

NPRS-PRF

Helping Accelerate Poverty Reduction in Asia and the Pacific

SUPPORTING PRO-POOR HEALTH POLICIES IN VIET NAM

Viet Nam has achieved significant economic progress in recent years and income poverty is declining. Consumption has surged among the poor as well as the nonpoor. Many of these achievements are attributable to a set of reforms collectively known as *doi moi*.¹ An important feature of *doi moi* is the reduction in public sector funding in the health sector.

Despite a reduction in poverty, about 20% of Viet Nam's population continues to live below the poverty line.² Poverty continues to be prevalent in rural areas and is particularly so among ethnic minority groups.

The benefits gained from economic growth have not been shared equally by the poor and the nonpoor. Inequality has increased in Viet Nam with poorer and marginalized groups benefiting the least. This is the case not only in income but also in access and outcomes in education and health. In 2002, the number of poor Vietnamese who were unable to work because of illness increased even as the total number of poor decreased.³

Poor health and limited public expenditure on health care are important causes of poverty in Viet Nam. High health-care costs for the service user result in indebtedness while poor health results in the loss of productivity for many households.

The Government of Viet Nam established the Health Care Funds for the Poor, through Decision 139.⁴ This was an important step toward making health care accessible to and affordable for the poorest one fifth of the population. The scheme began in 2003 when the Government established province-level funds either to purchase health insurance cards for the poor or to reimburse providers directly for health services provided to the poor.⁵

However, local capacity to implement Decision 139 needs to be strengthened at all levels, particularly in the areas of monitoring, reporting, and evaluation so that affordable health care is a reality for the poor. Likewise, the Government's poverty focus in its health financing strategy should be improved.

Toward Utilization of Cost-effective Health Care

Technical Assistance (TA) 4331-VIE: Support for Pro-poor Health Policies⁶ aims to support the Government of Viet Nam's efforts to increase utilization of cost-effective health care by the poor

and other vulnerable groups while simultaneously reducing the financial burden of high health-care costs on these same groups.

The TA aims to do this through two components: 1) an operational capacity-building component, which focuses on strengthening the Government's capacity to implement Decision 139; and 2) a policy research component, which is designed to provide the Government with a deeper understanding of key issues relating to financing health care for the poor. Specifically, the issues reviewed are: (i) the causal relationship between health and poverty; (ii) barriers to health-care utilization by the poor; (iii) factors related to household out-of-pocket expenditure on health care; (iv) and the demand for health insurance (particularly among the rural near-poor).

The TA has helped develop a list of monitoring indicators. Assessments were made of the existing monitoring and reporting systems for Decision 139 and of the related training needs in three provinces (Hay Tay, Gia Lai and Dak Lak).⁷

Field assessments revealed barriers to developing an effective and efficient monitoring and reporting system for Decision 139. These include: substantial variation among provinces in the procedures used to implement Decision 139 and in the types of information available; the absence of certain kinds of information on a timely basis at both the district and province levels, particularly with regard to financing service delivery; and inadequate staff resources for monitoring and reporting.³

The information gathered through TA 4331 was used to finalize the design of the monitoring and reporting software for Decision 139. A skills training package was also developed to accompany the software.

Meanwhile, the four research studies conducted under TA 4331 found that:

- The majority of poor and near-poor rural households are exposed to repeated episodes of catastrophic health-care expenditure, which intensify poverty but do not necessarily increase its incidence.
- Most of the differences in the barriers to education and health-care utilization between the poor and nonpoor occur due to the lack of education and health insurance coverage

among the former. However, findings indicated that cultural and language factors were less significant when relevant factors, such as income, education, and health insurance, are held constant.

- There is little evidence that the quality of care available in community health stations or the distance to the nearest hospital is a significant factor influencing service use. On the other hand, health insurance coverage and other demand-side factors, especially income and education, are strongly related to health-care utilization. For instance, a poor individual with health insurance coverage is as likely to consult a provider when ill as a nonpoor individual without health insurance coverage.
- Prior to Decision 139, other policies designed to improve access to health care by the poor and other vulnerable groups appear to have achieved some of their purposes. However, these policies were not backed up by sufficient resources until Decision 139 came into place.
- Even households with health insurance coverage face high out-of-pocket expenditure when they utilize the services of tertiary-level hospitals (provincial, regional, and central hospitals), not only in the form of substantial out-of-pocket expenditure on uncovered medical care but also in the form of high nonmedical costs (travel and related costs of patients and caretakers and the opportunity cost of patients' and caretakers' time).
- Household out-of-pocket expenditure increases sharply with patient's length of stay in the hospitals especially at the tertiary level. On the other hand, it declines sharply for patients in the 45–60 years age group and for better-educated patients. Catastrophic health-care expenditure occurs mainly in connection with lengthy inpatient stays both at the tertiary level, for the general population, and at any level for the poor.
- The studies found that richer and better educated households and households headed by females have a higher demand for health insurance, probably because they make greater use of tertiary-level hospitals facilities where the benefits of health insurance are considerably larger.

Overall, the studies suggest that demand for health insurance is: i) sensitive to price, ii) more sensitive to the quality and accessibility of provincial hospitals than to that of either community or district-level public facilities or private providers, and 3) very sensitive to household characteristics such as income and education level and sex of household head.

As such, government policies designed to facilitate access for the poor and other vulnerable groups may reduce the demand for health insurance.

Policy Implications

The four studies underscore the contribution of Decision 139 in improving existing pro-poor financing policies, as well as its importance as an appropriate policy in improving health-care utilization by the poor.

However, the findings indicate that households at risk of repeated episodes of catastrophic health-care expenditure, mostly poor or near-poor rural households, need assistance beyond subsidized health insurance. The longer-term adverse economic impact of chronically poor health on these households is much larger, with many households suffering from the accumulated impact of chronic income loss.

The studies suggested that the Government's pro-poor financing policies should focus more on alleviating the financial burden of longer inpatient stays and of repeated episodes of illness and less on providing support for occasional acute illnesses, including those that require relatively brief inpatient stays. Instead of terminating benefits to patients after 10 days, benefit provision should begin after 10 days.

Further, the pricing of voluntary health insurance premiums should consider more systematically the expected benefits of the targeted groups (and not individuals). At present, rural near-poor populations have much lower expected benefits from health insurance than the urban informal sector. The differentials in premiums should be sufficiently wide to promote the rapid growth of voluntary health insurance coverage.

Evaluating Policy Impact

In its final stages, the TA is supporting the government conduct an impact evaluation of the first 2 years' implementation of Decision 139, based on an analytical framework developed earlier by the TA. This work is a collaborative effort between the TA, the Ministry of Health, and the Vietnam-Sweden Health Cooperation program. The evaluation will use data mainly from the 2004 Vietnam Households Living Standards Survey and look particularly at the policy impact on health-care use and

Endnotes

- ¹ In 1986, Viet Nam launched the *doi moi* (renovation) policy discarding 3 decades of centrally planned socialism in a move toward market economy.
- ² www.engenderhealth.org/ia/cbc/vietnam.html
- ³ www.adb.org/Documents/Reports/Human_Capital_Poor_VIE/chap_03.pdf
- ⁴ Prime minister's Decision 139/2002/QD-TTg.2002. *Health Care for the Poor*. 15 October.
- ⁵ According to Decree No. 63 (2005), all beneficiaries of Decision 139 will be provided with health insurance cards issued by Vietnam Social Security (VSS) and will become members of the VSS Compulsory Scheme.
- ⁶ TA 4331-VIE: Support for Pro-Poor Health Policies was implemented from July 2004 to June 2006. The executing agency is the Ministry of Health. TA amount is %500,000.
- ⁷ TA 4331 Progress Report for PRF, July–Dec 2005.

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