A framework for the development of a new circular on capitation

Health financing is one of the building blocks of a strong health care 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 the identified health care needs.

The key functions of health financing are mobilization of funds, pooling of resources, allocation of resources, and purchasing of services. A cross-cutting issue that has implications for all of these health financing functions is the stewardship of health care financing.

Provider payment mechanisms can be powerful tools to promote the development of the 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.

Every health system has as its goal to contribute to the good health of the concerned population. It can achieve this best for those people it can reach and thus is more effective the higher its population health coverage is. The health coverage is therefore one of the indicators of health system performance. Universal health coverage, should secure access to adequate healthcare for all at an affordable price, and it is the ultimate objective of social health insurance.

After one year of the capitation model piloting based on the Decision No. 5380/QD-BYT in the four selected provinces, 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 and the practical application of the adjustments to the model are slow and the key stakeholders are reluctant to accept the methods to balance surpluses and overspending that health care facilities experience.

A new circular should provide a general framework and elaborate on the key elements for implementation of the new capitation model in line with good international practice and based on the key principles of social health insurance – solidarity, equity and risk sharing. The changes should be implemented gradually, step by step, in a few phases in order not to cause any critical distortions in the current health care financing system, especially with regard to the implementation of the capitation model. The transitional period can be used to implement necessary reforms for the development of a full-fledged capitation model.

The key elements for implementation of the new capitation model that should be embedded into the new circular on capitation are as follows:

1. **Balance all deficits and surpluses of the pilot health care facilities.**

   Prior the implementation of the new capitation model all budgets of the selected pilot health care facilities must be balanced, which means that all deficits and surpluses must be settled.

   Rationale:

   In order to objectively assess the functioning of the new capitation model, budgets of the pilot health care facilities must be balanced, otherwise monitoring and evaluation of the new capitation model could lead to wrong and biased conclusions.

2. **Define a package of outpatient services (capitation package) that will be financed by capitation budget.**

   A technical working group consisting of the MoH and VSS representatives, including participation of relevant national and international experts will be established. The main goal of the TWG is the development of a package of outpatient services that will be covered by capitation budget (capitation package of health services/**capitation package**).

   The package of outpatient services will be developed taking into account availability of financial resources, capacity of health care providers, especially commune health centers, priority health care needs for primary health care services and the health policy objectives of the Vietnamese government, focusing on the expansion of the universal health coverage.

   Rationale:

   If the package of outpatient services is not defined, capitation budget could only be calculated based on historical data, which does not allow for development of the health care service provision.

   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.

3. **Define standards/requirements (HR, equipment, buildings, available data, etc.) for the health care facilities that will pilot the new capitation model.**

   A technical working group consisting of the MoH and VSS representatives, including participation of relevant national and international experts will be established. The main goal of the TWG is to define the minimum requirements that health care facilities should fulfill in order to be included in the implementation of the new capitation model.

   The requirements will be developed taking into account availability of financial resources, capacity of health care providers, especially commune health centers, priority health care needs for primary health care services and the health policy objectives of the Vietnamese government, focusing on the expansion of the universal health coverage.

   Select the health care facilities/districts/provinces that meet the criteria and would be able to pilot the new capitation model.

   Rationale:

   Universal health coverage, should secure access to adequate healthcare for all at an affordable price. 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.

   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 health care facility can provide fewer services and usually of a low quality, consequently, population would not use public health services or will seek the health care in a facility that can provide higher

level and more quality services, which is one of the main reasons for current overcrowding of the hospitals.

Defining the requirements and supporting the development with additional financing through the development fund will enable gradual strengthening of the grassroots level of health care delivery, improvement of quality, efficiency and effectiveness.

4. Design a capitation model based on age groups and using adjustment coefficients according to utilization patterns of the selected age groups.

A technical working group consisting of the MoH and VSS representatives, including participation of relevant national and international experts will be established. The main goal of the TWG is the design of a capitation model based on age groups and using adjustment coefficients according to utilization patterns of the selected age groups.

The new capitation model for payment of outpatient services will be developed taking into account availability of financial resources, capacity of health care providers, especially commune health centers, priority health care needs for primary health care services and the health policy objectives of the Vietnamese government, focusing on the expansion of the universal health coverage.

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

The design of the new capitation model will include:

a. *Determination of age groups.* The age groups will be defined in agreement with MoH and VSS considering the availability of data for specific age groups and utilization patterns.

The age groups could be redefined in the future without issuing a new circular.

b. *Construction of adjustment coefficients.* Risk adjustment factors will be 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, some positive discrimination in favor of certain vulnerable groups (poor, near poor, children, elderly, minorities, etc.) can be applied as well.

If needed, the adjustment coefficients could be redefined in the future without issuing a new circular.

c. Defining additional coefficients related to quality improvement, performance (RBF/P4P approach) and scope of services enhancement, or any other criteria.

If needed, the additional adjustment coefficients could be redefined in the future without issuing a new circular.

<u>Rationale:</u>

Currently, 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.

The allocation of funds based on the amounts collected 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.

Risk pooling is the fundamental function of an insurance and provides for its economic sustainability as well as the sharing of individual risks associated with ill health across all the insured. Basically, increasing the size of the group improves the extent of risk pooling since the consequences of an individual needing costly treatment are spread. In a similar vein it is important to cover a wide risk mix. Health risks are spread unevenly across income groups. Pooling only low-income groups or those with a high risk of disease undermines the financial sustainability of any health insurance scheme as it would result in either too little income or too high expenditures. To provide access to health care to all and be financially viable an optimal risk pooling can only be achieved by covering the entire population, possibly through mandatory health insurance.

The existing 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. Input based retrospective budgeting does not provide sufficient support for development of health care and long term sustainability of the health care facilities.

5. **Apply capitation model only for payment of outpatient services at primary health care level**.

Currently, commune health centers are, in fact, organizational units of the secondary health care level (district hospitals, district health centers) and do not have the autonomy of an independent legal entities (staff of a CHC is on a payroll list of a district hospitals/DHC, the CHC receive medicines and consumables in kind, etc.). The CHCs also do not have sufficient capacity to manage a capitation budget and to provide all health care services defined by a capitation package of health care services. Therefore, application of capitation model for payment of outpatient services at primary health care level needs to be implemented in two phases:

1) **The first phase** – transitional period - the capitation budget will be allocated to the district hospitals and district health centers for financing of the outpatient services, which is the existing practice in two pilot provinces.

In this period, until the capacity of the commune health centers for provision of capitation package services is not fully strengthened, the services from the capitation package will be covered by capitation budget:

- At the commune health centers; and
- If justified and/or based on the referral from the commune health centers, at the policlinics, the district hospitals and the district health centers.

During the transitional period the development fund will be established in an amount equal to a certain proportion of the total annual capitation budget committed for outpatient services. This proportion would be agreed between MoH and VSS.

The development fund will be allocated to the health care facilities in the begging of a fiscal year. The fund will be used for capacity improvement of the commune health centers in order to support them to fulfill the requirements (human resources, equipment, buildings, infrastructure, etc.) for inclusion in the new capitation pilot model.

The details about allocation procedures of the development fund will be elaborated in the Annex to this Circular.

The capacity assessment of the commune health centers will be undertaken during the year 2016, based on the criteria that will be defined under point 2 (a package of outpatient services covered by capitation budget) and point 3 (requirements). There is an ongoing assessment of the grassroots level capacities in 10 EU-HF target provinces and some of these data could be used for this purpose.

The assessment methodology will be detailed in the Annex to this Circular.

2) **The second phase** - the funds will be allocated directly to the commune health centers once their capacity is fully strengthened and their legal status clarified.

Implementation of capitation model only for payment of outpatient services at primary health care level should contribute to the strengthening of grassroots health care delivery and improve efficiency, effectiveness and quality of health care services.

In addition, it should 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 of the Vietnamese government.

Rationale:

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.).

Under current capitation model health utilization habits of the population and the doctors' attitude ultimately influence the structure of capitation expenditures. 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/grassroots health care delivery.

Analysis of the financial data 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. Currently, the deficits are significantly higher in the provinces that implement capitation model mix for payment of outpatient and inpatient services.

6. **Shift from retrospective to prospective budget planning**.

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).

Shifting from retrospective to prospective budgeting would need to be done in a two steps:

1) **The first step** – transitional period - the total capitation fund will be calculated using the historical expenditures corrected for forecasted inflation rate (source: MoF or GSO) for the next year.

During the transitional period the package of outpatient services will be defined and fully costed.

2) **The second step** – Once the package of outpatient services is defined and fully costed the total capitation fund will be calculated based on actual costs of health care services.

Rationale:

Current methodology for calculation of total capitation fund is based on historical expenditures and do not consider inflation and increase in consumption of health care services, medicines and consumables. 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.

Significant disproportion of outpatient and inpatient expenditures has been registered in pilot provinces, favoring the latter. Input based retrospective budgeting does not provide sufficient support for development of health care and long term sustainability of the health care system.

7. **Improve, simplify and accelerate procedures related to allocation and disbursement of the capitation funds.**

   Verification of claims related to provision of outpatients services under the new capitation model or any other capitation funds requests related to the implementation of the new capitation model must be processed in the shortest period of time and in the most efficient manner.

   Rationale:

   Time consuming administrative procedures for settlement of surplus and deficit cause loss of real value of retained funds over time due to inflation rate and do not provide sufficient financial space for the development of health care aiming to address actual health care needs.

8. **Revise current principle of balancing the capitation budgets and provide a safety net for pilot health care facilities**.

   All pilot health care facilities must have a warranty that a deficit incurred during the piloting period, if verified and justified, would be balanced from the social security reserve funds or other sources.

If a provider incurs costs that are not justified, and that are 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 shall retain and reinvest all surpluses.

How the health care facilities will use a surplus will be defined and elaborated in an Annex to this Circular.

Rationale:

The current practice for settling surpluses and deficits is not conducive to strengthening grass-roots 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.

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.

9. Improve current reporting system, medical and financial data and information flow.

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.

Improve coordination between MoH, VSS, PSS, DSS, DoH and health care facilities at central and subordinate levels.

All medical and financial data must be exchanged between relevant institutions at least on a monthly basis.

Rationale:

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 as well.

Current data management system is fragmented, medical and financial reporting is slow and inefficient. It does not provide sufficient amount 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.

10. **Clearly define and elaborate roles and responsibilities of MoH, VSS and the pilot health care facilities.**

    The new operational manual for piloting of the new capitation model cannot be amended without consensus of MoH and VSS, and only terms and conditions provisioned by this new operational manual can apply – all other rules and regulations do not apply to the pilots.

    Instructions sent to the implementing facilities must be consistent and clear based on a good coordination and mutual agreement of the Ministry of Health and Vietnam Social Security.

    Continuous guidance and technical support to the organizational units in the pilot provinces and districts (PSS, DSS, DoH, etc.), as well as to the pilot health care facilities must be provided during the implementation.

    Monitoring and evaluation mechanisms and indicators must be based on SMART criteria (S)pecific-(M)easurable (A)chievable, (R)elevant, (T)ime-bound, in order to enable effective and efficient measuring of the achievements towards the fulfillment of the objectives of the capitation model.

    The monitoring and evaluation mechanisms and indicators will be developed jointly by MoH and VSS and will be integral part of the operational manual.

    <u>Rationale:</u>

    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.

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

    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. If any of the key stakeholders intends to amend the implementation framework without consensus, it raises serious concerns about integrity of the piloted model.

11. **Develop a new operational manual for implementation of the new capitation model.**

    A technical working group consisting of the MoH and VSS representatives, including participation of relevant national and international experts will be established. The main goal of the TWG is the development of the new operational manual for implementation of the new capitation model.

The new operational manual will be developed taking into account all aforementioned issues aiming to mitigate and overcome the identified procedural problems in respect to the implementation.

Rationale:

The wording of the current 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.

In addition, the new capitation model will be designed based on different principles; therefore there is a need to develop the new operational manual.