The Guidelines for the Circular on capitation

The Guidelines are developed in line with the findings and recommendations elaborated in the Capitation Assessment Report, which is prepared by EU Health Facility international health financing and national health insurance short-term experts.

Executive Summary

Based on the key findings and lessons learnt from the implementation of the capitation pilot in the provinces Bac Ninh, Ninh Binh, TT-Hue and Khanh Hoa, these Guidelines, through introduction of the capitation based on age groups, aim to assist the Ministry of Health in achieving the following goals:

- 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 effectives;
- Assure continuity of health care;
- Improve health management information systems by improvement of medical and financial data and information flow.

The Guidelines elaborate on the key elements and the rationale for the reforms; describe the activities that need to be implemented in order to develop the new capitation model. The sequencing of the proposed interventions and activities, the responsibilities of the key counterparts, the time frame for the implementation of the activities and the milestones are presented in Annex 1.

It is very important to keep in mind the conditionality of the proposed reforms. Implementation of some of the interventions or activities would require fulfillment of some preconditions and/or finalization of some prior activities. For an example, the capitation package of outpatient services should be developed prior the costing exercise, or the age groups should be agreed prior the design of the adjustment coefficients and the new capitation formulas.

The reforms should not be implemented ex abrupto, but they 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 current capitation model. There should be a transitional period of at least one year during which all technical details needed for implementation of the new circular and development of the full-fledged capitation model will be elaborated in details and agreed. The implementation of the new capitation model should start at the beginning of a fiscal year.

Until then, it would be advisable to suspend implementation of the current capitation pilot in the aforementioned four provinces.

Introduction

The ultimate objective of social health insurance is universal health coverage that should secure access to adequate healthcare for all at an affordable price. Every health care system can achieve the best for those people it can reach and thus it is more effective the higher its population health coverage is. 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.

The majority of population in Vietnam still lives in rural areas[1] with an income far below average income in the country and the most of the health services are provided in these urban areas - cities and towns. Usually, rural population will postpone a visit to a health care facility, which is located far away from their place of residence due to additional costs (transportation, accommodation, etc.) that they need to incur in order to get a needed service. As a result, since rural population does not get access to health care at a place of residence their health status is in most cases worse than those who live in urban areas.

Effective universal health coverage in Vietnam will require better use of available resources and placing higher priority on primary health care. The way providers are currently paid does not give priority to primary health care and does not reflect the costs of delivering services.

After two years of the revised capitation piloting based on the Decision No. 5380/QD-BYT in the four selected provinces (Bac Ninh, Ninh Binh, TT-Hue and Khanh Hoa), the problems related to calculation of total capitation fund, application of cost 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. The identified problems are not only related to the capitation model itself, but also to the external factors, such as, the ambiguous system of referrals, weak public finance management in the health sector, the limitations of legal provisions, etc.

In this respect, the new Circular should provide a general framework for application of the capitation model that will enable improvement of the primary health care services at the grassroots level by increasing quality of services, providing the incentives for staff, making sufficient resources available at the grassroots level of health care delivery, avoiding unnecessary referrals, and controlling the costs.

The general framework and 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 - are elaborated below.

The key elements for implementation of the new capitation model

[1] http://www.indexmundi.com/vietnam/demographics_profile.html

1. Establish a Technical Working Group

A technical working group (TWG) consisting of the MoH representatives (Medical Services Administration, Department for Planning and Finance, Health Insurance Department, Health Legislation Department, Health Equipment and Works Department, IT Department, etc.), VSS representatives, including participation of other relevant national and international experts should be established. The Department of Planning and Finance should have a leading role in steering the process, coordinating the activities and reporting to the Ministry of Health on the achievements and challenges. The main tasks of the TWG are:

- to define the list of outpatient services (capitation package) that will be covered by capitation budget;
- to define the minimum requirements/standards that health care facilities should fulfill in order to be involved in the implementation of the new capitation model;
- to elaborate the key elements of the new capitation model:
    - age groups,
    - cost adjustment coefficients for selected age groups,
    - additional adjustment coefficients related to quality improvement, performance, staff incentives, etc.,
- to develop the new operational manual for implementation of the new capitation model,
- cost the capitation package, and
- any other task related to implementation of the new capitation model that will be assigned.

The number of TWG members could vary depending of the scope of work related to a specific task, and it will be not necessary that all members of the TWG participate in all activities listed above.

2. Define a list of outpatient services that will be financed by capitation budget.

The capitation package of outpatient services will be developed taking into account availability of financial resources, capacity of health care providers, priority health care needs and the health policy objectives of the Vietnamese government, focusing on the expansion of the universal health coverage and limiting the overuse of costly services and unnecessary referrals.

The capitation package of services should not be misread as the Basic Health Services Package (BHSP), because the capitation package would contain only the outpatient services that will be financed from the health insurance (HI) capitation fund. It would be advisable to include the capitation package list of services into BHSP.

In order not to cause any distortions in the current flow of health care funds (state budget, HI, other sources), costing of the capitation package will be structured according to the existing elements of the health insurance capitation costs (consultation fees, consumables, etc.). Based on the availability of financial resources in the future, could be considered full costing of the capitation package, which would include the costs of salaries, capital investments and other costs.

Rationale:

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 pre-defined package of health services.

If the list of outpatient services is not defined and costed, then the total capitation fund could be only calculated based on historical expenditures, as it is, currently, the common practice in Vietnam, which does not allow for development of the health care service delivery.

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

The minimum requirements/standards will be defined in line with existing legal provisions and taking into account availability of financial resources, capacity of health care providers, priority health care needs and the health policy objectives of the Vietnamese government. Focus should be on expansion of the universal health coverage, improvement of quality, increase of scope of services provided, strengthening of the grassroots level of health care delivery, reduction of unnecessary referrals and provision of incentives for health personnel.

Based on the minimum requirements/standards will be developed an assessment questionnaire for the health care providers at the grassroots. Following the results of the assessment the MoH will make a decision which health care facilities will be involved in the implementation of the new capitation model.

At the initial stage would be advisable to include only the health care facilities that already meet the most if not all requirements/standards (HR, equipment, buildings, available data, etc.) for implementation of the new capitation model without any substantial investments. At the latter stages, gradually, would be included other health care facilities, based on the improvements in the capacity to meet the requirements/standards.

The facilities that do not meet the requirements/standards will continue to provide the health care services in line with their current capacity. For these health care facilities should be provided a technical support for development of a plan for improvements in line with the results and findings of the assessment questionnaire. The costs of the interventions/activities aimed towards the capacity improvement (HR training, civil works, purchase of the equipment, upgrade of infrastructure, etc.) will be financed from a development fund that should be created based on the agreement between MoH, MoF and VSS. The main purpose of the fund would be to support development of the grassroots level of health care delivery enabling inclusion of additional health care providers in the new capitation model.

Rationale:

By promoting the universal health coverage and health insurance enrolment a government intends to secure access to adequate healthcare for all citizens and alleviate the financial risks of ill health.

The issue of bypassing the lower levels of health care is directly related to scope and quality of services provided at these levels, which lead to increase of the costs of services in the system in general. 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, therefore the population usually do not use public health services or 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/standards for the grassroots level of health care facilities, and supporting the development by allocating additional financial resources through the development fund, will enable gradual strengthening of the grassroots level of health care delivery, improvement of quality, efficiency and effectiveness at the level that is the most accessible to the majority of the population.

4. Introduce a gate keeping mechanism

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

Defining the capitation package of outpatient services will enable introduction of the gate keeping mechanism in the health financing in Vietnam, which will in turn improve control of unnecessary referrals and allow for efficient control of costs.

Once the capitation package of services is defined all registered HI card holders in a health care facility that has a capacity to provide these health care services in line with minimum requirements/standards would be obliged to use the services in this specific health care facility.

In order to prevent use of the outpatient services that can be provided at primary level, which are currently more costly if provided at higher levels of health care (secondary and tertiary), the prices for these outpatient services should be set at the same price for all levels of health care (primary, secondary, tertiary).

Rationale:

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 unnecessary referrals.

5. Elaborate a capitation model based on the age groups.

The new capitation model for payment of outpatient services will be based on the age groups and cost adjustment coefficients for these age groups. The cost adjustment coefficients should be constructed taking into account availability of financial resources, capacity of health care providers, priority health care needs and the health policy objectives of the Vietnamese government, especially related to

solidarity, funds pooling and risk sharing, as well as in relation to the expansion of the universal health coverage, cost efficiency and effectives of health care service provision.

The elaboration of the new capitation model will include:

- *Determination of the age groups.* The age groups will be defined by the TWG and approved by the MoH, 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.
- *Construction of cost 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 cost adjustment coefficients could be redefined in the future without issuing a new circular.
- *Defining additional coefficients* related to quality improvement, performance, scope of services, incentives for health personnel or any other criteria. If needed, the additional adjustment coefficients could be redefined in the future without issuing a new circular.

Rationale:

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 statutory social health 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.

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

Prior the implementation of the new capitation model all budgets of the selected pilot health care facilities must be balanced. All deficits and surpluses must be settled in order to allow objective monitoring and measuring the outputs and outcomes of the new capitation model.

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. Thus, corrective mechanisms and measures, if needed, would not be designed appropriately and would not assure effective and efficient mitigation of identified problems.

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

Currently, commune health centers (CHC) are, in fact, organizational units of the secondary health care level, either district hospitals (DH), or district health centers (DHC) and do not have the autonomy of an independent legal entity. The personnel of a CHC are on a payroll list of DH or DHC and a CHC receive medicines and consumables in kind. It is anticipated that some CHCs do not have sufficient capacity to manage a capitation budget and to provide all health care services that will be included in the capitation package. Therefore, application of capitation model for payment of outpatient services at primary health care level needs to be implemented in two phases:

- **The first phase** – in the transitional period during 2016 the capitation budget will be allocated to the district hospitals and/or district health centers for financing of the outpatient services, which is the existing practice in two out of four current 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*;
  - *the district hospitals*, *the district health centers* and *equivalent health care providers at the grassroots level* (if justified and/or based on the referral from the commune 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 the MoH, MOF 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 minimum requirements/standards (human resources, equipment, buildings, infrastructure, data, etc.) for implementation of the new capitation pilot model. The details about allocation procedures of the development fund will be elaborated in line with legal provisions.

  The capacity assessment of the commune health centers will be undertaken during the year 2016, based on the criteria that will be defined as it was elaborated in point 3 of this chapter. 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 line with the legal provisions.

- **The second phase** - the funds will be allocated directly to the commune health centers once their capacity is fully strengthened to meet the minimum requirements/standards for implementation of the new capitation model.

  Implementation of the new capitation model only for payment of outpatient services at primary health care level should contribute to strengthening of grassroots health care delivery, assure equity, improve efficiency, effectiveness and quality of health care services at a location that is the most accessible to a HI card holder.

  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.

8. **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:

- **The first step** – in the transitional period during 2016 the total capitation fund will be calculated using the historical expenditures corrected for a forecasted inflation rate for the following year

using the MoF or GSO data. During the transitional period the capitation package of outpatient services will be defined and fully costed.

- **The second step** – Once the capitation package of outpatient services is defined and fully costed the total capitation fund will be calculated based on the total number of HI card holders and costs of the capitation package per a HI card holder.

  The costs of the capitation package per a HI card holder would be calculated based on the costing of current HI capitation elements (consultation fees, consumables, etc.). Once the financing of the health care is streamlined, it would be possible to do a full-costing of the capitation package, which will include costs for salaries, capital investments, and some other costs that are currently not covered by HI capitation fund.

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 at grassroots level and long term sustainability of the health care system.

9. **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.

10. **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. The detailed instructions with regard to this issue should be jointly developed by the MoH, MoF and VSS in line with legal provisions in place.

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/ districts/facilities subsidize the rich one.

11. 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 (MoH, VSS, PSS, DSS, DoH and health care facilities) 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.

12. **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.

Rationale:

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.

13. Develop a 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 is designed based on different principles; therefore there is a need to develop the new operational manual.

Scope and subjects of application

1. Scope of application

This Circular provides for payment of insured outpatient health services by capitation.

The capitation model will be applied only for payment of outpatient health services in commune health centers (CHC), district hospitals (DH), district health centers (DHC) and equivalent health care providers at grassroots level.

The list of outpatient health services (hereafter referred to as the capitation package) will be defined and issued by the Ministry of Health (MoH). Only outpatient health services that are included in this list will be reimbursed from capitation fund.

2. Subjects of application

The health care facilities which have registered for delivery of insured health services at grassroots level and signed contracts with social security agencies.

The health care facilities must meet the requirements with regard to personnel, equipment, premises and data in order to apply capitation as a provider payment method.

These requirements will be developed by MoH taking into account the availability of financial resources, service delivery capacity of the health care facilities, priority health care needs, Government's health policy objectives and achievement of universal health coverage.

Departments of Health will perform the assessment based on the instructions provided by the MoH.

General principles

1. Capitation payment is the payment of a pre-determined amount of money for a pre-defined scope of services per registered health insurance (HI) card holder at a health care facility for a certain period of time;
2. The use of the capitation payment method is intended to improve the primary health care services at the grassroots level by increasing quality of services, provide incentives for staff, make sufficient resources available at grassroots level, avoid unnecessary referrals, and control costs.
3. All budgets of the health care facilities that will implement this Circular must be balanced. Prior the implementation all deficits and surpluses must be settled.

4. The total capitation fund is calculated based on the total number of HI cards registered at the CHC, DH, DHC and equivalent health care providers at grassroots level, and the cost of the capitation package per HI card.

   The cost of the capitation package is based on the costing of the outpatient services included in the capitation package.

   The MoH will revise and update the list of services included in the capitation package as needs and priorities change and shall eventually incorporate it in the outpatient primary health care services of the basic health service package (BHSP) once it is officially approved.

5. The capitation model is based on the age groups and cost adjustment coefficients related to the utilization patterns of the selected age groups.

   a) Age groups will be determined based on the availability of data, analysis of the utilization patterns of the age groups and health policy priorities.

   b) Cost adjustment coefficients will be calculated based on the utilization patterns of the selected age groups.

   c) Adjustment coefficients related to health policy objectives, quality improvement, performance, scope of service or any other criteria will be developed based on the decision of the MoH.

6. The health care facilities are responsible and entitled to manage the capitation fund in the most efficient and effective manner and shall not collect any additional fees from the HI card holders for the health services that are included in the capitation package.

7. Social security organizations are responsible to supervise and guarantee the benefits of HI card holders.

Determination of the capitation fund and adjustment coefficients

Determination of capitation fund, cost adjustment coefficients, additional adjustment coefficients and capitation budget for health care facilities will be possible once the age groups are defined and capitation package of health services is defined and costed. The calculations will be based on the formulas presented below.

1. Total capitation fund will be calculated based on the formula:

$$TCF = N*C$$

TCF : Total capitation fund

N : Total number of HI cards registered at the CHC, DH, DHC and equivalent health care providers at grassroots level

C : Cost of capitation package per HI card

2. Cost adjustment coefficients:

Cost adjustment coefficients are defined by the MoH based on national data on health expenditure on the capitation package of services of the pre-defined age groups.

The MoH is responsible to decide on the age groups and to define the reference age group for calculation of the cost adjustment coefficients for all other age groups. The reference age group is the group with the lowest expenditure per HI card within the selected time frame.

The cost adjustment coefficients will be calculated as presented below:

$$Xi = \frac{\frac{TEi}{Ni}}{\frac{TEr}{Nr}}$$

i : Age groups, (i=1,..n)

Xi : Cost adjustment coefficient for a specific age group, (i=1,..n)

TEi : Total expenditure on the capitation package of services of a specific age group, (i=1,..n)

Ni : Total number of HI cards of a specific age group, (i=1,..n)

TEr : Total expenditure on the capitation package of services of the reference age group

Nr : Total number of HI cards of the reference age group

3. Capitation base rate:

The capitation base rate is determined by the total capitation fund, the total number of HI cards registered within each age group at CHC, DH, DHC and equivalent health care providers at grassroots level and corresponding cost adjustment coefficients for age groups.

$$CBR = \frac{TCF}{\sum_{i=1}^{n}(Ni * Xi)}$$

i :Age groups, (i=1,..n)

CBR : Capitation base rate

TCF : Total capitation fund

Ni : Total number of HI cards of a specific age group, (i=1,..n)

Xi : Cost adjustment coefficient of a specific age group, (i=1,..n)

4. Capitation budget for each health care facility is calculated as below:

$$\boldsymbol{CB = \sum_{i=1}^{n} (Ni * Xi * CBR)}$$

i : Age groups, (i=1,..n)

CBR : Capitation base rate

Ni : Total number of HI cards of a specific age group registered in a health care facility, (i=1,..n)

Xi : Cost adjustment coefficient for a specific age group, (i=1,..n). The cost adjustment coefficient of the reference group is 1.

5. Adjustment coefficients:

Adjustment coefficients related to health policy objectives, quality improvement, performance, scope of service or any other criteria will be developed based on the decision of the MoH.

Development fund will be created to support the strengthening of the health care delivery at grassroots level. The sources of development fund and allocation mechanisms will be agreed between MoH, VSS and Ministry of Finance (MoF).

Results based financing will be applied to provide incentives for the health staff at the grassroots level aiming to improve the quality and enhance the scope of services.

Adjustment of capitation budget

If there is a change in a number of HI cards registered at a health care facility, Provincial Social Security (PSS) is obliged to informing the health care facility and respective Department of Health (DoH) about this change.

If the cost of capitation package changes due to increase or decrease in prices of health services, introduction of new health services in the capitation package, changes in the functions and duties of a health care facility or any other related factors, the two parties shall agree to adjust the capitation budget accordingly.

Utilisation of capitation budget

1. Capitation budget is used for payment of outpatient services included in the capitation package for HI card holders registered at this health care facility.

2. Surplus

   - If a health care facility achieves efficiency gains and incurs costs that are lower than allocated capitation budget, it shall retain and reinvest all surpluses.
   - If the capitation budget includes health care expenditures incurred at the commune level, the facility contracted provision of health services at a CHC shall allocate the surplus to this CHC based on the number of HI cards registered at the CHC. The health care facilities will use the remaining surplus according to legal provisions.

3. Deficit

   - If a health care facility incurs costs that are not justified, and that are greater than allocated capitation budget, this health care facility is liable for them.
   - If deficit is caused by force majeure such as outbreaks of epidemic diseases, increase in the incidence of serious health problems, PSS and DoH shall agree on the settlement of the deficit for these health care facilities. If the provincial reserve fund is insufficient to settle the deficit, PSS will report this case to VSS for consideration and settlement.

Annex 1 – Capitation Road Map with the timetable

	Priority Interventions / Activities	Responsible parties	Other stakeholders involved	Milestones/ expected results	2016				2017			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Define the capitation package of outpatient services that will be financed by capitation budget												
1.1	Establish the technical working group for the development of the capitation package	MoH	VSS, EU-HF, providers, users, other interested parties	The TWG established								
1.2	Develop the capitation package of outpatient services	MoH	VSS, EU-HF, providers, users, other interested parties	**The capitation package is developed**								
1.3	Cost the capitation package	MoH	VSS, EU-HF, MoF, providers, other interested parties	**The capitation package is costed**								
2. Define standards/requirements (HR, equipment, buildings, etc.)												
2.1	Establish the technical working group for standards/requirements	MoH	VSS, EU-HF, providers, other interested parties	The TWG established								
2.2	Develop set of standards/requirements for implementation of the new capitation model	MoH	VSS, EU-HF, providers, other interested parties	**Set of minimum standards defined**								
3. Select the pilot health care institutions												
3.1	Draft the assessment questionnaire	MoH	VSS, EU-HF, providers, other interested parties	The questionnaire drafted								
3.2	Conduct the assessment	Departments of Health in provinces	VSS, EU-HF, providers	The assessment conducted								
3.3	Selection of the pilot health care institutions	MoH	VSS, EU-HF, providers	**The pilot health care**								

				institutions selected								
4. Elaborate the new capitation model												
4.1	Establish the technical working group for elaborating the key elements of the new capitation model	MoH	VSS, EU-HF, other interested parties	The TWG established								
4.2	Determine the age groups	MoH, VSS	EU-HF, GSO, other interested parties	**The age groups are determined**								
4.3	Construct cost adjustment coefficients for the age groups	MoH	VSS, EU-HF, other interested parties	**Adjustment coefficients constructed**								
4.4	Develop additional adjustment coefficients related to quality, performance, etc.	MoH	VSS, EU-HF, other interested parties	**Additional coefficients developed**								
5. Balance the budgets of the selected pilot health care facilities												
5.1	Settling the deficits and surpluses	VSS	MoH, MoF, EU-HF, other interested parties	**The budgets are balanced**								
6. Develop operational manual for the new capitation model												
6.1	Establish the technical working group for the development of operational manual	MoH	VSS, MoF, EU-HF, other interested parties	The TWG established								
6.2	Draft the operational manual - define principle for settlement of surplus and deficit - apply capitation only for outpatient services at primary level - total capitation fund calculation - calculation of capitation budget for health care facilities - allocation of capitation budget - reporting - define roles and responsibilities of the implementing partners (MoH, VSS, providers, etc.)	MoH	VSS, MoF, EU-HF, other interested parties	**The operational manual is drafted**								
7. Training of the pilots												
7.1	Develop training materials in	MoH, VSS,	Other interested	Training								

	health management, health economics and health financing	EU-HF, MoF	parties	materials are developed								
7.2	Conduct training in health management, health economics and health financing	EU-HF, MoF	MoH, VSS, other interested parties	**Training conducted**								
7.3	Develop training materials for implementation of the operational manual	MoH, VSS, EU-HF	MoF, other interested parties	Training materials are developed								
7.4	Conduct training for implementation of the operational manual	MoH, VSS, EU-HF	MoF, other interested parties	**Training conducted**								
8. Piloting												
8.1	Implementation of the new capitation model	MoH	VSS, EU-HF, MoF, other interested parties	**The new capitation model piloted**								