CHAPTER 3

Master Plan Goal 2: Improving Financial Protection and Equity

This chapter examines how best to reduce the out-of-pocket (OOP) costs of health care. The previous chapter provided recommendations for raising enrollment rates. High enrollment rates would, however, have little impact on financial protection and equity if OOP costs remain high. OOPs are persistently high in Vietnam due to a combination of: (a) increases in coverage-related utilization and/or spending; (b) cost recovery by providers to make up shortfalls in Vietnam Social Security (VSS) reimbursement rates; and (c) higher prices and/or provision of unnecessary services that are a result of the distorted incentives structure that providers face. Ensuring strict controls on balance billing and providing a right-sized basic benefits package that can be fully financed through VSS reimbursements and subsidies would be the most effective way to control growth of OOP costs. Both will require systemic reforms over the medium to longer term, including reforms to provider payment mechanisms and the delivery system. In the short to medium term, strengthening the implementation of the copayment policy, making the policy more transparent with easily accessible grievance mechanisms, further reducing copayments for the poor, introducing catastrophic cost coverage, and shifting patients' preference toward lower-cost generic drugs would contribute to stemming the growth of OOPs.

The Government of Vietnam's (GoV) Master Plan has set the goal of progressively taking steps to reform health financing mechanisms so as to reduce OOP payments made by patients to under 40 percent by 2015. This chapter discusses why OOPs are a concern for policy makers, examines the reasons why OOPs are still high despite increasing levels of coverage, and provides recommendations on how to improve financial protection, focusing on measures to increase depth and scope of coverage.

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Implications of High Out-of-Pocket Payments for Financial Protection and Equity

High OOP payments can expose households to financial risk including that of impoverishment, deter utilization, and often result in inequitable health-seeking behavior that is correlated with ability to pay rather than to need (WHO 2010). In short, high OOPs are inimical to the goal of achieving universal coverage (UC). Expanding the breadth of coverage and enrolling as much of the population as possible is not guaranteed to reduce the OOP burden on the population and thus improve financial protection and equity. If social health insurance (SHI) beneficiaries are liable for high copayments or direct payments (inadequate depth of coverage), or if the scope of the SHI benefits package is limited (inadequate scope of coverage), SHI beneficiaries may still incur high OOP payments.

It is notable that rising SHI coverage and SHI spending in recent years in Vietnam has not translated into a decline in OOP payments incurred by households. Even in 2010, with a coverage rate of almost 60 percent of the population, the OOP share of total health spending remained relatively high at 57.6 percent (figure 3.1). Vietnam's OOP share of total health spending is the second highest in the East Asia and Pacific (EAP) region—below that of Myanmar but higher than that of the Philippines, Indonesia, and China. Moreover, the OOP share of total spending is much higher than would be expected given Vietnam's income level (figure 3.2). Cross-country evidence shows quite clearly that a greater reliance on OOPs results in more catastrophic payments for households and greater

Figure 3.1 OOP Share of Total Health Spending and SHI Coverage in Vietnam (1995–2011)

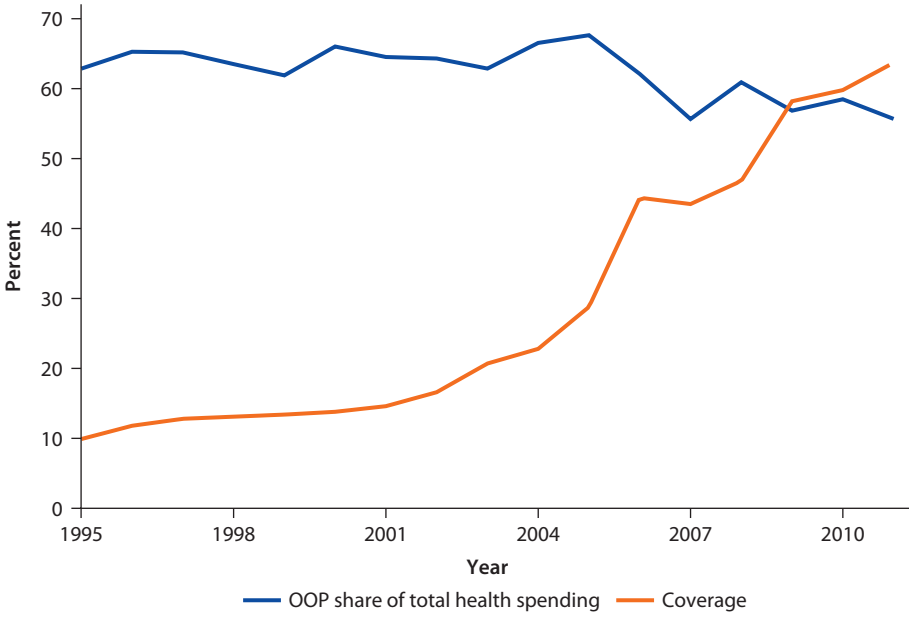

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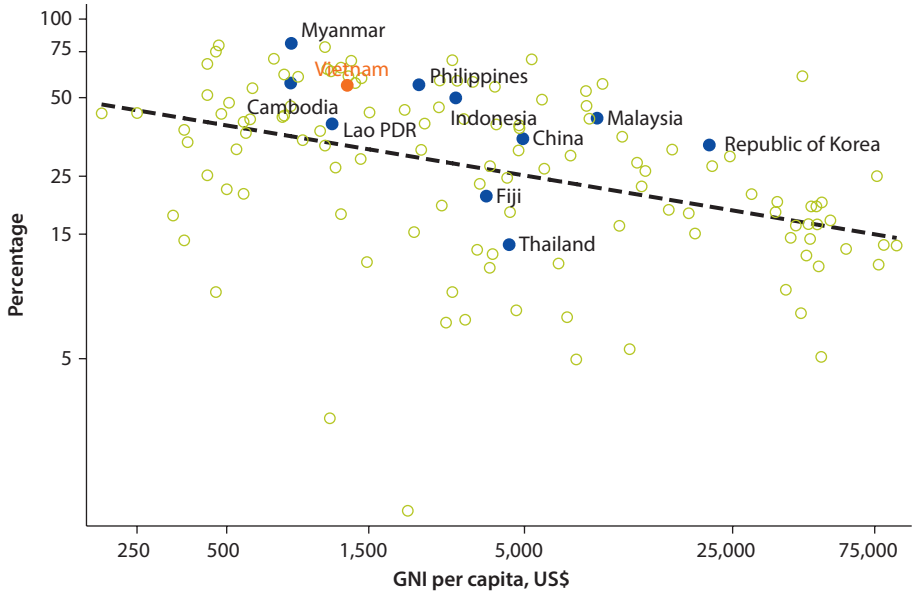
Figure 3.2 OOP Share of Spending in Vietnam and Other EAP Countries (2011)



Source: Estimates based on WHO (2014). and the reference for the back of the chapter is: World Health Organization, 2014. National Health Accounts—Global Health Expenditure Database. http://www.who.int/nha/expenditure_database/en
Note: x and y axis in log scale. GNI = gross national income.

inequality of service use (Van Doorslaer et al. 2006; World Bank 2013). This is clearly the case in Vietnam, as is elaborated on below.

Rich households account for the bulk of all OOP spending. About 25 percent of total OOP health spending comes from the top economic decile of the population. Only about 4 percent of total OOP spending comes from the bottom two economic deciles. On average, about 4–5 percent of total household consumption expenditure across all deciles is devoted to OOP spending (figure 3.3).

For the poor, who have limited disposal income and savings or assets, high OOP spending can be catastrophic and/or impoverishing. Figure 3.4 shows that the share of households experiencing catastrophic OOP spending[1] in the poorest two quintiles has changed little over time. The same is true of the probability of OOP-related impoverishment[2] for the poorest quintile, although not for the second-poorest quintile (Hanoi Medical University and WHO 2012). This implies that, despite increases in SHI coverage, OOP payments continue to have a catastrophic and potentially impoverishing effect on poor households. In short, Vietnam SHI provides limited financial protection, particularly for poor households.

When the poor have limited financial protection for health, this leads to large inequalities in utilization, and potentially large inequalities in health outcomes. Measures of financial protection, such as those presented in figure 3.4, are not adjusted for need. Since the poor are usually in worse health than the better-off, these measures of financial protection understate the true degree of inequality. The data in table 3.1 show the poorest and richest quintile's shares of hospital

Figure 3.3 Total OOP Spending by Economic Decile (2010)

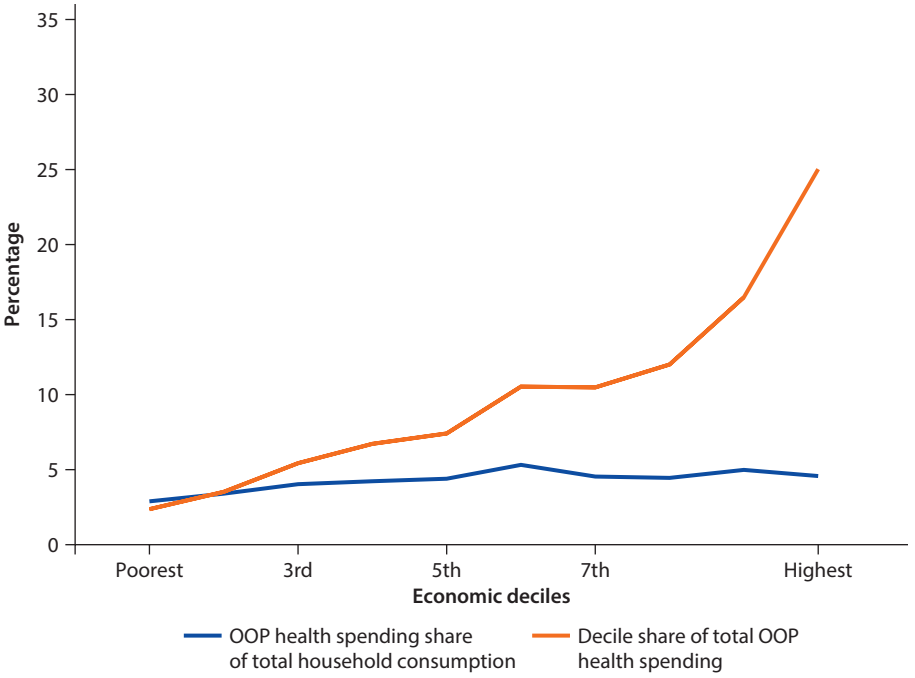
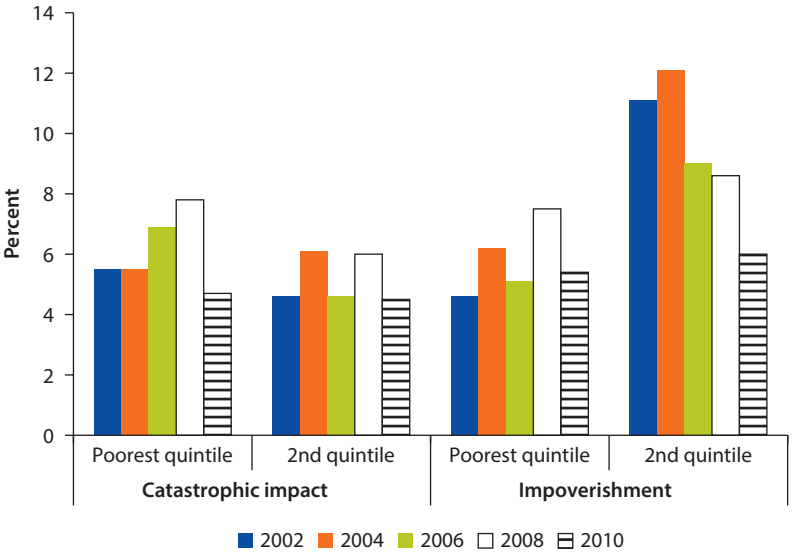


Figure 3.4 Share of Poor Households Experiencing Catastrophic and Impoverishing OOPs



Source: Hanoi Medical University and WHO 2012.

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Table 3.1 Poorest and Richest Quintile Shares (Percent) of Total Utilization (2006–10)

		Hospitals		*Nonhospital (CHS)*	
Year	*Quintile*	*Inpatient (episodes)*	*Outpatient (visits)*	*Inpatient (episodes)*	*Outpatient (visits)*
2006	Poorest quintile	15	10	45	28
	Richest quintile	24	35	6	10
2008	Poorest quintile	17	11	32	32
	Richest quintile	24	29	3	9
2010	Poorest quintile	19	11	35	31
	Richest quintile	19	32	6	7

Source: HSPI 2010.

Table 3.2 Distribution (Percent) of Last Health Facility Used by Poverty Status, Ethnicity, and Health Insurance Coverage (2009)

	Kinh[a] nonpoor		*Ethnic minority nonpoor*		*Kinh poor*		*Ethnic minority poor*	
	Without HI	*With HI*	*Without HI*	*With HI*	*Without HI*	*With HI*	*Without HI*	*With HI*
Private sector	71	22	51	11	42	15	43	9
CHS	13	46	18	55	30	54	37	67
District hospital	5	18	21	24	16	25	14	22
Provincial hospital	11	14	10	10	12	6	6	2
Number of health facilities in the sample	392	245	353	242	198	381	284	615

Source: Yen et al. 2013.
Note: The differences among the different groups were statistically significant. HI = health insurance; CHS = commune health stations.
a. The Kinh ethnic group constitutes approximately 82 percent of the country's population.

and nonhospital utilization during 2006–10. The poorest quintile accounts for a disproportionately large share of nonhospital visits, mainly to commune health stations (CHSs). Meanwhile, the richest quintile accounts for a significantly greater share of the hospital visits. It is notable, however, that the distribution of hospital inpatient visits has improved from 2006 to 2010: in 2010, the poorest and richest quintiles accounted for the same share of public hospital inpatient visits. Data in table 3.2 from a different survey carried out in selected districts show that poor ethnic minority households are far more likely to use CHSs than district or provincial hospitals. The nonpoor make greater use of the hospitals.

Underlying these utilization patterns are large inequalities in the quality of care received by the poor and ethnic minorities. As mentioned above, the poor, particularly poor ethnic minorities, are more likely to visit CHSs, which are less well-resourced and staffed by providers who exert less effort. The rich visit hospitals, which are staffed by doctors and better supplied with medicines and other inputs than CHSs. This inequality in quality of care is as important as inequality in the quantity of care. Castel (2009) showed that in the Kom Tum province ethnic minorities and informal sector workers received less expensive services than nonpoor patients with the same disease. The study also showed that financial barriers imposed by hospitals were cited as the most prominent barriers to

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access by the poor and ethnic minorities, rather than culture or distance. Moreover, inequalities in health care use are a concern because they are potentially related to inequalities in actual health outcomes. There is evidence that this is indeed the case in countries in Europe and Central Asia, for instance (World Bank 2012).

Understanding Why Out-of-Pocket Payments Are Persistently High

Insurance coverage should, by definition, reduce the OOP burden on households; so why has the OOP share of total spending remained persistently high in Vietnam?

1. Increases in coverage-related utilization and/or utilization-related spending.
   Estimates from 2010 Vietnam Living Standard Survey (VLSS) data indicate that the distribution of OOP health spending is roughly aligned with that of the share of the population covered (that is, over 60 percent of total OOP spending reflects direct payments for health from those covered) (Tandon, Harimurti, and Pambudi 2013). SHI enrollees had higher outpatient utilization rates (38.9 percent among enrollees, 29.5 percent among others) and admission rates (9.2 percent among enrollees, 5.7 percent among others).[3] This is consistent with the global evidence that an expansion of government-funded health care, regardless of whether it is from insurance or general revenues, will tend to increase the quantity of care received, which will put upward pressure on OOPs when the generosity of coverage is less than 100 percent. Copayments, deductibles, and excluded items such as drugs will result in more OOPs as service use increases (World Bank 2013).
2. VSS reimbursements/subsidies do not completely cover the SHI benefits package and providers end up recovering their costs via OOPs from patients.
   SHI reimbursement rates have not kept pace with increases in the price of medical services and drugs for nearly two decades. The first national fee schedule was established in 1995, and was updated only once (in 2006, to add 992 mostly complex medical services) before the most recent revision, which went into effect in May 2012. Prior to this recent update, the prices of services had not been adjusted, even in line with inflation (Tandon, Harimurti, and Pambudi 2013). As a result, VSS picked up only a portion of the total cost of care, leaving providers to claim the remainder through user fees from patients. In this context, providers also faced strong incentives to provide the most profitable services covered under SHI or provide services not covered under the benefits package (Lieberman and Wagstaff 2009).
   The recent increase in the fee schedule will not necessarily reduce the OOP burden on households. The fee schedule determines the prices that hospitals charge for their services. Both VSS and households pay according to the fee schedule. Increasing the fee schedule would only reduce the OOP burden on households if most of the population is already insured.

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With a significant share of the population (37 percent) still uninsured, increasing the fee schedule may worsen the lack of financial protection because the uninsured will incur these higher fees as OOPs. In addition, with weak and poor quality primary care, patients will continue to bypass commune and district level services and incur even higher fees for bypassing.

3. Higher prices and/or oversupply of services are a consequence of the distorted incentive structure that providers face.
   As will be discussed in chapter 7, providers face strong incentives to oversupply services. The scope of the benefits package is expansive, but not evidence-based or rationed in any way. Expensive, high-tech procedures are included in the benefits package and subject to high copayments (Van Tien et al. 2011). Balance billing is widespread with hospitals charging patients for "better quality" technical services, pharmaceuticals, and supplies that are not part of the official price list and package.[4] Drug prices are exceptionally high. The higher prices paid by hospitals are passed on to patients, which contributes further to cost escalation and high OOP payments (Van Tien et al. 2011).
4. There is no cap on copayment expenditures.
   SHI includes caps on benefits, but no cap on copayment-related charges. This is one of the main determinants of the high rates of catastrophic spending and impoverishment.
5. Beneficiaries have a poor understanding of insurance entitlements, particularly copayment policies.
   As discussed in chapter 2, many of those who are eligible for insurance do not have a good understanding about the entitlements, limits of coverage, and copayment policies. This results in patients not enrolling in SHI, not using the card even when they are enrolled, or paying more in copayments than they should.
6. Deficiencies on the supply side lead patients to seek care outside the range of covered services.
   Primary care facilities, specifically CHSs, are of poor quality, understaffed, and lacking in key inputs, as shown in chapter 1. As a result, patients are forced to bypass them to access higher levels of care, where they incur higher copayment rates, or seek care at private health facilities, which are not covered by SHI. The majority of OOPs are incurred on self-treatment and private sector services, which are not covered by SHI (figure 3.5).

Regional Patterns in Out-of-Pocket Spending and Coverage

Despite increasing rates of insurance coverage, a high level of OOP health spending is a common phenomenon in the EAP region. As is the case in Vietnam (figure 3.1), the share of OOPs in total health spending in Indonesia and the Philippines has remained high despite rising insurance coverage rates (figure 3.6). Only in China and Thailand has the increased rate of insurance coverage been accompanied by a decline in OOP spending.

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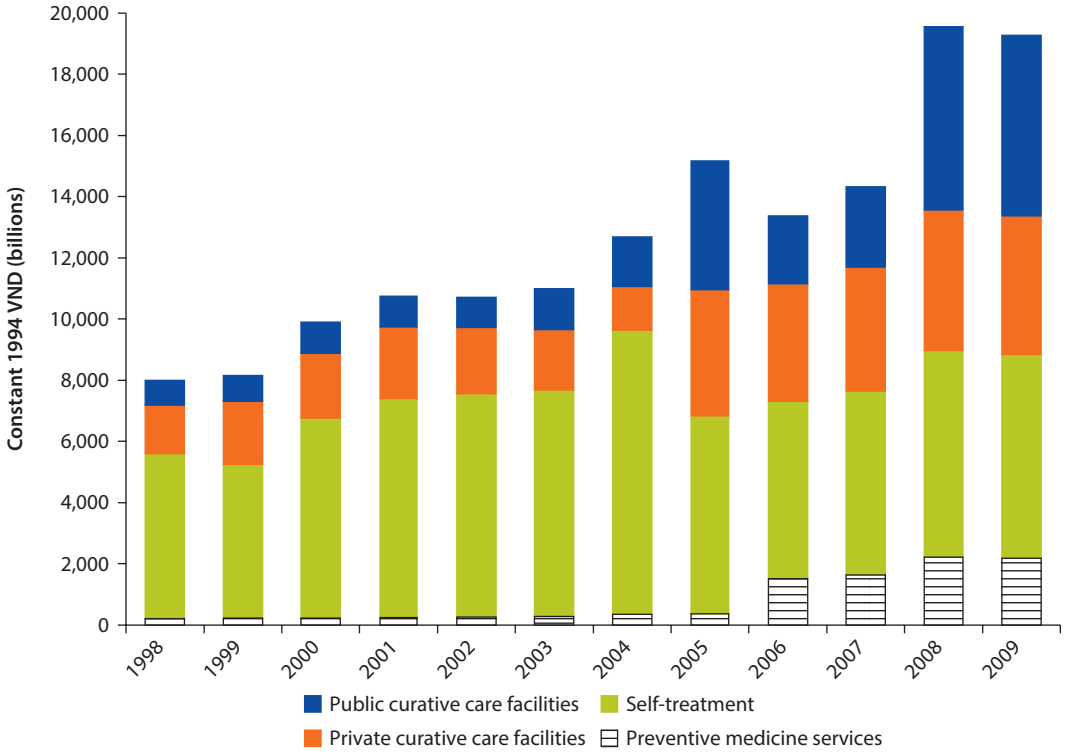
Figure 3.5 Trends in Real OOP Spending by Health Service Activity (1998–2009)



Source: World Bank 2013.

In Indonesia and the Philippines, the explanation for high OOP spending is similar to that in Vietnam:

1. Since the benefits package is comprehensive on paper, but not fully financed by SHI/subsidies in practice, providers resort to balance billing from patients.
2. Providers and beneficiaries have a relatively poor understanding of their benefits and entitlements and fail to make use of them.
3. Supply-side deficiencies, particularly at the primary care level, mean that the insured end up self-referring to higher levels (incurring higher copayments) or seeking care in the private sector (not covered by insurance).

In Thailand, by contrast, the implementation of Universal Coverage Scheme (UCS) was preceded by significant public sector investments to strengthen the supply side. This meant that the health service delivery system had the capacity to absorb the increases in health care utilization following the implementation of UCS. The strong supply side, combined with significant payment and purchasing reforms to control costs, meant that the implementation of UCS was not accompanied by significant increases in OOPs as in other countries. In China, the decline in the share of OOPs in total spending is simply due to large injections of budgetary resources into the health sector.

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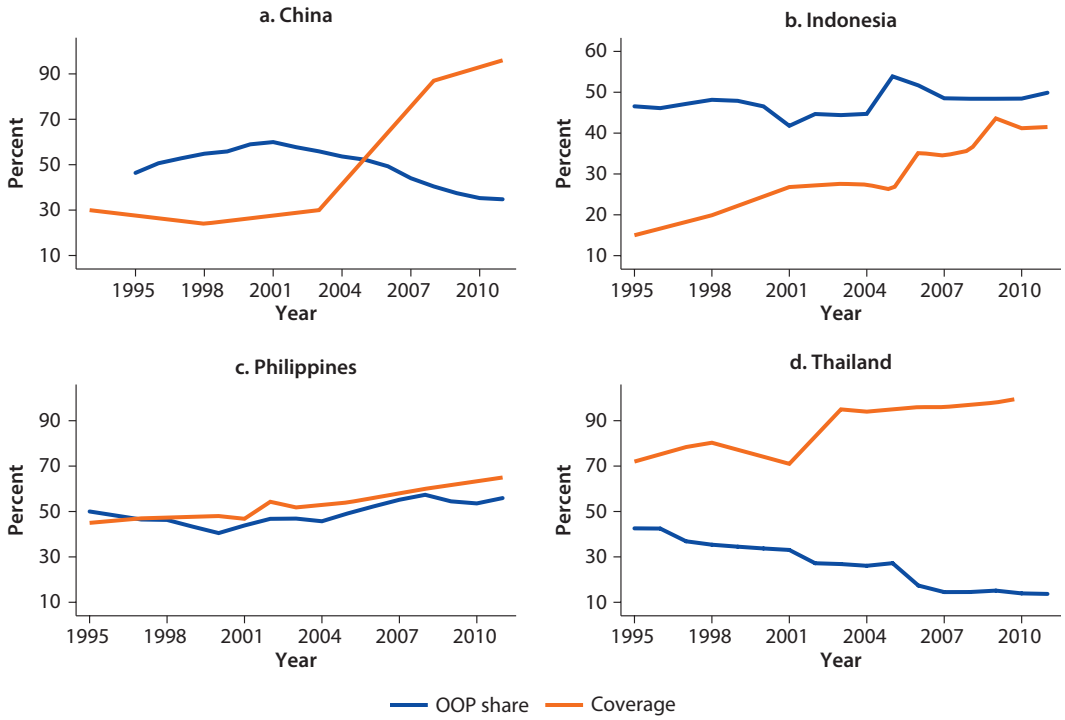
Figure 3.6 Patterns in OOP Spending Shares and Insurance Coverage (1995–2010)



Source: Tandon, Harimurti, and Pambudi 2013.

Recommendations

Efforts to rationalize and cost out the benefits package, and ensure that it is fully financed by VSS reimbursements and subsidies, albeit with a limited role for copayments, will be critical for addressing the OOP problem in Vietnam. Equally important are provider payment and purchasing reforms, which will be instrumental in monitoring provider behavior, controlling balance billing, and curbing the practice of overprescribing drugs and overproviding services. All of these issues are discussed in chapter 7. The following are a set of recommendations that can be implemented prior to, or alongside, the broader benefits package and provider payment reforms so as to immediately address the OOP problem.

Short Term:

Recommendation 1: Strengthen implementation of the copayment policy, including grievance mechanisms: make the policy more transparent and easy to understand; improve enforcement of the policy; ensure patients are well informed and able to access appropriate grievance mechanisms.

A copayment policy exists that, at least in principle, protects the poor through exemptions and reductions in the copayment rate. In practice, copayments are a barrier to accessing health care for the poor because patients end up being

charged considerably more than what is dictated by the copayment policy. The following recommendations should help address this problem:

1. The copayment policy should be simple and transparent—easy to determine for the patient and easy to communicate for the provider.
2. Copayments should only be paid at the cashier and a receipt provided at the end of the transaction.
3. Information, education, and communication efforts (chapter 2) should incorporate clear information about the copayment policy.
4. Patients should be well informed—not only about the policy, but also about grievance mechanisms that are relatively easy to access for all.
5. Correct implementation of the copayment policy should be monitored and enforced. When a provider is found not to be complying with the policy, there should be mechanisms to sanction them.

Medium Term:

Recommendation 2: Further reduce or waive copayments for the poor and vulnerable groups such as ethnic minorities.

Additional measures might be needed to protect the poor and other vulnerable groups such as ethnic minorities from OOPs. One option is to further reduce or waive copayments entirely. Providers would then need to be compensated for this, possibly through increased supply-side subsidies. Another alternative is to implement Decision 14, thus subsidizing the cost of auxiliary utilization-related expenditures such as travel and meal costs for the vulnerable groups.

Recommendation 3: Introduce catastrophic cost coverage.

Some countries have specific coverage to provide protection against catastrophic costs. For instance, in Japan, no more copayments are charged once monthly copayments reach a certain level. Since catastrophic payments are more likely to affect the poor (who do not have savings to fall back on), an equitable way to do this is to vary it by income. In Japan, the threshold for the monthly copayment amount is tiered into three levels according to the enrollee's income, and a 1 percent copayment is levied for the amount above the threshold.

Challenges associated with introducing catastrophic cost coverage include having accurate information on an enrollee's OOPs during the month or year to assess whether the catastrophic limit has been reached. This is difficult in a setting where the health insurance management information system is weak, and where individuals may seek care from several different hospitals. Unique patient identifiers are a key for making this work. Many copayments—such as informal payments—may be undocumented. Still, the benefits of such coverage in terms of protecting Vietnamese households from financial catastrophe and impoverishment are enormous. Thus, making the necessary investments to implement the catastrophic cost coverage would be worthwhile.

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Notes

1. Catastrophic OOP spending is defined as OOP spending exceeding 40 percent of the household's capacity to pay. A household's capacity to pay is defined as effective income remaining after basic subsistence needs have been met. Effective income is taken to be the total consumption expenditure of the household.
2. A household is defined as being impoverished by OOPs if a nonpoor household's consumption falls below the poverty line once OOPs are taken into account. The poverty line is defined as the food expenditure of the household whose food expenditure share of total household expenditure is at the 50th percentile.
3. Empirical evaluations carried out during the course of SHI's evolution show mixed results with regard to the impact of insurance on utilization and OOPs. Some studies (Wagstaff 2007) found that free health care for the poor had a positive impact on utilization but no significant impact on OOPs, while others (Bales et al. 2007; Wagstaff 2009) found that the same program reduced OOPs significantly but had no impact on utilization. There are no evaluations yet of the post-2008 expansion of SHI coverage.
4. For instance, under a recent World Bank project that financed a health insurance package of services, the difference between the cost of the package and what health insurance actually financed was attributed to balance billing for extras such as more up-to-date surgical thread and pharmaceuticals that are not included in the VSS lists (information provided by Kari L. Hurt, project task team leader).

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