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Investing in Health for Economic Development in Vietnam:

Report on Opportunities and Constraints for a National Macroeconomics and Health Program

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This report presents the findings from the mission work as outlined in the Terms of References that can be found in Appendix 1. The opinions and conclusions expressed are those of the authors and do not necessarily reflect those of the Government of Vietnam or WHO.

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Currency Equivalents

Currency Unit = Dong (VND)

US$1 = 15,750 (as of September, 2005)

Government Fiscal Year:

January 1 to December 31

Abbreviations and Acronyms

CHS	Community Health Station
CMH	Commission on Macroeconomics and Health
DFID	Department for International Development
FPR	Food poverty rate
GDP	Gross Domestic Product
GSO	General Statistical Office
HCFP	Health Care Fund for the Poor
HEPR	Hunger elimination and poverty reduction
HPI	Human Poverty Index
MEH	Macroeconomics and Health
MOH	Ministry of Health (Vietnam)
MOLISA	Ministry of Labor, Invalids and Social Affairs
OOP	Out of pocket
OTC	Over the counter (drugs)
PPA	Participatory Poverty Assessment
SIP	Sector Investment Program
SWAp	Sector-Wide Approach
THC	Township health center
UNDP	UN Development Program
VHLSS	Vietnam Household Living Standards Survey (2002)
VHS	Village health station
VHW	Village health worker
VLSS	Vietnam Living Standards Survey (1993, 1998)
VND	Vietnamese Dong
VNHS	Vietnam National Health Survey
VMEH	Vietnam Macroeconomics and Health
WHO	World Health Organization

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None of the persons mentioned here or interviewed during the assignment are responsible for any opinions stated in this report. In particular, all errors are the responsibility of the authors.

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Summary of Main Aim, Findings, and Recommendations

Aim: The principal aim of the mission is to assess and make recommendations on the scope for developing a national program on macroeconomics and health in Vietnam.

Findings: The mission revealed opportunities, constraints, and risks with pursuing the development and implementation of a national program on macroeconomics and health in Vietnam. The main opportunities include the existence of a program outline developed by the Central Party Commission on Social Issues, a high level of awareness of the importance of investing in human capital for economic development, and the current policy challenges facing the government that might usefully be addressed within the framework of a national program on health and economic development. The main constraints include the narrow human resource base on which to draw on for the implementation of the program, the seemingly incoherencies in the policy development process, and the still fragile policy analysis capacity. The main risks of pursuing a national program on macroeconomics and health involve the danger of putting additional burden on the current policy development structure. Without due consideration of the need for mainstreaming such an initiative so as to avoid layering on the program on top of existing processes, the implementation of the program might be counterproductive.

Recommendations: With the above opportunities, constraints, and risks in mind, the recommendation of the mission is to pursue the MEH program in an incremental approach by further developing the existing proposal along the lines suggested in the report with a view to develop a complete national CMH in the medium term.

Executive Summary

This report presents the findings from a mission undertaken by the authors in September of 2005 to Vietnam. The aim of the mission was to assess the opportunities and constraints for pursuing a national Macroeconomics and Health program in Vietnam. The report consists of three main parts. The first part, Health and Economics, provides the background and objectives of the work along with a discussion of some of the particular aspects of the health sector from an economic perspective. The second part, entitled Economic, Poverty, and Health Developments in Vietnam, describes the socio-economic development of Vietnam along with a summary of the key policies that are currently on the agenda in the country. The third and final part of the report presents a set of alternative proposals for the development of a Vietnam Macroeconomics and Health (VMEH) program. In addition, this part contains a discussion of some of the main policy goals and the related issues and questions that the government would need to address, potentially within the framework of a national program on macroeconomics and health.

The work is partly based on the Report of the Commission on Macroeconomics and Health (CMH) of 2001 and on the existing proposal for such a program that has been developed by Vietnam. The CMH takes a broad approach to health and focuses on the importance of investing in health for economic growth and socio-economic development. One of the main proposals of the report was to set up national CMHs at country level, bringing together the main stakeholders, including the Ministry of Finance, Ministry of Health, and policy analysts, with a view to mobilize resources for health and improve the policy development process.

Vietnam has made impressive achievements in the past decade or so in terms of sustained economic growth and poverty reductions. In terms of health outcomes, Vietnam display considerably better outcomes than most other countries at the same level of development. Important challenges remain, however, and further efforts will be needed to effectively address remaining problems of poverty and social exclusion. Furthermore, new challenges for the health sector in particular, and the country more generally have developed.

The Vietnamese government has formulated ambitious policy goals in the health sector, the most important of which is universal health insurance by 2010. Related to this goal is the implementation of special health care funds for the poor and the scaling up of voluntary health insurance for the rural population. The successful implementation of these and other

policies will put to the test the national capacity to, among other things, monitor and evaluate the impact of the programs, not least from a poverty perspective.

The success of the policy programs will also depend on the capacity to assess the particular economic aspects of many of the health financing initiatives currently on the agenda. The report discusses a selection of these aspects with a view to highlight the importance of considering these during implementation of the policies.

The mission revealed both opportunities and constraints for the development of a national CMH. The main opportunities include: a high level of awareness of the importance of health for economic development and poverty reduction; a high level of awareness of the importance of human capital development for economic growth and poverty reduction; the formulation of a principal proposal for the development of the health sector much in the spirit of the MEH approach; and the active engagement of the Central Party in developing a national program. The principal constraints include: a narrow human resource base for conducting rigorous policy analysis; further needs to make the policy development process more coherent; inexperience and possibly unawareness of the importance of strategic implementation of policies; underdeveloped monitoring and evaluation systems. With these opportunities and constraints in mind, the report develops alternative proposals in which the opportunities are utilized and the constraints are addressed.

Based on the authors' understanding of the background documentation, the information obtained during meetings and interviews with key stakeholders in Vietnam, and on cursory analysis of the available data, the authors suggest that a task-force (or similar group) is formed consisting of the main health and other development partners of the country. The overall aim of the group would be to identify how Vietnam can develop an equitable and efficient health system that will include pro-poor health service delivery. The main task of this group would be to formulate policies based on rigorous analysis of the available information. However, the authors strongly advice that such an approach is only pursued on condition that (i) it is ascertained that it brings real value-added to the existing policy development process, and (ii) it engages all relevant stakeholders with a clear mandate, including convening powers and an identified leadership role. Fulfilling the first condition would require that the VMEH program be streamlined with the existing structure and not layered on so as to avoid making the policy process more cumbersome. The second condition would require that a formal institution is set up recognized by the relevant governmental authorities and possibly also the National Assembly. If these conditions cannot be met, the authors suggest that a step-wise approach is

taken in which the initial step would involve a group of key policy analysts charged with, one, the careful assessment of the main health and development challenges currently facing Vietnam, and two, development of a health and development investment agenda, outlining alternative steps and their implications for equity and efficiency, list of priorities, and the financial requirements needed for its implementation. The authors emphasize the opportunity for developing such a program based on the existing proposal of Vietnam, which, importantly, includes the notion of an "inter-sectoral working group" and the implementation of a series of workshops around identified themes. This report identifies some of the key issues and policy questions that might usefully be included in such a process. Next steps include the identification of the members of the working group, its formal status and mandate, and the exact scope and content of the outlined agenda.

Part I: Health and Economics

This part of the report provides a brief introduction and background to the work that will be presented in subsequent chapters. It also presents the overall aim and scope of the report, highlighting the prospective approach inherit in the task. Importantly, it also explains some of the main limitations of the study, emphasizing that the report is not a fully-fledged health sector review that looks at all or even most of the dimensions pertaining to the health sector. Finally, it contains a discussion on some of the linkages between macroeconomics and health as well as some of the fundamental issues that bring the two topics together. The main purpose of this discussion is to emphasize the importance of health for economic development and to describe some important economic aspects of the health sector. Specifically, it emphasizes the need for due consideration of these aspects during health financing reforms.

1.1. Introduction and Outline

This report presents the findings from the assignment conducted during a 10-day visit to Hanoi by the authors in September and October of 2005. During the visit, they met with an extensive set of individuals representing a wide share of the various partners involved in the economic, planning, and health sectors, both from the Government side, the academic and research institutions as well as the international development community.

The report is outlined as follows. The remaining sections of this part present the aim, scope and limitations of the report. In the next part, the developments and future challenges of the Vietnamese health sector are discussed using the available macro data and drawing on the relatively large body of evidence that is becoming available in Vietnam. The final part of the report outlines a proposal for a macroeconomics and health (MEH) program. In particular, it discusses, among other issues, the purpose, scope, and expected outcomes of such a program.

1.2. Background

In 2000, the World Health Organization (WHO) set up a Commission on Macroeconomics and Health (CMH) with a view to raise global awareness of the importance of health in

economic development and poverty reduction. In the fall of 2001, the Commission launched its report on the need for increased investments in health to improve the lives of the poor and to reduce the burden of disease for sustained economic growth in low- and middle-income countries. The report was the product of a two-year concerted effort involving a large number of both high-ranking public officials and senior experts in economics, development, and public health. The main findings and recommendations of the CMH report are summarized in Box 1 (see also www.cmhealth.org for background reports).

One specific proposal of the CMH was to establish equivalent commissions at the national level to bring health investments to the fore in country development policy discussions. Several countries have since adopted the proposal and yet others are in the early stages of establishing national commissions on macroeconomics and health (NCMH); see, for example, Sri Lanka, Nepal, Malawi, and Senegal. Recently, Vietnam expressed an interest in pursuing efforts to establish a similar process (see note from, Central Party Commission on Social Issues, 2004 in Appendix 2). The note describes the main health challenges facing the country and the need for increased investments along with improvements in the operation of services. The main objectives of the initiative are "to raise high profile of health in the national and provincial agenda; equip policy makers, from both health and economic planning, at all level of decision making with relevant information and evidences for them to make informed and coherent health and economic development policies. These policies will help to mobilize adequate resources and supports to achieving the national health goals. The findings and conclusions from the project will be important inputs for the upcoming 10th Party Congress, planned in 2006." As noted above, one particular objective of this report is to assess the current proposal and make recommendations on the continued process; see Part III of the report for details.

Box 1. Summary of Main Findings and Recommendations of the Report of the Commission on Macroeconomics and Health (CMH)

Main Findings of the CMH Report include:

 # 1: Health is an important value in itself and an important input into the economic development process.
 # 2: A relatively small number of diseases and health problems account for a large share of the global burden of disease.
 # 3: The HIV/AIDS pandemic requires special attention due to its far reaching consequences if not checked.
 # 4: Investments in reproductive health are an important component in the efforts to improve the health of the poor.
 # 5: An effective financial program to combat the major diseases of the poor (including AIDS) would require an estimate $30-$40 per person per year, the main part in the form of public spending.
 # 6 and 7: Additional resources will need to come from increased domestic resource mobilization and from international development partners.
 # 8: Service delivery systems need to focus on developing the primary health care level (or close-to-client).
 # 9: More investments in global public goods for health are needed for successful disease prevention and reduction.
 # 10: Special efforts are needed to ensure access to essential medicines in poor countries.

Main Recommendations of the CMH report include:

 # 1: establishment of a National Commission on Macroeconomics and Health (NCMH).
 # 2: increase in domestic budgetary resources for health of 1% of GNP by 2007 and 2% of GNP by 2015.
 # 3: adequate grant resources for health to be provided by the donor community for low-income countries to ensure universal coverage of essential interventions and scaled-up research for diseases of the poor.
 # 4: the international community to establish new funding mechanisms, including: the Global Fund to Fight AIDS, Tuberculosis and Malaria, a global health research fund, and country programs should direct at least 5% of outlays to operational research.
 # 5: additional financing (through the World Bank and IMF) for disease surveillance at the international level, analysis of global health trends (burden of disease), analysis of international best practices in disease control and health systems, technical assistance and training.
 # 6: adapting the existing orphan drug legislation in the high-income countries to cover diseases of the poor.
 # 7 and 8: pharmaceutical industry to ensure access of low-income countries to essential medicines at the lowest viable commercial price and to license their production to generics producers WTO member governments to ensure sufficient safeguards for developing countries to invoke compulsory licensing for imports from third-country generics suppliers.
 # 9: IMF and World Bank to work with recipient countries to incorporate the scaling up of health and other poverty-reduction programs into a viable macroeconomic framework.

Source: WHO (2001).

To assist countries with the planning and implementation of the NCMH process, the WHO established a special unit charged with coordination and the provision of technical assistance to countries. The goal of the Macroeconomics and Health (MEH) approach is to promote increased and more effective investments in health and health related sectors in low and middle-income countries to achieve sustainable and equitable outcomes for the health of the poor. The focus is on strengthening efforts of countries and sub-regions that are committed to the MEH process so that they can complete the process of preparation of health

investment plans in support of, among other objectives, the Millennium Development Goals (MDGs). It is important to recognize that there does not exist a ready made format of the MEH approach; each country needs to design its own version of the MEH suitable for the specific conditions and needs of the country. Furthermore, given most countries' already overburdened economic and health policy making bodies, it is vital that the MEH not present an additional layer in the existing policy framework of the country, but rather is allowed to function as a catalyst by providing strategic coordination and high level analytical inputs in the policy development process.

1.3. Aim, Objectives, and Scope

The Terms of References for the mission are found in Appendix 1. They specify that the overall mission objectives are (i) To assess the specific country situation relevant to the development of a macroeconomics and health programme, (ii) To assess the relevance, and adjustments if needed, of the proposal submitted by the country to Sida (Swedish international development co-operation agency), (iii) To facilitate the establishment of an institutional framework for national MH interventions, and (iv) To facilitate dissemination and discussion of MH messages among major stakeholders. Furthermore, the specific objectives are to elicit information among key stakeholders, including government and ministerial representatives, donor partners, members of the civil society, and individual researchers, health and economic development with a particular focus on poverty reduction.

Although the objectives are broad in scope, the report will take a predominantly prospective approach to the main purpose of the mission. To this end, the report recognizes and emphasizes that the adoption of the MEH approach is a process that in most cases will take several years to implement and to develop fully.

1.4. Limitations

This report is far from a complete take on the Vietnamese economy, its poverty situation, or the implication of health for socio-economic development in the country. Instead, it focuses on a set of key issues for effective policymaking and analysis in the health sector with a view to develop a comprehensive program on economic development and poverty reduction in the context of health. Consequently, the report is not a sector review that takes a comprehensive look at all or even most of the aspects pertaining to the performance and challenges of the

respective sectors. Most vital statistics and information on the Vietnamese economy and health sector can be found in other reports, some of which are listed in the Reference list of this report.

Moreover, time and other resource constraints have not permitted a profound analysis of every aspect of the identified key issues. Some questions have been dealt with more than others, sometimes for good reasons as all issues are not of equal importance and sometimes for reasons of lack of information or ambiguity as to the actual nature of the question of interest. In those cases, the report highlights the potential need for further analysis.

Finally, the report does not provide a detailed analysis of the available data. In particular, micro level evidence is not presented in terms of first hand analysis but referred to as needed. Specifically, the report does not assess any uncertainty as to the quality of the data. Part II of the report contains a presentation and brief discussions of some of the key quantitative indicators of the economy, the poverty situation, and the health developments.

1.5. Macroeconomics and Health: A Framework for Effective Health Policy Making

Macroeconomics and health economics are two distinct fields of economics, where the first deals mainly with aggregate entities within the fiscal, trade, and monetary policy areas, and the second mainly with the health related behavior of the individual (i.e. the micro level). Although it is recognized that the focus of the Macroeconomics and Health approach is the health sector, it might be useful to look more carefully at some of the linkages between the two areas, before entering into a discussion that would be based on assumptions rather than on a clear understanding of where the two areas overlap.

At the most general level, there should be no misunderstanding of where the two fields meet. In most countries, the health sector accounts for a substantial share of the overall economy, sometimes as much as over 14 percent of GDP. Regardless of whether health care is financed privately or publicly, the mobilization of these substantial amounts will have both direct and indirect macroeconomic effects, either in terms of reduced private consumption or in terms of public tax or social fees policies. More specifically, the health status of the population can affect the overall economy in several ways. First, healthy children are more likely to attend school and learn more while there. Second, healthy workers are more productive, which, all else equal, imply higher incomes. Third, people in good health have an incentive to save and

invest more and, by living longer, the ability to actually do so. Higher rates of saving and investments are strong determinants of overall economic output growth. Finally, individuals' perceptions of future good health of, in particular, their children, promotes the demographic transition from large to smaller families. Again, a strong force behind economic growth is this transition that changes the overall dependency burden of the economy by altering the composition of the population.

1.6. The Market for Health and Health Care

This section is divided in two sub-sections: 1) characteristics of the health sector, which explain the role of government. These do not exclude elements of markets but stress aspects, which need to be taken into consideration before releasing market forces in the health sector; 2) policy instruments that may be used to affect behavior of the actors of the health market.

Basic characteristics of the health sector

Macroeconomists and other policy makers often assume that the traditional market model can be applied to achieve an efficient outcome in the health sector. According to this theoretical model producers deliver goods and services and consumers pay for them. The producers use these payments to cover the costs of labor, capital and material. The consumers, assumed to be utility maximizers, will pay the price only if the utility of the good or service exceeds the price. At the margin, the price equals utility. The producers, assumed to be profit maximizers, will increase production as long as prices are higher than marginal costs. At the margin price equals production costs. Prices tell both producers and consumers how much a commodity really cost to produce and how much consumers value it. Given a set of assumption, the market model guarantee that: 1) least-cost methods will be used in the production of health services; 2) an optimal mix of different health services and other goods will be produced, and 3) those who finally gets the health services (and other goods) are those who value them most highly. Thus, the market solves all questions that otherwise have to be addressed in administrative government decision-making. So according to the model there is no role for the public sector in the health sector. What is wrong with this simple model in case of health care? Also in the health care sector, there are consumers, sellers and costs. The answer is that there is an extensive literature analyzing why market mechanisms are deficient as a tool for the allocation of resources for the health sector. Among the reasons: uncertainty about the need for health care and the results of treatments, asymmetric information between producers and consumers, the lack of a profit motive for producers and the presence of

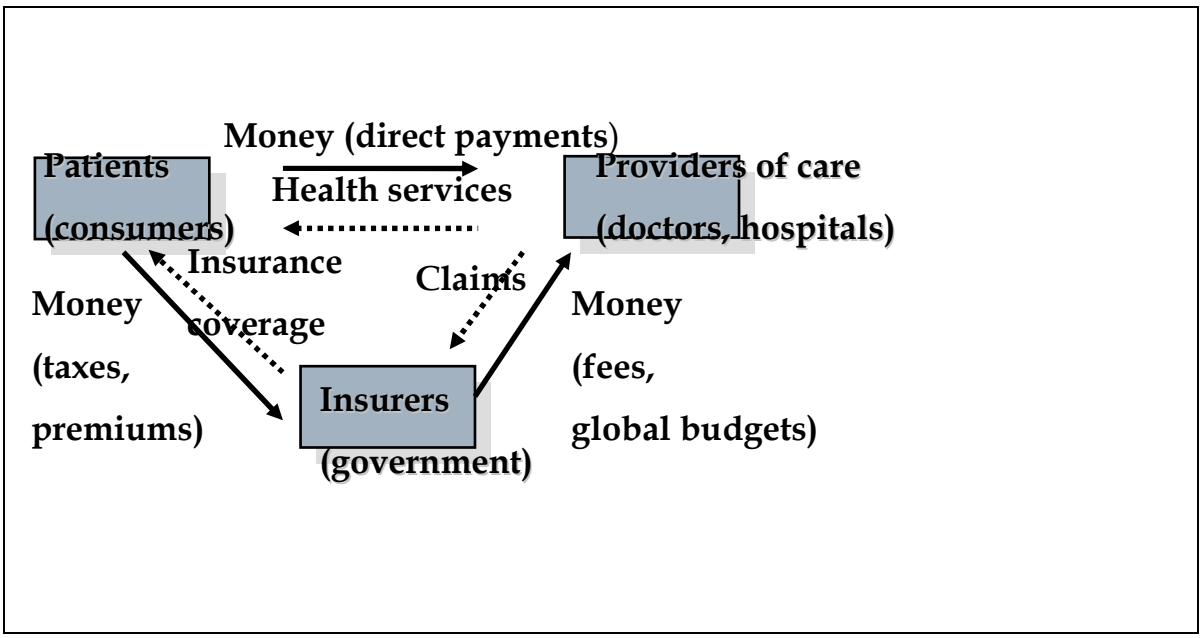
positive and negative externalities, see Arrow (1963), Culyer (1971), and Pauly (1978). This may justify public interventions when the above aspects makes the market economy do not work properly, although all interventions must be judged from the trade-off between imperfect markets and imperfect government policy making.

For most individuals, future health status is uncertain and the probability of contracting a serious disease is low. However, if the rare event occurs, the financial consequences can be significant. In fact, in all countries health spending is extremely skewed. According to Pauly (2004) a rule of thumb is that about 20% of households will make about 80% of health spending of the population and that this hold for developed as well as developing countries. Thus, while most individuals have only small health spending in a given year, a relatively small number have very large spending. Although there is weak empirical evidence on the strength of risk aversion, it is likely that most individuals are risk averse to some extend, and therefore most people try to maximize security and minimize risk. While it is difficult for the individual to prevent the occurrence of disease, it is possible to protect oneself against the financial consequences. If a large number of individuals are pooled together, their joint losses can be calculated. This is the great merit of insurance: the uncertain individual loss is replaced by a certain expenditure, the insurance premium.

The introduction of a third party --- a insurer --- complicates the financial relations in a market triangle of the health sector as seen in all health systems. The insurer provides insurance protection in exchange for premiums and pays the producers for the care delivered. The flow of money between the patients and the providers are small in developed countries, although not always in all developing countries. For example, in Vietnam direct payments from the patients to the providers are substantial (see below). This is due to lack of insurance coverage resulting from a low demand for health insurance.

Figure 1 shows three actors interacting in the health care market triangle.

Figure 1. Patients, providers, and insurers in the health care market



Third party reduces the problems associated with risk and uncertainty but introduces another problem known as *moral hazard*. This problem has three aspects. First, the reduced risk for financial catastrophe reduces the incentive to undertake preventive measures (ex ante moral hazard). Second, if the event occurs, the incentive for the insured to economize on the resources used for treatment is reduced, thus leading to over utilization as compared with a situation where the individual is uninsured and has to pay the full cost (ex post moral hazard). Third, there may be a tendency of heavily insured societies to introduce new medical technologies more rapidly, because developers know that the price elasticity of the consumer will be low and so they can count on demand for expensive new technologies which there would be no market in the absence of insurance (dynamic ex-post moral hazard) (Weisbrod 1991).

The problem of moral hazard is created by the fact that different actors have different kinds of information, and, usually, the third party has the most limited information. There are also other problems of this asymmetric information and other market failures such as externalities, which creates problems on the markets for health care market and health insurance. For example, in most health systems in developed countries, health insurance is to a large extend provided by the government in form of compulsory insurance, and there are several reasons for this:

- In a private insurance market, adverse selection may prevent some individuals from gaining access to insurance. Because it is costly to gain information about individual risks, premiums are generally related to the "average" patient. Thus, individuals with

low risks may not insure because premiums are too expensive; conversely, high risk individuals may find it difficult to get insurance as insurers try to avoid those individuals because they might also produce losses for the company, there is a risk for cream-skimming, i.e. insurers have an incentive to select "low risk" individuals and exclude "high-risk" individuals from the insurance market. These problems occurs when insurance is voluntary rather than compulsory, i.e. when everyone is in the insurance pool.

- The government may use insurance to redistribute financial resources from low-risk individuals with high incomes to high-risk individuals with low incomes. One problem with private insurances is that people with the highest expected health spending will pay the highest risk-related insurance premiums, while they have the lowest incomes.
- The government may seek to avoid the problem of free riders. If an individual chooses not to insure, the government may still end up paying for care, because it is morally unacceptable to leave someone untreated.

The asymmetry of information between producers and consumers have also be used as an argument for measures to protect the consumers for being exploited by the producers in the competitive market. This can explain the design of the delivery of health care (Arrow 1963, Weisbrod 1978). According to Evans (1984) the consumers' transactions with for-profit health care providers are limited in most health systems as most care is provided by public institutions or private not-for-profit institutions. The main argument has been that by reducing competition the incentives to exploit the consumers are reduced. A side effect is of course that the incentives to high productivity are reduced. A certain amount of "organization slack" may be accepted in organizations without competition (Evans 1984). The trade-off is between a system without competition and organizational slack on the one hand and exploited consumers on the imperfect competitive market on the other hand. We need more information to assess this trade-off.

Within the market triangle including insurers, providers and patients, as all health systems have in common, there are uncountable diversities. These are related to the organization of insurers and providers, the method of mobilizing resources to third party, the method of reimbursement of providers and the method of direct payments from patients.

Policy instruments of actors in the market triangle of health care

There are a number of policy instruments available to influence behavior of the actors in the market triangle. Musgrove (1996) distinguish between five "instruments" to affect health care performance: 1) financing of health care; 2) provisions of health care; 3) information to consumers, providers and insurers; 4) regulation of personal behavior, firms, providers and insurers; 5) mandates for health care or insurance coverage.[2] Knowledge about the relationships between various instruments, structural factors and outcomes provide a basis for well-founded policy actions.

For third party the instruments refer to institutional arrangements of third party, i.e. the insurance function, its organization, financing and allocation of funds to different health activities, which determine the size of the funds available for health care, who controls the funds, who benefits and who bears the financial burden. Third party can be organized along many dimensions. The insurance can be paid for by the market or government, it can be compulsory or voluntary, and it can be individual or collective (community rating). Government can finance health care in two ways. Either can government act as an insurer itself or can government subsidize and regulate the private insurance market. A disadvantage with government financing is that the use of the tax system generates disincentives, i.e. excess burden, which means that the cost of spending a specific amount through taxation is higher than that amount (see below). The advantage with collective insurance (private or public) relative to individual insurance is that administrative cost may be lower in the former type. In general this may be the case for public insurance. However, here the use of taxes to finance the public activities generates a tax burden, see above. As pointed out by Pauly (2004), this observation may be especially relevant for developing countries with poorly administered tax systems which may lead higher costs after all. According to Pauly (2004), this is an argument to limit the amount of insurance financed by the public sector. Of course, the importance of this argument depends on the size of the tax burden for a given developing country and the extend that administrative processes will not be improved in the near future. In the case of Vietnam, the information on this is scant, although it may be expected that efficient administrative procedures is high on the policy agenda in a transitional country like Vietnam with a high economic growth. Another advantage of collective insurance is that the adverse selection problem is eliminated or reduced. A disadvantage with collective insurance is that individual preferences may not be perfectly matched as would be the case for individual insurance where the individual can buy exactly that insurance he/she wish.

[2] Hsiao (2003) term these as "structural factors" (or "control knobs") of different aspects of health care performance and identify instruments that may be used to alter the values of these factors.

The financing of government are important for both equity and efficiency perspectives. For developed countries, studies have found that direct and indirect taxes tend to be progressive and regressive, respectively, whereas social insurance contributions are less progressive than direct taxes and even regressive in some countries. Individual payments are strongly regressive private insurance are less regressive or even progressive in some countries which is due to that it is richer people that tend to by private insurances. The progressivity of private insurances is even more pronounced in developing countries (Knowles et al 2003). From an efficiency perspective excess burden of taxation arise since taxation may affect individuals economic behavior through changes in the labor supply, e.g. through changes in number of hours willing to work or through increases in number of hours willing to work in the informal sector. So for a government intervention to be desirable the social value of the intervention must be larger than the excess burden. There are few estimations of the excess burden in different countries and for developing countries no estimates exist at all. A Swedish study concluded however, that excess burden for a payroll tax or VAT is lower than excess burden for an income tax (Hansson 1984). Since the tax burden increases with the marginal tax rate, Jönsson and Musgrove (1997) suggest among other things that the tax base should be composed of many different taxes at lower rates rather than few taxes at higher rates, e.g. income taxes, VAT. This would also increase the stability of financing and protect from cyclical variations. Government financing may also affect total health spending due to moral hazard, although this aspect is shared with private insurance. However the way government intervene in the health sector may also be important on moral hazard. For example, when government finance care through tax subsidies on health insurance premiums this stimulates over-insurance. There is also the possibility of too low spending in health care systems when government is the insurer and finance is based on general taxes (Jönsson and Musgrove 1997).

Government financing may also affect the allocation of resources within the health system, hopefully in a way that increases the efficiency. The raised funds of third party may be allocated to prevention, surgery, drugs, outpatient or inpatient care. It is not a general rule that prevention is better than treatment. In the relatively young area of the economics of epidemiology, findings suggest that it is not always preferable to try to eradicate a particular disease as opposed to controlling it. One reason for this is the herd effect of immunization, which suggests that it is enough to vaccinate around 80 percent of a given population to achieve the objective of effective disease control. Other examples for specific diseases and health conditions can also be given. For example, studies have shown that treatment of TB is secondary prevention for the sick individual, but is also primary prevention since it prevents

transmission to others. Likewise, in the case of sexually-transmitted diseases (STD), treatment of the infection is prevention of transmission to others. In other cases, such as malaria, effective control involves both treatment (early detection and treatment) and prevention (insecticide treated bed nets). In yet other types of health services, prevention and treatment work even more synergistically. For example, maternal health services include antenatal care, which is primary preventive through education and folic acid supplements, and secondary preventive through screening for factors that might lead to complications during delivery, such as high blood pressure and anemia. Tertiary prevention of complications is provided through emergency obstetric care (EOC), for women with, for example, eclampsia (Walley et al., 2001).

For the health care providers the main instruments relate to the structure of organization of health care provision and how the providers are reimbursed. A number of instruments may be identified: 1) public monopoly vs. competition in the provision of health care; 2) degree of decentralization involving which level of government that should be responsible for health care provision, i.e. central, regional or district levels; 3) vertical integration which involve the decision whether preventive, secondary and tertiary care services should be provided by separate and independent clinics and hospitals or by integrated networks of providers with clear referral guidelines; 4) ownership of health care facilities, i.e. should the organization be for-profit, not-for-profit or public institution, which all behave differently; 5) reimbursement method of the reimbursement used to pay providers for their services which may influence provider incentives. The main payment methods of the physicians are fee for services (FFS), fee per capita (capitation) or salary which influences the physician's decision regarding the quantity and quality of services provided, numbers of hours of work, etc. Similar incentives will be created for hospitals, i.e. whether hospitals are reimbursed by a fixed budget, FFS or case-based payment; government regulations of the providers, e.g. laws, decrees, orders, codes, administrative rules and guidelines; 6) information to providers may also influence physicians' behavior through e.g. increased knowledge.

The importance of payment methods to providers link to the controversial supplier-inducement hypothesis as an explanation for the increase in health spending (see Evans, 1984; Rice, 1983; Cromwell and Mitchell, 1986; McGuire et al, 1988; Newhouse, 1992). Supplier-induced demand can arise for several reasons, although the form it could take and its extent depend on institutional arrangements. Under a FFS system, doctors may adjust their work load in response to changes in the environment so that their target income can be maintained (Evans, 1974). When the stock of doctors increases and the work load decreases doctors may

induce the patients to use more services at higher prices, i.e. conditional on the target income hypothesis we have supplier-induced demand. Empirical relationships have been reported between the stock of physicians, the remuneration system and the number of surgical operations, and between the number of hospital beds, hospitalization rates and average length of stay in hospital, and between the physician stock and total outpatient expenditure.[3] Further since costs may not be borne by the patients, it may be even easier for doctors to suggest more expensive treatments. These risks are potentially large in transitional low-income countries such as Vietnam where regulation and control mechanisms are weak and where public health sector is underfunded. OECD (1995b) suggests that gatekeeper arrangements can provide for better continuity in health care while also acting as a barrier to moral hazard. A gatekeeper may reduce the risk of multiple visits for the same sickness episode, particularly where there is an over-supply of physicians, strong competition among the physicians for market shares and remuneration on a fee-for-service basis.

For the patients, many instruments may be used to change economic incentives of consumers (patients) either to increase or decrease use of health care overall for different types of health care or patient groups. For example, one issue is whether increases in insurance coverage result in too high health spending? There are two dimensions involved in insurance coverage: the population covered and the share of individual medical bills covered which may lead to increased spending due to moral hazard. User fees are one common way to control moral hazard. Studies on impact of user fees on demand for health care consistently show that increased (decreased) user fees decreases (increases) use of health care. This is also consistent with studies of the willingness to pay for health care, where the demand for health care decreases at higher price levels. The studies also indicates that the price elasticity is rather low, i.e. that the percentage change in the use of health care is lower than the percentage change in the price.

Other instruments are available which also affect consumers demand for health care through influences of other costs including travel and time costs. This explains why optimal fees may be zero or even negative for certain segments of the population, e.g. poor people in rural areas. It may be necessary to provide these groups with for example conditional cash transfers or general income support to encourage them to seek appropriate care when sick. Other

[3] However, greater competition among doctors may encourage them to be more willing to comply with patient demands for referrals, prescriptions or other health services, particularly where the cost of these services is covered by insurance. Furthermore, the prediction of greater spending with additional physicians with no induced demand may also be consistent with classical microeconomics, because a positive association between the number of doctors' and doctors visits may reflect true demand factors; for example, a larger number of doctors may increase the availability of health care supply since there is less distance to travel and less time to wait, and unit price does not fall because of administratively set prices (see Carlsen and Grytten, 1998).

important instruments are consumers believe, expectations, life styles and preferences, which may also be influenced by information through advertising, education and general health information. Such actions may be particularly effective in developing countries where levels of health-related knowledge in general are low in different population segments.

2. Part II: Health, Poverty, and Economic Development in Vietnam

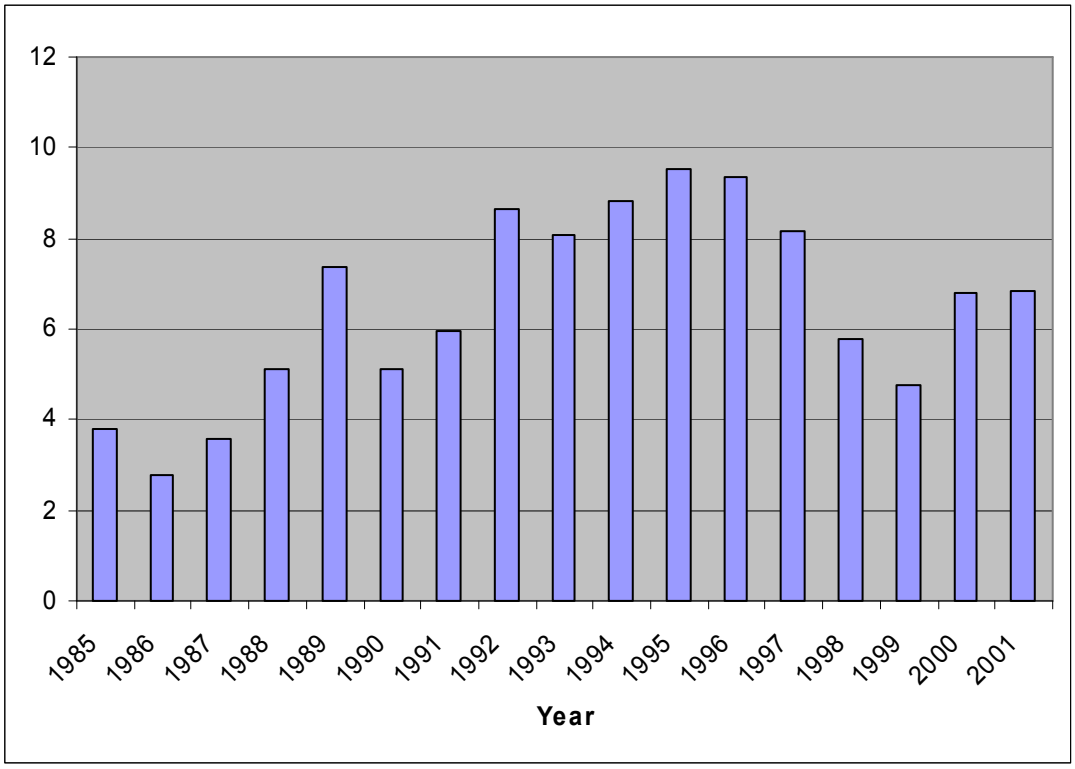
This part of the report presents a broad overview of some key developments regarding economic growth, poverty reduction, and health outcomes in Vietnam in the past decade or so. It first looks at some macroeconomic indicators, including economic development and government spending. Based on some recent analyses, it then discusses the achievements made in poverty reduction and notes some remaining challenges. The main health sector developments are described in the third sub-section, focusing on health financing, the health system, and health outcomes. Finally, the main health policy issues are noted, the further discussion of which is continued in Part III of the report. It should be stressed that most of these issues have been analyzed in considerable more detail elsewhere, including Glewwe et al (2004), World Bank et al. (2003), MoH (2002), and Tran-Nam and Pham (2003).

2.1. Macroeconomic Developments in Vietnam

Economic development in Vietnam since the initiation of economic reforms in 1986 – known as doi moi (renewal or renovation) – has been impressive by any standard. Growth in real GDP in the past 10 years or so has been around 6 percent and was projected to reach over 7 percent in 2004 (IMF data sheets). A description of the economic reforms to date is beyond the scope of this report; more can be found in, Ministry of Finance, Ministry of Planning and Investments, IMF, and in various World Bank publications. A broad analysis of also the social impact of reforms can be found in Binh and Chi (in Tran-Nam and Pham, 2003). Also, Adams (2005) provides an overview of the Vietnamese health system from a macroeconomics perspective.

Figure 3 shows the annual real growth in gross domestic product in Vietnam in the period 1985 to 2001 using data from the World Bank (WDI, 2003). Overall, growth during this period has been strong and sustained. Growth rates declined considerably during the Asian Financial crisis in the late 1990s. Recent estimates indicate strong growth also after 2001 and the economy is projected to grow by more than 7 percent this year. Projections for the coming years also suggest continued strong growth, although several uncertainties are noted. With inflation largely in check, real growth is expected to continue to be high.

Figure 3. Real annual GDP growth, 1985-2001 (1985=100)



Source: World Development Indicators 2003.

Notwithstanding these rates of economic growth, Vietnam is still a poor low-income country (LIC) with a GDP per capita of around USD 428 in 2004 according to IMF data and poverty is still widespread, particularly in rural and remote areas (VDR, 2005). The per capita income level of Vietnam is around the average for the group of LICs and about half of the regional average (IMF, 2005).

An important macroeconomic issue for Vietnam at this time is accession to the World Trade Organization (WTO). It is the government's ambitions to join WTO before the end of the 2005. Although there remain several uncertainties regarding this prospect, it is possible that accession to WTO will have implications also for the health sector. In particular, factors such as trade in health insurance, access to pharmaceuticals, and mobility of human resources for health might be important to consider after joining the organization.

Around one fifth of GDP goes toward government revenues and government expenditures make up around 27 percent of GDP (IMF Art_IV, 2005; borrowing accounts for the difference creating a fiscal deficit of some 5 percent). Notably, grants (ODA) make up only a

very small share of government revenue suggesting that Vietnam is not an aid-dependent country from an economic perspective.

Total government spending on health account for around 6.5 percent of total public spending. Table 1 shows the share of health and education spending of total public spending.

Table 1. Spending on health and education in relation to total government spending, 1997-2001 (%)

Category	1997	1998	1999	2000	2001	2002
Health	6.1	7.1	7.0	6.3	7.1	6.4
Education	14.1	17.4	16.6	15.8	16.3	16.7

Source: Ministry of Finance/PER-IFA, 2005

Clearly, education is receiving a much larger share of public resources than the health sector. In relation to GDP, Vietnam spent just above 1 percent on health in the years 1999 to 2002, which is slightly less than that spent on rural development (VDR, 2005). Spending on education and training in the same period went from around 3.5 percent to 4.5 percent of GDP. While the differences in spending on health and education are noteworthy, it should be recalled that investments in education are important also for improved health outcomes. It is in fact likely that the relatively favorable educational outcomes in Vietnam partly explain the comparatively good health outcomes; see below. It also seems that spending in the education sector is better targeted than in the health sector. For example, estimates suggest that the incidence of education spending is 18 (21) percent for the poorest (richest) quintile (i.e. almost the proportional share of spending reaches the poorest (richest) 20 percent of the population), while the corresponding figure for health spending is only 12 (29) percent (WDI, 2003).

A related issue, and one of critical importance in the MEH-context, is whether higher government spending in health care (and education) lead to better health outcomes. The empirical evidence on this is mixed, which may not come as a great surprise since health outcomes are not only related to spending levels but also to efficiency in use of resources. However, some recent studies looking at public spending in the social sectors using aggregate cross-sectional data suggest that levels of government expenditures in these sectors are positively related to both access to and attainment in schools and to reductions in the mortality rates of infants and children (Gupta et al., 1999).

2.2. Recent Poverty Developments in Vietnam[4]

Vietnam has made impressive achievements in poverty reduction in the past decade or so. Along with the high rates of economic growth, levels of income poverty have been reduced from around 58 percent in 1993 to around 37 percent in 1998 and 29 percent in 2002.[5] The main driving factors behind these reductions in income poverty have been rapid economic growth, land redistribution, and job creation in the private sector. Other contributing factors include, improvements in infrastructure, diversification of agricultural production, and commercialization of crops.

As impressive as these achievements are, they are far from universal. Deep pockets of poverty remain in Vietnam and inequalities are on the rise. In particular, differences exist between the skilled and the unskilled, the urban and the rural population, and between the ethnic majority and the large number of ethnic minority population groups.

Further poverty reduction may prove harder to achieve and apart from a more effective public investment program, will most likely require an increased reliance on more and better targeted programs, such as exemption mechanisms, voucher systems, and potentially even conditional cash transfer (CCTs) programs.[6]

Furthermore, there is a need to further strengthen and develop the national system for monitoring and evaluation of program implementation, including the CPRGS, the Vietnam Development Goals (VDGs), and the next Five-year socio-economic development plan. In particular, the government might want to consider implementing policies and programs in a more strategic manner, including randomization with control groups for more effective impact evaluation. All of this would contribute to making the policy development process more evidence based.

Finally, there is a strong link between poverty and health in Vietnam, both in the short and the long term. Private spending on health contributes to increasing poverty rates, in the late

[4] This sub-section draws on, among other documents, the Vietnam Development Report 2004: Poverty (World Bank et al., 2003).

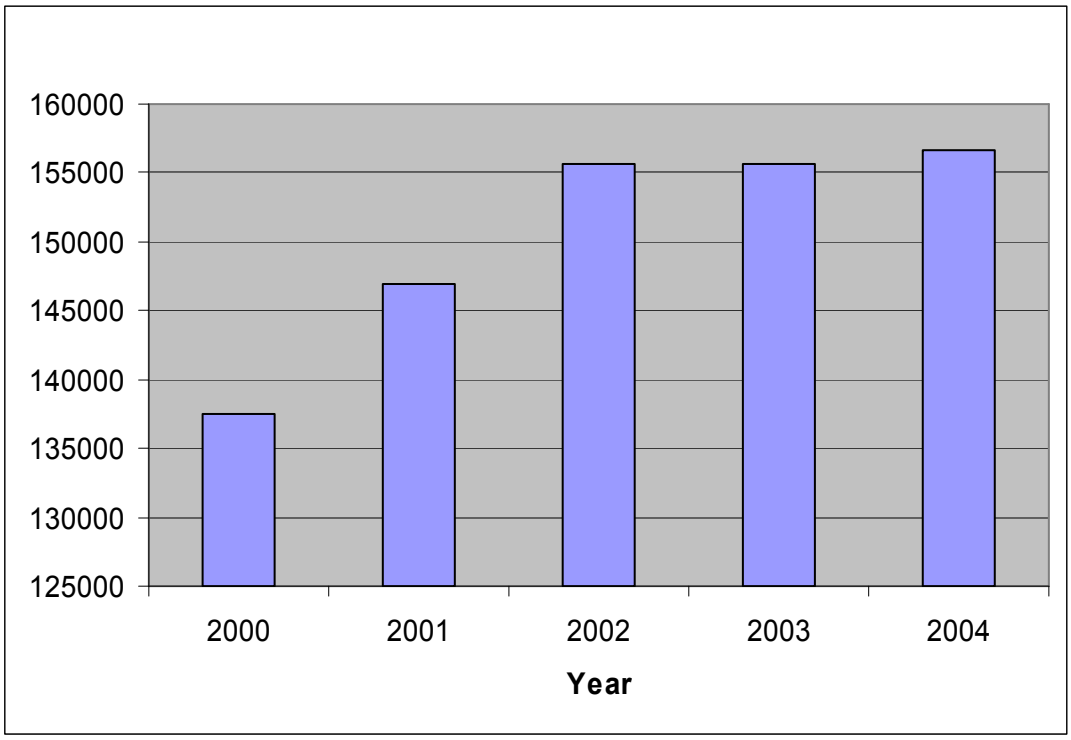
[5] Based on household consumption expenditure data.

[6] On the potential for CCTs in Vietnam, see Ekman (2005).

1990s by around 3.4 percent (Wagstaff and van Doorslaer, 2003). In the longer perspective, deficient health status, for example in the form of malnutrition, may lead to reduced human capital development and subsequent reductions in the income generating capacity of the individual.

The government has introduced various measures to address these issues, most notably the implementation in 2003 of provincial level Health Care Funds for the Poor (HCFP) to cover the health care costs for the poor and ethnic minorities. While it is too early to draw any conclusions as to the impact of these Funds on utilization and expenditure requirements of the beneficiaries, some smaller studies and other reports suggest that utilization has increased since their introduction. It is noteworthy, however, that these increases cannot be detected in the aggregate data. Figure 3 shows the reported number of visits to public health care providers in the period 2000 to 2004.

Figure 3. Total number of visits to public providers, 2000-2004 (thousands)



Source: MoH, Health Statistics Yearbook, various years.

It should be emphasized that no conclusions can be drawn from the above on the effect of the HCFP on utilization by the beneficiaries, it is notable that the positive trend in the number of visits in the years prior to the introduction of HCFP in 2003, is reversed after its implementation. Moreover, even in regions with high shares of beneficiaries of the policy decision, the same pattern is found (see Ekman, 2005a, for more details).

2.3. Recent Health Developments in Vietnam

This sub-section describes some of the main health developments in Vietnam. It focuses on financing, the health care system, services, and outcomes. It is a brief overview of these developments, the details of which have been described elsewhere; see for example, MoH, 2002.

Health Financing

Overall, according to the available National Health Accounts (NHA) data Vietnam spends around 5.5 percent of its total resources on health, or around $18 (at official exchange rate in 2002) per capita per year. This is similar to the average level of health spending in the group of low-income countries. However, the same estimates also show that public spending on health is well below the average of this group of countries. Compared with most other countries in the low-income group, health spending in Vietnam is predominantly private out-of-pocket (OOP) spending with only relatively small shares for prepayment or insurance. In 2002, OOP spending accounted for almost 88 percent of total private spending on health. In addition, estimates suggest that around $9 is spent on pharmaceuticals (MoH, 2004), often in the form of antibiotics as a result of self-treatment. This is a relatively high share of spending and in combination with the high rates of antibiotics resistance in the country, gives cause for concern about the efficiency in health spending. Notably, other estimates suggest that total spending on health in Vietnam is around 8 percent of GDP (or $28 per capita; WHO, 2003). This is a very high number and if true would suggest little need for increased investments in health, but rather reinforce the call for more efficient (or cost-effective) investments in health

Table 2 shows some selected health financing indicators for Vietnam and the average for the group of low-income countries for the years 1998 to 2002.

Table 2. Selected health care financing indicators for Vietnam and average for the group of low-income countries, 1998-2002

Indicator: ---------- Country/Group:	Total Expenditure on Health, % GDP					Government Expenditure on Health, % total health expenditure					Per-capita expenditure on health (USD)				
	1998	1999	2000	2001	2002	1998	1999	2000	2001	2002	1998	1999	2000	2001	2002
Vietnam	4.9	4.9	5.2	5.1	5.2	32.7	32.7	28.1	28.2	29.2	18	18	21	21	23
LDC Average	5.0	5.0	5.0	5.1	5.3	42.7	42.5	43.6	44.2	45.2	21	21	21	23	26

Source: WHO, 2005.

Overall, Vietnam spends around the average of total spending on health for the group of low-income countries. However, public spending on health is considerably lower than the comparison as is per-capita total spending on health. Based on what has also been discussed above, it would seem that total health spending in Vietnam is roughly equal to that of other countries in the same income group, but that public spending on health is considerably lower and that private spending is predominantly out-of-pocket at the time of need. Taken together, these indications suggest that health financing in Vietnam may have detrimental effects for the poor and socially excluded groups with respect to their financial access to health care.

Health Care Systems Development

In terms of the health system, Table 3 shows the values for selected health systems indicators for Vietnam and the average for the group of low-income countries.

Table 3. Selected health systems indicators for Vietnam and LIC average, most recent years

Indicator: ---------- Country/Income Group:	Number of physicians per 10.000 inhabitants	Number of nurses and midwives per 10.000 inhabitants	Number of health workers per 10.000 inhabitants	Hospital beds per 10.000 inhabitants
Vietnam	5.7	7.7	13.4	24
LIC average	6.5	14.5	21.1	33

Source: WHS, 2005.

It should be noted that the values for most of the indicators are heavily influences by the relatively large figures for the group of former Soviet Union states low-income countries. Closer analysis shows that for most of the health systems indicators Vietnam ranks below

these states but has considerably higher values than most other countries in this group. Although it is difficult to draw any conclusions from such a comparison, it might give an indication of the relatively high dependence on higher levels of care, i.e. secondary and tertiary level hospitals, in the Vietnamese health system. And while this might pose a problem in itself (high recurrent costs among other things), it is a particular problem if this level of care is allowed to expand at the detriment of the primary health care level that is of such fundamental importance for effective health care for the poor. In addition, national data also suggest considerable variation in health systems development across various regions and provinces in the country. For example, the poorer regions of the north and the Central Highlands have considerably fewer professional health staff than the rest of the country (GSO, 2005)

Health Service Delivery

The next table shows a selection of health service indicators for Vietnam and the average for the group of LIC. Of particular interest is that of immunization coverage levels.

Table 4. Selected health service indicators for Vietnam and LIC average, most recent years

Indicator	Immunization coverage (%) among 1/year olds			Antenatal care coverage	Births attended by skilled birth attendant	TB treatment success under DOTS
	Measles	DTP3	HepB3			
Country/Group:						
Vietnam	93	99	78	70	85	92
LIC average	72	72	38	75	85	76

Source: WHS, 2005

With the notable exception of antenatal care coverage, Vietnam has considerably better health service outcomes than other low-income countries. Although further analysis would have to be made, it is likely that the successful immunization campaigns contribute to the generally favorable health outcomes of the country compared with those of other countries in the same income group.

Of particular importance in Vietnam, as indeed in most other low- and middle-income countries, is the role of the private sector in service delivery. Over the past decade or so, both

traditional and western type services have been increasing their share of total health care delivery, particularly at the primary health care level, but increasingly also at the level of hospital services. For example, household level data show that private clinics account for around half of all first contact providers nationally. Importantly, also the poor go to private providers for primary health care services despite having to pay the full cost, often out-of-pocket. It is likely that the private sector (both for-profit and not-for-profit) will continue constituting an important and significant share of the health care system in Vietnam.

Health Outcomes

Some of these outcomes are shown in table 5 for Vietnam and the average values for the groups of LICs and MICs.

Table 5. Selected health outcomes for Vietnam, LIC, and MIC, 2001

Indicator / Country/Group	Life expectancy at birth, total (years)	Infant mortality rate (per 1,000 live births)	Under 5 mortality rate (per 1,000 live births)	Maternal mortality rate (per 100,000 live births)
Vietnam	69	30	38	200
LIC average	59	80	121	N.A.
MIC average	69	33	41	N.A.

Source: WDI, 2003.

As has been shown before, Vietnam displays considerably better health outcomes than most other low-income countries. The table shows that for several indicators, those of Vietnam are as good as or even better than those of middle-income countries. Notwithstanding these health achievements, Vietnam faces several challenges that may threaten the health of the population and contribute to substantial economic costs. These include, but are not restricted to, increased non-communicable diseases requiring more specialized care, HIV/AIDS infections, public health problems like injuries, accidents, and tobacco consumption, and new health threats from infections like avian flu.

2.4. The Role of Development Partners

Compared with most other low-income countries (LICs), Development Assistance in Health (DAH) represents a small share of total health spending. Table 6 shows that in 2002, DAH

accounted for less than 2 percent of total spending on health compared with almost 19 percent on average in the group of LICs.

Table 6. Development Assistance in Health as % of total expenditure on health

	Year						Average
Country/Country group:	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**1998-2002**
Viet Nam	5.6	2.8	3.4	2.7	2.6	1.8	2.66
LICs average	16.50	15.73	16.86	18.27	17.37	18.70	17.39

Source: WHO-WHR 2005, Annex 5, Selected National Health Accounts Indicators.

In addition, while the trend seems to be an increase of DAH in other LICs, this share is on the decrease in Vietnam.

Despite this relatively low share of health aid in total spending, the external development partners seem to have a relatively strong position in policy development and debate. References from policy analysts and technocrats are frequently made to the need for "a strong voice" from partners in the dialogue with the policy makers. There also seems to be a rather heavy reliance on external technical assistance for policy analysis.

Bearing in mind that Vietnam is a low-income country with very limited resources both in terms of finance and analytical capacity, and while continued support will be needed for some time to come, this dependence on external assistance should be addressed, especially given the limited financial resources coming from this source. Moreover, donors do not always speak with one voice, but often differ in opinion on particular issues. For example, in discussions with a small selection of the development partners during the current mission, opinions seemed to range from one end of the spectrum to the other on the question of how to better organize and co-ordinate DAH in Vietnam by means of a sector investment program (SIP) or Sector-Wide Approach (SWAp). Also, external advice may not always be suitable for the particular context or of sufficiently high quality. Consequently, the ability to make judgments on external advice needs to be developed at the national level.

Discussions are currently ongoing on the future shape of the organization and level of coordination of DAH in Vietnam. Although these discussions are of some relevance, it is important that they do not contribute to drawing attention away from the really critical issues and questions that are currently on the policy agenda. Some of these are noted below and discussed in more detail in the final part of the report.

International NGOs, in collaboration with national partners, play an important role in the health sector in Vietnam, particularly in service delivery and public health and preventive interventions. Particular areas of foci include maternal and child health and HIV/AIDS. International organizations also play an increasingly important role in advocating health and health care from a rights perspective. Given their close experiences to the primary health care sector in Vietnam, in particular in remote areas, international NGOs are well placed to assume a strategic role for the further development of this important part of the health care system.

As the Vietnamese economy continues to grow, the role of the international development partners in terms of health financing is not likely to increase in any significant manner. An important finding from the discussions with a selection of the main donors during the mission revealed, however, that their presence will continue and that they aim at continuing playing an important role in terms of policy development. What was also clear from the meetings was that opinions ranged considerably on a number of issues, including on the future role of the Ministry of Health in the new context and on the scope for moving towards a sector investment program or similar approach.

2.5. Current Policy Issues and Goals

The government of Vietnam has set up several important policy goals for the health sector, perhaps the most significant of which is universal health insurance by 2010. In order for this goal to be achieved, a number of policy decisions have been taken and several programs have been initiated. The most important of the current policy goals and programs affecting the health sector are (policy decision when relevant[7]):

- Universal health insurance by 2010
- Free health care for children under 6 years of age
- Health Care Funds for the Poor (HCFP) (Decision 139)
- Financial autonomy to service providers (Decree 10)
- Development of the health sector (Decree 46)
- Regulation on health insurance (Decree 63, Circulars 21 and 22)

[7] A summary of the main decisions can be found in Appendix 4.

It is beyond the scope of this report to discuss all of these in any detail. It should be noted, however, that many of the issues do have a bearing, directly or indirectly, on the poor and socially excluded. Moreover, and of fundamental importance, along with each of the policies comes an extensive list of related issues and policy questions that the government will have to address. Some of these are discussed in the final section of the next part of the report.

Of additional importance is the ability of the key health sector institutions, including the Ministry of Health, to conduct high quality policy analysis on these and other issues. While the ability no doubt has increased significantly over the past decade or so, within the area of health economics and health financing and in impact evaluation more generally, there would seem to be needs for further strengthening and development.

3. Part III: Proposal for a Vietnam Macroeconomics and Health Program

This part of the report presents the proposal for the development of a national program on macroeconomics and health in Vietnam. Based on the findings of the mission as presented in the preceding parts of the report, this part discusses the main opportunities, constraints, and risks involved in pursuing such an endeavor. Specifically, the objectives, timing, and critical conditions for its implementation are discussed. Although a national commission on macroeconomics and health is a temporary institution, it is emphasized that the introduction of such a program is a medium- to long-term (i.e. 3 to 5 years with clearly specified targets along the way) commitment to improve the efficiency of investments in health. Furthermore, it is of critical importance that the introduction of a national MEH program provides real value added to the existing policy development process and that all relevant stakeholders are truly committed to the process. Failure to live up to these two critical conditions would imply that additional preparations are needed before engaging in a fully-fledged CMH process. Alternatively, a more step-wise approach is assumed whereby a more limited group of actors are engaged in assessing the various policy issues at stake. This report will outline proposals to both of these effects.

3.1. Proposal for Vietnam National Commission on Macroeconomics and Health (VMEH)

As emphasized above, the MEH approach is not an end in itself, but a tool for effective policy development. Thus, the main **purpose** of the program would be to make the health policy development process more efficient, coherent, and accountable than is currently the case. The overall **aims** of the VMEH would be to increase investments in health and to make such investments more effective, efficient, and equity oriented.[8] Some **specific objectives** might include identifying sources of financing, clarifying priorities, and specifying the role of health in socio-economic development.

The principal mandates of the national commission on macroeconomics and health would be to advise the government on all major health-related development issues of the country. Its

[8] Whether increased health spending in Vietnam is really needed is a matter for further analysis since, as noted above, as much as 8 percent of total resources may already be dedicated towards health.

tasks would be to provide the careful analysis, advice on policy options, and direct actions in terms of health financing, including resource mobilization and allocation. The principal output of the commission would be a national health investment plan for the medium- and long term with a view to ensuring that health can make an optimal contribution to the socio-economic development of Vietnam.

Drawing on the experiences of other countries, the following **specific tasks** of the Vietnam Macroeconomics and Health program are listed:

1. Mobilization of all relevant partners for effective health policy making
2. Assessment of the main health and public health challenges facing the country
3. Specification of clear targets for future health development and reduction of the burden of disease
4. Careful analysis of the main causes of the disease burden
5. Development of a coherent set of priority actions
6. Monitoring of the implementation, outcomes, and results of all major health policies
7. Evaluation of the impacts of all major health interventions, particularly on health and poverty

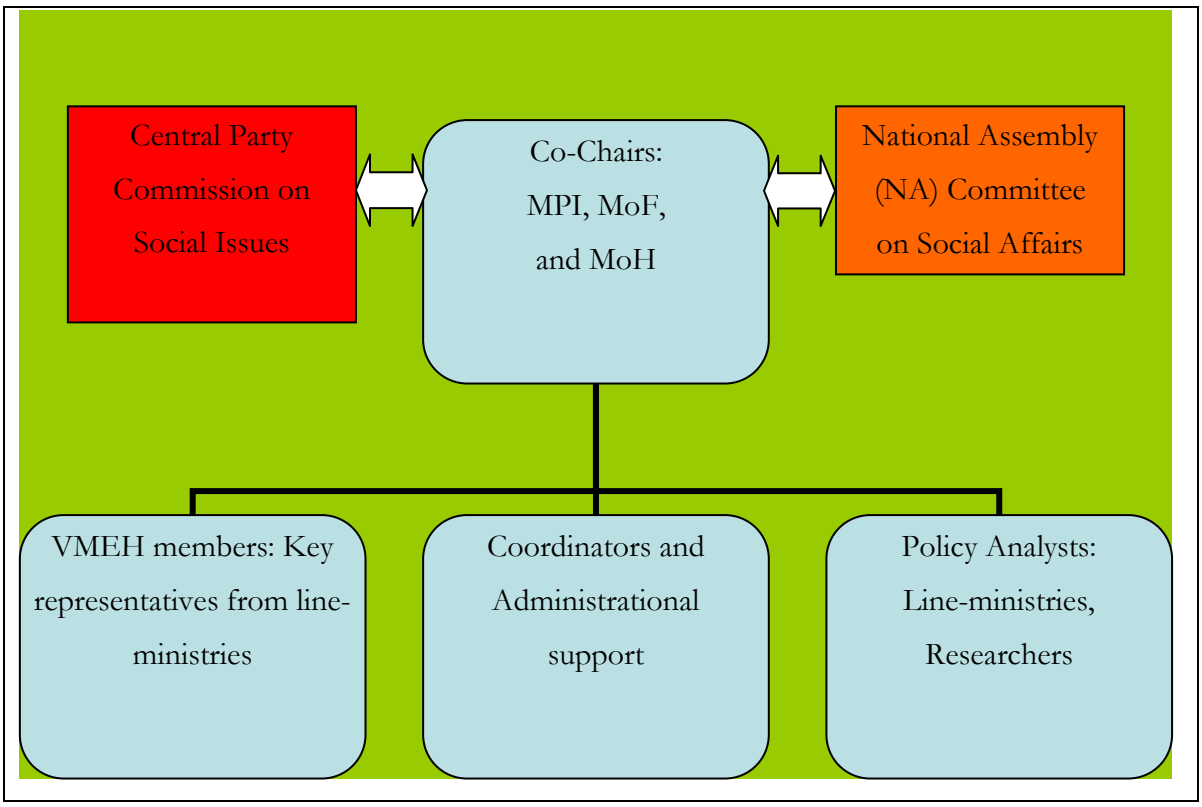
Institutional Framework and Organizational Structure

Based on past experiences and on lessons learnt from other countries, it is of critical importance that the VMEH commission engages all relevant stakeholders with a clear mandate, including convening powers and an identified leadership role. This would possibly require that a formal institution is set up recognized by the relevant governmental authorities, the Central Party, and the National Assembly.

This sub-section outlines a potential organizational framework for a VMEH program. The outline draws on similar structures that have been suggested in other countries. The exact organizational structure of the VMEH program will have to be further discussed in order to identify the one that suits the country best. Generally, the CMH-approach suggests a convening group of co-chairs from the main ministries. In the case of Vietnam, the co-chairs would be the ministers (or persons appointed by the respective ministers) of Planning and Investment, Finance, and Health.

Figure 4 displays a possible proposal of the overall organizational structure of a national commission on macroeconomics and health.

Figure 4. Suggested Outline of VMEH Organizational Structure



The co-chairs will be charged with setting the aim, scope, and specific objectives of the VMEH program. Importantly, the co-chairs would be jointly accountable for the implementation of the program.

The analytical basis on which to formulate policies should be developed by a core group of researchers and policy analysts. The group should consist of analysts from the social sciences and health, including, economists, health economists, and public health experts. The group of analysts would be responsible for conducting the rigorous analysis of a clearly specified set of key issues and questions to which they should present feasible policy alternatives.

Serving as the link between the policy makers and the analysts should be a group of key high-level functionaries from the relevant ministries and possibly other government agencies. This body should also be responsible for ascertaining the advancement of the work agenda of the program. Finally, administrative support to the program should be provided by a group of full-time administrative managers.

The Commission on Macroeconomics and Health (CMH) emphasized that the national counterpart of this commission is a temporary setup working under a well-defined work plan with specific tasks and identified outputs. A proposal for the VMEH program includes a preliminary timetable of an initial two years after which the process is evaluated against the set targets and planned outputs. Based on the outcome of the evaluation, a third year might be contemplated should the need exist. During this period, a series of working groups should be organized to assess each of the main policy issues. Potentially, these working groups might be organized broadly around the themes of the Commission of Macroeconomics and Health: Health and Economic Development, Health and the International Economy, Domestic Resource Mobilization, Global Public Goods for Health, Opportunities and Constraints to Scale up Interventions, and finally, The Role of International Development Assistance in Health. These are all issues that would fit into the Vietnamese policy debate on health and development provided that they are formulated to suit the local context.

As noted in the first part of the report, a key objective of the mission work is to assess the specific situation relevant to the development of a macroeconomics and health program in Vietnam. Based on what has been reported elsewhere on health and development in Vietnam and on what has been learned during the mission, it is the authors' beliefs that a national commission on macroeconomics and health might present an important opportunity for the country at this time. However, such an approach should only be pursued provided that it would bring real value-added to the current situation in terms of making the policy development process more efficient and coherent. Given the already quite cumbersome policy development process in the country, the authors do not recommend that the MEH-approach is adopted if it only risks adding another layer onto the existing policy making structure. Moreover, the successful implementation of a national commission on macroeconomics and health would require the engagement of all relevant stakeholders with a clear mandate, including convening powers and an identified leadership role.

3.2. An Alternative Incremental Approach to Developing a National Program on Health and Development

In the absence of assurances that, first, the VMEH program would improve upon the present situation by replacing some of the existing processes and not simply be layered on to the current structure, and second, that a 'champion' for the national commission can be identified, the authors recommend that a more incremental approach is adopted. Importantly,

such an approach can usefully be built around the existing proposal from Vietnam; see Appendix 2 for details.

While there are several ways in which a stepwise approach to developing a CMH-type of program might be implemented, the authors would recommend that the principal focus of such an approach be on the policy analysis and research component. The main task of the group of analysts would be to formulate alternative policy options relating to the key policy issues that are currently on the agenda in Vietnam. The analysis should be based on rigorous quantitative and qualitative analysis of the existing data. If information is missing on important issues, data development activities should be initiated. An important additional effect of such an approach would be to develop and strengthen the national capacity for serious policy analysis. The work may usefully be organized into separate working groups each looking at a specific issue; see below. The groups should be headed by experienced researchers and obtain only strategic technical assistance from international experts.

Proposal of Development of Health Sector in Vietnam from the Central Party Commission on Social Issues

In early 2005, the Vietnamese Central Party Commission on Social Issues submitted to WHO a proposal for the development of the health sector in Vietnam; see Appendix 2. Although the proposal is not a complete description of a national commission on macroeconomics and health, it contains some important elements in the spirit of the CMH that may usefully be further developed. In addition to describing the background to the current situation in the health sector, the note outlines the activities of the proposed project, including the formation of "an inter-sectoral working group" to oversee and facilitate the project implementation. Furthermore, the proposal suggests that a series of workshops or seminars are organized based on the report of the CMH and on selected themes pertinent to the Vietnamese context. Importantly, the proposal recognizes the role of advocacy for the role of health in economic development and poverty reduction. It would therefore seem to provide an interesting opportunity on which to build a national commission (or similar set-up) for health and economic development, much in the spirit of the Commission on Macroeconomics and Health and its recommendations.

The authors would therefore suggest that further consultations are carried out with representatives from all relevant stakeholders, including the ministries of finance, planning and investment, and health as well as with representatives from the research community, on

(i) the formalization of the inter-sectoral working group, (ii) the organizational framework of the proposed work program, and (iii) the content of the thematic workshops/seminars, including basis for discussion and responsibility of the analysis. Ideally, the outcome of the consultations would be a formal and recognized institutional set-up for coherent and efficient health and development policy making in Vietnam. In addition, efforts should be taken to identify the potential scope for drawing on existing processes in order to make the implementation of the process as efficient as possible. An explicit goal of the work might be the development of a complete proposal for a Vietnam National Commission on Macroeconomics and Health to be discussed at the next Central Party Congress in 2006.

While the above discussion has identified and focused on the main opportunities for the development of a program on macroeconomics and health in the Vietnamese context, the work has also identified a number of risks and constraints to such an approach to health policy development. First, if the two conditions noted above are not sufficiently adhered to, the introduction of a MEH program in Vietnam may lead to subjecting the existing policy development environment and its key players to unnecessary additional strain without providing any real value-added. Second, inability to engage all stakeholders in the process will seriously jeopardize the implementation of the program. In particular, the non-health sector representatives need to be serious partners in the process. Finally, the successful implementation of a national MEH program will require the identification of a strong champion with a clear leadership role, including convening powers.

3.3. Policy Development and Current Issues and Questions

The previous sub-sections outlined two alternative approaches (the direct approach and the indirect approach) to developing a national macroeconomics and health program in Vietnam. In particular, it was noted that a constructive approach might be to develop further the existing proposal to suit the Vietnamese context. Regardless of which option is chosen, the government will have to tackle a number of issues and questions related to the successful implementation of the current policy goals. Some of these goals and policy initiatives were noted in the second part of the report. This sub-section discusses in somewhat more detail the various goals and the related policy issues and questions that need to be addressed by the government. The particular aspects and considerations that were discussed in sub-sections 1.5 and, in particular, 1.6, above, will have a bearing to some extent on almost all of the policy goals.

At the overall level, there would seem to be a need to consider several issues of a general nature. First, the government might want to reconsider the way policies are implemented by making more strategic use of experimental designs in order to be able to evaluate the true impact of policy alternatives before scaling up interventions to the national level. Second, there would seem to exist an urgent need to further develop the national monitoring system and evaluation capacity in the country. In particular, the computerization of the health information system is an issue of some priority. Third, Vietnam needs to further strengthen the national capacity for rigorous quantitative policy analysis. Experience from other countries suggests that the existence of skilled technocrats within the country can play a crucial role in the formulation and implementation of policies based on good evidence. Fourth, related to the above is the need to make data widely accessible for policy analysts and researchers, both at the national and international level. Vietnam is blessed with a relatively broad set of data not least at the household level, but it is only the systematic analysis of these data that will contribute to strengthening policy development. Related to the issue of data is the need to push for further efforts to explore the possibility of generating and using additional information, including register data that could be linked to survey data. And finally, the government might want to consider conducting economic evaluation tools more strategically to make better use of scarce resources.

In what follows, is a list of policy goals along with a brief discussion of the related issues and questions of each goal.

Universal health insurance by 2010

This is perhaps the most important current health policy goal of the government and a series of policy questions are closely related to it. First, it has not been made clear to the authors of this report exactly what this policy goal means. While it may imply the idea that by 2010 all Vietnamese should be covered by health insurance, it is not clear what type of insurance will cover which population groups and what will be the effective financial protection rate. Decree 63 and the accompanying Circular 21 and 22 provide some guidance to these questions, but further clarifications are needed on, among other things, the associated costs of universal health insurance, the sources of financing, and the exact nature of the benefit package. For example, policy makers need to look at the optimal financing mix of this goal. One part will clearly be covered through social health insurance with contributions from the formally employed. The government also envisions the wide implementation of voluntary

health insurance, in particular for the rural population. This will most certainly be very challenging given the many obstacles to the use of voluntary health insurance, some of which were discussed in sub-section 1.6 above. Furthermore, the use of deductibles, co-payments, and coinsurance need to be further detailed.

Health Care Funds for the Poor

This policy initiative is related to the above as it forms part of the public compulsory health insurance package. While it is too early to draw any conclusions as to the impact of the policy, there are several factors that may suggest that its effect might be more limited than what is expected by the government. First, the poor may refrain from seeking care for reasons other than the associated direct costs. For example, they might live too far from a service provider, or they may reduce health care consumption due to the other indirect costs related to seeking care. Finally, the poor may feel less inclined to seek care for fear of being stigmatized.

These and other reasons would suggest that the government might want to consider alternative approaches to reaching the poor with health care services. One alternative approach is to introduce what is referred to as conditional cash transfers (CCT) programs whereby poor family receive cash benefits on condition that they undertake certain actions thought to be favorable to the human capital development of, in particular, their children, like keeping them in school, visit health clinics, and participate in nutrition programs. Such programs have proved to be very successful in reaching the poor in, in particular, Latin America. The scope for CCTs in the Vietnamese context is discussed in Ekman (2005b).

Free health care for children under 6 years of age

The exact scope of this policy is not clear to the authors of this report, but it would presumably imply that all Vietnamese children under six are provided with health care free of direct user charges at public providers or at private providers that have contracted with the authorities. While this is a admirable ambition of the government, it is not clear why, in a poor country like Vietnam, children of parents with a very strong ability to pay for care should be provided with free health care. Also, the benefit incidence of this policy may be questionable given the better access to pediatrics health care that the better off has in the country. Moreover, it cannot be ruled out that the policy gives rise to certain levels of moral hazard, something that would put additional strain on scarce public resources as discussed above in sub-section 1.6.

Improving maternal health and reducing child malnutrition

These two policy goals are included in the Millennium Development Goals and, consequently form part of the national development goals. While Vietnam has made commendable progress on both of these goals as noted above, several challenges remain. In particular, these health problems affect the poor and socially excluded in remote areas. Improving maternal health and reducing malnutrition requires strong primary health care systems and outreach services, including prenatal care programs. Based on discussions with several observers during the mission work, it is clear that Vietnam faces several challenges in this regard. This impression is further reinforced when studying, for example, the recent Master Plan for health systems development (MoH, 2005a). While primary health (the grassroots level as it is referred to in Vietnam), reproductive, and maternal health services is emphasized, it is far from clear that they really feature sufficiently high on the policy agenda, which seems to be excessively focused on high-tech services that would in all likely events cater for the better off population groups.

As discussed above, child malnutrition may present a series threat to long-term economic development. The relatively deep pockets of severe child malnutrition that exist in Vietnam, may present considerable challenges to reduce poverty for generations. Special efforts may prove necessary to combat child malnutrition, including conditional cash transfers as discussed above.

The above list of policy goals and associated issues and questions is only indicative and considerably more deliberations are needed to identify the exact specifications in each case. Furthermore, there is a strategic need to make an explicit list of priorities so as to make the policy development process more coherent and consistent. The overall view of the authors of this report is that this might usefully be done within the existing proposal of the Central Party Commission on Social Issues with the aim of developing a national program on health and economic development much in the spirit of the Commission of Macroeconomics and Health.

Main conclusions and recommendations

The principal aims of the mission were to assess and make recommendations on the scope for developing a national program on macroeconomics and health in Vietnam. On the whole,

these aims have been achieved. The mission revealed both opportunities and constraints as well as risks with pursuing the development and implementation of a national program on macroeconomics and health in Vietnam. The main opportunities include the existence of a program outline developed by the Central Party Commission on Social Issues, a high level of awareness of the importance of investing in human capital for economic development, and the current policy challenges facing the government that might usefully be addressed within the framework of a national program on health and economic development. The main constraints include the narrow human resource base on which to draw on for the implementation of the program, the seemingly incoherencies in the policy development process, and the still fragile policy analysis capacity. The main risks of pursuing a national program on macroeconomics and health involve the danger of putting additional burden on the current policy development structure. Without due consideration of the need for mainstreaming such an initiative so as to avoid layering on the program on top of existing processes, the implementation of the program might be counterproductive.

Based on the information that the mission was able to assess before, during, and after the mission to Vietnam, the main recommendations of the mission are the following:

- Further develop the existing proposal to include specific issues and questions for further analysis.
- Identify the key national agencies and institutions to be involved in the process, including names of people or positions within the institutions.
- Ascertain that all relevant national partners are actively and constructively involved in the process.
- Identify and agree upon a time plan with a view to develop a complete national CMH in the medium term.

Importantly, the mission does not recommend that Vietnam attempts to implement a full national program on macroeconomics and health at this time as the risk of such an attempt being counterproductive are real, given the already ambitious policy program of the government.

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* In addition to the above list of documents, the authors also reviewed additional material of less formal character.

Appendix 1: Terms of Reference

TERMS OF REFERENCE FOR EXPERT SUPPORT TO VIETNAM MACROECONOMICS AND HEALTH ACTIVITIES

Background

The goal of the Macroeconomics and Health (MH) approach is to promote increased and more effective investments in health and health related sectors in low and middle-income countries to achieve sustainable and equitable outcomes for the health of the poor.

The focus is on strengthening efforts of countries and sub-regions that are committed to the MH process so that they can complete the process of preparation of health investment plans in support of the Millennium Development Goals.

CMH intends to use the expert to provide support for technical assistance to *analyse constraints and opportunities* for the Macroeconomics and Health process in Vietnam.

The expertise

MH work entails two distinct sub-disciplines of economics: macroeconomics and health economics. While both are based on the general theories and principles of economics, they each require distinct knowledge and experience for each sub-discipline. Consequently, it has been suggested that Professor Ulf Gerdtham and Dr Björn Ekman, both at Lund University, jointly carry out MH support to Vietnam. Ulf Gerdtham is professor of health economics with solid background in, among other things, health financing and health equity, while Björn Ekman has a PhD in economics with a major in health financing in low- and middle-income countries and with extensive background in macroeconomics and poverty analysis. It is expected that the two will be able to cover all relevant fields within macroeconomics and health through complementary and joint areas of expertise. The overall areas of responsibility for Ulf Gerdtham and Björn Ekman are, respectively, health economics and financing and macroeconomics and health financing. The two experts will carry out the core of their work

in the course of a mission of ten days that will take place in the second half of September 2005.

Mission Objectives

1. To assess the specific country situation relevant to the development of a macroeconomics and health programme.
2. Assess the relevance, and adjustments if needed, of the proposal submitted by the country to SIDA.
3. Facilitate the establishment of an institutional framework for national MH interventions.
4. Facilitate dissemination and discussion on MH messages among major stakeholders.

Specific Tasks

1. In consultation with WHO Headquarters, WHO Regional Office in Manila and WHO Country Representative's Office, make a detailed plan for the visit.

2. Collect and review information on health and poverty, according to the specific responsibilities detailed below.

3. Have discussions with senior officials of relevant ministries, major donors, selected NGOs, research institutes, and other organizations to assess the situation of health sector and development status and get their views on:
- awareness on poverty and health issues with different stakeholders;
- government commitment to health spending and poverty reduction;
- current patterns of health spending, health outcomes and potential for improvements;
- gaps in information, necessary for pro-poor planning;
- local planning and research capacity;
- actions taken so far to prepare for macroeconomic and health strategy;
- significant constraints that might hamper implementation of macroeconomics and health work;
- specific support needed to take forward a macroeconomics and health strategy;
- advisability to establish an institutional framework for national MH process and political/technical task forces, terms of reference, institutional aspects etc.

Specific tasks for Ulf Gerdtham are to collect and review information on:

- the structure and organization of the health system, including health care financing;
- available data for health sector planning and management;
- current patterns of resource allocation for health, health outcomes and potential for improvements;
- roles of public, private and NGO sector in health;
- presence of health strategy, implementation and impact.

Specific tasks for Björn Ekman are to collect and review information on:
- overview of donor support for the health sector;
- presence of health sector-wide approach (SWAp), implementation and impact;
- role of Poverty Reduction Strategy Papers (PRSPs), other poverty reduction mechanisms and their health content;
- HIPC status, if relevant;
- current investment flows and funds supporting existing health sector and sustainable development initiatives.

In addition to the above specific tasks, both consultants will also consider any planned and relevant review(s) of the health sector as needed. In particular, the consultants will liaise with such reviewers and make available any information that may be considered of importance to the review.

For the effective implementation of the mission, the consultants will obtain logistic and organizational support as needed by the WHO Country Representative Office in Ha Noi.

Expected Outcomes

The consultants are to make recommendations to WHO on options to further support the process. The key final product from the overall expertise is expected to be a situational analysis identifying, and making recommendations on, options to assist the country in the medium to long term, for an effective MH process. The consultants are therefore expected to draft the analysis based on all of the above and provide recommendations for the roles of the Government, other organizations, civil society, WR Office, and Sida during the planning phase. The consultants are to make a briefing to WR, WHO Regional Office and Headquarters on findings and recommendations. In addition, the consultants should make due preparations for presenting their preliminary findings in Ha Noi at, for example, a workshop with specially invited participants from various sectors.

An overall report is to be submitted to the WHO Regional Office and HQs not later than 3 weeks after the completion of the mission. The report will focus on prerequisites for and the conditions concerning the successful implementation of a sustained national CMH process within the overall health sector reform framework of the country, highlighting both options and constraints for sustained and comprehensive financing of the scaling up efforts. The report will support the ongoing consultations with Sida on funding or co-funding the country process based on an agreed upon country proposal.

Appendix 2: Proposal from Vietnam Central Party Commission on Social Issues on Health Sector Development in Vietnam

DEVELOPMENT OF HEALTH SECTOR IN VIET NAM

Project Implementing Agency: **Central Party Commission on Social Issues**

Funding Agency:
Co- Implementing Agency: **WHO**

I. Background:

Viet Nam has one of the fastest growing economies in the world. GDP growth averaged around 7% per annum for the last decade. Nevertheless, Viet Nam is still a very poor country with a GDP per Capita of $411 in 2001. Although Viet Nam is among the poorest countries in the world, its vital health indicators are comparable to those of middle-income countries. These achievements are the results of Vietnam's egalitarian health policies in the past. The health service network is divided to three levels: grassroots (commune and district); provincial; and central levels. At the current, 100% of commune health stations having mid-wife and health workers working full time. Among them, 60% of commune health stations having a doctor. More than 80% of villages having village health workers Life expectancy, for instance, is 10 years longer for Vietnamese women than would be expected given the level of development. Viet Nam has been successful in providing preventive health services, controlling the spread of communicable diseases and in achieving relatively good health for the population. This was achieved in part because of its extensive health care delivery network with a strong primary health care component and well organized national health programmes.

However, the social and economic change in Vietnam in the last 10-15 years has profound impacts on the health sector. Despite the achievements gained in the past, the current health system appears to have many shortcomings and is facing significant challenges.

The current health situation can be characterized as follows:

- Still a high prevalence of chronic malnutrition among the under five population and of low birth weight;
- Relatively high maternal mortality and neonatal mortality, mainly in ethnic minorities and in remote areas and high rate of induced abortion;
- An unfinished agenda in infectious, vector-borne and communicable diseases;

- A steady increase in non communicable diseases such as cardiovascular diseases, cancers, diabetes;
- New or re-emerging diseases such as SARS, TB, HIV/AIDS, dengue fever, and Japanese encephalitis are increasing.
- Increasing importance of life-style related diseases (tobacco, alcohol and drug abuse, injuries-road accidents, violence, suicide, mental health); drug abuse;
- Emergence of high drug resistance to common antibiotics.

Despite the growing health care needs of the population, total health spending per capita per year is about $ 21 and accounted for 5.27% of GDP (NHA 2000). A worrying feature is that general public spending for health is accounted for as low as 28% of total health expenditure, the rest 72% is private spending, mainly in the form of direct out-of-pocket payment. Though Vietnam has experienced high economic growth rate in the last 10 years, the economic growth does not translate into health development. ODA represents only 2.2% of total health expenditure (NHA 2000). The health system, especially, the grassroots levels, has been seriously under-funded. Access to health care for vulnerable people, especially the poor, and general quality of care, have become urgent issues.

The key major and overarching issues that health policy makers in Vietnam are seeking solutions to, are:

1. Ways to increase resources for health, which have to principally and largely rely on:

    a) Increased government general tax-based funding for health, especially increased subsidy for people who can not afford to pay for services
    b) Increased funding for health through social health insurance, and expansion of health insurance coverage for rural poor population. This can be achieved through introducing of health insurance schemes appropriate to the context of each locality and provinces/ communities.
    c) Increased other resources for health care, including external resources and user fees but with clear instruction for use so that not to undermine equity in health care

2. Ways to organise the service provision (primary health care and hospital services) for better use of the increased resources and achieving better quality of services. This will be achieved through:

    a) Ways to reorganise and finance for primary health care services
    b) Ways to reorganise and finance for hospital services
    c) Ways to reach vulnerable population.

Vietnam is moving to further decentralization in decision making and resource allocation. The project therefore targets policy makers and important stakeholders at both central and provincial levels. It is important for policy makers and other stakeholders to be aware about the country's socio-economic situation, understanding the linkages between poverty reduction and economic growth and poor health and the cost of health care for the poor. The ultimate goal is to make the country's sustainable and quality growth, not at the expense of, but based on good health of the population.

II. The project objectives:

The activities under this project aim to raise high profile of health in the national and provincial agenda; equip policy makers, from both health and economic planning, at all level of decision making with relevant information and evidences for them to make informed and coherent health and economic development policies. These policies will help to mobilize adequate resources and supports to achieving the national health goals. The findings and conclusions from the project will be important inputs for upcoming 10th Party Congress, planned in 2006.

III. Project activities and estimated budgets

Activities	Product	Budget	
		2005	2006
1. Forming an inter-sectoral working group to oversee and facilitate the project implementation. The project team is headed by Prof. Pham Manh Hung, Vice head, Central Party Commission on Social issues	Working group formed		
2. Launching and disseminating the findings from WHO's Commission on Macro Economics and Health study. • One workshop and three thematic seminars • Technical assistance (2 weeks) Assessment of key findings from CMH applied to the country and local specific context. Analysis of linkages between poor health and poverty and macro-economic growth in Vietnam and advocacy • Technical assistance (1per x month) • Local consultants (5 per x 2 months) • One dissemination workshop	Report about key macroeconomics and health findings applicable to Vietnam.		
3. Country analysis on major disease burden and essential, cost-effective interventions and suggested plan for scaling up • Technical assistance (1per x 1 month) • Local consultants (5 per x 2 months) • One dissemination workshop	Study report including suggested health investment plan		
Costing of the scale up/ health investment plan. Ways for mobilising adequate resources for health. • Technical assistance (1per x 1 month) • Local consultants (5 per x 2 months) • One dissemination workshop	Finalisation of Health Investment Plan		
4. Ways to organise and deliver essential health services to needy population. Mobilising public, private and NGO/ civil sector. • 3 regional workshops • One central workshop	Workshop recommendations		
5. Social health insurance. Ways to expand coverage and mobilise resources. Ways to improve social health insurance management and performance at provincial and local level. • 3 regional workshops • One central workshop	Discussion paper on ways to achieve universal coverage		

Sub-total			
TOTAL OF TWO YEARS			
Programme Support Costs (13%)			
Grand Total			

IV. Project implementation strategies:

The project will operate in close links with and using results from other WHO - MOH on-going collaboration in health system and health financing area such as the work in National Health Account, Health Insurance development plan; Master Plan of health financing; 5 year health plan, etc.

The project will use mixed expertise and involve experts from key sectors like health, finance and economic planning and research.

Appendix 3. List of People Met During Mission

Partner/ Agency	Person –in-charge
Hanoi Medical University, Health Economics Unit	Mrs Nguyen Kim Chuc
WHO	Briefing w/WR
Health Policy & Strategy Ins. (MOH)	Dr Dam Viet Cuong and colleagues
World Bank	Mr. Sandy Lieberman
School of Public Health, Health Economics Department	Dr Le Vu Anh, Dr.Vu Xuan Phu, and Dr. Trung
Central Institute for Economic Management	Mr Dinh Van An, Dr. Le Xuan Ba
Ministry of Finance	Mrs Do Thuy Hang (cancelled)
Ministry of Planning and Investment (MPI)	Mr Ho Minh Chien, Mr. Tran Kim Nguyen
MOH, Department for Planning and Financing	Mr. Minh and Ms. Sarah Bales
MOH, Department for Health Insurance	Dr Nghiem Tran Dung
Party Commission for Science and Education	Prof Pham Manh Hung
ADB	Ms. Lisa Studdert
EC	Ms Annkle Claire Leon and Ms. Anouk Van Neck
GSO	MS Dua- Social Sector and Mr. Tung
District Health Centre Visit CHS	Field Visit to Hai Phong Province
Provincial VSS + Provincial Health Service	Dr. Vy and colleagues
Care International	Ms. Barbara Bale

Appendix 4. Key Policy Documents and Decisions of the Government

This note describes some of the key policy documents and decisions concerning the health sector in Vietnam. The list of decisions and regulations is presented in chronological order and contains brief descriptions of the main contents. The list is not conclusive.

Decision 139: Health Care Funds for the Poor; Prime Minister October 15, 2002

This prime minister decision was taken in October of 2002 and concerns the establishment and implementation of province level Health Care Funds for the Poor (HCFP), 75 percent of which will be covered by central government resources with the balance covered by the provinces themselves. The beneficiaries of the decision are the poor (as defined by MOLISA decision no. 1143 of Nov. 1, 2000; this decision was replaced by MOLISA decision no. X of DATE containing adjusted poverty lines), ethnic minorities, and inhabitants of certain communes in difficult circumstances ('135-communes'). According to the decision these target groups are entitled to health care free of direct user charges at public health care providers and at private providers that have contracted with a specified government agency. In addition, the decision specifies that also other individuals than those specified above are to receive reduced health care costs for especially costly treatments due to severe health conditions. As to implementation, the decision specifies that the Funds can choose between two alternative ways in covering for the target groups. Either they purchase health insurance cards from the Vietnam Social Security (VSS) and distribute these to the beneficiaries, or they reimburse directly the health care providers for the services to the beneficiaries. In order to benefit from the decision, beneficiaries are obliged to use their local health facility and not contact a different facility at a higher level or different level.

Circular 14: Instructions on the implementation and management of the HCFP as established in Decision 139; Ministry of Health December 16, 2002

This inter-ministerial circular sets out the instructions on the organization, establishment, management, utilization, and clearance of the HCFP. Among other things, the circular specifies that the Funds are to be established at the provincial health bureaus and that providers are to be fully reimbursed for the service costs by the health insurance agency without the use of a co-payment policy. This agency is also responsible for monitoring the financial affairs related to this form of cost coverage. Regarding direct reimbursement, the Fund sets aside different amounts depending on the level of care. In vetting the alleged costs,

the Fund may contract with the health insurance agency to undertake such services. Based on the financial situation of the Fund, the Provincial People's Committees can decide to also cover the costs for non-beneficiaries encountering sudden financial difficulties due to series illness requiring high-cost care. Finally, the Ministry of Health is principally responsible for supervising and evaluating the implementation of the HCFP.

Resolution No. 46: On people's health protection, care and promotion in new context; Politburo February 23, 2005

This party resolution outlines the aim and means for improving population health in Vietnam in light of some of the recent changes and challenges that are facing the country. It starts out by describing the improvements in the health sector over the past 10 years, including health outcomes, health care, and health financing. It then discusses some of the remaining weaknesses of the health sector, including insufficiently comprehensive reforms, inability on behalf of the health system to meet people's needs, increasing inequalities, public health deficiencies, and unethical behavior of some health staff. The Resolution mentions several reasons for the current weaknesses, including poor government management, incoherent policies, weak government supervision and regulation of private actors, insufficient public investments in health, irrational and ineffective health financing policies, and weaknesses in human resources for health.

Against this background, the Resolution identifies four important challenges: new or emerging health problems and negative health related behaviors, increasing health care needs of a growing and aging population, increased health care costs, and finally, the influence from abroad of both new diseases and competition in the health technology sector.

Subsequently, the document sets out a description of the visions for the health sector for the coming years. Areas that are mentioned include the need to further develop the health care system (as described in more detail in the Master Plan for the Health System for 2010 and a Vision to 2020), renovating health financing policy (increase public spending, reducing direct user fees, universal health insurance by 2010, and further developing the management capacity of the health insurance system), developing human resources for health, strengthening government stewardship role, and enhancing government management capacity in health. Importantly, the Resolution also emphasizes the need to develop effective monitoring and evaluation mechanism for the successful implementation of national policies.

Decree 63: Issuing Health Insurance Regulation; Ministry of Finance decision of May 16, 2005

This decree sets out the regulations for health insurance in Vietnam as an attachment. It specifies the MoH as the leading agency in providing guidance on the implementation of the regulation. In the first section, it defines the main terms and concepts of health insurance making a distinction between voluntary and compulsory insurance. Section two on policy and payments, contains eight articles specifying issues related to, among other things, the provider reimbursement systems (FFS, capitation, and DRGs among others) and exemptions from benefit packages (including, leprosy, TB, malaria, STDs, and family planning as these are covered under the national programs for health). Notably, the VSS is charged with providing guidance on the piloting of new provider payment methods (Article 14).

The third section consists of two articles on, respectively, responsibilities and methods for contributions to compulsory insurance. Among other things it is specified that for compulsory health insurance, contributions amount to three percent of the individual's income of which the employer pays two percent and the employee one percent. The next section contains four articles detailing the rights and responsibilities of, respectively, the insured members, the employers, the VSS, and the contracted providers. It is noted that one of the responsibilities of the VSS is to develop action plans for and solutions to the implementation of universal health insurance (Article 19.2.i) and to further develop the effectiveness of compulsory health insurance. The final section on compulsory health insurance (Chapter V) sets out some of the fiduciary requirements for the management and utilization of the fund. It is stated that the MoF and the MoH shall provide detailed guidance in this regard.

Chapter VI of the regulation is on voluntary health insurance. It consists of four articles on the objectives, principles, and management of the various forms of voluntary health insurance, including supplementary and community-based health insurance programs. Furthermore, it is specified that the MoH and the MoF shall define the scope of benefits and the scale of contributions for voluntary health insurance based on the costs of health services. Finally, it is stipulated that the MoH shall cooperate with VSS to pilot complementary health insurance (Article 26.2 and 3).

The next section specifies the organization and management of health insurance. In Article 28.2 VSS is charged with the task of implementation of health insurance policy while the

MoH is responsible for developing policies and regulations on health insurance (Article 29.2.a). In addition, the MoF, MOLISA, and the Home Office are responsible for the implementation of their state management function over health insurance, and finally, the People's Councils at the provincial level are responsible for the implementation of health insurance within their areas, including the control, monitoring, and inspection of health insurance programs.

Section eight specifies the various roles and responsibilities of the various state agencies regarding complaints and violations. Among other things the following responsibilities are defined: The Ministry of Health has the responsibility to deal with complaints concerning insured health care treatment; The Ministry of Finance is in charge of complaints concerning the management and utilization of Heath insurance fund; The Home Office shall deal with complaints concerning the management of health insurance staff; The People' Councils of the provinces and centrally-ruled cities shall deal with complaints concerning health insurance in their areas, as stipulated by the law and within the scope of authority (Article 31.3). Also, Article 33.1 stipulates that contracted health facilities, insurance funds, and VSS are subject to the control and supervision of authorized state agencies and specialized inspection agencies in issues relating to health insurance. The final section (Chapter IX) of the regulation specifies the provisions for the implementation of the decree.

Circular No. 21: On the Implementation of Compulsory Health Insurance; MoH and MoF, July 27, 2005

This inter-ministerial circular provides guidance on the implementation of compulsory health insurance as described in Decree 63 above. In line with the decree, the circular specifies the beneficiaries of compulsory insurance, the benefits and exemptions of insurance, procedures for coverage and payment, the rights and responsibilities of the various parts involved in the system, and finally the provisions for implementation of the policy.

Decision No. X: On Health Care for the Poor and the Ethnic Minorities; Prime Minister, (Forthcoming)

This decision will replace Decision 139 on health care funds for the poor of October, 2002. It entails some important and quite profound changes in relation to the original decision. Generally, the decision specifies the implementation of a mechanism for health care for the

poor and ethnic minorities. Specifically, it identifies five types of beneficiaries divided into two groups:

Group 1:

1. The poor as identified by MOLISA decision number X of Y, 2005.
2. Those who have recently escaped from poverty.
3. The near poor ethnic minorities (income equal to 1-1.5 times that of poor households) in rural areas.

Group 2:

1. The ethnic minority household with incomes 1.5 times that of poor households in rural areas.
2. The near poor Kinh households with incomes 1.5 times that of poor households.

As noted, the group of 'near poor' is now defined officially.

As before, the HCFPs are financed by the state government, donors, and other organizations and individual contributions. The main difference compared with the preceding decision is that the central government contribution is expected to cover 30 percent of the insurance premium for the beneficiaries.

Regarding the implementation mechanisms, the decision specifies that the Chairmen of the Provincial People's Committees (PPCs) are responsible for purchasing health insurance cards (with a premium of 50-60,00 VND) for the beneficiaries in group 1 above, and for supporting at least 30 percent of the premium for voluntary health insurance for the group 2 beneficiaries. In addition, the PPCs are charged with managing – including defining and approving beneficiaries in each specific case – the special support to those individuals who have fatal diseases and require high cost treatment (specified as costing more than 10 million VND per treatment episode). Specifically, the Fund will cover half of the costs exceeding 10 million VND with a cap on 10 million VND.

A number of agencies are charged with various responsibilities. Specifically, the MoH is responsible for providing guidance to providers on the health care services to the poor, while MOLISA is responsible for the identification of the beneficiaries. The MPI is charged with

coordinating support from donors and other organizations. The VSS is responsible for issuing the health insurance cards for the group 1 beneficiaries and for promoting voluntary health insurance for the second group, as well as for organizing and managing the health care for all targeted groups. Furthermore, the Vietnamese Fatherland Front Central Committees are responsible for participating in the monitoring and implementation of the decision. And finally, the PPCs are responsible for organizing and directing the implementation of the decision at the local level. In particular, they are charged with providing annual reports according to the requirements of the MoH and MoF for further submission to the Prime Minister.