Socialist Republic of Vietnam
European Union

Mission Report

EU Health Facility

Capitation model assessment report

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Asian Management and Development Institute, Liverpool School of Tropical Medicine
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<th>Description</th>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CHC</td>
<td>Commune Health Centre</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DoF</td>
<td>Department of Finance</td>
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<tr>
<td>DPF</td>
<td>Department of Planning and Finance</td>
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<tr>
<td>DRG</td>
<td>Diagnoses Related Groups</td>
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<tr>
<td>DSS</td>
<td>District Social Security</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>EU-HF</td>
<td>European Union Health Facility</td>
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<tr>
<td>FFS</td>
<td>Fee-for-service</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HSCSP</td>
<td>Health Sector Capacity Support Project</td>
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<td>HSPSP2</td>
<td>Health Sector Policy Support Programme 2</td>
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<tr>
<td>HEMA</td>
<td>Health Care Support to the Poor of the Northern Up-lands and Central Highlands Project</td>
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<tr>
<td>HI</td>
<td>Health Insurance</td>
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<td>HSPI</td>
<td>Health Strategy and Policy Institute</td>
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<td>IP</td>
<td>inpatient services</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>OP</td>
<td>outpatient services</td>
</tr>
<tr>
<td>PBF</td>
<td>Performance Based Financing</td>
</tr>
<tr>
<td>PSS</td>
<td>Provincial Social Security</td>
</tr>
<tr>
<td>RBF</td>
<td>Results Based Financing</td>
</tr>
<tr>
<td>SMART</td>
<td>Specific, Measurable, Achievable, Relevant, Time-bound</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>USAID</td>
<td>The United States Agency for International Development</td>
</tr>
<tr>
<td>VND</td>
<td>Vietnamese currency</td>
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<tr>
<td>VSS</td>
<td>Vietnam Social Security</td>
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<tr>
<td>WB</td>
<td>The World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1 Executive Summary

The main objective of the assignment is the analysis of a revised capitation model, which is currently piloted in 38 health care facilities (district hospitals, district health centres, and commune health centres) in four provinces: Bac Ninh, Ninh Binh, TT-Hue and Khanh Hoa (Annex 6).

Currently, the revised capitation model is applied for payment of outpatient services in 8 health care facilities in Bac Ninh and in 13 health care facilities in Ninh Binh provinces, while 8 health care facilities in Khanh Hoa and 9 health care facilities in TT-Hue provinces apply the model for payment of, both, outpatient and inpatient services.

A previous capitation model was implemented according to Circular No. 09/2009/TTLT-BYT-BTC in Ha Giang and Binh Duong provinces. For the purpose of comparison with the current one, field visits were also organized to these pilot sites of the former capitation model.

The assessment of the revised capitation model is conducted as a qualitative study with limited use of quantitative data, but sufficient for the purpose of the analysis. The analysis is based on:

- a desk review of legal and policy documents, including official statistics and relevant reports of the development partners (Annex 2);
- the meetings with key counterparts and development partners (Annex 5);
- the field visits to pilot provinces (Annex 4); and
- the information and data collected from the officials at the Ministry of Health (MoH), Vietnam Social Security (VSS) and the pilot health care facilities.

The assessment elaborates on the functional and implementation arrangements of the revised capitation model implemented according to the Decision No. 5380/QD-BYT of the Ministry of Health and provides:

- an overview of critical issues related to the design, organizational and functional features of the revised capitation model;
- the methodology for revenue collection, calculation and distribution of capitation budget to pilot health care facilities in four pilot provinces; and
- the relevance of the current capitation model to pursue health policy goals of the Vietnamese government.

The analysis of the revised capitation model resulted in the following key findings:

- Current methodology for calculation of total capitation fund is based on historical expenditures. This kind of budget planning is retrospective and input based; thus, it cannot support the development of health care and reflect the changes of health service providers' capacity over time, especially with regard to quality improvement and enhancement of scope of services that are financed by capitation budget. A health system where costs are not managed with foresight is bound to arrive at a breaking point.
- The capitation funds are pooled and distributed based on the membership in a health insurance group, which does not provide significant assurance that actual health care needs are going to be met. Moreover, it reinforces existing inequities in budget allocation to the pilot health care facilities, across pilot districts and provinces, and among health insurance members.
• Fragmentation of risk pools creates additional inequities and raises serious equity concerns since those who contribute less get less funds and not necessarily have sufficient resources to receive all needed health care services, due to poorer health infrastructure and lack of higher level services in poor and remote areas.

• The cost containment mechanisms are weak and the pilot health care facilities incurred significant deficit during only one year of implementation of the revised capitation model.

• The wording of the operational manual is often vague and inconsistent, especially with regard to the elaboration of the capitation formulas and calculation methodology.

• There are no clearly defined criteria and instructions for application of the adjustment coefficients (K1, K2, and K3).

• Monitoring and evaluation mechanisms in place are weak and do not enable effective and efficient measuring of the achievements towards fulfillment of the objectives set in Decision No. 5380/QD-BYT.

• The current practice for settling surpluses and deficits is not conducive to strengthening grassroots health service delivery. In case of a surplus, the pilot health care facilities can only use up to 20% of total amount; while in case of a deficit the pilot health care facilities must balance it by themselves.

• With this management of deficit and surplus there is no safety net for the facilities in the pilots and in practice we have a situation in which the poor provinces subsidize the rich provinces, since the health care facilities in poor provinces, usually, due to poorer health infrastructure, lower utilization rate and lack of higher level services do not spend available budgets and register a surplus.

• Inconsistent instructions sent to the implementing facilities due to weak or lack of coordination between the Ministry of Health and Vietnam Social Security, at central and peripheral levels.

• The health management information system is fragmented; medical and financial information and data flows do not enable information based decision making.

• Insufficient guidance and technical support to the pilot provinces during implementation has been reported.

The identified problems and shortcomings of the current capitation model based on Decision No. 5380/QD-BYT could be addressed by the following interventions:

• Design and develop a weighted capitation model based on age groups (Annex 1) using adjustment coefficients based on utilization patterns of the selected age groups.

• Consider implementation of the capitation model only for payment of outpatient services at primary health care level for a predefined package of health services.

• Define a list of essential health care services that will be paid by capitation. In the future, once a basic benefit package is developed, it would be advisable to establish a direct link between the capitation model and the basic benefit package.

• Develop a new operational manual to enable better conditions for piloting and provide more informative guidelines for implementation of capitation.

• Enable cross-subsidization from individuals with higher contributions to those who can contribute less - pooling of funds; and from those with lower incidence of illness to those who require care more frequently – risk sharing, in order to mitigate current fragmentation of risk pools that creates inequities.
Conduct a structural revision of the current capitation formulas and methodology in line with proven international good practice aiming to provide efficient and effective tool for pursuing the health policy goals of the Vietnamese government.

Integrate principles of solidarity and equity in the capitation model to assure pooling of funds and risk sharing in line with health care needs and positive discrimination in favor of the poor, ethnic minorities, the elderly and other vulnerable groups.

Support drafting a new circular based on the agreement about the proposed recommendations with the key counterparts (MoH, VSS) and other relevant policymakers (Ministry of Finance, Ministry of Justice, etc.), since the proposed changes would require amendment of current legislation.

Clearly define and thoroughly elaborate the roles and responsibilities of the Ministry of Health and Vietnam Social Security at central and subordinate levels.

Strengthen the monitoring and evaluation system considering the following:

- Revise and/or develop indicators that allow measuring progress towards set objectives;
- Define monitoring and evaluation indicators based on SMART criteria - (S)pecific-(M)easurable (A)chievable, (R)elevant, (T)ime-bound;
- Develop, improve and standardize all reporting forms;
- Strengthen monitoring and evaluation capacity of the key counterparts;
- Assure continuous monitoring and regular reporting on progress.

Shift from retrospective budget planning to prospective budget planning – this is the common principle for all capitation models.

Integration of health management information system is needed to enable undisturbed flow of medical and financial data and information, both, vertically and horizontally.

Establish a gate-keeping system to filter access to the higher levels of health care - a gatekeeper must be a fund holder.

Establish/improve cooperation between MoH, VSS and the Ministry of Finance (MoF), especially with regard to revenue collection, financial management and financial reporting.

The assessment report contains the following sections:

1. Introduction with an overview of provider payment mechanisms and international experiences in this regard;
2. Background information on capitation piloting and ongoing health financing reforms in Vietnam;
3. Analysis of implementation arrangement elaborates on the implementation modalities and framework of the revised capitation model;
4. Analysis of capitation formula and calculation methodology provides detailed elaboration of the shortcomings with regard to calculation of capitation budget and allocation of funds;
5. Policy implications of the revised capitation model analyzes the potential of the revised capitation model to contribute to the achievement of health policy goals;
6. Recommendations for revision of the current capitation model and its methodology and for reform of policy factors that significantly influence implementation of the capitation model.
7. Conclusions gives an overview of a recommended modality for implementation of proposed interventions; and
8. Relevant annexes.
In recent years a number of capitation assessments have been undertaken and numerous reports have been compiled by national and international experts, but often the recommendations have not been fully implemented. Hopefully, the results of this assessment would trigger the policymakers for an immediate action and initiate health sector reforms in domain of provider payment mechanisms that are so much needed.

It is to remember, however, that capitation is not a cure-all and will not resolve all health financing problems, but if applied properly and if complemented by other payment mechanisms in use, it can make a positive difference. Capitation should be considered as an integral part of health financing system, together with fee-for-service (FFS), diagnosis related groups (DRGs) and other provider payment mechanisms in place.
2 Introduction

The European Union (EU) has been supporting poverty reduction in Vietnam and the country’s integration into the world economy since the 1990s. Since then, the European Commission (EC) has provided more than €600 million in grants for specific projects and programmes, mainly in the area of education and health, rural development, governance and economic cooperation. EU development cooperation with Vietnam currently focuses on support to Vietnam’s programmes to address poverty and support the health sector.¹

In addition to the EU, a number of development partners actively support the health sector as well. This support continues, with the projects aimed at further strengthening the health sector and building on the successes that have been achieved in domain of the legal framework development, improvement of health indicators related to the achievement of Millennium Development Goals (MDGs), human resources, health insurance (HI) and many other areas. Despite the progress, still, a lot should be done, especially concerning the access to health care services, quality of health care and health financing reforms.

The benefits of investing in health are significant and not limited to improving the health of the population - there can be significant economic returns and social benefits. People must be healthy to be able to contribute to social and economic development, because development goals cannot be achieved without a healthy population, therefore, every government has an ultimate goal of meeting the health care needs.

However, the economic situation is often unfavourable, and financial, administrative and other constraints make this goal difficult to achieve. Thus, all these constraints must be considered when pursuing the health policy goals of the Vietnamese government.² ³

The attainment of health policy goals in an anticipated period of time requires mobilization of human, technical and financial resources to meet identified health care needs. How to finance health plans and how to make the best use of available resources are the most critical issues for any country. It is always the matter of a trade-off between costs and benefits.

Different strategies and various options for mobilising resources for health have been applied by countries depending on their economic, political, ideological and other relevant conditions. The Government of Vietnam opted for introduction of social health insurance due to the considerable potential of social security programmes directed towards the provision of health care services. These programmes have a long history and systems of delivering basic health care, financing concepts and legislation that suit the conditions of many countries have been tested and applied.

Nevertheless, there is no standard model that can satisfy the needs of all countries. The policy options, technical issues and factors influencing the development of social security programmes need serious analysis, consideration and better understanding when introducing social health insurance schemes.

As social health insurance expanded rapidly in Vietnam during 2006–2010, the government share of social health insurance financing rose from 29 % to almost

50% (Figure 1)\(^4\). Government percent health spending increased at a faster rate than economic growth from 2006 to 2010. On the other hand, contributions from employers, employees, and individuals have declined as a share of total revenues. Vietnam, like other countries in the region, has recognized that expanding coverage based on contributory mechanisms alone is not feasible in a context where a large share of the population is still poor, or in the informal sector, or both.

![Figure 1 Trends in social health insurance financing 2006 to 2010](image)

Development of a strong health system is essential for improved health outcomes. Therefore, development partners are putting health systems strengthening at the top of the agenda for global health, supporting efforts to transform health systems to expand access, coverage, quality, and efficiency of health care services.

Health financing is one of the building blocks of a strong health system. With good governance and an appropriate mix of provider payment mechanisms, policymakers and leaders are able to align financial, technical and human resources with policy objectives, procure medical supplies efficiently and effectively, and deliver quality services according to identified health care needs. The key functions of health financing are the mobilization of funds, pooling of resources, allocation of resources, and purchasing of services (Figure 2).\(^5\) A cross-cutting issue that has implications for all of these health financing functions is the stewardship of financing.


\(^5\) Ibidem.
Provider payment mechanisms can be powerful tools to promote the development of health care systems and achieve health policy objectives; therefore, provider payment mechanisms should accomplish far more than simply the transfer of funds to cover the costs of services.

Changes in provider payment mechanisms can provoke fundamental positive or negative metamorphosis in the mode of health care service delivery, which in turn affects health care outputs and in a long-term it affects health care outcomes. Thus, to get the best value for money a number of factors must be taken into account (availability of resources, health care needs, health priorities, health expectations, accessibility of health care services, utilisation patterns, quality of health care services, etc.).

All capitation payment systems are, as the name implies, based on a payment per person, rather than a payment per service provided. Under capitation, the health care providers are paid, periodically, a fixed amount per insured person to finance the costs of a defined package of services. Some form of risk adjustment is usually included into a capitation model to compensate health care providers for variations in predictable health needs across different population groups, such as age and sex groups. In addition, depends on the country, some positive discrimination in favour of certain vulnerable groups can be applied as well.

Per capita payment models are output based, and the unit of output is the coverage of all predefined services for an individual for a fixed period of time, usually one month or one year. The key principle is that the payment to a provider is not linked to the inputs that the provider uses or the volume of services provided. Therefore, some risk is shifted from a purchaser (health insurance agency) to a health care provider (health care facility). If a provider incurs costs that are

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greater than allocated capitation budget, a provider is liable for them. If a provider achieves efficiency gains and incurs costs that are lower than allocated capitation budget, it can usually retain and reinvest this surplus.

2.1 Health financing reforms – lessons learned and experiences of other countries Approach / Strategy

To a large extent, the pressures for cost containment are attributable to the higher growth rate of health spending compared to aggregate income. Firstly, because of population aging more medical services are needed. Secondly, medical technology advanced remarkably in the last years, so treatments have become more expensive.

Intervention for cost containment is deemed necessary when "capacity to pay" of the economy as a whole is lower than the costs of the population’s health care requirements; generally the latter relates to budget constraints in the public sector, as well as to the limits on what households can afford to allocate for health care from their incomes.

The introduction of cost containment instruments dates back to the 1970s during the global economic recession, but its pervasive use has only been apparent since 1990. Cost containment instruments can be classified into four groups, on the basis of whether they are monetary or non-monetary, and whether they are designed to target providers or consumers.

Countries widely use monetary incentives to restrain consumer demand in the form of co-payments: consumers have to pay part of the cost of services out-of-pocket and health insurance and/or government pays the rest. They also use many non-monetary incentives to regulate provider behaviour, including clinical guidelines, clinical pathway management or the use of standardized evidence-based treatments. However, attention has focused increasingly on the use of monetary incentives targeting providers.

Different types of provider payment mechanisms have been used to pay for health care services, but whether cost containment can be achieved and needed health services provided within the available budget, depends on cost containment instruments that are integrated in each of these provider payment mechanisms. The findings on advantages and disadvantages of different provider payment mechanisms used in OECD countries are summarized in Table 1.7

<table>
<thead>
<tr>
<th>Provider payment</th>
<th>Potential Advantages</th>
<th>Possible Disadvantages</th>
<th>Empirical Evidence of a selected country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>Cost containment, equitable provision, easy administration</td>
<td>Low productivity, low quality of service, low moral of providers, informal payment with out-of-pocket money</td>
<td>In Hungary, most medical specialists are public employees and salaried. Physicians receive the bulk of informal payments. Since 2002, the current government has raised the salary by an average of 50% to tackle the problem.</td>
</tr>
<tr>
<td>Budget</td>
<td>Cost containment, simple to administrate</td>
<td>Low investment in technologies, selection of patients, patient shifting, substitution costs under sectoral budget</td>
<td>The German hospital care system uses flexible budgets to control expenditures. Every hospital has a budget. In case of exceeding this budget hospitals get only the variable costs of the DRG remuneration inside the budget corresponding to around 35% of the surplus. Therefore hospitals have a strong incentive to stay inside the budget.</td>
</tr>
<tr>
<td>DRG</td>
<td>Cost containment, cost-effective treatment, reduction in unnecessary care</td>
<td>Selection of patients, increase in admission, premature discharge, monitoring cost, under-treatment</td>
<td>In Australia DRG payment is considered to be efficient but criticized for “quicker by sicker discharge”. Attention now is being paid to developing comparable measures of quality and health outcomes.</td>
</tr>
<tr>
<td>FFS</td>
<td>High accessibility. High quality in the presence of completion</td>
<td>Overprovision, high administration cost</td>
<td>The Belgian reforms in 1990s were focused mainly on eliminating abuse, inefficiency, over supply and over consumption resulted from the nature of FFS system.</td>
</tr>
<tr>
<td>Capitation (GP based care)</td>
<td>Cost containment, provision of preventive care</td>
<td>Under provision, increase in referral to hospitals and specialists, low quality of care</td>
<td>In Spain general practitioners receive a fixed salary plus a capitation component. This can depend either on the age of patients they treat or the nature of the population in their service area. E.g. the percentage of the population over 65 years of age. The exact kind of capitation component depends on the province as it is</td>
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</table>
Historically, health care providers in the same country have been paid according to different provider payment mechanisms. However, reforms in the OECD countries demonstrated a movement towards the simultaneous use of different provider payment mechanisms, in other words paying the same provider in different ways. Some reform experiences with mixed payment mechanisms in the OECD countries are elaborated in Table 2.

### Table 2 Combination of provider payment mechanisms

<table>
<thead>
<tr>
<th>Combination</th>
<th>Countries</th>
<th>Theoretical background</th>
<th>Reform Experience of selected country</th>
</tr>
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<tbody>
<tr>
<td>Capitation + FSS</td>
<td>Czech, Denmark, Finland, Italy, New Zealand, Norway, Portugal, Slovakia, UK</td>
<td>FFS encourages providers to reduce number of referrals to hospitals.</td>
<td>The 1992 and 1999 Italian reforms complemented the basic capitation fee given to GPs and paediatricians with additional FFS remuneration for specific treatments (e.g. minor surgery, preventive cares, post surgery follow up).</td>
</tr>
<tr>
<td>DRG + Budget</td>
<td>Australia, Czech, Denmark, Germany, Hungary, Italy, New Zealand, Norway</td>
<td>The case mix adjusted budget will improve accessibility of services.</td>
<td>In Portugal the case-mix adjusted component of each hospital budget has been increased; the implementation of the model started in 1997 as 10% DRG-based and reached 50% in fiscal year 2002.</td>
</tr>
<tr>
<td>FFS + Budget</td>
<td>Czech, Hungary, Netherlands, Poland</td>
<td>The tendency of overprovision of services under FFS can be capped by limits.</td>
<td>Since 2000 in Netherlands, hospital financing efforts have been undertaken to</td>
</tr>
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8 Ibidem.
2.2 Ongoing health financing reforms in Vietnam

The Ministry of Health considers policy development in health financing and the expansion of social health insurance coverage as high priorities for the sector. The main directions of the health financing reform are the development of health financing strategy 2016-2025, revision of provider payment mechanisms and development of a basic benefit package.

It is clear that capitation as a payment mechanism should be directly linked to the definition of the basic benefit package; the MoH also acknowledges the need of an overarching and coherent approach to the provider payment mechanisms using social health insurance to attain universal health coverage (UHC) within a sustainable health financing strategy.9

A Roadmap towards Universal Health Insurance was approved by the Prime Minister of Vietnam in 2013.10 In the same year, the National Assembly approved a Resolution11 stipulating that at least 75% and 80% of the population should be enrolled in health insurance scheme by 2015 and 2020, respectively. According to this Resolution, development of a basic benefit package covered by health insurance must be completed by the beginning of 2018.

The European Union is implementing Vietnam Health Sector Policy Support Programme HSPSP-2, 114,000,000 EUR in total, from 3/2015 to 6/2019, aiming to sustain poverty alleviation and inclusive economic growth in Vietnam through provision of support for the development of a Vietnamese health care system towards equity, efficiency and improved quality in line with the country's health sector strategies.

The specific objective of the programme is to support the timely achievement of key health sector policy objectives, as laid out in the 5-year plan for the health sector (2011-2015). It will also contribute to the development and implementation of health policy and planning for the period 2016-2020.

The support will particularly focus on progress towards universal health coverage and improvement of availability and quality of health services at lower levels (districts and communes), thereby contributing to the reduction of hospital over-crowding.

A specific emphasis on equity will be given by focusing on 10 provinces considered to be the poorest: Lai Chau, Son La, Dien Bien, Kon Tum, Gia Lai, Ha Giang, Lao Cai, Cao Bang, Yen Bai and Dak Nong12 (Figure 3).

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10 Prime Minister Decision No. 538/QD-TTg, Approving the scheme for implementation of the Roadmap towards Universal Health Insurance for the period 2012-2015 and by 2020.
11 National Assembly Resolution No: 68/2013/QH13, Promoting implementation of policy and regulations on health insurance, heading towards universal health insurance.
Figure 3 HSPSP-2 target provinces
A World Bank’s recent report\textsuperscript{13} underlined the need to strengthen health financing arrangements in the social health insurance by reducing inefficiencies in the current mix of provider payment mechanisms, rationalizing the costs of the benefits package, defragmenting the procurement of pharmaceuticals and generating additional revenues through rises in tobacco taxes and progressively increasing premium contribution rates.

In Vietnam, the World Bank (WB) is implementing the Central North Region Health Support Project with the objective to strengthen district level curative and preventive health services and improve their accessibility for the economically vulnerable population in the Central North region (marked in green Figure 4).

There are two components directly related to the health financing reform:

- The first component of the project is supporting health insurance for the near poor population aiming to expand access to health insurance for near poor households in the Central North region and to improve the system’s capacity to manage health insurance.
- The second component of the project is strengthening district health services and it will also include a Results Based Financing (RBF) pilot to improve the performance of hospitals and preventive health centers in Nghe An province.\textsuperscript{14}

The development objective of the North East and Red River Delta Regional Health System Support Project for Vietnam is to increase the efficiency and equity in the use of hospital services in selected provinces of the North East and Red River Delta regions (marked in orange and red in Figure 4). The following project components are related to the health financing reform:

- strengthening the capacity at grassroots level to deliver quality services, aiming to support the government master plan on reducing hospital overcrowding through increasing the capacity to provide more and better quality health services at lower level;
- reducing the financial barriers to access health services by the economically vulnerable to support the implementation of the government master plan on universal health coverage through reducing the financial barriers to accessing health services, particularly for the poor and near poor, and
- to ensure adequate management structure, processes and human resource capacities, and to setup mechanisms for effective monitoring of activities and evaluation of results.\textsuperscript{15}

\textsuperscript{14}http://www.worldbank.org/projects/P095275/central-north-region-health-support-project?lang=en
\textsuperscript{15}http://www.worldbank.org/projects/P122629/north-east-red-river-delta-regional-health-system-support-project-nerrdhssp?lang=en
The USAID-funded Health Financing and Governance project:16

- Provides technical support and advisory to the Department of Planning and Finance (DPF) at the MoH and VSS with regard to piloting of capitation payment mechanism;
- Working with key stakeholders to establish a standardized approach to costing antiretroviral therapy (ART) that will in turn help set appropriate rates for the reimbursement of facilities delivering ART. With accurate information to set these rates, the VSS can assess the financial impact of integration of ART into the social health insurance benefit package, communicate additional funding needs to key decision-makers, and ensure its longevity;
- Assessing options for integrating the procurement and supply chains for antiretroviral, methadone and anti-tuberculosis drugs into one government-led system and generating recommendations for USAID support; and
- Working with the MoH to define and implement a package of basic health services to be funded by social health insurance.

Lux Development is implementing the project Supporting Policy on Health Care for the Poor in the Provinces of Cao Bang and Bac Kan.

The project supports the provincial authorities in Bac Kan and Cao Bang in the implementation of pro-poor health policies. To improve their health, the project focuses on access to quality primary health care services and looks at the insti-

16https://www.hfgproject.org/where-we-work/asia/vietnam/
tutional aspects, as well as the demand and supply side of health care. This includes improving the collection and use of financial data and strengthening the coordination and development of the institutional framework for alternative financing mechanisms, including Performance Based Financing (PBF).

In addition, the project supports the financing system of the health sector and the strengthening of its coverage for the poorest in three pilot districts of the two provinces of Bac Kan and Cao Bang. The project also aims to improve the quality of the social security card system.

Finally, in its pro-poor approach, the project focuses on providing specific technical and managerial capacity to commune health centres.\(^\text{17}\)

\(^{17}\) http://www.lux-development.lu/en/activities/project/VIE/027
3 Background

3.1 Background to the current assignment

The Ministry of Health and Vietnam Social Security together with international partners have invested a lot of resources and efforts in the development and implementation of capitation. Significant achievements have been made so far, but there is still a lot to be done to establish efficient cost control through creation of an appropriate system of incentives emphasizing higher quality of health care at lower costs.

The first capitation pilot in Vietnam was implemented within the framework of The Key Improvements in Community Health Project (2005-2010) in Hoa Binh province. The project was financed by Belgium Development Agency, aiming to improve access to good quality of primary curative health care services, especially for the poor people in remote and disadvantaged areas. The project piloted new payment mechanisms starting with capitation in the Commune Health Centres (CHC), and a mixed system with 50% capitation and 50% fee-for-services, in the district hospitals.18

Until the endorsement of the Law on Health Insurance19, one of the main health service provider payment mechanisms was fee-for-service. The fee-for-service payment system suffered from overuse of hospital services and over prescription, creating financial strain on health insurance fund.

In response to weaknesses of the fee-for-service payment mechanism, the Law on Health Insurance (2008) mandated the use of capitation as one of three main methods of payment, along with fee-for-service and diagnoses-related groups. Circular 09/200920 provided additional guidance on implementation of different methods of provider payments and prescribed that Departments of Health (DoH) in provinces should develop a roadmap under which at least 30% of primary health care facilities would be financed based on capitation by 2011, with increase to 60% in 2013, and full coverage of 100% to be reached in 2015.

Piloting of capitation model continued with EC bilateral support through Health Care Support to the Poor of the Northern Uplands and Central Highlands Project (2006-2012) (HEMA) and Health Sector Capacity Support Project (2013-2014) (HSCSP).

HEMA was a health financing project that supported the establishment of the Vietnamese government's health care fund for the poor. It targeted the poorest communities and ethnic minorities in remote areas of five provinces in the Northwest and Central highlands regions. The project provided technical support to improve the quality of essential packages of health services for the poor and financial support for the poor to purchase those packages of health services. The project has reached 3,026 of the poorest villages in 253 localities, in 33 districts

18 http://healthmarketinnovations.org/program/kich-key-improvements-community-health
19 Law on Health Insurance, the National Assembly, No. 25/2008/QH12, Hanoi, November 2008.
of five poorest provinces of Vietnam, with health care packages being provided to 1,122,078 poor people.\textsuperscript{21}

In the beginning, capitation was piloted in commune health centres in 2 provinces (Gia Lai, Kon Tum), later it was expanded to community health centres in another 3 provinces (Bac Ninh, Bac Giang and Ha Nam).

Thorough analysis of a capitation model regulated by Circular 09/2009/TTLT-BYT-BTC was conducted by international and national experts. The results were not satisfactory since the application of capitation has veered away from conventional application of such model in other countries.\textsuperscript{22} Very specific design of capitation model and its application for, both, payment of inpatient and outpatient services, calculation of total capitation fund based on historical expenditures and lack of a defined package of services to be paid by capitation, created a number of misallocations and inefficiencies. Some facilities provided an excess of costly services not included in the calculations for the capitation fund and run over allocated capitation budget. It seems clear that the calculation of a base rate and the adoption of the current coefficients for the adjustment of the base rate for different health insurance groups did not correspond to health care needs.

With an intention to rectify such inadequacies and to provide evidence for revision of calculation methodology, the Ministry of Health decided to identify 4 pilot provinces that will implement the revised capitation model in line with the Decision No. 5380/QD-BYT. The piloting of the revised capitation model\textsuperscript{23} was launched at the beginning of 2014 in the provinces Bac Ninh, Ninh Binh, TT-Hue and Khanh Hoa, with the objective of producing scientific evidence for revision of the capitation payment method prescribed by Circular No. 09/2009. In addition to the Decision No. 5380/QD-BYT, Circular 41/2014\textsuperscript{24} further clarified financing of health care facilities from social insurance contributions and changed current design of the revised capitation model.

After one year into the pilot activities, the problems related to calculation of total capitation fund, application of adjustment coefficients and allocation of capitation fund remained unresolved. The uptake of the proposed reforms is slow and the districts are reluctant to accept the methods to balance surpluses and overspending that health care facilities experience.\textsuperscript{25}

At the beginning of 2015, based on the comments of the Ministry of Finance and Vietnam Social Security, the MoH decided to extend the piloting further\textsuperscript{26} and to undertake assessment of the revised capitation model.

As requested by the Vice Minister of the MoH, the EU-Health Facility currently provides technical support through international and national experts with experience in health financing, social health insurance and provider payment methods, including capitation. The main task is to perform the situational analysis and give comments, advice and directions to sustain progress at three levels - health financing strategy, health insurance and improved capitation in Vietnam.

\textsuperscript{21} http://europa.eu/rapid/press-release_MEMO-12-222_en.htm
\textsuperscript{22} ToR, EU technical assistance in provider payment methods and health financing, EU-HF, August 2015.
\textsuperscript{23} Ministry of Health Decision No. 5380/QD-BYT. Approving the project on pilot implementation of the revised capitation payment method for health care insurance, Hanoi, November 2013.
\textsuperscript{25} The Ministry of Health, Report on difficulties and challenges in piloting the capitation payment method, Hanoi, 27 July 2015.
\textsuperscript{26} Ministry of Health Decision No. 635/QD-BYT. Extending the project on pilot implementation of the revised capitation payment method for health care insurance, Hanoi, February 2015.
3.2 Overall objective of the assignment and main activities

The overall objective of the assignment is to provide technical inputs and support MoH to progress toward universal health coverage through social health insurance.

Specific objectives are:

- to improve and adjust the design, methodology and procedures for definition and calculation of rates and coefficients for the capitation payment mechanism;
- support the production of adapted regulation; and
- to help improving the linkage and coherence of different lines of work of MoH in the reform of health sector financing.

Additionally, progress on health insurance payments reforms, defined as performance indicator No.2, is one of the preconditions that will be used to determine the level of disbursement of the variable budget support tranches from the EU.\(^{27}\)

To this end, the assessment report will be used as a reference indicator since it provides an overview of the implementation progress in capitation.

In line with the above listed specific objectives and based upon the request of the MoH, technical assistance through the EU-Health Facility will focus on the following activities:

- Study the regulation on health insurance provider payments, particularly in capitation, relevant pilot projects reports and international literature;
- Review the design, implementation and results of the different capitation pilots including the formula for calculating capitation rate;
- Draft an assessment report on the pilots and provide technical advice to revise/develop new approaches to capitation and adjusted capitation formula;
- Facilitate a consultation workshop to discuss possible options for the revision of the capitation payment mechanism and a road map for its implementation;
- Suggest points to be incorporated in the revised regulation governing provider payment by capitation and support the drafting of the circular;
- Produce a report on the status of capitation in Vietnam with a summary of findings, conclusions and recommendations.\(^{28}\)

3.3 Assessment methodology

The assessment is a qualitative study based on a desk review of relevant legal and policy documents, including review of the reports prepared by national and international experts in cooperation with national institutions and development partners, as well as the official statistics from General Statistics Office.

A number of local counterparts from the Ministry of Health and Vietnam Social Security, including national and international experts have been met.

Together with key counterparts from MoH, VSS and Health Strategy and Policy Institute (HSPI) field visits to the pilot provinces\(^ {29}\) are organised. Data and infor-

\(^{27}\) Performance indicators SRC-2.
\(^{28}\) ToR of the international health financing expert, EU-HF, Sept. 2015.
\(^{29}\) For the sake of better understand and comparisons, in total, 6 provinces have been visited - 4 provinces are piloting revised capitation model based on the Decision No. 5380/QD-BYT, 2 visited provinces piloted capitation according to Circular 09/2009 (Ha Giang, Binh Doung).
Information collected during the field visits, extensive follow-up discussions and meetings with key stakeholders are used for further analysis and detailing of the assessment report.
4 Assessment of the capitation model currently in use

The assessment focused on the main forces of the implementation environment - two groups of factors that strongly impact implementation of the revised capitation model (Figure 5).

Internal factors are directly linked to the revised capitation model and they are defined by the operational manual:

- design of the revised capitation model;
- capitation formula;
- calculation methodology;
- information and data flow;
- reporting system; and
- monitoring and evaluation mechanisms.

External factors are out of capitation framework, but they significantly impact implementation of the revised capitation model:

- revenue collection;
- system of referrals;
- quality of health care;
- system of standards; and
- knowledge, skills and abilities of health professionals.

Analysis of internal and external factors is elaborated in the following sections:

a) Analysis of implementation arrangement elaborates on the implementation modalities and framework of the revised capitation model implemented in line with the Decision No. 5380/QD-BYT;
Assessment of the capitation model currently in use

b) **Analysis of capitation formula and calculation methodology** points out major shortcomings of the capitation formulas, calculation methodology and allocation of capitation budget;

c) **Policy implications of the revised capitation model** are analyzed with regard to the contribution to the achievement of health policy goals.

### 4.1 Analysis of implementation arrangement

The implementation arrangements of the revised capitation model are based on Decision No. 5380/QD-BYT. The approved Proposal is an operational manual for the implementation and it elaborates on:

- the key counterparts for implementation of the revised capitation model;
- the terms and conditions for piloting;
- a set of basic indicators for monitoring and evaluation;
- proposed revisions of calculation methodology to address identified shortcomings of the capitation model based on Circular 09/2009/TTLT-BYT-BTC; and
- a work plan and timelines for implementation of the activities.

To make the analysis and the findings easier to follow, some of the most critical points of the operational manual have been quoted in italic and marked in bold:

**Equation 1:** Chapter 3.2. - Some definitions and terms used in the pilot (page 12)

*Health care fund for primary health care provider is defined as follows:*

- Health facilities **delivering both outpatient and inpatient services are entitled to use 90% of the health care fund** which is allocated based on the total number of HI cards registered at such facilities;
- Health facilities **delivering only outpatient services are entitled to use 45% of the health care fund** which is allocated based on the total number of HI cards registered at such facilities;

According to the latest available data, only about 30% of medical interventions take place in primary health care outpatient settings. Normative discrimination of outpatient and inpatient expenditures, as it is formulated above, does not help to mitigate this problem.

Additionally, it does not provide sufficient financial space to health care providers to address actual health care needs of the HI card holders registered in these facilities. It is very difficult to predict structure of capitation expenditures so precisely - 45% for outpatient and 45% for inpatient services. Moreover, this is not in line with intention of the Vietnamese government to encourage utilization of outpatient services at primary health care level and to help reducing the growing pressure on already overcrowded hospitals at secondary and tertiary level.

Significant disproportion of outpatient and inpatient expenditures has been registered in pilot provinces, favouring the latter. Information collected during the field visits to the pilot provinces TT-Hue and Khanh Hoa, which apply capitation for payment of outpatient and inpatient services, showed significant difference in structure of capitation expenditures among health care facilities (Figure 6).

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31 Financial resources can only be transferred to the level of the district hospitals or district health centres since the commune health centres are not independent legal entities - they are organisational units within the district hospitals or district health centres.
The diagram above shows that under current model health utilization habits of the population and the doctors’ attitude ultimately influence the structure of capitation expenditures. Doctors, however, are bound by ethical standards and they are expected to act according to these standards, but, in practice it might be different.

A transfer of a patient to a higher level for provision of a health care service that could be provided at a lower level is “desirable” – since a consultation fee at an upper referral level is higher than a consultation fee at a lower level for the same health care service. Consequently, this kind of “patients’ encouragement” leads to overspending at higher level facilities due to “unjustified referrals”, which does not provide any incentive for strengthening of primary health care.

Further analysis of the data presented in the diagram above leads to a conclusion that current capitation model for payment of outpatient and inpatient services does not have significant cost containment potential and based on the experience of the pilot health care facilities it is very difficult to keep capitation budget balanced.

Equation 2: Chapter 3.4 - Options for pilot implementation (page 14)

<table>
<thead>
<tr>
<th>Scope of services</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services for HI card holders registered for primary health care at a certain health facility, except for costly services</td>
<td>Outpatient and inpatient services for HI card holders registered for primary health care at district and commune levels, except for costly services</td>
<td></td>
</tr>
</tbody>
</table>

According to the data collected during the field visits, the health care facilities that apply the revised capitation model for payment of outpatient and inpatient services, by majority accrued significant deficit during one year of implementa-

32 The Ministry of Health, The Ministry of Finance, Joint circular promulgating the maximum price bracket for health services provided by public health facilities, No.: 04/2012/TTLT-BYT-BTC, Hanoi, February 2012.
Assessment of the capitation model currently in use

In Khanh Hoa province, 4 out of 8 pilot health care facilities had, on average, the deficit of around 13.3% (in total 13,769 billion VND), while in TT-Hue province, all 9 pilot health care facilities had, on average, the deficit of around 20.4% out of total capitation fund allocated to the pilot health care facilities in 2014 (in total 16,167 billion VND).

Application of capitation for payment of outpatient services is a common and good international practice, which has been proved by numerous successful international examples (Estonia, Finland, Italy, Slovenia, etc.).

Current capitation model mix, as it is applied in Vietnam, is very difficult - almost impossible to manage effectively. If the capitation is applied for payment of outpatient and inpatient services it is also very difficult to efficiently control the costs. It would require the development of very sophisticated cost containment mechanisms and knowledge driven decision-making system based on fluidity, real-time data and information flow within highly integrated web-based health information system.

Current procedures and principles for resolution of overspending and surplus are main points of dispute among MoH, VSS, and the pilot health care facilities.

**Equation 3: Overspending and Surplus regulations**

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principles to resolve overspending and surplus</strong></td>
<td><strong>Principles to resolve overspending and surplus</strong></td>
</tr>
<tr>
<td>Surplus - service providers can use it</td>
<td>Surplus - service providers can use it</td>
</tr>
<tr>
<td>Overspending - service providers must balance it by themselves</td>
<td>Overspending - service providers must balance it by themselves</td>
</tr>
</tbody>
</table>

Even though it was agreed and clearly stated in the operational manual, as it is shown above, that surplus could be used by the pilot health care facilities, in practice, only up to 20% could be used by the providers, while 80% of the surplus is retained in a reserve fund.

Pilot health care facilities must balance overspending/deficit by themselves. It is obvious that there is no safety net for pilot health care facilities and this is one of the major shortcomings of the implementation arrangement of the revised capitation model.

Additionally, the current model does not assure any support for strengthening and development of grassroots health care delivery, because it prioritises inpatient health care and use of more costly higher level health care services.

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33 According to the MoH and VSS, reported deficit amounts to 30 billion VND.
34 The Ministry of Health, Report summary of the implementation of the capitation pilot project, Hanoi, October 2015.
Equation 4: Chapter 4.1 - Indicators (page 25)

The indicators used to assess the results of pilot are identified based on the criteria of effectiveness, feasibility and sustainability with the following indicator groups (indicators can be added and adjusted during the project implementation):

(1) Rational use and allocation of H1 fund, control of costs of H1 medical service

- Proportion of capitulated fund for H1 medical services at district and commune level in total provincial H1 medical costs;
- Average cost per visit for OP services in capitulated hospitals;
- Average cost per visit for IP services in capitulated hospitals;
- Total H1 payment for referral medical services in capitulated hospitals;
- Total H1 payment for self-referral in capitulated hospitals;
- Proportion of facilities with surpluses;
- Proportion of facilities with deficits;
- Frequency in use of Local OP services/H1 card/year in the facility;
- Frequency in use of Local IP services/H1 card/year in the facility;

(2) Improving quality of health service, meeting patients expectation

- Proportion of treatment complied with treatment guidelines for selected illnesses;
- List of technical health services that health facility can provide;
- Proportion of technical health services the health facility can provide compared with the required list corresponding to hospital classification;
- Levels of satisfaction of the insured patients;
- Average length of stay;

(3) Controlled unexpected impact of each option especially the irrational referral

- % of referrals to higher levels;
- % of rational referrals;
- % of self-referral to higher levels among registered H1 card holders;
- % of using 10% reserved fund by health facilities for excessive referrals;
Monitoring and evaluation system has been established and criteria for monitoring and evaluation were developed, but with limited success, since some of the indicators, if defined as above, are difficult to measure or difficult to be measured objectively.

The set of monitoring and evaluation indicators is not significantly related to health outputs and promulgated objectives of the revised capitation model that are presented in the operational manual:35

- Ensure resources and financial mechanism for delivery of quality health care services;
- Connect cost control to quality improvement;
- Increase the efficiency of budget management and use of health facilities;
- Strengthen health care at grass-roots level;
- Ensure equity in allocation of the health insurance fund.

Calculations

The calculation methodology will be elaborated in details in the following section, but it is very important to underline at this point that all calculations in the current capitation model are based on historical data and do not significantly reflect health capacity changes over time. Input based retrospective budgeting does not provide sufficient support for development of health care and long term sustainability of the health care facilities.

Reporting

Numerous difficulties have been reported in relation to the availability of medical and financial data, and data flow between health care facilities, as well as between Provincial Social Security and DoH, especially with regard to data on referrals and self-referrals. This observation was also confirmed in the monitoring and evaluation report prepared by MoH.36

Current data management system is fragmented, medical and financial reporting is slow and inefficient. It does not provide sufficient amount of real-time data for information based decision making and effective financial management, which is one of the reasons for weak cost control of the current capitation model.

Guidance and technical support

Lack of guidance and insufficient technical support to the Provincial Social Security (PSS), District Social Security (DSS), the Departments of Health and health care facilities in the pilot provinces is evident.

Moreover, the implementing agencies in provinces confirmed that they still didn’t get any instructions for calculation of capitation budgets for the current year. Even though it is just two months until the end of the fiscal year, the pilot health care facilities still receive only advance quarterly allocations.37

If a decision on allocation of funds would be delayed further, this would, for sure, add on existing capitation budget deficits, since some of the health care providers already spent all advance funds committed for 2015. The most of them already ran out of money and accumulate deficit. The facilities also struggle to continue with provision of health care services.

It is reported that terminology and language of the operational manual is often vague and inconsistent, which causes some problems especially to staff that is in charge of calculations.

35 The Proposal for pilot implementation of revised capitation payment for health services under health insurance scheme, Decision No. 5380/QD-BYT, 30 December 2013.
36 Monitoring and evaluation report on revised capitation payment for health services under health insurance scheme, 21 March, 2015.
37 Advance allocation is set at 80% of HI capitation expenditure for previous year.
Coordination

Insufficient or sometimes lack of coordination between MoH and VSS is adding up to the difficulties with regard to the implementation of the revised capitation model.

Roles and responsibilities are sometimes overlapping and confusing. Lines of communication are not clearly defined and often contradictory signals and instructions are coming from MoH, VSS and their offices in the pilot provinces.

The terms and conditions agreed by all parties at the beginning of the implementation process are not fully obeyed, and currently, there are certain attempts for unilateral changes of the terms and conditions defined in the operational manual based on the Decision No. 5380/QD-BYT.

It must be clear to all key stakeholders, once they define and approve an implementation framework to test a model, only terms and conditions provisioned by this implementation framework can apply – all other rules and regulations do not apply to the pilot. If any of the key stakeholders intends to amend the implementation framework without consensus, it raises serious concerns about integrity of the piloted model.

Currently, MoH and VSS confronting the opinions how to tackle the issue of the deficit accumulated in 2014, and, still, there is no agreement how to calculate and distribute capitation budgets for 2015, even though there are only 2 months left until the end of the fiscal year. If the agreement will not be concluded very soon this could severely harm the confidence and trust in capitation as a provider payment mechanism.

- Avoid normative structuring of health expenditures, since it is not an appropriate mechanism to allocate available financial resources for health care services that would be able to address actual health care needs.
- Encourage utilization of outpatient services at primary health care level and help reducing the growing pressure on already overcrowded hospitals at secondary and tertiary level, which is one of the policy objectives.
- Develop efficient cost control mechanisms (a gate-keeping mechanism or a stricter referral system) to make the capitation model more resistant to the patients’ utilization habits and the doctors’ attitude.
- Consider implementation of capitation model only for payment of outpatient services at primary health care level, in order to support strengthening of grassroots health care delivery and improve efficiency, effectiveness and quality of health care services.
- Provide safety net for pilot institutions regarding the settlement of deficit;
- Agreed principles and procedures with regard to allocation of a surplus cannot be changed unilaterally during the implementation.
- Improve and strengthen monitoring and evaluation system considering the following:
  - Revise and/or develop indicators that allow measuring progress towards set objectives;
  - Define monitoring and evaluation indicators based on SMART criteria;
  - Develop, improve and standardize the reporting forms;
  - Strengthen monitoring and evaluation capacity of the key counterparts;
  - Assure continuous monitoring and regular reporting on progress.
- Capitation budget should be calculated based on actual costs of health care services in order to better reflect the reality of growing health care needs.
Assessment of the capitation model currently in use

- Assure timely free flow of relevant medical and financial data among PSS, DSS, and DoH, and among pilot health care facilities, both, vertically (top down, bottom up) and horizontally, especially with regard to the referrals and self-referrals.
- Terminology and language of the operational manual should be concise and consistent.
- Provide continuous guidance and technical support from MoH and VSS to pilot institutions and to pilot health care facilities.
- Improvement of coordination at central and subordinate levels is a must!

4.2 Analysis of capitation formula and calculation methodology

4.2.1 Calculation of total capitation fund

Calculation of total capitation fund, as well as calculations of fund for outpatient (OP) and inpatient (IP) services are based on the Decision No. 5380/QD-BYT. The methodology is elaborated in details by the Proposal for pilot implementation of the revised capitation payment for health services under health insurance scheme, which is the operational manual for piloting of the revised capitation model.

Detailed analysis of capitation formula and calculation methodology is presented below, supported by quotations with references to specific pages of the operational manual.

Calculation of the total capitated fund (page 37)

\[
\text{Total capitated fund} = P \times \text{Total Health Insurance fund (for health services) of the next year.}
\]

in which: \( P \) is the proportion of HI payment for health services subjected for capitation in total HI medical costs of the previous year.

Calculation of capitation fund for outpatient services

- For Option 1 (outpatient services):
  \[ P_1 = A_1 / Q \]

in which:

\( P_1 \) is the proportion of HI payment for local OP services at district level and lower in total HI medical costs of the previous year.

\( A_1 \): Total HI payment for local OP services at district level and lower.

\( Q \): Total HI medical services reimbursed in the previous year.

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38 Approving the project on pilot implementation of the revised capitation payment method for health care insurance, Decision No. 5380/QD-BYT, December 2013.

39 Proposal – Pilot implementation of revised capitation payment for health services under health insurance scheme, November 2013.
Calculation of capitation fund for inpatient services

- For Option 2 (outpatient and inpatient services):

\[ P_2 = A2/Q \]

In which:

- \( P_2 \) is the proportion of H1 payment for local OP and IP services at district level and lower in \textit{total H1 medical costs of the previous year};
- \( A2 \): Total H1 payment for local OP and IP services at district level and lower;
- \( Q \): Total cost of H1 medical services reimbursed in the previous year.

Total cost of H1 medical services includes:

- Costs of local H1 medical services (OP and IP) in all facilities providing H1 medical services;
- Costs of referral H1 medical services (referrals by rules and self-referrals), (inside or outside the province);
- Direct reimbursed by H1 agency for the insured;
- Costs of services directly paid outside the capitation fund;
- Costs for primary health care.

Firstly, the misleading wording and inconsistent instructions provided in the operational manual causes a lot of confusion, as it is reported by the pilots.

The words marked in bold above are the missing words in Vietnamese version of the operational manual that is in use in the pilot provinces. Just reading the text, without the words marked in bold, makes difficult to understand what data should be used for calculation.

One can argue that on-the-job instructions have been provided and that all pilots received readymade tables for calculation, but what happens when someone needs to refer to the operational manual and to confirm what kind of data should be inserted in the tables and in which cell. There are more similar examples in the operational manual, but to avoid unnecessary repetition this will not be elaborated further.

Secondly, all calculations are based on historical data and current capitation formula only provisions for retrospective budget planning. This kind of budgeting does not allow for any development and it is not able to significantly reflect changes in the capacity of the health service providers over time, especially with regard to enhancement of scope of services that are paid by capitation. This should be reconsidered and current methodology accordingly amended, since a health system where costs are not managed with foresight is bound to arrive at a breaking point.

Thirdly, based on the data provided by the officials in the pilot provinces, on average, annual increase in prices of medicines and other medical consumables was 3%, while price increase of health care services was 5% in 2014. Inflation rate as measured by the consumer price index was 4.1% in 2014.\(^{40}\)

In order to develop a provider payment model that assures financial sustainability of the health care provision, the following factors must be taken into account in the process of capitation budget planning:

- annual inflation rate,
- increase in prices and consumption of medicines\(^{41}\) and other medical consumables;

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\(^{40}\) http://data.worldbank.org/indicator/FP.CPI.TOTL.ZG

\(^{41}\) Vietnam is currently one of the fastest growing pharmaceutical markets in Southeast Asia. Business Monitor International (BMI) in their report “Vietnam Pharmaceutical and Healthcare Q2 2014” revealed that pharmaceutical market value of Vietnam has increased from US$3.30...
• increase in prices and consumption of health services.\(^{42}\)

### 4.2.2 Calculation of the base rate and HI groups’ coefficients

**Average base rate (page 39)**

The average base rate is determined by the total fund of capitation payment and total number of cards registered at district level or less, which is adjusted by the coefficient according to 6 HI groups.

**Coefficients for each of the HI groups (page 39)**

The coefficient for each group is calculated based on costs for health services and number of HI cards of that group in previous year.

\[
TY_{(i)} = \frac{C_{(i)}}{\sum_{j=1}^{6} \frac{C_{(j)}}{TT_{(j)}}} / 6
\]

\(TY\): Cost coefficient for each group  
\(TT\): Total number of HI cards (all province – district level) for each group in the previous year  
\(C\): Costs of HI medical services  
\(PA1\) = Costs of Local OP services at district level for each group in the previous year  
\(PA2\) = Costs of Local OP + IP services at district level for each group in the previous year  
\(m\), \(i\): HI Group \(m\), \(i\) (from 1 to 6)

**Calculation of average base rate adjusted by cost coefficient (page 40)**

\[
BR = \frac{TQ}{\sum_{j=1}^{6} (TT_{(j)} * TY_{(j)})}
\]

\(BR\): Adjusted average base rate  
\(TQ\): Total fund for health services  
\(PA1\): Total fund for Local OP services in the year  
\(PA2\): Total fund for Local OP + IP services in the year  
\(TY\): Cost coefficient for each group  
\(TT\): Total number of HI cards (all province – district level) for each group in the year  
\(i\): HI Group \(i\) (from 1 to 6)

\(^{42}\) Vietnam’s healthcare services and pharmaceuticals markets were worth US$10.6 billion and US$3.3 billion respectively in 2013. The Business Monitor, Vietnam Pharmaceuticals & Healthcare Report in Sep 2014 forecasts annual nominal growth rates of approximately 15 per cent until 2018 for both.
Capitated fund for each facility (page 40)

\[ Q_{\text{f}m} = BR \sum_{i=1}^{5} (TT_{m(i)} \times TY_{m(i)}) \]

- \( Q_{\text{f}m} \): Capitated fund for each facility
- \( BR \): Adjusted average base rate
- \( PA1 \): BR for option 1
- \( PA2 \): BR for option 2
- \( TY \): Cost coefficient for each group
- \( TT \): Total number of HI cards registered in a facility for each group in the year
- \( i \): HI Group \( i \) (from 1 to 6)
- \( m \): Facility \( m \) (from 1 to the total number of facilities)

According to current legal provisions, there are 5 groups of HI members enrolled in health insurance scheme in Vietnam.\(^{43}\) HI group membership is a basic criterion for collection of HI fund revenues in other countries, as well. Grouping of HI members might be different from country to country, but the principle is the same - each HI group pays different amount of premiums based on social status and income.

Based on the Law on health insurance (2008)\(^{44}\), which was in force at the beginning of implementation of the revised capitation model in 2014, capitation formulas and all calculations, as it can be seen above, were constructed based on 6 groups of HI members. Currently, due to amendments to the Law on health insurance,\(^{45}\) all calculations are based on 5 HI groups, but this change is not incorporated and reflected in the operational manual.

Basis for calculation of capitation budget is HI membership and current methodology is exclusively based on this criterion. Such a model reinforces existing inequities in resource allocation with regard to the pilot health care facilities, across pilot districts and provinces, and among HI members.

Since the funds are, both, pooled and distributed based on HI membership, this raises serious equity concerns about current methodology, since it is not in line with basic principle of social health insurance – contributions are collected according to financial capacity and benefits are provided according to the needs of HI members.

Health conditions requiring preventive or curative health care services, which occur during every individual’s life, can lead to financial commitments that many people cannot meet from their own resources or those of their family. However, when risks and resources are pooled among a larger group with different probabilities of requiring care, the security of each individual is enhanced. The larger the group of HI card holders, the higher are the chances that the funds pooled together will be sufficient to pay for the health care that each HI member is likely to require. Therefore, in order to make a significant move towards universal health coverage, it would be advisable to avoid fragmentation of risk pools at the level of a health care facility, at the level of a district and/or a province.

In fact, the current calculation of the capitation budget is not significantly linked to actual health care needs since it is based on historical expenditure of the previous year. The expenditure, thus, reflects unequal (i.e. lower) utilization rates of the poor, as well as use of less costly services, in contrast to their actual health care needs, which would probably imply higher utilization rates because

\(^{43}\) Joint Circular No.: 41/2014/TTLT-BYT-BTC, 24 November 2014.
\(^{44}\) The National Assembly, Law on health insurance, No. 25/2008/QH12, Hanoi, November, 2008.
\(^{45}\) The National Assembly, Amendments to the Law on health insurance, No. 46/2014/QH13, Hanoi, June, 2014.
Assessment of the capitation model currently in use

of poorer health and living conditions. This is partly due to financial barriers in light of copayments unrelated to income and with no ceiling, as well as due to poorer health infrastructure and lack of higher level services in poor and remote areas.

Obviously, solidarity implies cross-subsidization from individuals with higher contributions to those who can contribute less - pooling of funds; and from those with lower incidence of illness to those who require care more frequently – risk sharing.

4.2.3 Adjustment coefficients K1, K2, and K3

Adjustment coefficients (K1, K2, and K3) (page 40)

There are 3 adjustment coefficients:

- Adjustment coefficient based on availability of HI medical services in capitated hospitals (the availability of services): K1
- Adjustment coefficient based on volume of service delivery (volume of service delivery): K2
- Adjustment coefficient based on policy: K3

The capitated funds allocated to health facilities are adjusted according to coefficients (K1, K2 and K3). However, during the pooling, these coefficients can be applied, calculated, changed and modified.

Coefficient K1 - Adjustment coefficient based on list of HI medical services (the availability)

- This coefficient is used for calculation adjustment based on capacity of list of service delivery. The list of services is regulated by Department of healthcare management for all levels.
- The list is divided into 2 parts – a list of mandatory services (MS) that compels health providers to carry out. The second list of services includes hierarchic services (HS) for each level, but the requirements for this list are not high as those for the first list and this second list is not cover for the first list. When a hospital cannot reach the number of services in the second list, they will not be penalized as much as they will be for the first list. Hence, the coefficients for these 2 lists may be different: 5/2, 4/2, 3/2 or 5/1 ... or 1 (the same proportion – the 2 lists have an equivalent value).
- This coefficient is calculated by the 2 lists in order for provinces to consolidate the lists according to the roadmap without a significant disparity.

- There is a specific list for each option. Because some categories are only for IP services – hence, if it is calculated by option 1, IP services are excluded. For option 2, all services are included according to technical hierarchy.

Conditions for calculating

- The list of services is needed to update regularly.
- The specific list belonging to a defined group should be based on practice and development strategy applied by the province.
- The level of requirements among the lists should be determined according to strategy of sector development in the province and it can be changed annually to improve capacity of service delivery of health facilities in the province.

Coefficient K2 – Adjustment coefficient based on performance of health services (evaluation and adjustment based on performance)

- This coefficient is calculated by number of visits for healthcare in the facility applying capitation.
- This coefficient is used for adjustment of health services with the purpose of enhancing capacity of healthcare in facility applying capitation.
- The adjusted average base rate (calculated above) is related to costs of each HI group, but not related to healthcare activities. This may lead to the situation that the health facility under-provides health services (low number of visits for healthcare) for the insured registering primary care there. As a result, facilities having good performance (provide large number of health services) face possibility of deficits (over-spending or low profits), while facilities having poor performance get huge surpluses (high profits).

- This calculation method follows the allocation by proportion.

Coefficient K3 - Adjustment coefficient based on policy

- This coefficient is used to adjust by development policy in the province. The lowest level of this coefficient is 1 and the highest level depends on the province to reasonably adjust.
- The method follows allocation by proportion.
There are no clearly defined criteria for development and implementation of the adjustment coefficients K1, K2, and K3.

Adjustment coefficient K1 - based on availability of HI medical services in capitated hospitals: The K1 is not in use! If one carefully reads the instructions for K1 it is very reasonable decision, but this coefficient, if defined properly and applied to commune health centres, district hospitals and district health centres, has a huge potential to support strengthening of grassroots health care delivery!

Adjustment coefficient K2 - based on volume of service delivery: This coefficient as it is constructed encourages oversupply of health care services and makes cost containment very difficult, especially in Vietnam where fee-for-service used to be and still is the main provider payment mechanism in a mindset of the health professionals. Eventually, it could be very effective if applied for payment of prevention and promotion. This is something that should be considered and discussed at technical level!

Adjustment coefficient K3 - based on policy. It is very important to provide incentives for pursuing health policy goals, but application of this coefficient should be linked with measurable health indicators (infant mortality rate; prevalence of some chronic disease, etc.). Same as above, application for prevention and promotion services should be considered!

4.2.4 Calculation of the base rate for CHC

Base rate for Commune Health Centers (CHC)

Formula:
\[ C = f \times U = f \times (S + M1 + M2 + V) \]

In which:
- \( C \) = Base rate/HI card holder
- \( f \) = Frequency of annual number of visits for healthcare in CHC unified in capitation model
- \( U = (S + M1 + M2 + V) \) = average cost/visit for healthcare in CHC
- \( S \) = consultant fee (approved by provincial people committee)
- \( M1 \) = average cost for drugs/visit
- \( M2 \) = average cost for other services/visit
- \( V \) = average cost for consumables/visit

The formula for calculation of base capitation rate for CHCs is not in use. At the moment this can be justified with the fact that CHCs do not have capacity to be, both, the fund holders and the gatekeepers, at least due to the following reasons:

- scope of services provided in CHCs is very limited;
- capacity for provision of quality health services is low;
- there is a need for strengthening of management capacity;
- lack of knowledge and skills in domain of financial management;
- shortcomings of existing information systems and medical/financial data and information flows;
- the system of referrals,
- the CHCs are not legal entities, but organizational units within hospitals.
Capacity building and training in domain of management and finance, quality assurance, improvement of information and data flows, and scope of services enhancement should be high on the priority agenda of the policymakers. Moreover, because the CHCs, district hospitals and district health centres are on the “frontline” of the health care system in Vietnam. These grassroots level health care facilities should have a capacity to play roles of a fund holder and a gatekeeper, otherwise health financing reform will have a very limited positive result.

Recommendations related to capitation formula and calculation methodology are presented below:

- Design and develop weighted capitation model based on age groups using adjustment coefficients based on utilization pattern coefficients of these age groups.
- Restructure current formula for calculation of the capitation budget for health care facilities to better reflect health care needs and to assure solidarity and equity among HI members.
- Pooling of capitation funds during piloting phase should be at least at the level of a province to assure better preparation for national roll-out.
- Capitation budget should be calculated based on actual costs of health care services and in line with identified health care needs of the registered HI card holders.
- Redefine existing adjustment coefficients (K1, K2, and K3) including criteria for implementation, and provide clear instructions for application of the adjustment coefficients.
- Apply following adjustments for calculation of capitation budget:
  - annual inflation rate,
  - increase in prices and consumption of medicines and other medical consumables;
  - increase in prices and consumption of health services.
- Even though it has been already highlighted, it is worth repeating - terminology and language of the operational manual must be concise and consistent.
4.3 Analysis of the policy implications of the revised capitation model

Policymakers and political leaders face tough choices and trade-offs when considering where to allocate the limited resources at their disposal. Competing priorities make such decisions very hard, and political dynamics often have a bigger role in determining the answers than evidence-based evaluations of value for money.

Some policy implications have been elaborated earlier from the capitation payment system perspective, but they are here elaborated again in a more detailed manner, from the perspective of the health policy goals of the Vietnamese government, which are listed below:

- Universal health coverage - ensure that everyone (the poor, the minorities, people in disadvantaged or remote areas, bordering areas or islands and highly susceptible people) can access high-quality basic health care services;
- Strengthening the grassroots health care delivery;
- Development of the health care system;
- Equity/fairness;
- Innovate the operational and financial mechanism of health agencies in order to adapt to the socialist-oriented market economy institutions in the health sector’s activities;
- Improve efficiency and effectiveness;
- Continuity of health care;
- Improve health management information systems.

Achievement of universal health coverage is one of the priorities in the Health Agenda of the Government of Vietnam. According to the Roadmap towards HI Universal Coverage for the period of 2012-2015 and by 2020, the key general objectives are:

- expanding the health insurance coverage in terms of the percentage of the population participating in health insurance and the scope of health services the insured can benefit from;
- reduction of the ratio of out-of-pocket payments for health services;
- guaranteeing the benefits of the insured;
- proceeding to universal health insurance, contributing to creation of stable financial sources for the people’s health care toward fairness, efficiency, quality and sustainable development.

There is a growing demand to understand the policy levels that can influence the attainment of universal health insurance objectives. No country has reached a perfect state of UHC where literally every person receives every health service they need, without suffering any financial hardship. Countries should regard their health reforms as an ongoing process in which they aim to make continuous progress towards universal coverage. One of helpful ways to conceptualize the strategic choices is the policy box used by WHO (Figure 7).

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46 Approving the scheme for implementation of the roadmap towards universal health insurance for the period 2012-2015 and by 2020, Decision No. 538/QD-TTg, March 2013.
Assessment of the capitation model currently in use

This approach helps policymakers realize that they need to make trade-offs across three key dimensions (population, services, financial protection), and that progress along only one dimension might not be the best course of action.

For example, promising free health services is an ineffective strategy if there is inequality in access or if services are of poor quality. Initial design decisions should be made with three underpinning principles in mind:

- **Equity**: Make the path to UHC fair and equitable. This is a core objective of UHC reforms, supported by WHO.49
- **Resilience**: Ensure that the health system can survive potentially catastrophic crises and emergencies. This can be enhanced (or undermined) by the decisions made in terms of the levels of coverage and service packages. The recent Ebola outbreak in West Africa, which has decimated healthcare systems in Sierra Leone, Liberia and Guinea, illustrates the lack of resilience in these health systems, where coverage levels are some of the lowest in the world.50
- **Sustainability**: Design the system for long-term sustainability. Many middle- and high-income countries are currently grappling with the challenge of rapidly increasing healthcare costs while experiencing low or negative economic growth.51

In allocating financial resources, policymakers need to make choices on population and service coverage, and make trade-offs between these two dimensions. Countries usually pursue one of two broad strategies (Figure 8):

- Extend coverage to the whole population for a priority package of services;
- Prioritize specific population groups (for example, people in formal employment or the poorest in society), offering them a broader range of services.

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50 Chotia F. Ebola drains already weak West African health systems. BBC News Africa. Available at: www.bbc.co.uk/news/world-africa-29324595

The principle of solidarity implies cross-subsidization from individuals with higher contributions to those who can contribute less - pooling of funds; and from those with lower incidence of illness to those who require care more frequently – risk sharing.

Current practice in Vietnam in this respect is different. The key principle for distribution of social health insurance funds is based on HI membership - as much revenue is collected from HI card holders registered in a health care facility, after deductions at central and provincial levels, the rest of the funds will be allocated for provision of health care services at this health care facility.

If capitation funds are pooled and distributed based on the HI membership, then there is no need to pool the funds since there is no risk sharing among HI members, which raises serious equity concerns about current methodology because it reinforces existing inequities in resource allocation.

Currently, out of total HI revenues collected, 10% is deducted at central level (VSS) for management costs, administrative costs and a central reserve fund. The rest 90% of total HI revenues is divided into two parts - 10% for a reserve fund at provincial level and 90% for health service provision. Taking this into account, in fact, out of 100% collected HI revenues, only 81% of total HI revenues are earmarked for provision of health care services at the beginning of a fiscal year, and these earmarked funds are then distributed on quarterly bases to the health care facilities (Figure 9).

According to current legal provisions VSS is entitled to retain up to 5% of total HI revenues to finance management and administrative costs, which means that reserve funds, both, central and provincial, approximate up to 14% of total HI revenues.
Assessment of the capitation model currently in use

Figure 9: Structure of total health insurance fund

The portion of 81% of total HI revenues earmarked for the health care facilities is further distributed based on a principle - 90% for health care provision (fee-for-service, capitation, and other expenditures) and 10% retention for over-referrals.

As a conclusion, out of 100% collected HI revenues only about 72% are reaching the health care providers during a fiscal year. The rest 28% of total HI revenues is out of flow at least 15-24 months, or in some cases even longer.\(^5\) Time consuming administrative procedures for settlement of surplus and deficit cause loss of real value of retained funds over time due to inflation rate.\(^5\) (Figure 10).

Figure 10 Value of retained funds over time

It is not that there should not be any verification of claims or the reserve funds retentions, but process of deficit verification and settlement should be less time consuming and more efficient.

Current practice for resource allocation and balancing of the HI budgets is significantly opposite to the intention of the Vietnamese government to strengthen the grassroots health service delivery. In case of a surplus health care facility is

\(^5\) It was reported that some health care providers still did not receive any deficit settlement allocations for years 2011, 2012, and 2013.

\(^5\) http://data.worldbank.org/indicator/FP.CPI.TOTL.ZG
entitled to retain up to 20% and the rest 80% is retained by PSS. The retained amount by PSS is then used to cover a deficit in the provinces which have reported overspending. A PSS can cover up to 60% of reported deficit, while the rest 40% should be verified by VSS, and if justified, it will be covered from the central reserve fund.

The shortage of staff in rural areas, and the absence of explicitly articulated priorities resulted in limited availability and quality of services. In practical terms this means that if a province can provide fewer services and usually of a low quality, consequently, population would not use public health services and this province would probably have a surplus at the end of a fiscal year. A province that can provide higher level and more quality services will usually report a deficit at the end of a fiscal year. Following the principle for allocation of a surplus and settlement of a deficit described above, in fact, the poor provinces subsidize the rich provinces. Hypothetically, development trend of health care in a poor and a rich province could be presented by Figure 11.

Figure 11: Hypothetical trend influenced by current allocation policy

Policy measures should be better harmonised and aligned. Shifting from fee-for-service payment mechanism towards capitation could be a good base for efficient cost-containment and strengthening of grassroots health care delivery, while on the other hand, implementation of hospital autonomy scheme provides an incentive for providers to over-supply. This trend is reinforced by current reimbursement policy for patients who bypass the referral system. Provider-induced demand and reimbursement policy have encouraged over-supply and over-utilisation of hospital services, especially of high-tech costly services and at higher referral levels.

The issue of bypassing the lower levels of health care is directly related to scope and quality of services provided at these levels. How to address this issue depends on the proposed mitigation measures and on the current system of referrals, which is an external factor, out of capitation framework, but it significantly impacts implementation of the revised capitation model.

Health management information system is fragmented and cannot support information based decision making. In practice, district hospital is a fund holder of a capitation budget not a CHC. If a patient goes to a CHC and if she/he is referred to a district hospital, usually, there is no any feedback about a treatment, if not explicitly requested. In this case, there are negative consequences, both, with regard to financial reporting and the continuity of health care (Figure 12).
Assessment of the capitation model currently in use

Reporting on medical and financial data is not standardized and usually the data in the forms used by MoH do not correlate to the data in the forms used by VSS and vice versa. As an example, figures for total number of registered HI members per HI group and data about provided health care services do not match.

Integration of health management information system to be able to assure undisturbed flow of medical and financial data, both, horizontally and vertically (bottom-up and top-down) between different levels of health care, as well as between key stakeholders is a must in order to address some of the information gaps related to referrals and self-referrals (Figure 13).

Analysis of policy implications of the current capitation model showed that it cannot be used as an efficient and effective tool for pursuing the health policy goals related to solidarity, equity, pooling of funds and risk sharing according to health care needs, and strengthening the grassroots level of health care in Vietnam.

Figure 12 Current health management information system and data flow

Figure 13 Integrated Health Management Information System
The recommendations related to the relevance and policy implications of the current capitation model will be elaborated together with other recommendations in the next section.
5 Recommendations

Despite the fact that many previous analysis of the capitation model have identified a number of challenges and provided valuable recommendations, still, some critical roadblocks and problems sustained.

However, capitation is an integral part of the health care financing system, together with fee-for-service and diagnosis related groups, thus, some of the identified problems that are out of the scope of the current assignment will be addressed during the following phases of technical assistance and support through the EU Health Facility.

Based on the analysis of external and internal factors that impact implementation of the current capitation model, the operational manual, the capitation formulas and methodology the main recommendation would be to:

Design a weighted capitation model based on age groups and using adjustment coefficients according to utilization patterns of the selected age groups. The model would be based on good and successful international practices aiming to enable cross-subsidization from individuals with higher contributions to those who can contribute less, and from those with lower incidence of illness to those who require care more frequently, enabling mitigation of the current fragmentation of risk pools that creates inequities and providing efficient and effective cost containment tool for pursuing the health policy goals.

Implementation of the recommendations presented below is needed for successful implementation of the main recommendation. The proposed interventions are listed in the chronological order with regard to the implementation timeframe.

5.1 Short-term (0-6 months)

1. **Apply capitation model only for payment of outpatient services at primary health care level.** This is the most common international practice with good results in similar contexts. However, the final decision whether to continue with implementation of capitation model only for payment of outpatient services or for payment of, both, outpatient and inpatient services is up to the policymakers in Vietnam.

2. **Balance all deficits and surpluses in all pilot health care facilities before the beginning of implementation of the new capitation model.**

3. **Define a package of health care services, which will be financed from capitation budget based on availability of resources and the priority health care needs.**

4. **Define age groups and construct adjustment coefficients on the basis of utilization patterns of the selected age groups.** Determination of adjustment coefficients could be challenging if there is no sufficient reliable data. Therefore, temporarily, adjustment coefficients could be calculated based on the available data from a household survey and utilization data recorded in the pilot provinces. Another option could be to define adjustments coefficients based on a positive discrimination in favor of specific policy objectives (e.g. focus on maternal and child health, focus on adolescent health, focus on specific chronic diseases, occupational health, the elderly etc.). In both cases would be necessary to correct adjustment coefficients on an annual basis.

5. **Clearly define and elaborate roles and responsibilities of MoH, VSS and the pilot health care facilities, including organizational units in the pilot provinces and districts (PSS, DSS, DoH, etc.).**
6. **Revise current principle of balancing the social health insurance capitation budgets**, since, as it has been explained in the previous sections, it is opposite to the aim of strengthening the grassroots health service delivery.

7. **Provide safety net for pilot health care facilities**, which means that all pilot health care facilities must have a warranty that a deficit incurred during the piloting period would be balanced from the social security reserve funds or any other sources.

8. **Shift from retrospective to prospective budgeting**. Capitation budget should be calculated based on actual costs of health services and in line with priority health care needs. A health system where costs are not managed with foresight is bound to arrive at a breaking point.

9. **Redefine existing adjustment coefficients (K1, K2, and K3) including criteria for implementation**, and provide clear instructions how to apply these adjustment coefficients aiming to assure a certain level of incentives for the health professionals to improve the quality of health care services.

10. **Develop new operational manual** for implementation of capitation model taking into account that all terms and conditions elaborated in the new operational manual must be agreed and cannot be changed without the consent of key counterparts (MoH, VSS and pilot health care institutions). The new operational manual must be only reference framework for piloting of the new capitation model. The language should be concise and consistent to be able to provide clear instructions to the implementers. Continuous technical and advisory support should be supplied during the implementation of the new capitation model.

### 5.2 Mid-term (6-12 months)

11. **Conduct capacity building and training activities** for implementation of the new capitation model to relevant implementing agencies at central, provincial, district and commune level. Continuous technical and advisory support must be provided during implementation with clear division of roles and responsibilities of each agency in providing such support.

12. **Establish/improve cooperation between MoH, VSS and the Ministry of Finance (MoF), as well as between DoH, PSS and Departments of Finance (DoF) in provinces with regard to revenue collection, budget planning and financial reporting.** This is a precondition for prospective budget planning and long term sustainability.

13. **Strengthen monitoring and evaluation system** considering the following:
   - Revise and/or develop indicators that allow measuring progress towards set objectives;
   - Define monitoring and evaluation indicators based on SMART criteria;
   - Develop, improve and standardize the reporting forms;
   - Strengthen monitoring and evaluation capacity of key counterparts;
   - Assure continuous monitoring and regular reporting on progress.

14. **Provide capacity building and training in health management (providers), health financing and health economics (providers and purchasers) that are involved in implementation of the new capitation model.**

15. **Support drafting a new circular.** If the implementation of proposed changes is accepted and approved by the policy makers, drafting of the new circular would be the next step in implementation of recommenda-
tions, since some of the proposed changes would require revision of the existing legal framework.

5.3 Long-term (12-36 months)

16. **Improve the quality of health care services at the grassroots level** in order to shift utilization of the health care services from currently predominant use of secondary level (hospitals) to primary level (commune health centers) aiming to reduce overcrowding of hospitals and to support establishment of a gate keeping mechanism within the health care system in Vietnam.

17. **Review and revise existing system of referrals** enabling establishment of a gatekeeper in the health care system - the gatekeeper must be a fund holder.

18. **Improve revenue collection.** Efficient revenue collection is essential for sustainability of a social health insurance scheme, thus, the revenue collection should be high on the agenda of the policymakers. In order to be addressed appropriately, it should be discussed and elaborated with participation of the MoF, VSS and MoH as soon as possible.

19. **Capitation as a provider payment mechanism** should be directly linked to a basic benefit package, at some point in the future once the basic benefit package is defined. Direct link with the basic benefit package would assure more efficient and effective use of resources and much clear definition of rights and benefits for health insurance card holders.

20. **Integration of health management information system** is needed to assure undisturbed flow of medical and financial data, both, vertically (bottom-up and top-down) and horizontally, between different levels of health care (primary, secondary, tertiary), as well as between different stakeholders outside the boundaries of the health care system. MoH and VSS reporting forms related to medical and financial data should be standardized.

21. **Elaborate proposals for amendments of the existing legal framework** that would enable successful roll-out of the capitation model nationwide (system of referrals, standards, accreditation, quality assurance, etc.)
6 Conclusions

The capitation payment model, as it is currently applied in Vietnam, does not share the same principles of the capitation payment models that are successfully implemented in other countries (Estonia, Finland, Italy, Slovenia, etc.).

However, there is no standard model that can satisfy the needs of all countries, but to make a capitation model an effective cost containment tool that enables pursuing the health policy goals, some basic principles must be respected. A health system where costs are not managed with foresight is bound to arrive at a breaking point. Therefore, any provider payment mechanism, including capitation, should not be an end in itself, but it should be a tool that would enable translation of a health policy into the health care services aiming to meet the health care needs. The policy options, technical issues and factors influencing the development of a capitation model need serious analysis, consideration and better understanding when introducing the social health insurance schemes.

Capitation should be considered as a complementary provider payment mechanism and integral part of the current health financing system, together with fee-for-service and diagnosis related groups. In that context, some positive effects of capitation could be averted by deficiencies of other provider payment mechanisms in place or by restrictive legal and organizational arrangements.

The proposed recommendations cannot solve all organizational and structural shortcomings of the health financing mechanisms in place, since they are mainly focused on resolution of identified problems with regard to the implementation of the revised capitation model based on the Decision No. 5380/QD-BYT (2013).

If the proposed interventions would be applied with full support of the key counterparts and in line with good international practice and experiences, the recommendations could help removing or mitigating, some, if not all identified roadblocks and shortcomings, and contribute to the fulfilment of the health policy goals.

The recommendations should be implemented gradually, because it is not possible to implement all changes at once. A step by step approach in implementation of proposed recommendations would be the key principle in order not to cause any fatal distortions in the current system of health care financing in Vietnam.

The detailed list of activities and sequencing of proposed changes should be discusses and agreed with the key counterparts. Based on this agreement, a detailed work plan with a timetable will be developed.

To start from an even situation, it would be strongly advisable that all deficits and surpluses in all pilot health care facilities are balanced before the beginning of the implementation of the new capitation model.

Nevertheless, if not supported by all key counterparts, and accompanied with some necessary interventions directed towards mitigation of negative influences of the external factors, which could significantly affect implementation of the new capitation model, the results might be very limited.

Depending on the consensus about technical details of the proposed recommendations and willingness of the key counterparts to contribute to the reform process, some of the recommendations elaborated above, as it has been already suggested, could be implemented in a short-term, while others would be possible to implement in mid-term and long-term.
Annex 1: A simple example of a capitation model based on age groups
Annex 2: Information and Data Sources
Annex 3: Report summary of the implementation of the capitation pilot project – MoH
Annex 4: List of meetings in the pilot provinces
Annex 5: List of meetings with key counterparts and development partners
Annex 6: Administrative map of Vietnam
Annex 8: Minutes of the meeting on capitation on 19 October 2015 – technical level