for particular treatments; and 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 these various approaches—some of which sought to increase

inputs into the insurance fund and some of which aimed to control spending—would shape health financing in Vietnam in the years to come.

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 had started to prepare itself for that change. In theory, the 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 over five- or ten-year periods—far longer than three-year medium-term expenditure planning lasted. And by 2018, the new approach was still a work in progress.

As for the government-wide financial management information system, TABMIS, here too there was still a distance to go. The number of reporting units within the ministry was high, said Nam Lien, and people with the skills to enter data and use the system were still too few. Only a few civil servants had authority to use the system, as a result.

Nevertheless, Vietnam had made some progress toward the goal that the Politburo had set in 2005. Public spending on health rose quickly over the decade, even as general government expenditure on health 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 spent on health, to \$48.82 per capita in 2014 from \$15.52 per capita in 2005, in current U.S. dollars—a rate of growth that outpaced the

average in both low-income and lower-middle income countries.³⁸ Between 2005 and 2015, meanwhile the share of total health expenditures represented by out-of-pocket spending reportedly fell from 67 percent to 45 percent—a relatively high figure that still represented some progress.

The changing balance between public and private spending on health reflected the fact that more and more people were enrolling in Vietnam’s public health insurance programs. The percentage of the population covered by such programs rose from 37 in 2006 to roughly 77 percent in 2015.³⁹ Over the same period, the share of public spending on health occupied by social insurance rose to 35 from 27 percent.⁴⁰

REFLECTIONS

Officials in Vietnam’s health sector enjoyed support from the highest levels of the government and the Communist Party—and in particular, from the Politburo. The Politburo’s endorsement of progressively higher health spending and the rapid introduction of insurance policies that guaranteed more government subsidies cleared the way for the 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—not impossible, but certainly more time-consuming as a result of the meetings and workshops required to build support.

References

- ¹ World Bank Data, via <https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD?locations=VN&view=chart>
- ² World Bank Data accessed at <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=VN&view=chart>
- ³ With the poverty line defined as “the food expenditure of the household whose food expenditure share of total household expenditure is at the 50th percentile in the country.” See Hoang Van Minh, Nguyen Thi Kim Phuong, Priyanka Saksena, Chris D. James, Ke Xu. “Financial burden of household out-of-pocket health expenditure in Viet Nam: Findings from the National Living Standard Survey 2002–2010.” *Social Science & Medicine*, Volume 96, 2013, Pages 258-263, ISSN 0277-9536. <https://doi.org/10.1016/j.socscimed.2012.11.028>
- ⁴ World Health Organization Global Expenditure Database.
- ⁵ Quoted in Kirsten Priwitzter, *The Vietnamese Healthcare System in Change: A Policy Network Analysis of a Southeast Asian Welfare Regime*. Singapore: Institute of Southeast Asian Studies, 2012, p. 198
- ⁶ Ministry of Health Viet Nam and Health Partnership Group. *Joint Annual Health Review 2008: Health Financing in Viet Nam*, p. 69
- ⁷ Priwitzter, *The Vietnamese Healthcare System in Change*, p.198.
- ⁸ Hy V. Luong. “Vietnam in 2005: Economic Momentum and Strong State-Society Dialogue,” *Asian Survey*, 46, 1 (January/February 2006), p. 151
- ⁹ Socialist Republic of Vietnam. Comprehensive Development Design for the Health System in Vietnam to 2010 and Vision by 2020. Hanoi, June 30, 2006. <http://www.wpro.who.int/countries/vnm/VietnamMOH020101LCWHO0607.pdf>
- ¹⁰ Van Tien, T., H. T. Phuong, I. Mathauer, and N. T. K. Phuong. 2011. *A Health Financing Review of Vietnam with a Focus on Social Health Insurance (Bottlenecks in Institutional Design and Organizational Practice of Health Financing and Options to Accelerate Progress towards Universal Coverage)*. Geneva: World Health Organization.
- ¹¹ World Bank, *Project Appraisal Document on a Proposed Credit in the Amount of SDR39.90 Million (US\$54.33 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*, April 2003, <http://documents.worldbank.org/curated/en/942081468780601741/pdf/IDA1R200310082101VN1public0fin0mgmt.pdf>
- ¹² World Bank, *Project Appraisal Document on a Proposed Credit in the Amount of SDR39.90 Million (US\$54.33 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*
- ¹³ Nguyen Khanh Phuong. “Viet Nam: Review of Financing of Health-care, including Health Promotion,” in United Nations. *Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region*, 2009, p. 135 (for budget year 2006). Accessed at <https://www.unescap.org/resources/promoting-sustainable-strategies-improve-access-health-care-asian-and-pacific-region>

- ¹⁴ Matt Andrews, Marco Cangiano, Neil Cole, Paolo de Renzio, Philipp Krause, and Renaud Seligmann. *This is PFM*. CID Working Paper No. 285 July 2014.
World Bank, *Project Appraisal Document on a Proposed Credit in the Amount of SDR39.90 Million (US\$54.33 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*,
- ¹⁵ World Bank, *Project Appraisal Document on a Proposed Credit in the Amount of SDR39.90 Million (US\$54.33 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*,
- ¹⁶ World Bank. *Beyond the Annual Budget: Global Experience with Medium-Term Expenditure Frameworks*. Washington, DC: International Bank for Reconstruction and Development / The World Bank, 2013. P. 27.
- ¹⁷ Joshi, Srivastava, Van Nguyen, *FMIS Study of Selected PEMNA Members: Lessons for Other Countries*
- ¹⁸ Vietnam State Budget Law, www1.worldbank.org/publicsector/pe/BudgetLaws/VietnamStateBudget.doc
- ¹⁹ World Bank, *Implementation Completion and Results Report (IDA-37670 IDA-48630 TF-50988), Credit in the Amount of SDR49.10 Million (US\$63.83 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*, April 2014,
<http://documents.worldbank.org/curated/en/264541468319763280/pdf/ICR30840P075390C0disclosed060260140.pdf>
- ²⁰ World Bank, *Implementation Completion and Results Report (IDA-37670 IDA-48630 TF-50988), Credit in the Amount of SDR49.10 Million (US\$63.83 Million Equivalent) to the Socialist Republic of Vietnam for a Public Financial Management Reform Project*, April 2014,
<http://documents.worldbank.org/curated/en/264541468319763280/pdf/ICR30840P075390C0disclosed060260140.pdf>
- ²¹ Suhas Joshi, Arun K. Srivastava, Minh Van Nguyen, *FMIS Study of Selected PEMNA Members: Lessons for Other Countries*, Public Expenditure Management Network in Asia, http://blog-pfm.imf.org/files/pemna-t-cop_fmis-study-of-selected-pemna-member_lessons-for-other-countr...pdf
- ²² Ministry of Health of Vietnam. *Five-Year Health Sector Development Plan 2011–2015*. Hanoi: December 2010.
http://www.wpro.who.int/health_services/viet_nam_nationalhealthplan.pdf
- ²³ Ministry of Health of Vietnam. *Five-Year Health Sector Development Plan 2011–2015*. Hanoi: December 2010.
http://www.wpro.who.int/health_services/viet_nam_nationalhealthplan.pdf
- ²⁴ Ministry of Health of Vietnam. *Five-Year Health Sector Development Plan 2011–2015*. Hanoi: December 2010.
http://www.wpro.who.int/health_services/viet_nam_nationalhealthplan.pdf
- ²⁵ “Current Local Administration System in Vietnam.” *Vietnam Law and Legal Forum Magazine*. March 11, 2017.
<http://vietnamlawmagazine.vn/current-local-administration-system-in-vietnam-6058.html>
- ²⁶ World Bank. *Making The Whole Greater Than The Sum Of The Parts: A Review of Fiscal Decentralization in Vietnam: Summary Report, 2015*, p. 40. <http://documents.worldbank.org/curated/en/854701468187138479/pdf/103669-v2-WP-P128790-v2-PUBLIC-FDR-FINAL-Sept28-15.pdf>
- ²⁷ Phuong Nguyen-Hoang and Larry Schroeder. “An Analysis of Quasi-Decentralized Budgeting in Vietnam.” *International Journal of Public Administration*, 33: 12-13, 706.
<https://www.tandfonline.com/doi/abs/10.1080/01900692.2010.514449?src=recsys&journalCode=lpad20>
- ²⁸ Asian Development Bank. *Public Financial Management Systems—Viet Nam: Key Elements From a Financial Management Perspective*. Mandaluyong City, Philippines: Asian Development Bank, 2017, p. 12.
<https://www.adb.org/sites/default/files/institutional-document/225661/public-finmgt-systems-vie.pdf>
- ²⁹ In the decade after 2004, there were three stability periods: one from 2004 through 2006, another from 2007 through 2010, and a third from 2011 to 2015. World Bank. *Making The Whole Greater Than The Sum Of The Parts: A Review of Fiscal Decentralization in Vietnam: Summary Report, 2015*, p
<http://documents.worldbank.org/curated/en/854701468187138479/pdf/103669-v2-WP-P128790-v2-PUBLIC-FDR-FINAL-Sept28-15.pdf>,
- ³⁰ Le, C. *Fiscal Decentralization: Status and Solutions*. Hanoi: National Political Publishing House, 2006. Cited in Phuong Nguyen-Hoang and Larry Schroeder. “An Analysis of Quasi-Decentralized Budgeting in Vietnam.” *International Journal of Public Administration*, 33: 12-13, 706.
- ³¹ Phuong Nguyen-Hoang and Larry Schroeder. “An Analysis of Quasi-Decentralized Budgeting in Vietnam.” *International Journal of Public Administration*, 33: 12-13, 706.
- ³² Asian Development Bank. *Public Financial Management Systems—Viet Nam: Key Elements From a Financial Management Perspective*. Mandaluyong City, Philippines: Asian Development Bank, 2017, p. 12.
- ³³ Aparnaa Somanathan, Ajay Tandon, Huong Lan Dao, Kari L. Hurt, and Hernan L. Fuenzalida-Puelma. *Moving toward Universal Coverage of Social Health Insurance in Vietnam Assessment and Options*. Washington, D.C.: World Bank, 2014.
- ³⁴ Allen, Richard. “Managing Extrabudgetary Funds.” In *The International Handbook of Public Financial Management*, ed. Richard Allen, Richard Hemming, Barry Potter. Palgrave Macmillan, 2013. P. 396–411.
- ³⁵ Jonathan D. London. “The promises and perils of hospital autonomy: Reform by decree in Viet Nam.” *Social Science & Medicine*, Volume 96, 2013, Pages 232-240, ISSN 0277-9536, <https://doi.org/10.1016/j.socscimed.2013.07.009>

³⁶ World Bank, “Fiscal Management Reform for Middle-Income Vietnam,” April 2016, <http://www.worldbank.org/en/results/2016/04/15/fiscal-management-reform-for-middle-income-vietnam>

³⁷ WHO data, via <http://apps.who.int/nha/database/ViewData/Indicators/en>

³⁸ World Bank data, via <https://data.worldbank.org/share/widget?end=2014&indicators=SH.XPD.GHED.PC.CD&locations=VN-XM-XN&start=2000&view=chart>

³⁹ Ministry of Health of Vietnam, *Plan for people’s health protection, care and promotion 2016-2020*, [http://www.euhf.vn/upload/Strategic%20documents/82.%20MOH%205-year%20plan%20\(Eng\).pdf](http://www.euhf.vn/upload/Strategic%20documents/82.%20MOH%205-year%20plan%20(Eng).pdf)

⁴⁰ Vietnam Ministry of Health and Health Partnership Group. Joint Annual Health Review 2015. P. 58, 54. http://jahr.org.vn/downloads/JAHR2015/JAHR2015_full_EN.pdf



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