The Way Forward

There is an already long history of efforts to introduce a solid and reliable capitation payment system in Vietnam that so far could not deliver enough convincing results to enforce it nationwide. As part of the technical assistance **the EU-HF elaborated the fundamentals of capitation** and actively coached the technical working group and informed policy makers to better understand the implications of every decision in this regard, even if the approach had been widely used worldwide and explained.

The EU-HF had a high number of meetings and exchanges with MoH, VSS officials and Development Partners during 2016 to clarify and refine the different elements of capitation. The proposed model was presented and discussed in a meeting of the Technical Working Group in Health Financing of the MoH on "Consultation with Development Partners on the Health Financing Strategy for 2016-2025" celebrated in Hanoi on 15th of March 2016 and in the "Consensus Workshop on the Application of the Weighted Capitation Model in Vietnam" that took place in Hanoi on 16th of September 2016.

EU-HF recommends implementing a **simple and robust** approach to capitation that is open to further development and **should evolve to adapt to the changing conditions** in the facilities, the expansion of the available services and further **improvement of the legal environment**. The model can contribute to **cost containment**, facilitate that **sufficient resources are channelled to the grassroots level** and it includes **incentives for increasing the quality of services** under the current conditions.

One of the **strong recommendations**, related to further cost containment and reduction of health care expenditures, is **to consider expansion of a capitation package with selected preventive services related to reduction of leading causes of morbidity** (eg. hypertension, diabetes, some respiratory diseases, etc.).

A new and improved capitation payment model like the one developed by the EU-HF would contribute to the **progress of the National Health Financing Strategy** and the achievement of the Sector Reform Contract (SRC) indicator No. 2 of the EU Health Sector Policy Support Programme phase 2: Towards Equity and Quality of Health Services in Vietnam on progress of health

The European Union Health Facility has been established by the European Union Delegation to Socialist Republic of Vietnam in March 2015 as a part of the actions agreed with the Government of Vietnam within the framework of the EU Health Sector Policy Support Programme phase 2. Its major objective is to support the Ministry of Health and the Ministry of Finance in Vietnam for implementation of the measures foreseen in the Financing Agreement.

With funding of €114 million, this is the largest EU Sector Budget Support Operation in Asia. The Financing Agreement for the EU Health Sector Policy Support Programme phase 2 (EU-HSPSP 2) had been signed between the European Union and the Government of the Socialist Republic of Vietnam in December 2014, with the overall objective "to sustain poverty alleviation and inclusive economic growth in Vietnam through the 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 strategy". The 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 Nong. The EU Health Sector Policy Support Programme phase 2 is the largest EU budget support programme in health in Asia

To achieve these goals the European Union will transfer 100 million Euro directly to the state budget of the country, which will be distributed by the Ministry of Finance and the Ministry of Health as budget transfers to ten targeted provinces.

Disclaimer: This technical sheet had been produced by the European Union Health Facility. The content is the sole responsibility of the EU-HF and in no way be taken to reflect the views of the European Union

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A Project funded by the European Union

EPOS Health Management

A project is implemented by the Consortium

EU-HF TECHNICAL SHEET

Support to an improved capitation payment model in Vietnam

Background

The Ministry of Health (MoH) of Vietnam, with the support of Development Partners, launched at the beginning of 2014 a pilot capitation model in the provinces of Bac Ninh, Ninh Binh, TT Hue, and Khanh Hoa. After one year of piloting the implementation results have been reported as unsatisfactory, and in mid-2015 the MoH requested the European Union Delegation (EUD) to provide support and advice to develop an improved model.

The European Union Health Facility (EU-HF) was tasked to propose adjustments of the design, methodology and procedures for definition and calculation of the rates and coefficients for the capitation payment method, including revising the Circular on capitation. The EU-HF performed an assessment of the capitation model and suggested to design a weighted capitation model based on the age groups, which will be applied for reimbursement of essential outpatient services at grassroots (primary health care) level only.

Weighted capitation model - Major Policy Targets

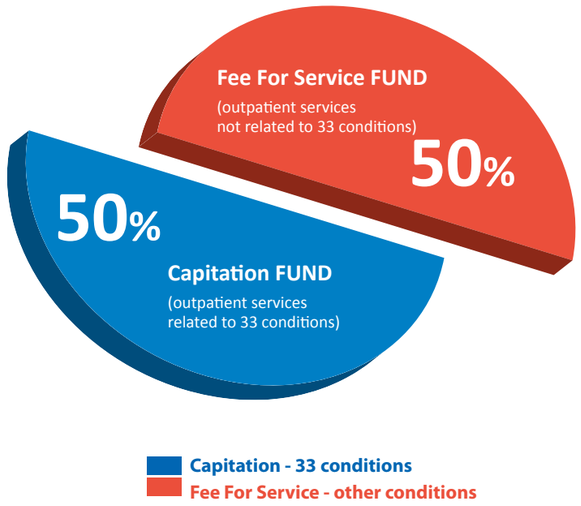
- **Strengthen grass-roots health care delivery** by applying the weighted capitation model to outpatient services at grassroots level health care facilities (Commune Health Stations, Polyclinics, District Hospitals, and District Health Centres).
- **Shift resources and provision of basic health services** to the grassroots level.
- **Improve cost control, efficiency and effectiveness** through introduction of a gate keeping mechanism and prospective budget planning.
- **Assure continuity of health care** by supporting effective communication and forwarding medical documentation vertically and horizontally.
- **Development of health care** by improving ICD-10 coding and reporting, encouraging use of Standard Treatment Guidelines (STGs), and prescription of generic and essential drugs.
- **Support improving the quality of health care at grassroots level**, which should avert overcrowding of secondary and tertiary level of health care facilities.
- **Contribute to equity/fairness, equality/sameness, and solidarity** by assuring pooling of funds and sharing the risk among users of health care and preventing the cream skimming.
- **Support the achievement of universal health coverage** by supporting the development of an equitable, effective, quality and sustainable health care system.

Weighted capitation model - Major Features

The EU-HF experts had a number of consultations with the Steering Committee for Health Financing Reform and with the Health Financing Technical Working Group (TWG). The weighted capitation model is designed with reference to scientific evidence, international practices, and it is adjusted to the Vietnamese context. The EU-HF proposal is based on the following criteria:

- **Capitation is compulsory for payment of outpatient services** at grassroots level health care.
- **Cover affordable package** of services **to address priority health care needs** considering **the delivery capacity** at grassroots level and **legal liability** of health insurance fund.
- **Define list of conditions** and related essential outpatient services (capitation package).
- **Costing** of **capitation package** based on official price list (Circular 37/2015/TTLT-BYT-BTC).
- **Apply capitation for payment of essential outpatient services related to 33 conditions selected based on:**
  - identified health care needs: reported leading causes of morbidity
  - essential outpatient services not included in vertical programs
  - capacity of health care facilities at grassroots level to provide outpatient services for the 33 conditions
  - Outpatient services related to other conditions will be paid by fee for service.
- **Age groups** are **determined** by consensus of the MoH and VSS.
- **Age group coefficients, capitation base rate and total capitation fund for each province** will be calculated by the MoH/VSS. Provincial capitation base rates and age group coefficients are instrumental for pooling of funds and risk sharing among different population groups, which is a basic function of social health insurance. The rational for such approach is the following:
  - To keep budgetary and fiscal risk control at central level;
  - MoH/VSS will have full control over calculations and implementation;
  - Flexibility by enabling central/one point revision and adjustment of the model (age groups, age group coefficients, capitation base rate, CPI, etc.);
  - Insufficient technical capacity of staff at provincial and district levels;
- **Capitation budget** (allocation capitation fund) for a district or a health care facility will be calculated by Provincial Social Security (PSS) based on the inputs from MoH/VSS (age groups, total capitation fund for a province, age group coefficients, capitation base rate) for a province.
- **Quality improvement indicators for monitoring and evaluation**
  - **Monitoring** in relation to applicable **hospital quality standards and quality assessment criteria** for district hospitals (Circular 19/2013/TT-BYT and Decision 4858/QĐ-BYT)
  - **Monitoring** in relation to the **national criteria for commune health until 2020** (Decision No.: 4667/QĐ-BYT).
  - **Monitor implementation of national Standard Treatment Guidelines** (eg. hypertension, diabetes type 2, etc.), which should assure **prescription of generic and essential drugs**.
- **Settlement of surplus and deficit** will be based on the following principles:
  - **Surplus** is fully at the disposal of health care providers.
  - **Deficit –** a health care provider will negotiate the settlement of a deficit with PSS/VSS.

TOTAL HEALTH INSURANCE OUTPATIENT FUND



Weighted capitation model - Major Challenges

Some of the difficulties for implementation of a capitation system in Vietnam are related to **non-conductive provisions in higher-level regulation** with direct unfavourable influence on the capitation payment mechanism (namely the Law on Health Insurance, No: 25/2008/QH12 and subsequent amendments). The negative effects of these legal provisions, to some extent, could be mitigated by a design of a capitation model and additional adjustments during implementation.

Challenges and proposed mitigation measures (Short Term and Long Term)

Challenge 1- AN EFFECTIVE GATE KEEPING MECHANISM IS NOT IN PLACE: A HI card holder can seek any services, even though not being registered, with any primary health care provider at district level (including those at district hospitals) in any district within the province of residence (Article 22, Clause 4, Law amendments to the law on health insurance, No 46/2014/QH13)	
ST mitigation- Improve flow of financial and medical data (horizontal and vertical) to create reliable patients' records and allow continuity of health care	**LT mitigation-** Amend the legal provisions to install a patient registration and first point of contact
Challenge 1.1- HI card holders can register for primary health care services at all levels, from CHS to central hospitals, which encourages demand and provision of services for simple conditions at higher levels with complex technology at higher costs (Article 26, Clause 1, Law on health insurance, No. 25/2008/QH12)	
ST mitigation- Assure use of Standard Treatment Guidelines (STGs) aiming to improve quality, assure equality of health care and to support prescription of generic drugs and use of medicines from essential list Introduce stricter referrals, i.e. definition of the primary health care provider	**LT mitigation-** Amend the legal provisions to enable one-entry-point (excluding emergency) to the health care system, which will assure gate-keeping role of the PHC physician
Challenge 2- WEAK SUPPORT TO CONTINUITY OF CARE PROVISION: Registration with a provider can be changed every 3 months, which can cause uncertainty and variation in the number of patients and volume of provided services. (Article 26, Clause 2, Law on health insurance No.25/2008/QH12)	
ST mitigation- Improve quarterly planning and reporting Improve flow of financial and medical data (horizontal and vertical)	**LT mitigation-** Amend the legal provisions to introduce annual registration for PHC services Integration of information systems that would enable up-to-date flow of information, including on-line registration of the patients
Challenge 3- HEALTH INSURANCE REIMBURSMENT OF SELF-REFFERALS: The compensation by HI fund for self-referrals at higher levels by-passing the grass-roots level does not contribute to avert self-referrals (Article 22, Clause 3, Law amendments to the law on health insurance, No 46/2014/QH13)	
ST mitigation- Introduce stricter compensation policy for self-referrals	**LT mitigation-** Amend the legal provisions to enable more efficient control of self-referrals
Challenge 4- VOLUNTARY APPLICATION OF CAPITATION IN PREVIOUS MODELS: There is no legislation that provisions application of capitation on a compulsory basis.	
ST mitigation- Assure COMPULSORY implementation of capitation for all health care facilities at grassroots level (DH, DHC, CHS, and Polyclinics).	