Agenda – 2nd Cambodia UHC Forum

Friday 7th December 2018

Time	Agenda Item
08:00 – 08:30	Registration
08:30 – 08:40	Introduction to the Forum – Dr Bun Samnang, Chief of Health Economics and Financing, DPHI, MoH
	National Anthem
08:40 – 08:50	Progress and challenges on the road to universal health coverage – H.E. Dr Lo Veasnakiry, Director of Planning and Health Information, MoH
08:50 – 09:00	Summary of recommendations from April 2018 Forum – Dr Kumanan Rasanathan, WHO
09:00 – 09:10	Welcome Remarks to the Forum – Dr Liu Yunguo, WHO Representative to Cambodia
09:10 – 09:30	Opening Remarks – H.E. Dr Mam Bunheng, Minister of Health
09:30 – 10:00	Coffee break and group photo
10:00 – 10:40	Cambodia moving towards UHC: Progress and Challenges (National Health Accounts 2012-2016, and Financial Health Protection 2009-2016) – H.E. Dr Lo Veasnakiry, Director of Planning and Health Information, MoH
10:40 – 11:05	Expanding Social Health Protection in Cambodia: an assessment of current coverage potential, gaps, and social equity considerations – Mr Pheakdey Sambo, Deputy Secretary-General, National Social Protection
11:05 – 11:25	Results of a study on ID Poor and MCH – Mr Klaus Baesel, GIZ
11:25 – 11:40	Coping with the costs of care seeking – Distress financing in Cambodia – Dr Bart Jacobs, GIZ
11:40 – 12:00	Questions and answers
12:00 – 13:30	Lunch
13:30 – 15:00	Panel Presentation and Discussion 1: Covering the informal sector: further lessons from the region Moderator: Dr Ir Por, NIPH - The New Cooperative Medical Scheme: expanding coverage in China – Ms Qiao Jianrong, WHO China - Strategies and sequencing to cover the informal sector in Vietnam – Ms Thi Kim Phuong Nguyen, WHO Viet Nam
15:00 – 15:30	Coffee break
15:30 – 16:30	Panel Discussion 2: What now, what later? Sequencing reforms towards Universal Health Coverage in Cambodia Moderator: Mr Erik Josephson, WHO - Ministry of Health – H.E. Dr Lo Veasnakiry, Director DPHI - Ministry of Economy and Finance - Mr Pheakdey Sambo, Deputy Secretary-General, National Social Protection Council - Ministry of Planning – H.E. Dr Koe Ou Ly, Director ID Poor Department - National Social Security Fund – H.E. Heng Sophannarith, Deputy Director of Health Insurance
16:30 – 16:45	Summary and Recommendations – H.E. Dr Lo Veasnakiry, Director DPHI, MoH
16:45 – 17:00	Closing Remarks – H.E. Professor Eng Huot, Secretary of State, MoH

Cambodia National Health Accounts 2012 – 2016

and

Financial Health Protection 2009 - 2016

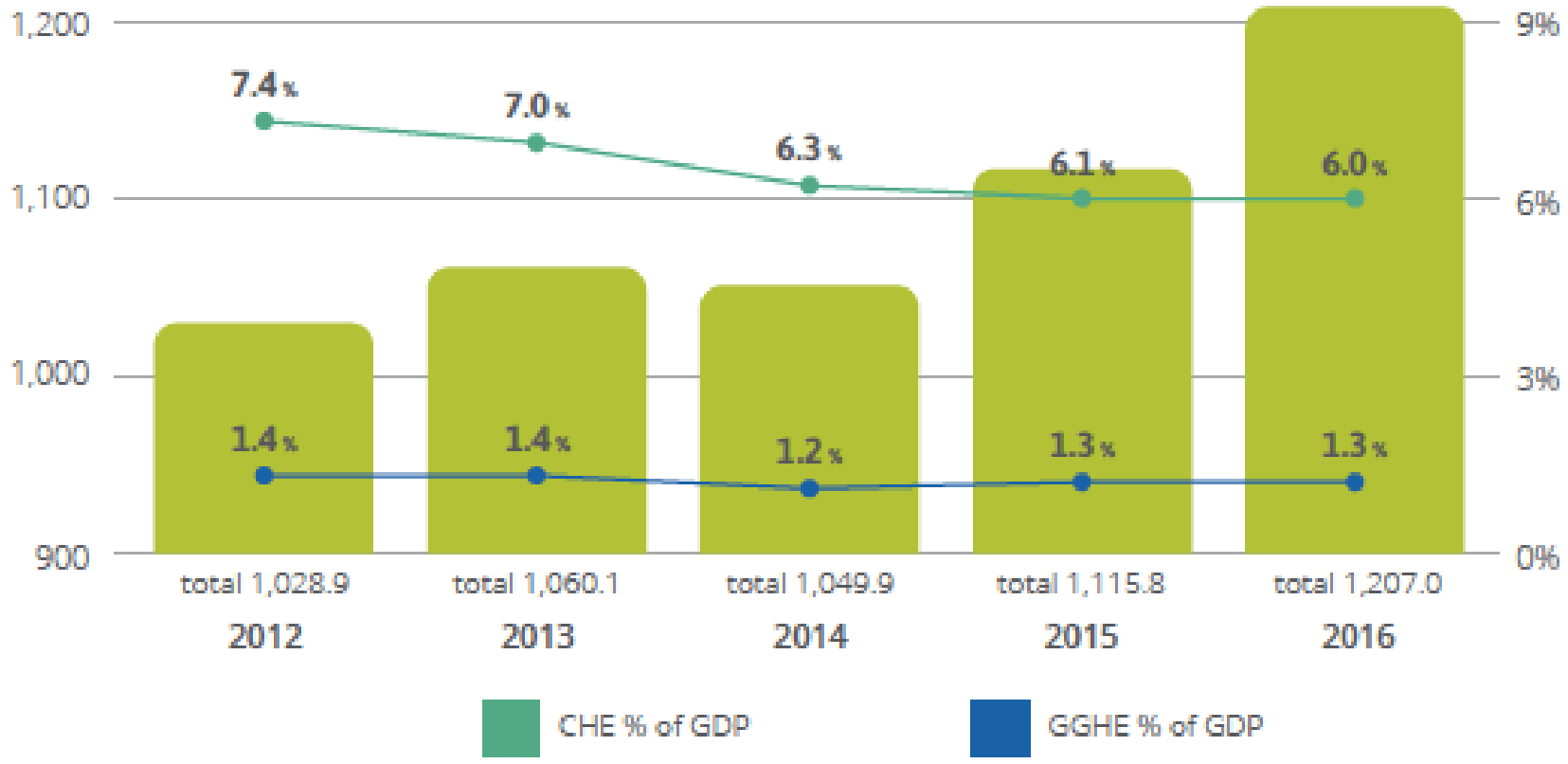
Dr Lo Veasnakiry (DPHI)
Mr Ros Chhun Eang (formerly DPHI, now PCA)
Dr Bun Samnang (DPHI)
Mr Mo Mai (WHO)
Ms Rochelle Eng (WHO)
Mr Erik Josephson (WHO)

World Health Organization
Western Pacific Region

Evidence to inform policy towards universal health coverage in Cambodia

Current health expenditure (2012 - 2016)

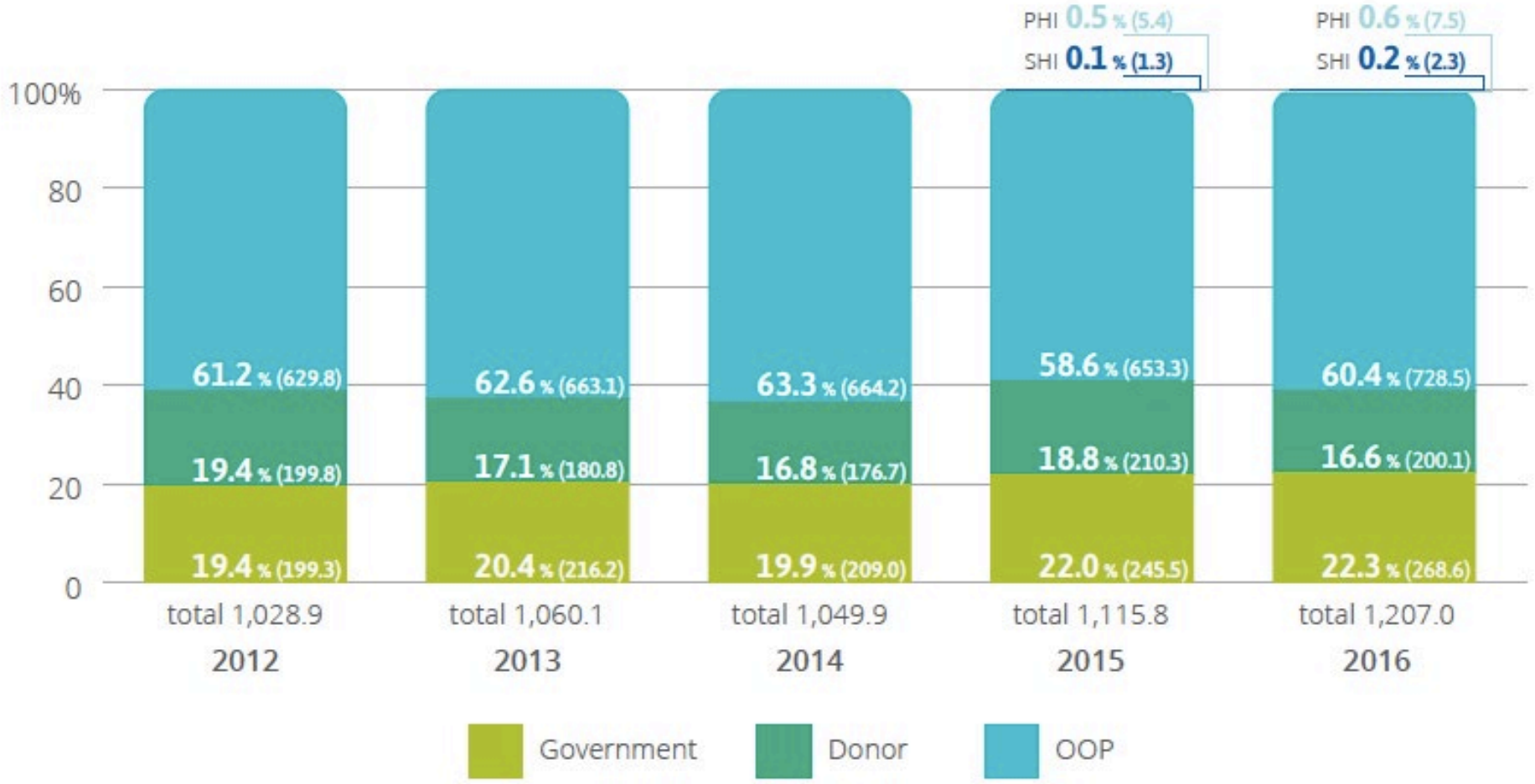
in US$ millions



CHE: current health expenditure; GGHE: general government health expenditure.

Current health expenditure (2012 - 2016)

by source (%)



Government health expenditure (2016)

Current health expenditure

6% of GDP

$1.21 billion

Viet Nam 5.7%

Lao PDR 2.8%

Thailand 2.9%

Total government health expenditure

1.3% of GDP

$269 million

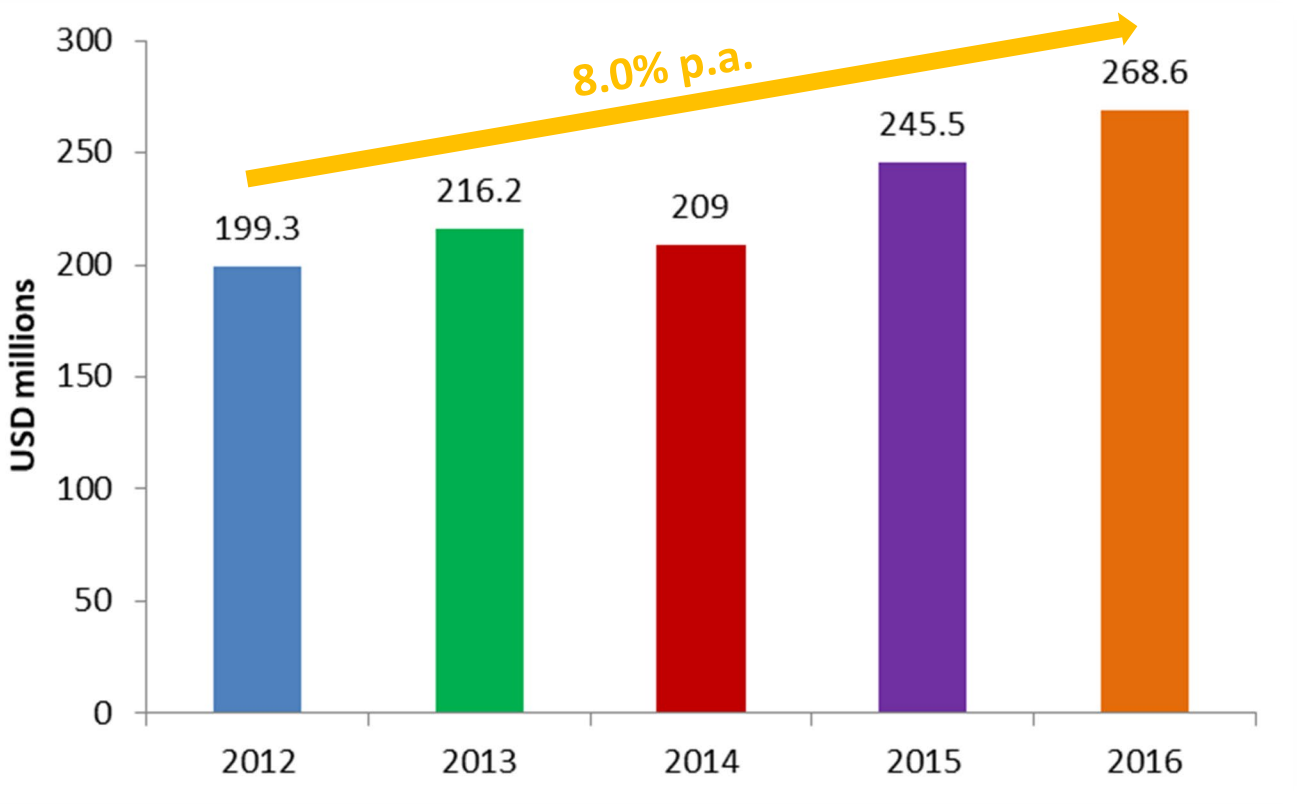
Viet Nam 2.5%

Lao PDR 1.3%

Thailand 2.2%

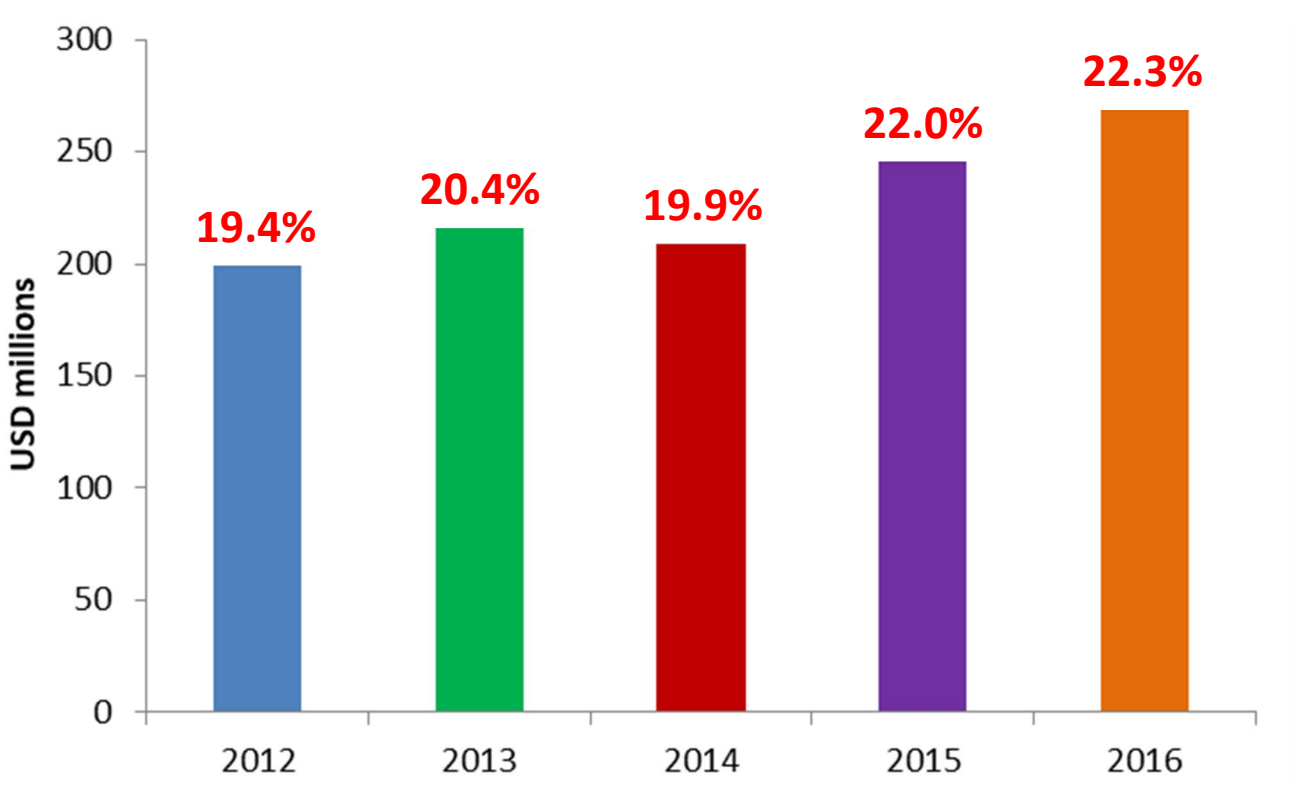
Difference comes from out of pocket expenditures, health insurance premiums, or donor contributions

Government health expenditure (2012 - 2016)



Government health expenditure (2012 - 2016)

(government expenditure on health / current health expenditure)



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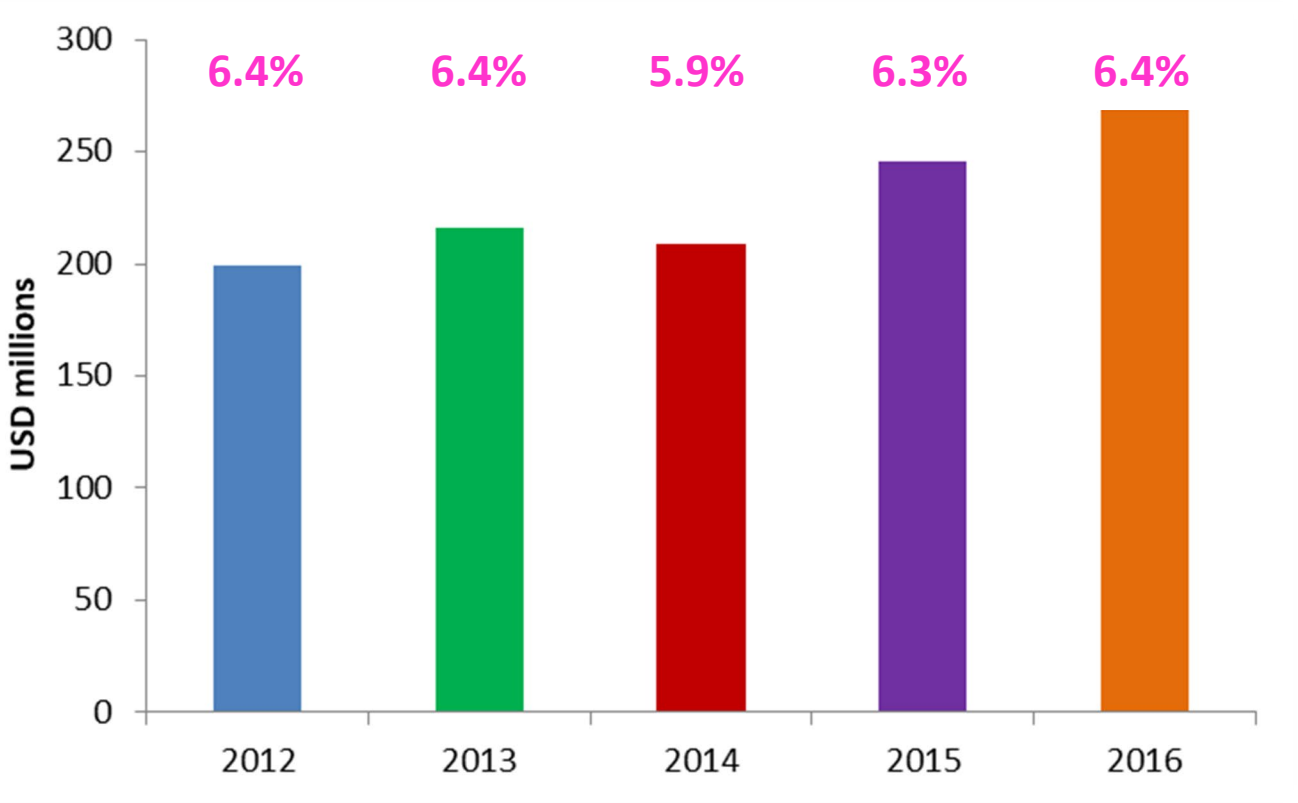

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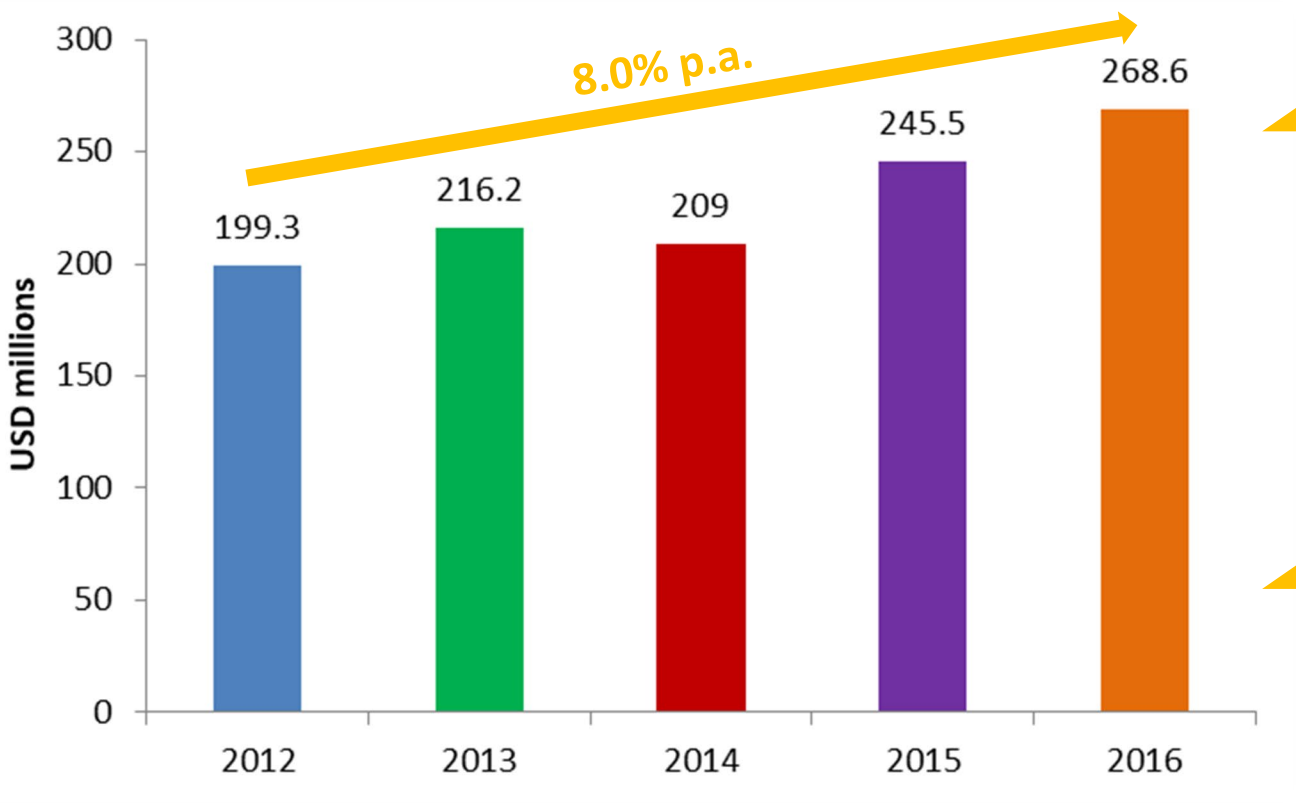


GDP growth

7.1% p.a.

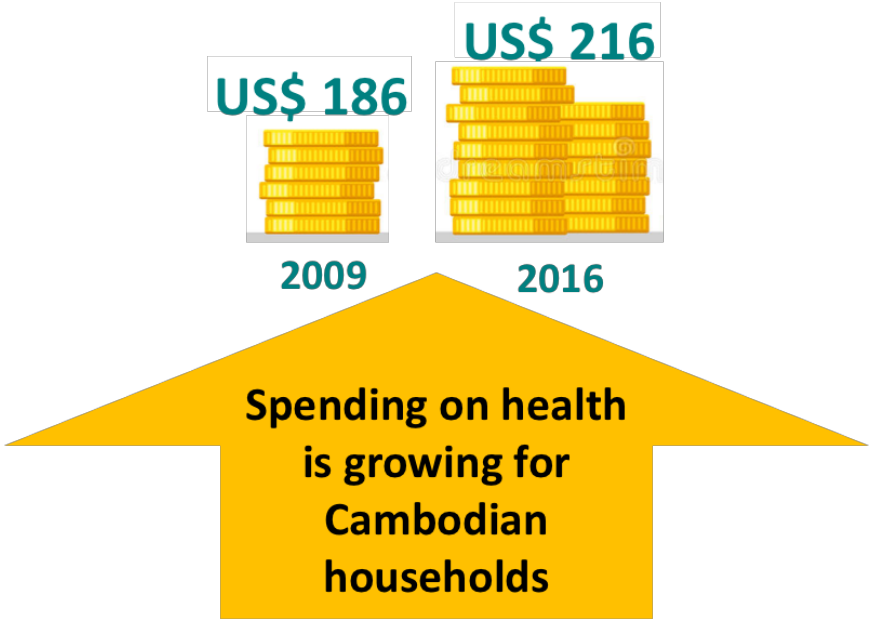
Government expenditure growth

8.5% p.a.

Out of pocket expenditure

Annual out of pocket expenditure has increased by $100 million in 4 years.
($630 million in 2012 to $729 million in 2016)

Annual out of pocket expenditure has increased by $200 million in 7 years.
($534 million in 2009 to $729 million in 2016)



These are significant increases. Out of pocket expenditures are rising more slowly than GDP, and also therefore more slowly than public expenditure on health.

Financial protection

Indicator	2009	2010	2013	2014	2015	2016
OOP health per capita per annum (US$)	41	44	45	45	44	48
OOP health per household per annum (US$)	186	204	210	204	197	216
Total household consumption expenditure (million US$)	7 969	9 314	12 482	13 601	14 820	16 149
Total OOP spending (million US$)	534	596	663	664	653	728
Incidence of households with catastrophic expenditure (%)	8.8	7.8	5.8	4.8	5.1	3.7
Incidence of households impoverished due to health payments (%)	5.7	5.3	2.5	2.1	1.4	1.6

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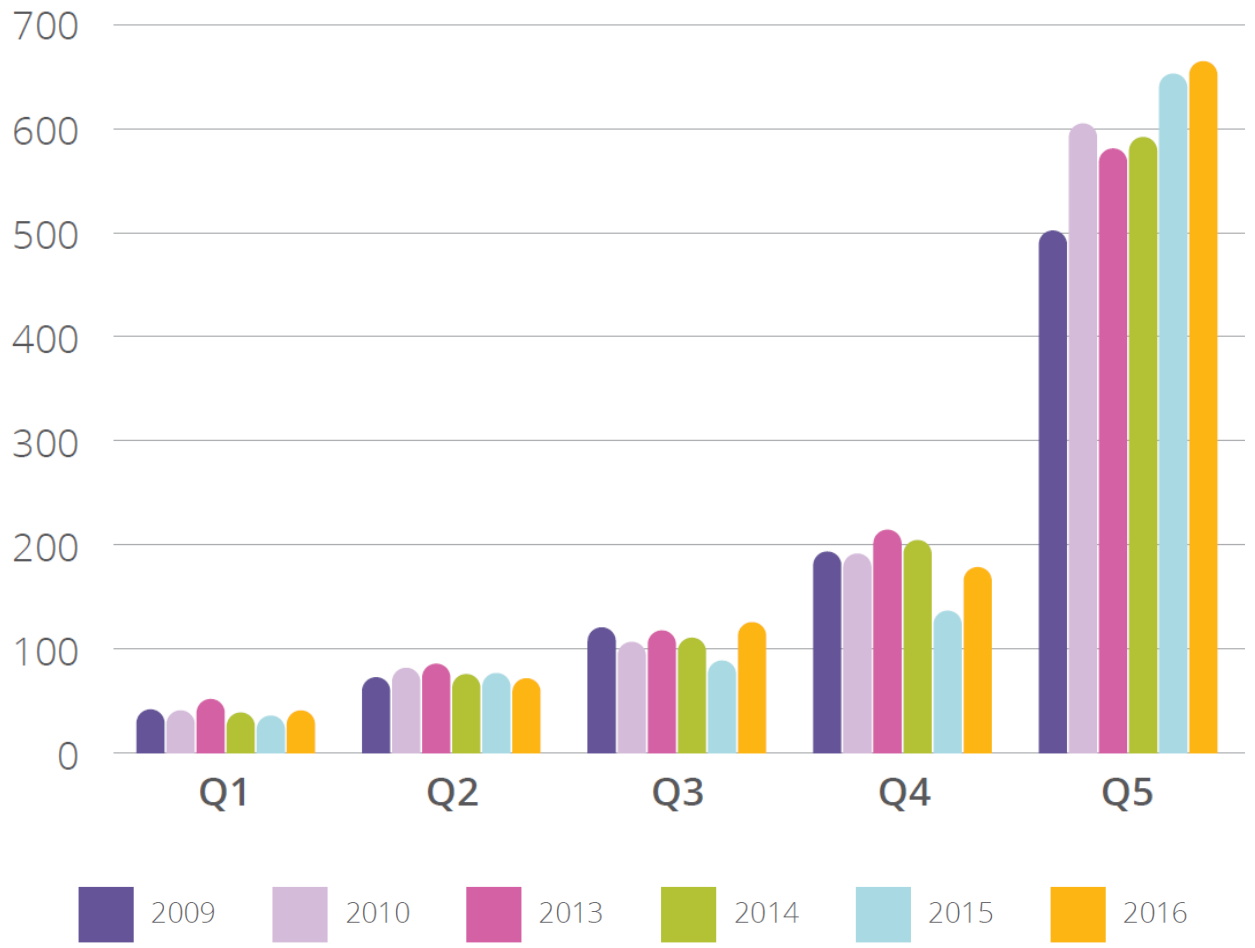
Catastrophic expenditure has reduced impressively. However 3.7% of households is still more than 500,000 people.

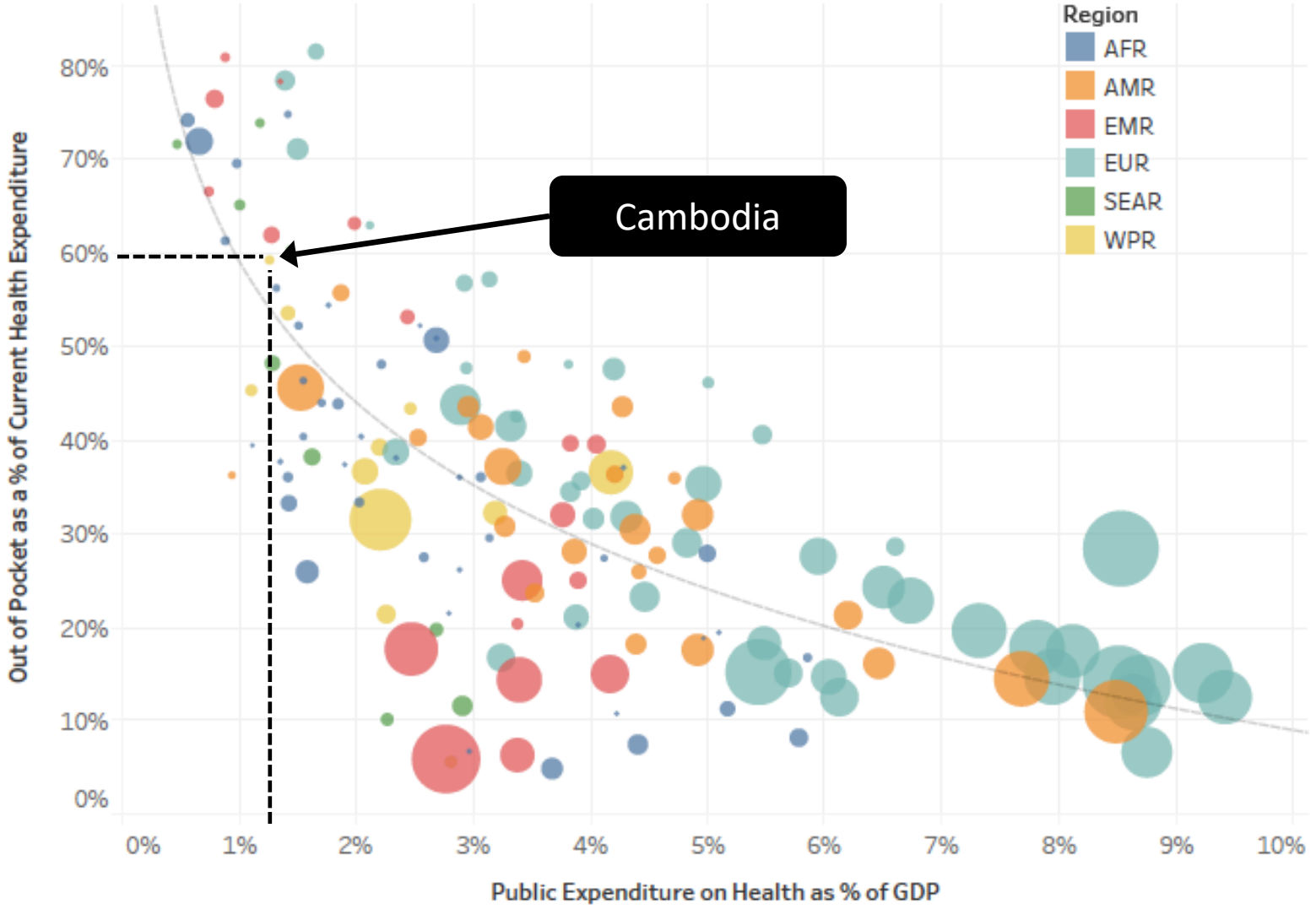
Percentage of households with members receiving free or subsidized care, 2014

	Total population receiving free or subsidized care	16.8%
Residence	Urban	12.5%
	Rural	17.6%
Wealth quintile	Quintile 1	29.1%
	Quintile 2	20.9%
	Quintile 3	16.1%
	Quintile 4	11.0%
	Quintile 5	6.6%

Out-of-pocket (OOP) on health per household by wealth quintile and residence, 2009–2016 (US$)



Public expenditure on health vs dependence on out of pocket payments



Note: Each bubble represents one country, and the size of each bubble represents the relative per capita GDP of the country.

Donor expenditure (2012 - 2016)

Current health expenditure by function (US$ million)	2012	2013	2014	2015	2016
Long-term care (health)	1.2	1.1	1.1	2.5	1.1
Rehabilitative care	0.9	1.9	1.7	2.3	2.2
Ancillary services	0.5	1.3	0.4	9.5	4.7
Other health care services	21.4	36.2	3.6	1.7	5.0
Preventive care	67.2	34.4	52.4	84.6	88.0
Medical goods (non-specified by function)	8.6	3.8	16.1	5.7	7.0
Governance, and health system and financing administration	37.5	69.9	66.8	46.4	42.6
Curative care	59.4	32.2	34.7	57.8	49.6
Total	**196.7**	**180.8**	**176.8**	**210.5**	**200.2**

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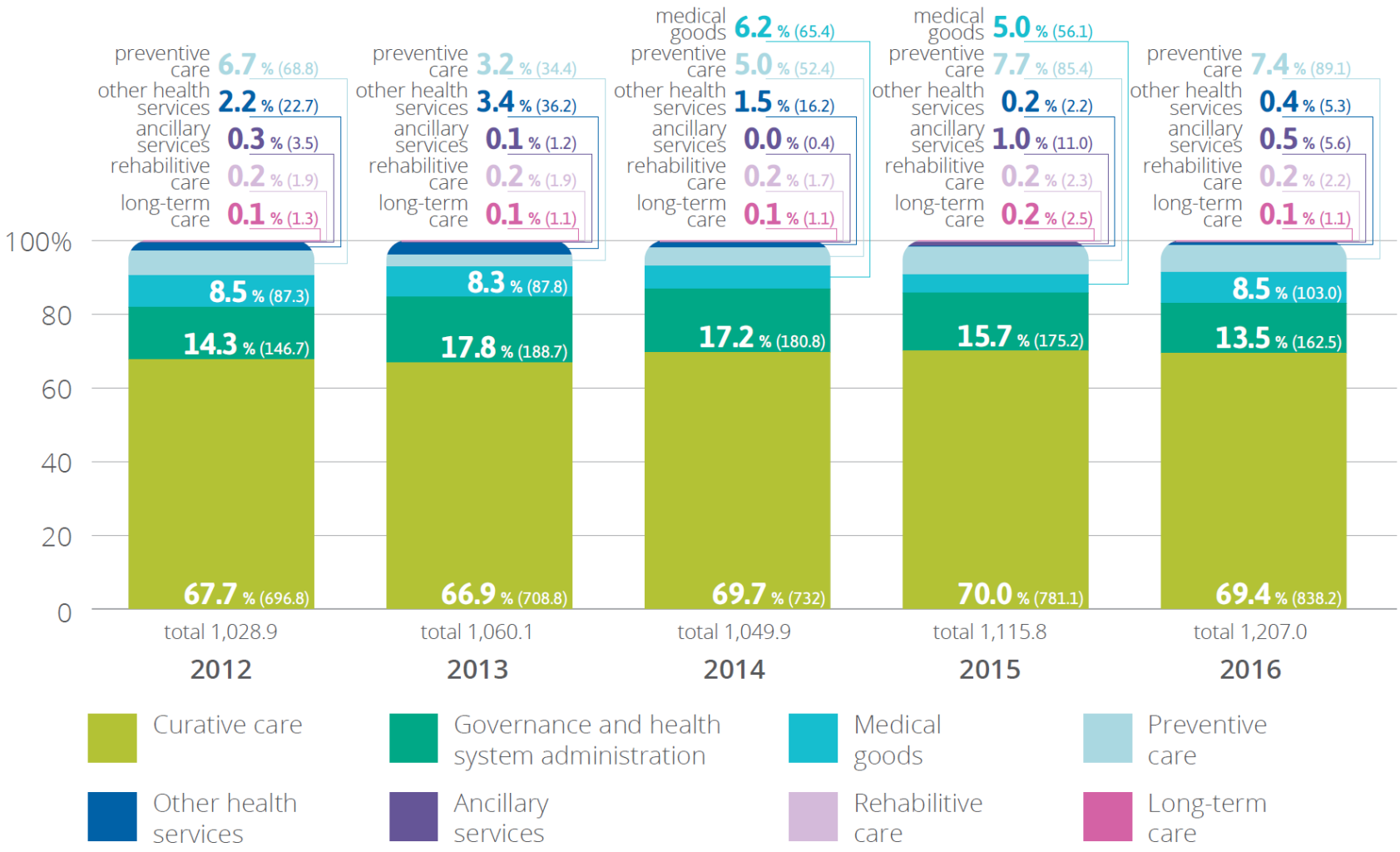
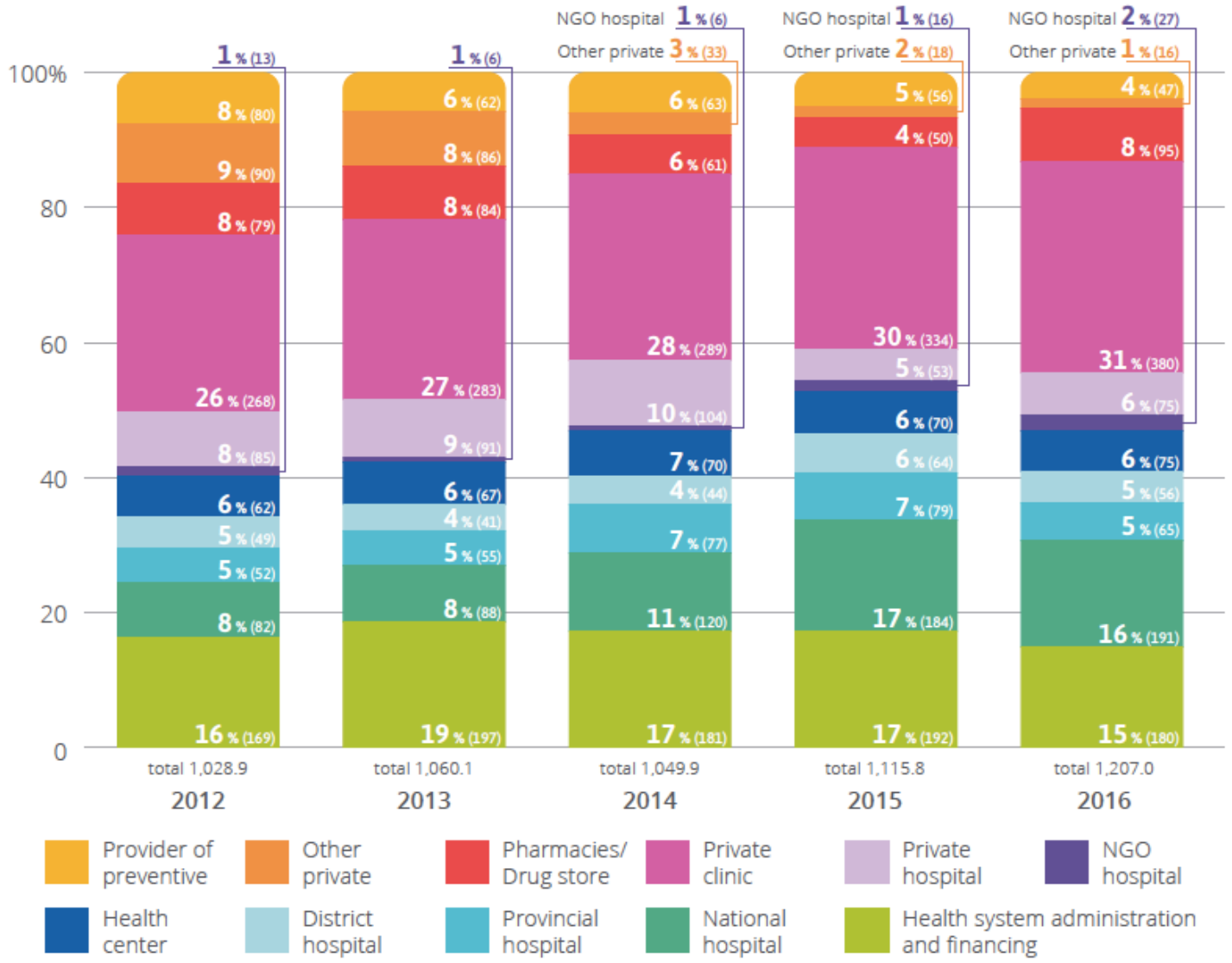
Preventive and curative expenditure (2012 - 2016)



Expenditure in public and private facilities



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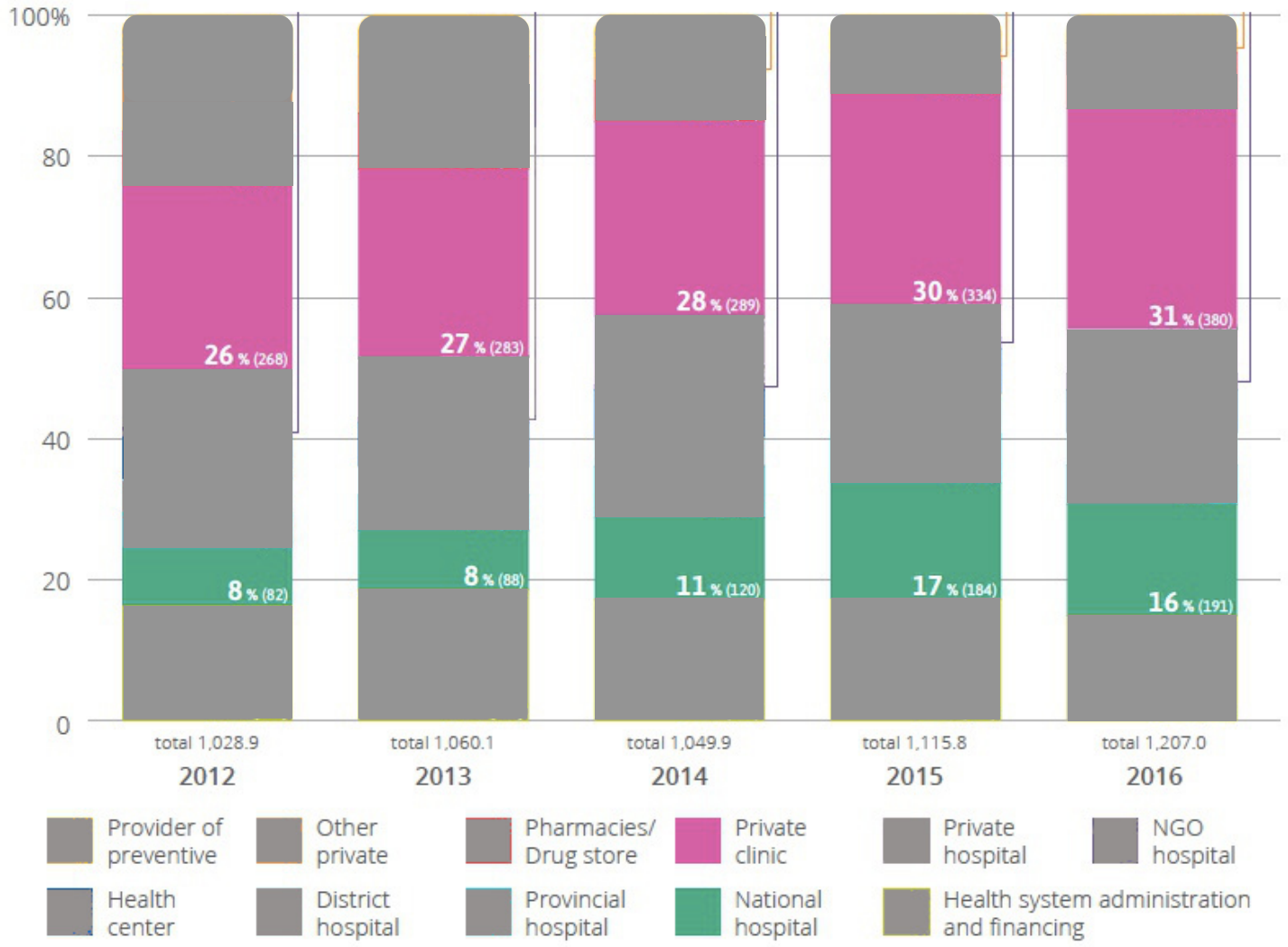
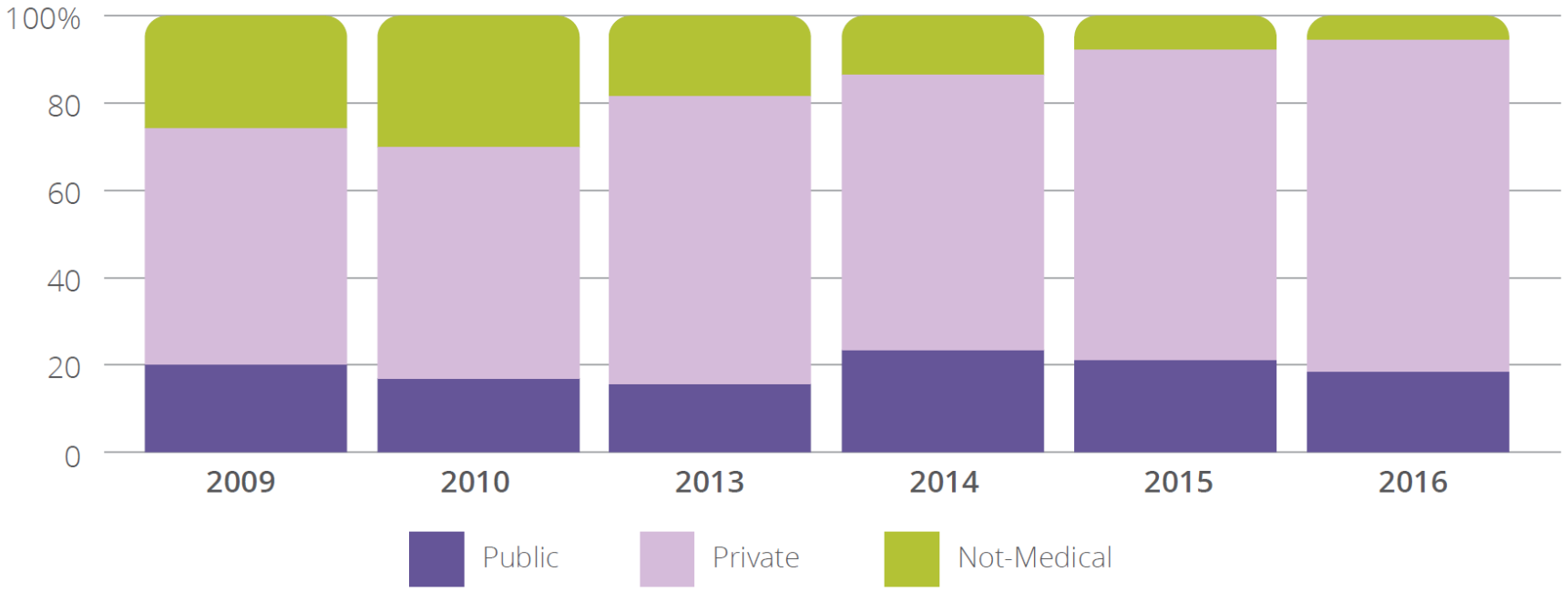


Choice of provider for the first visit



Containing hospital utilization and expenditure

A recent study calculated the per-outpatient visit expenditure (from all sources) in Cambodia at $3 in a public health centre, and $35 in a public hospital.

11x the expenditure for (virtually) the same interaction!

	Cambodia
Public facilities	
Health Centre	2.87
Hospital OP	35.16
Hospital IP	195.90
Private facilities	
Private clinics & pharmacies	4.86
Hospital OP	16.16

Cambodia National Health Accounts 2012 – 2016

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Evidence to inform policy towards universal health coverage in Cambodia

Expanding Social Health Protection in Cambodia: an assessment of the current coverage potential, gaps, and social equity considerations

Pheakdey Sambo, Deputy Secretary-General
National Social Protection Council

ក្រសួងសេដ្ឋកិច្ច និងហិរញ្ញវត្ថុ
អគ្គលេខាធិការដ្ឋានក្រុមប្រឹក្សាជាតិគាំពារសង្គម

Background

- Cambodia has experienced more than two decades of strong economic growth averaging 7.7% between 1995-2017 (World Bank 2018);
- About 4.5 million people (~28% of the population) remain near-poor and vulnerable to falling back into poverty when exposed to economic and other shocks (World Bank 2018);
- Vulnerability to poverty has increased as a large proportion of the population is concentrated at the bottom of the wealth distribution (ADB 2014);
- The existing health coverage schemes can collectively cover about 4.7 million Cambodians (~30% of the population) (MOH 2018);
- MOH aims to increase coverage to 8.12 million or 50% of the population by 2020 (MOH 2016).

HEF Extensions

- **Prakas 404 MEF/MOL/MOH (October 2017)**- HEF expansion to **informal workers**:
  - <8 hours;
  - Part-time;
  - Casual;
  - Seasonal.

- **Press Release MOL (December 2017)-** HEF expansion to special categories:
  - Informal worker;
  - Village chief;
  - Deputy village chief;
  - Village assistant;
  - Commune council;
  - Professional sport practitioners.

- **Notification Letter MOH 001 (January 2018)**- HEF expansion to special categories
  - Cyclo drivers.

Key questions

- How many people do not yet have a coverage mechanism and who are they?
- Who is benefiting the most from the current expansion efforts focused on workers and employees?
- How many informal workers are already eligible for coverage under the recent HEF expansion?
- What would be an equitable approach to premium contribution amounts?

Methods

- Secondary analysis of 2016 CSES data and other sources (Demographic and Health Survey, MOP population estimates, etc…)
- 3,839 households and 11,359 individual working age adults
- Identify employment groups to align with the health insurance coverage landscape
- Univariate and bi-variate statistics
- Assess a fair and equitable contribution using 4 approaches

Figure 1. Population proportion estimates for vulnerable (non-income related), employment, and residence groups

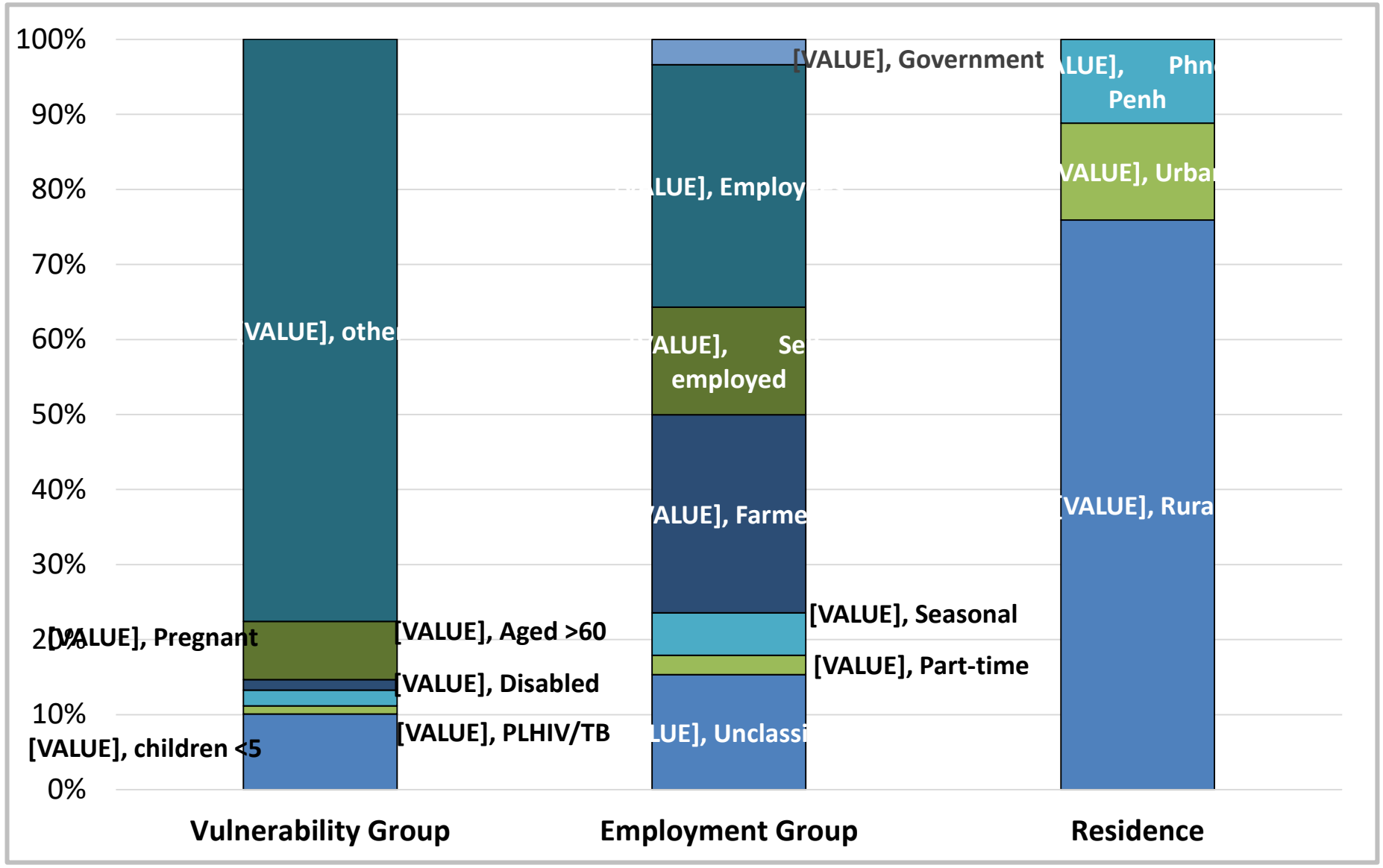


Figure 2. Proportional distribution of total income by wealth quintile

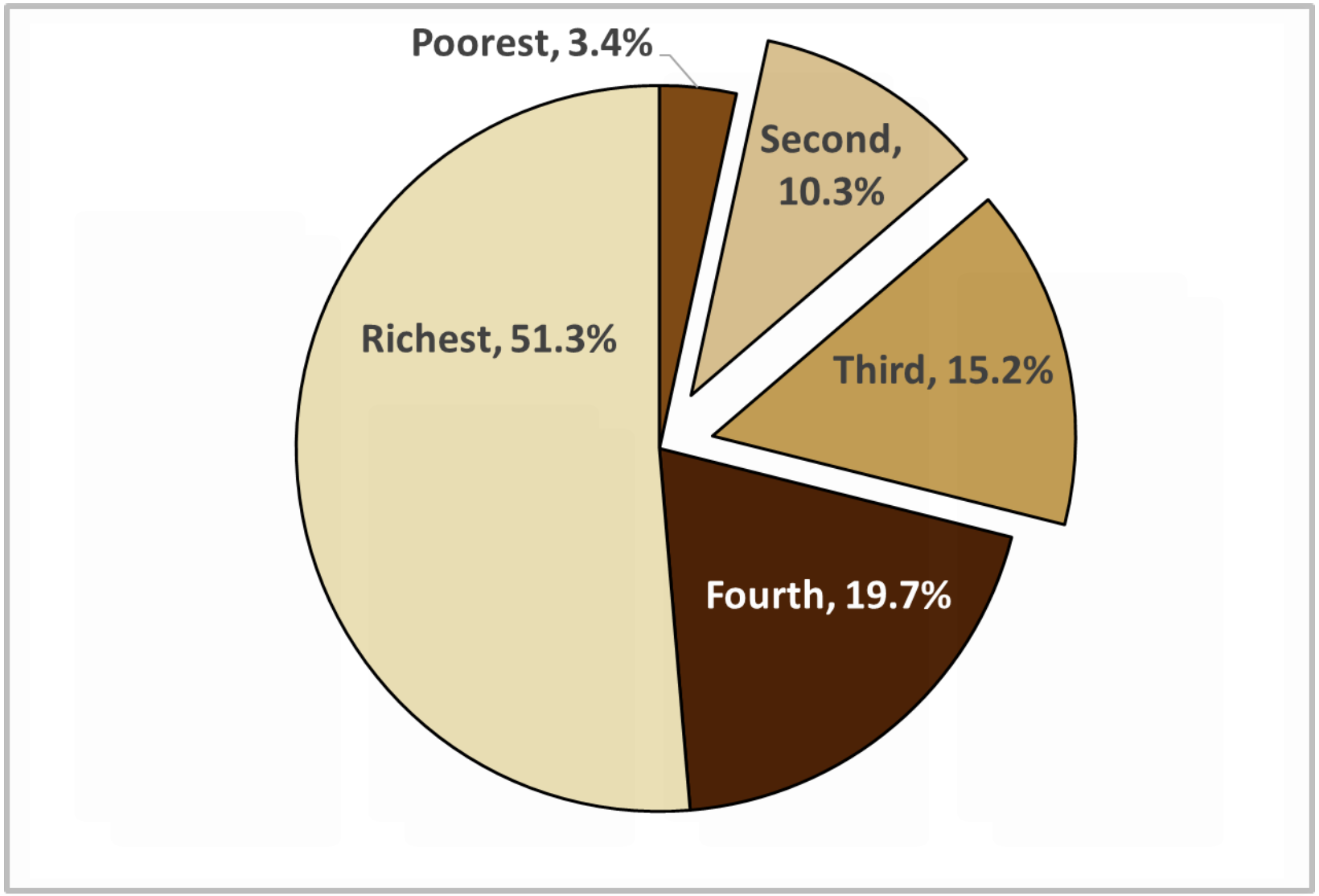


Figure 3. Employment category by wealth quintile among working age adults

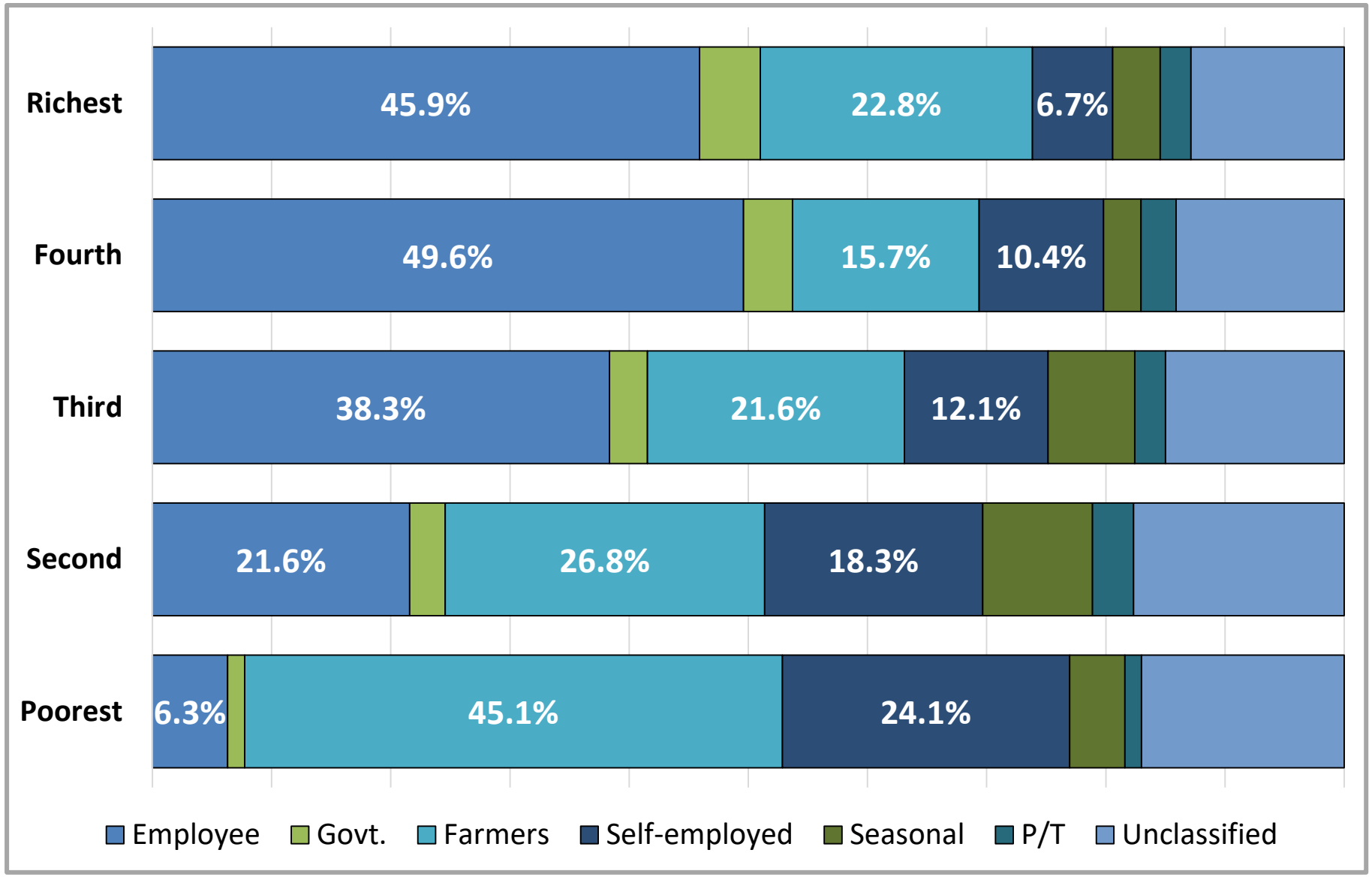


Figure 4. Population proportions by wealth quintile and employment group among working age adults

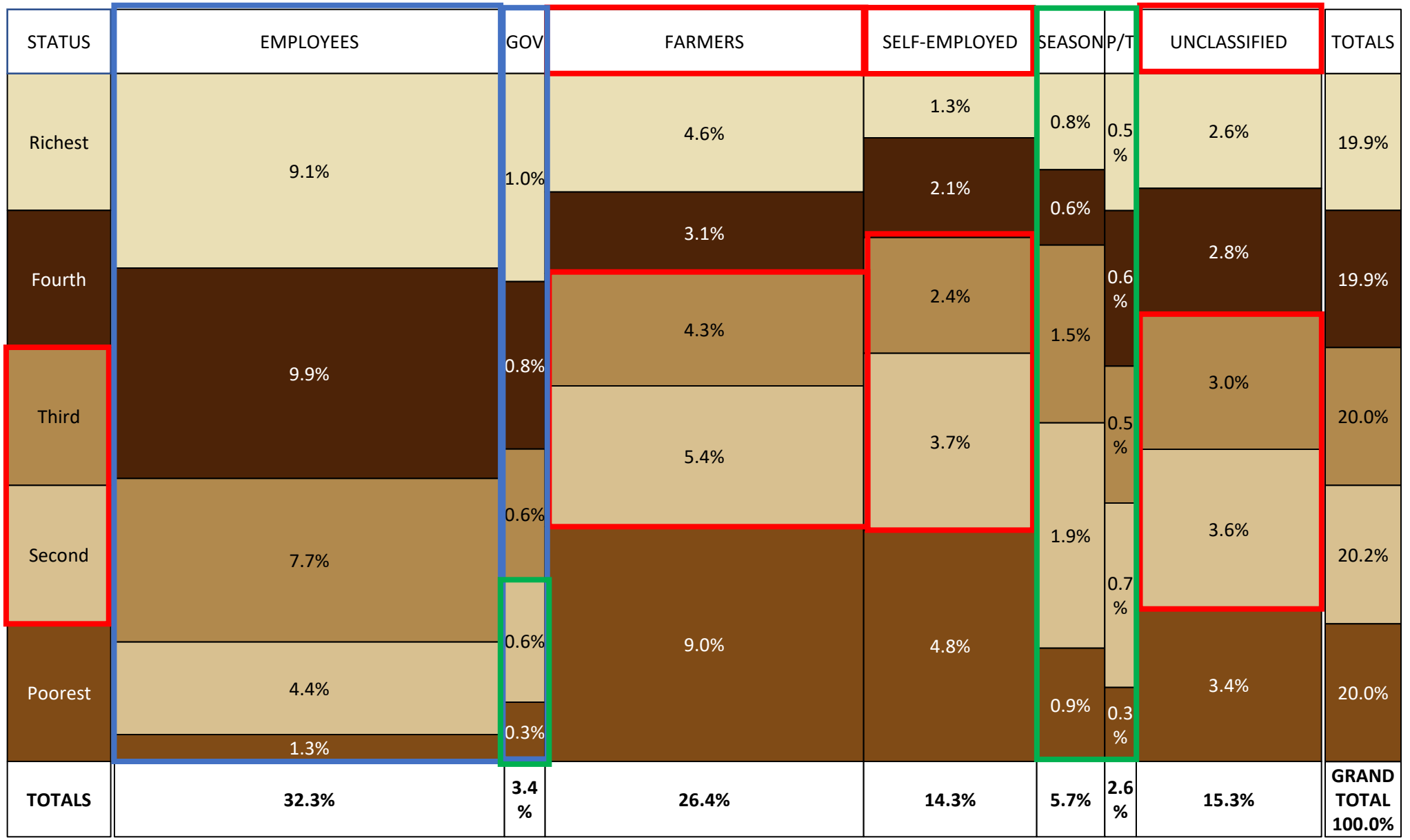


Figure 5. Monthly individual effective income by wealth quintile with averages and distances to the poorest quintile in USD

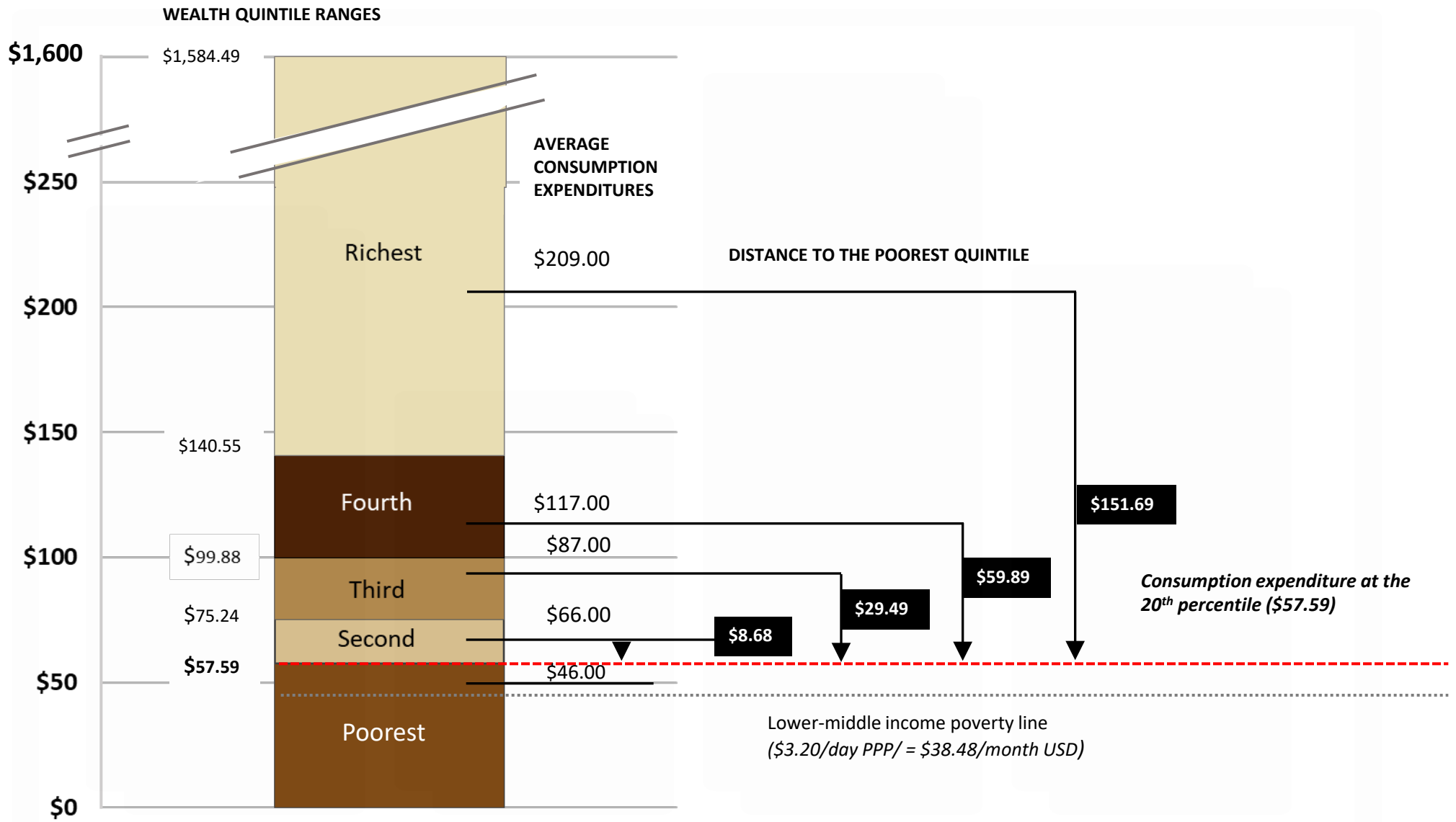
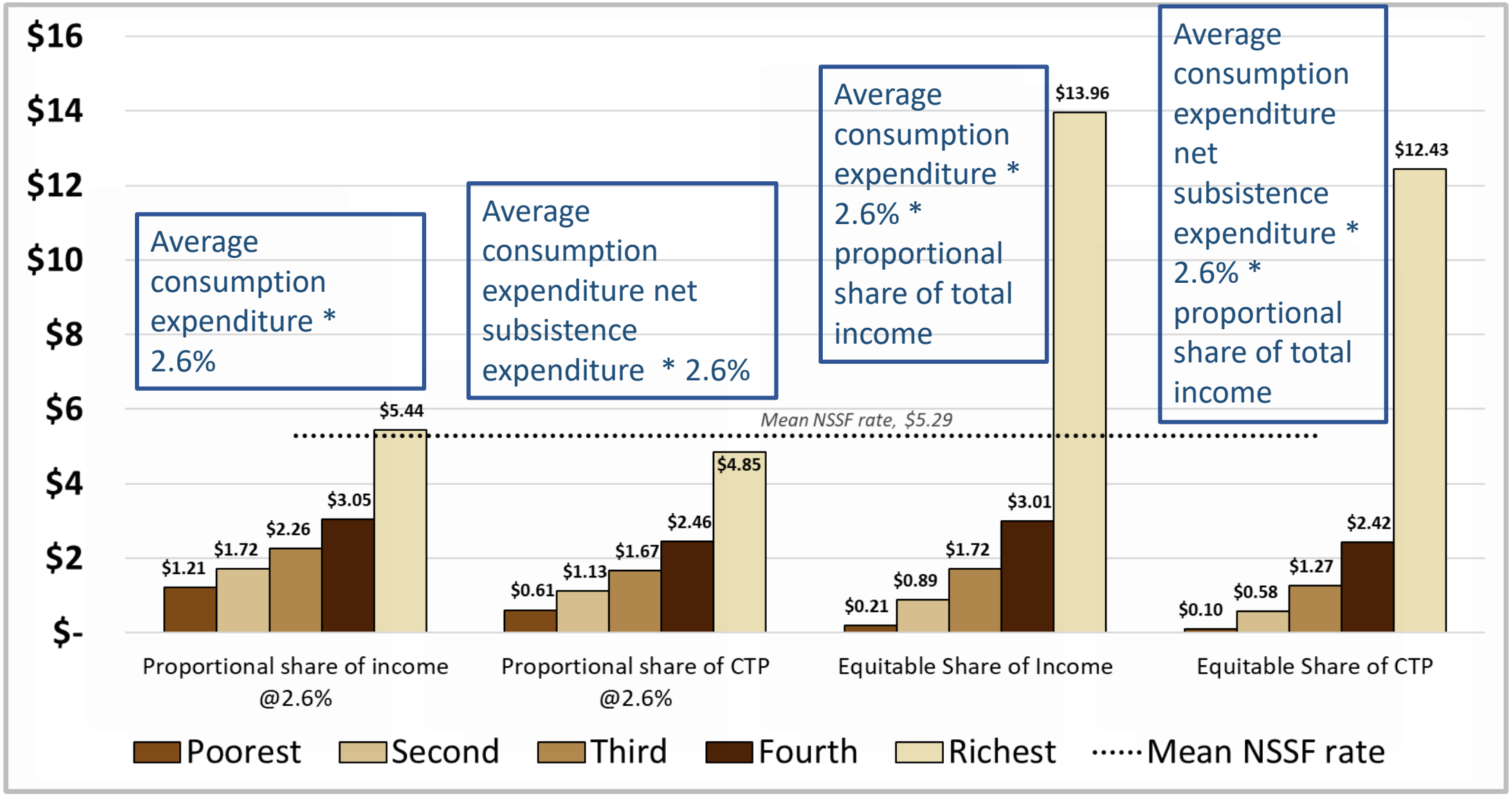


Figure 6. Proportional and equitable individual health insurance premium estimates (monthly) by wealth quintile



Conclusions

- Current health coverage expansion efforts to formal employees is likely to primarily benefit individuals from higher income HHs;
- Recent directives to expand HEF coverage to part-time and seasonal workers have limited potential: leaving significant gaps, particularly among vulnerable groups, farmers, and the self-employed;
- Capacity to pay (CTP) among individuals in the 2nd and 3rd wealth quintiles is limited;
- A fair and equitable approach to individual, monthly healthcare contribution payments would only amount to $0.58 - $1.72 US (2nd quintile) and $1.27 - $2.26 US (3rd quintile);
- The collection cost could potentially exceed the amount collected, particularly among the informal sector.

Ministry of Planning

IDPoor: enabling collaboration across sectors for maternal and child health in Cambodia



UHC Day Forum 2018

7 December 2018

Outline

- Interrelation between poverty and MCH
- IDPoor in a nutshell
- How does targeting work?
- Relevance of IDPoor for MCH
- Utilisation of IDPoor data in the health sector
- Summary
- Lessons Learnt

Interrelation between poverty and MCH

- **Equity in health care (HSP3):** All people in Cambodia have better health and wellbeing, thereby contributing to sustainable socio-economic development
  - Priority strategic intervention: Reduce the financial burden when accessing and utilizing health care services, especially for the poor and vulnerable

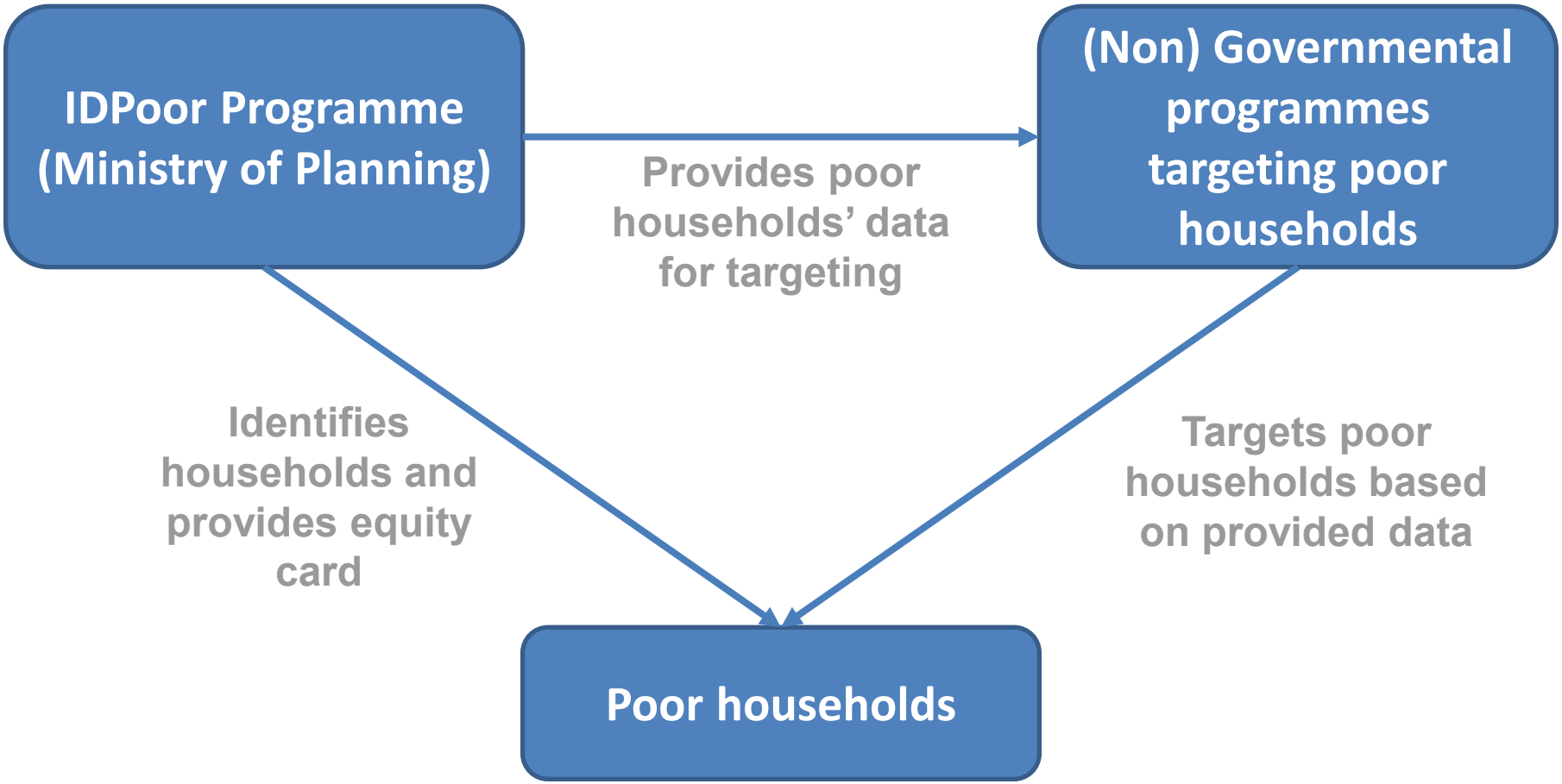
- Cambodia has made **significant improvements in reproductive, maternal, newborn, child and adolescent health** in line with MDGs 4 and 5

- Despite important progress, **equity in MCH remains a challenge** for the poorest:
  - Malnutrition is a major consequence of poverty, with severe consequences for health of mothers and babies and childhood development;
  - Stunting (impaired growth and development resulting from poor nutrition), a widespread problem in Cambodia, affects 42% of children in the poorest quintile compared to 19% in the wealthiest (CDHS 2014).

IDPoor in a nutshell

- **Cross sectoral poverty identification mechanism** implemented by the Ministry of Planning since 2005 (with support from GIZ on behalf of DFAT and BMZ)
- **RGC's mandatory standard tool for targeting pro-poor measures** (sub-decree 291)
- Combination of **proxy means test** and **community based targeting**
  - Community-based targeting: Village representative groups conduct interviews with poor households, results are shared and discussed with the village
  - Proxy means test: easily observable and verifiable household assets and characteristics (e.g. construction material of the house, possession of TV/radio, school attendance)
- Data is collected in 1/3 of the country each year → updated data available free of charge for each province every 3 years

How does targeting work?



Relevance of IDPoor for MCH

- **Over 50% of all poor household members are potential users of MCH services**
  - In total, 2.2 million poor people identified through IDPoor in 2015-2017 (approx. 14% of the population)
  - This includes 25% women in reproductive age (15-49 years) and 30% children aged 0-14 years

- **Across sectors, programmes use IDPoor data to target poor households**
  - 136 (non) governmental programmes were using IDPoor data in 2015 (62% of all programmes)
  - Amongst those, 37 programmes explicitly sought to reach women and children in sectors such as education (35%), agriculture and rural development (24%), human rights (19%), and health (14%)

Programme	Sector	Type of intervention	Eligibility	Coverage	Agency
Health Equity Fund (ongoing)	Health	Provides health services free at point of delivery, transportation to health facilities, food during treatment at hospital	IDPoor 1 and 2 households	Nationwide (all provinces)	Ministry of Health, multiple international donors
Vouchers for reproductive healthcare services (2011-17)	Health	Provided vouchers for essential healthcare related to pregnancy, birth, and family planning	Vouchers were distributed to IDPoor cardholders (IDPoor 1 and 2 households)	Three provinces	Ministry of Health, KfW Development Bank
NOURISH mother and child nutrition cash transfer incentive for health service utilisation (2014-19)	Health, nutrition, water and sanitation, agriculture	Provides conditional cash transfers to stimulate use of specific nutrition and reproductive health services; and vouchers for WASH and nutrition products	Pregnant women and children under 2 (IDPoor 1 and 2 households and an additional process to consider further poor households not included in IDPoor)	565 villages of the 20 poorest districts in three provinces (selection based on a poverty rate of 30% or higher using IDPoor data)	Save the Children; district, municipality, and commune authorities
Cash transfer pilot project for pregnant women and children in Cambodia (2015-17)	Health, nutrition	Unconditional and conditional cash transfers to increase the use of essential health and ANC/PNC services	Pregnant women and children under 5 (IDPoor 1 and 2 households)	57 villages in eight communes in one province	UNICEF; Council for Agricultural and Rural Development
Multi-sectoral Food Security and Nutrition (MUSEFO) (2015-20)	Health, nutrition, agriculture	Provides training sessions to farmers and families to grow a more diverse range of crops and improve their access to healthy foods	People vulnerable to food insecurity (including IDPoor 2 cardholders)	180 villages in two provinces (with families engaged in agricultural activities with more than 10% IDPoor 2 households)	GIZ; Council for Agricultural and Rural Development; provincial authorities
Primary school scholarships (2011-18)	Nutrition, education	Provides take home rations and cash transfer scholarships ($60 per year) to primary school children and their families	IDPoor 1 and 2 (students in grades 4-6 in schools in rural or remote areas)	Six provinces	Ministry of Education, Youth, and Sport; World Food Programme

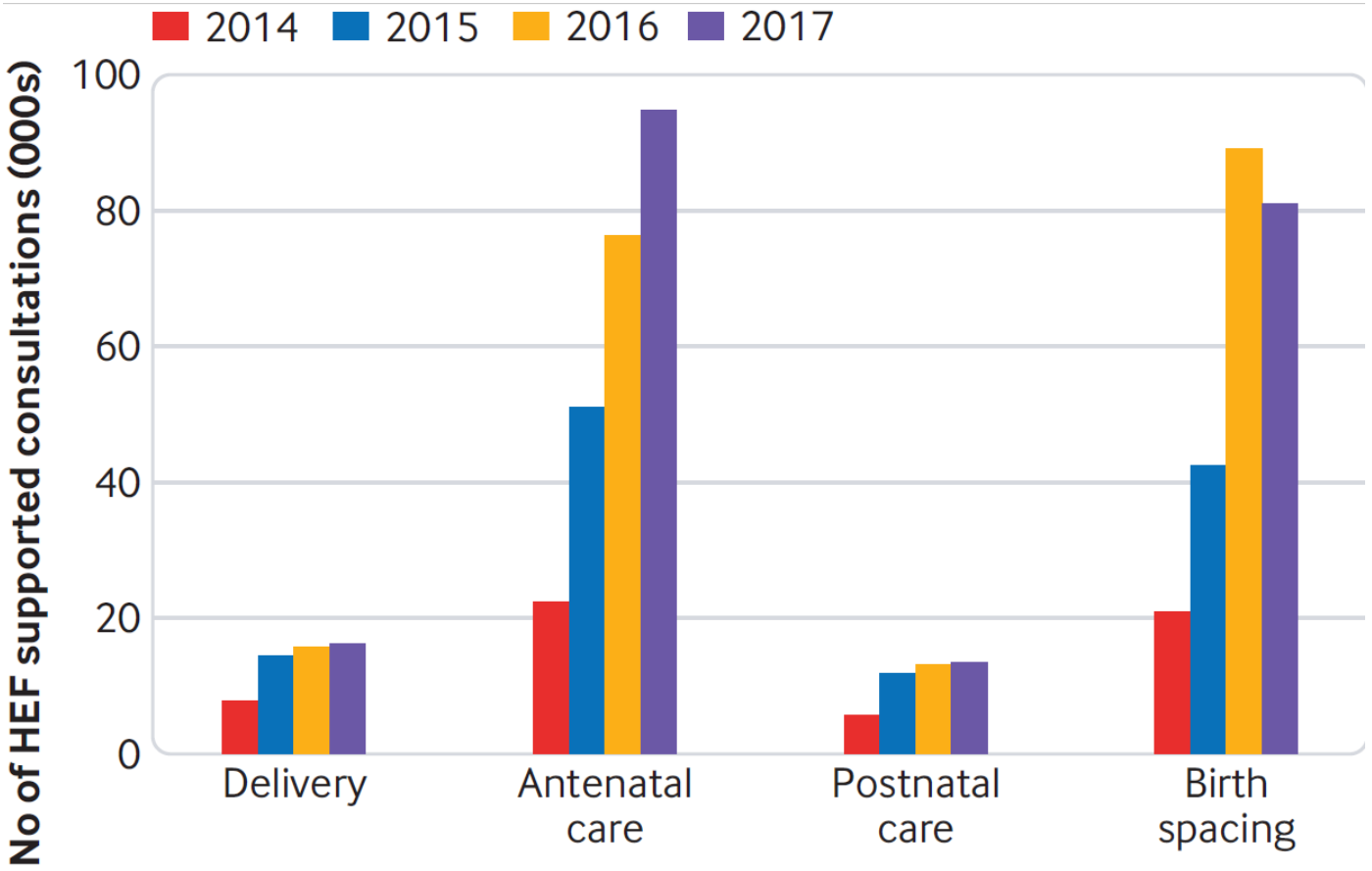
Utilisation of IDPoor data in the health sector

- The **Health Equity Fund (HEF)** of the Ministry of Health is the single largest programme using IDPoor data

- The Ministry of Health regularly **obtains IDPoor data and updates its patient registry**, which allows health facilities to verify eligible patients
  - HEF reimburses the health facility for the service provided to poor patients
  - A “post-identification” process can be carried out at health facilities to handle non-cardholding patients (“Post IDPoor”)

- **HEF benefit package:**
  - HEF covers user fees of poor patients for minimum and complementary service packages at health centre and referral hospital level (including maternal and newborn healthcare)
  - Poor patients are also entitled to non-medical benefits such as reimbursement of transportation costs to and from the referral hospital and food allowances

Number of HEF supported MCH consultations at health centre level



Number of HEF supported maternal and child health consultations at health centres for 2014-2017 from Cambodian Ministry of Health, Department of Planning and Health Information

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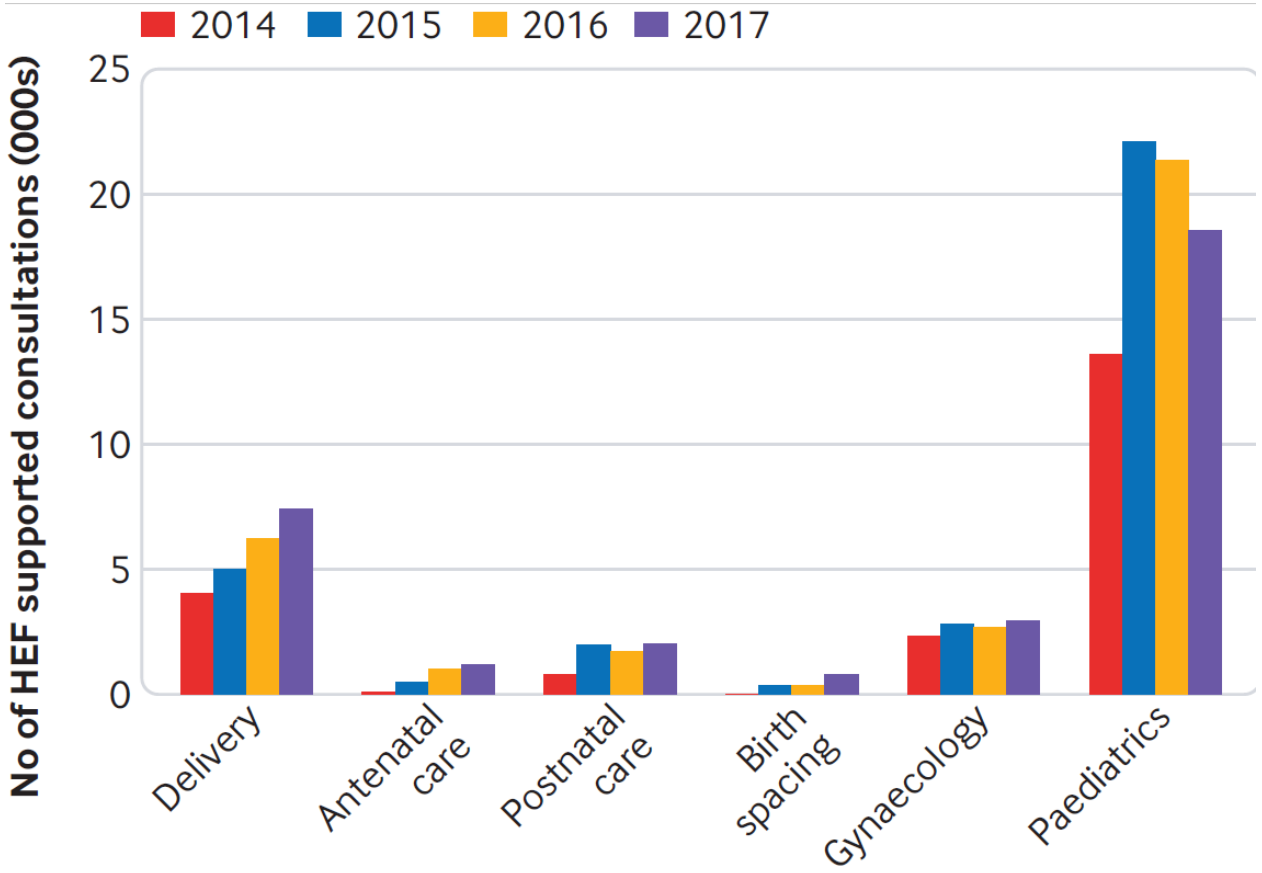

Number of HEF supported maternal and child health consultations at referral hospitals for 2014-2017 from Cambodian Ministry of Health, Department of Planning and Health Information

Summary

HEF (and indirectly IDPoor) may enable access to MCH services for poor women and children that they would otherwise be unable to afford

- The simple analysis shows that the use of MCH services among HEF supported patients has steadily risen between 2014 and 2017
- Increases in MCH service utilisation amongst HEF users occurred in a context of decreasing poverty

Further initiatives that have contributed to improvements in maternal and child health

- Supply-side (e.g. government delivery incentive scheme) and demand-side financing mechanisms (e.g. reproductive health vouchers)
- Increasing number of health facilities throughout the country and increasing availability and competency of midwives
- Implementation of behavior change interventions that increased awareness and demand at community level

Lessons Learnt

1. IDPoor data is used by (non-) governmental programmes to support poor mothers and children

2. A common target group and shared data can catalyse collaboration across sectors (health, nutrition, education…) to improve the wellbeing of poor people

3. IDPoor's role in facilitating access healthcare service for people must be evaluated using a system lens, considering the wide range of data users

4. IDPoor's data are intentionally easy to access, but with the drawback that IDPoor does not retain full information about who is using its data, and for providing which services where

5. Further efforts are on the way to make IDPoor fit for becoming an integrated information system for social assistance

Thank you for your attention!

Coping with the costs of care seeking
Distress financing in Cambodia

Por Ir, **Bart Jacobs,** Augustine Asante, Srean Chhim, Virginia Wiseman

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P4H SOCIAL HEALTH PROTECTION NETWORK

Measuring financial hardship concerning out-of-pocket expenses for health

- **Capacity-to-pay (CTP):** disposable income
- **Catastrophic health expenses**: OOPE> 40% of CTP
- **Impoverishment**: CTP < poverty line after OOPE

- **Distress financing**: borrowing with interest for OOPE

Why does it matter

- High interest rates, especially amongst poor people
  - 2.5% per month equals 30% per year
  - 10% per months equals 120%
- Need to take loan to service interest previous loan

What else?

Negative impact health

- USA: high stress, depression, low self-rated health
- Stress: metabolic and cardiovascular diseases

  health-related behaviours: diet, physical activity, substance abuse

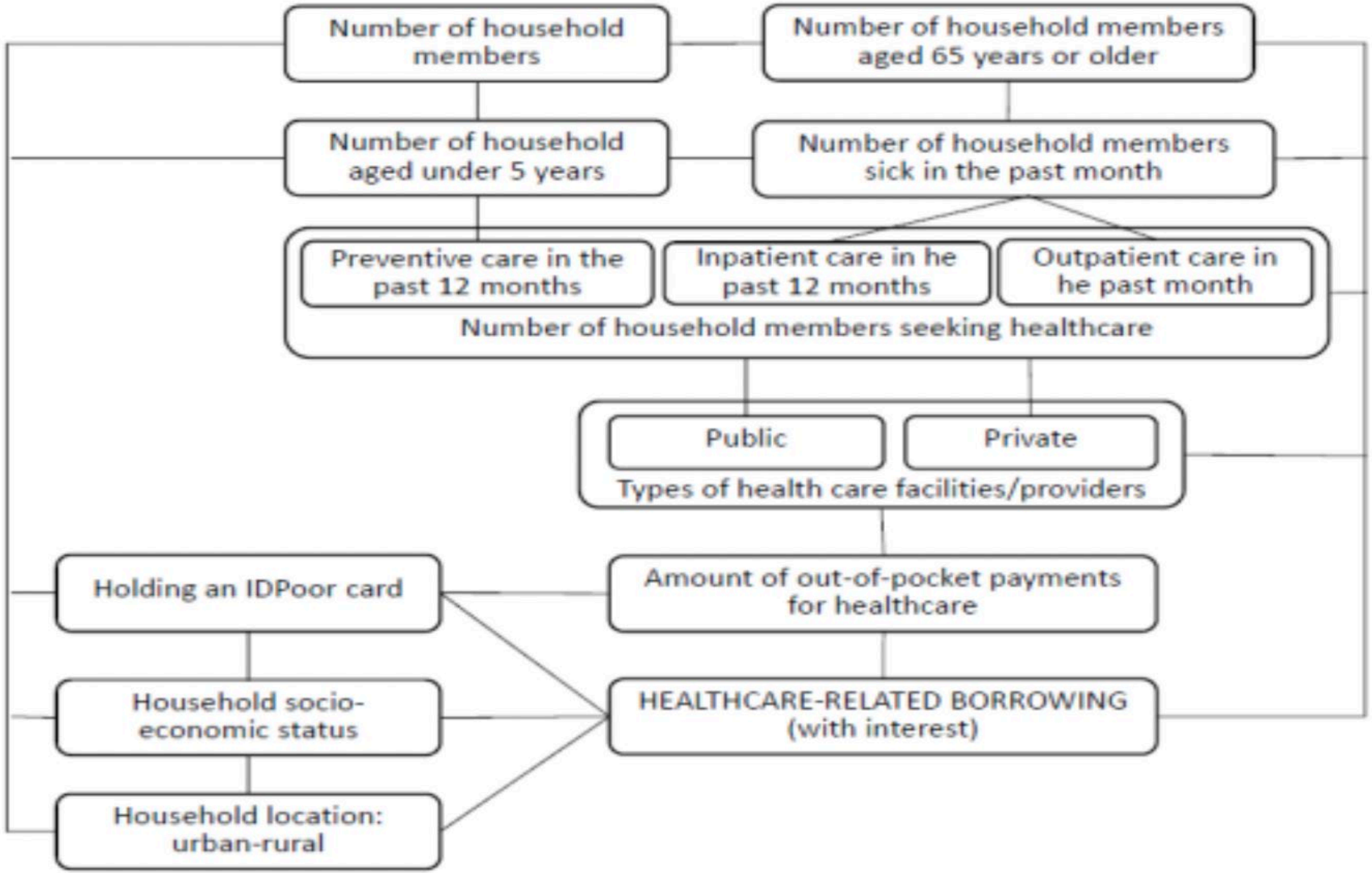
Cambodian situation

- **2014 CSES**
  - average interest rate 2.6% per month or 31.2% per year

- **2014 DHS**
  - 11% of people with an illness borrowed
  - 2.4% of people with OOPE <= US$1
  - 28% if OOPE => US$100

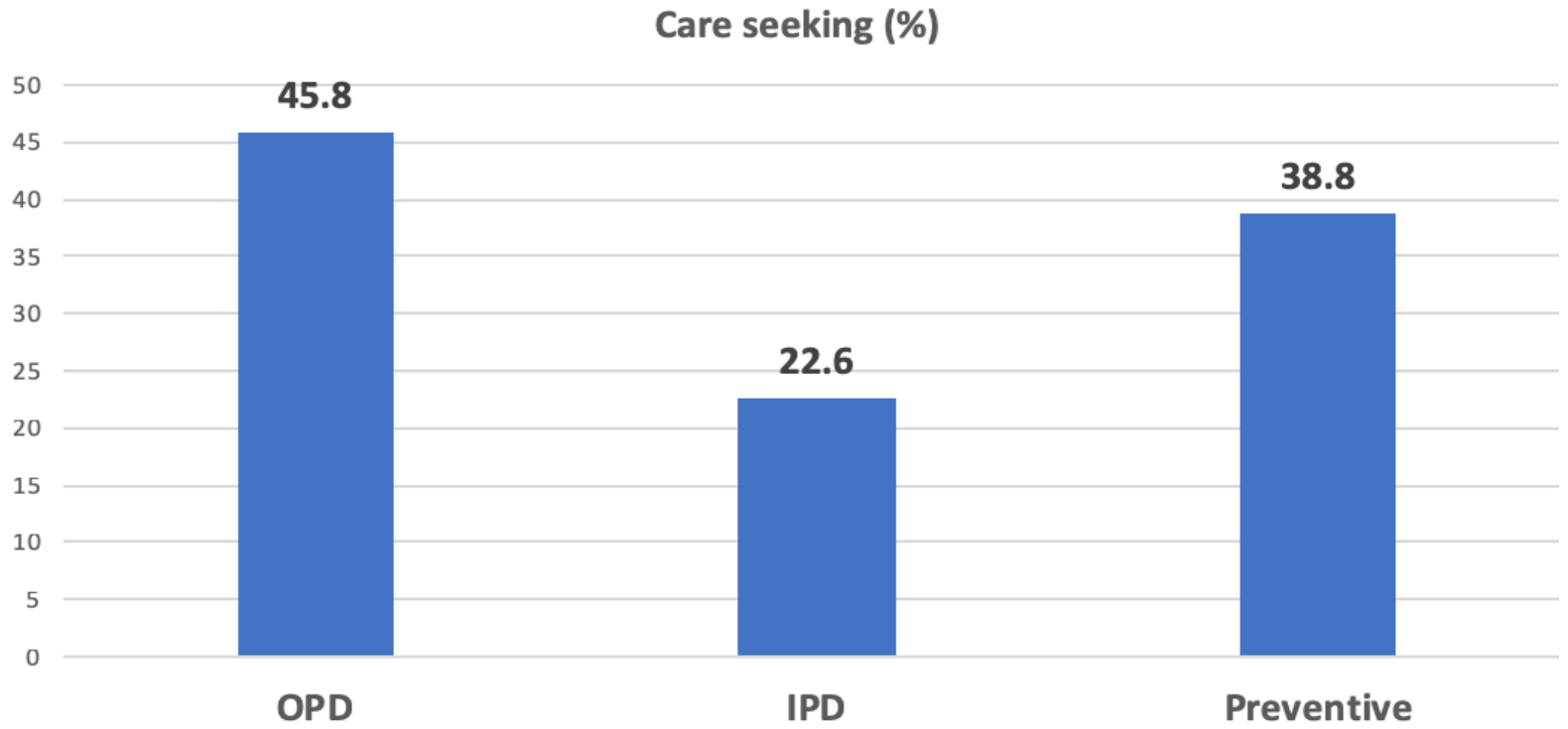
The study

- national cross-sectional survey of 5,000 HH (24,739 members) in 2016
- 80% rural, 20% urban
- Lumpsum OOPE comprised payment for healthcare by all HH members in past year, including
  - service fees
  - medicines
  - informal payment
  - laboratory tests
  - room fee
  - food
  - accommodation
  - traveling

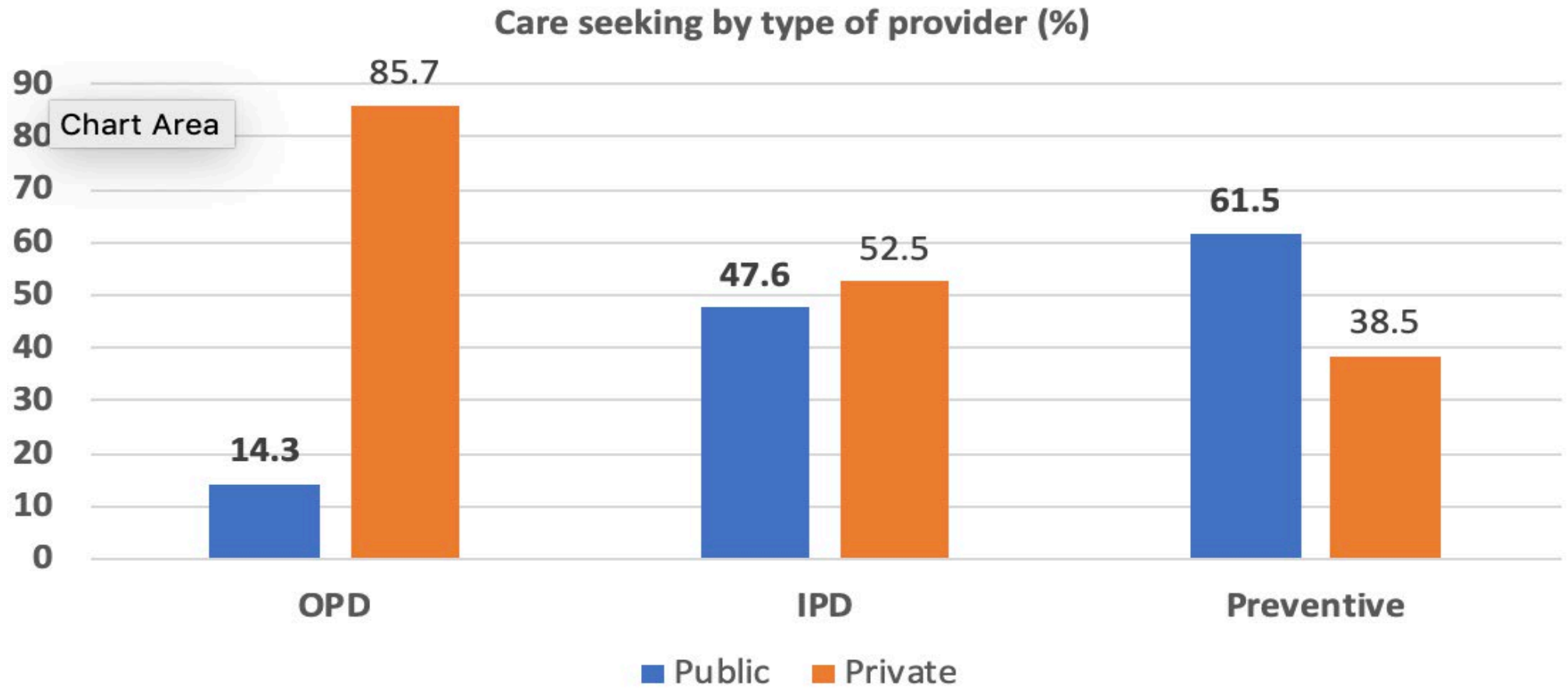

Number of household members
Number of household members aged 65 years or older
Number of household aged under 5 years
Number of household members sick in the past month
Preventive care in the past 12 months
Inpatient care in he past 12 months
Outpatient care in he past month
Number of household members seeking healthcare
Public
Private
Types of health care facilities/providers
Holding an IDPoor card
Amount of out-of-pocket payments for healthcare
Household socio-economic status
HEALTHCARE-RELATED BORROWING (with interest)
Household location: urban-rural

Results

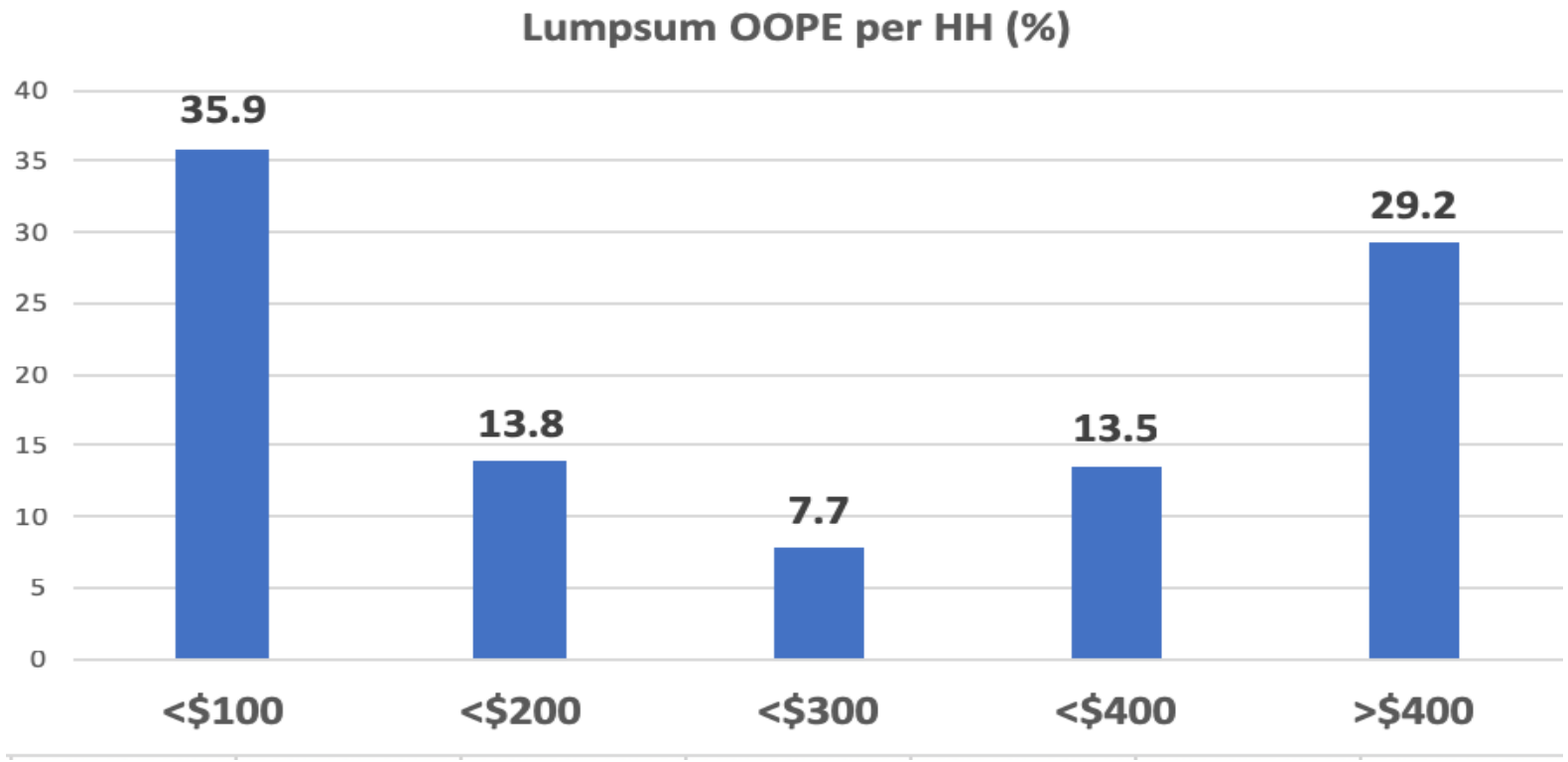
Of the 5,000 HH → 4,996 at least one incidence of healthcare utilization (OPD/30 days; IPD/1 year, preventive/1 year)



Results (2) Care seeking



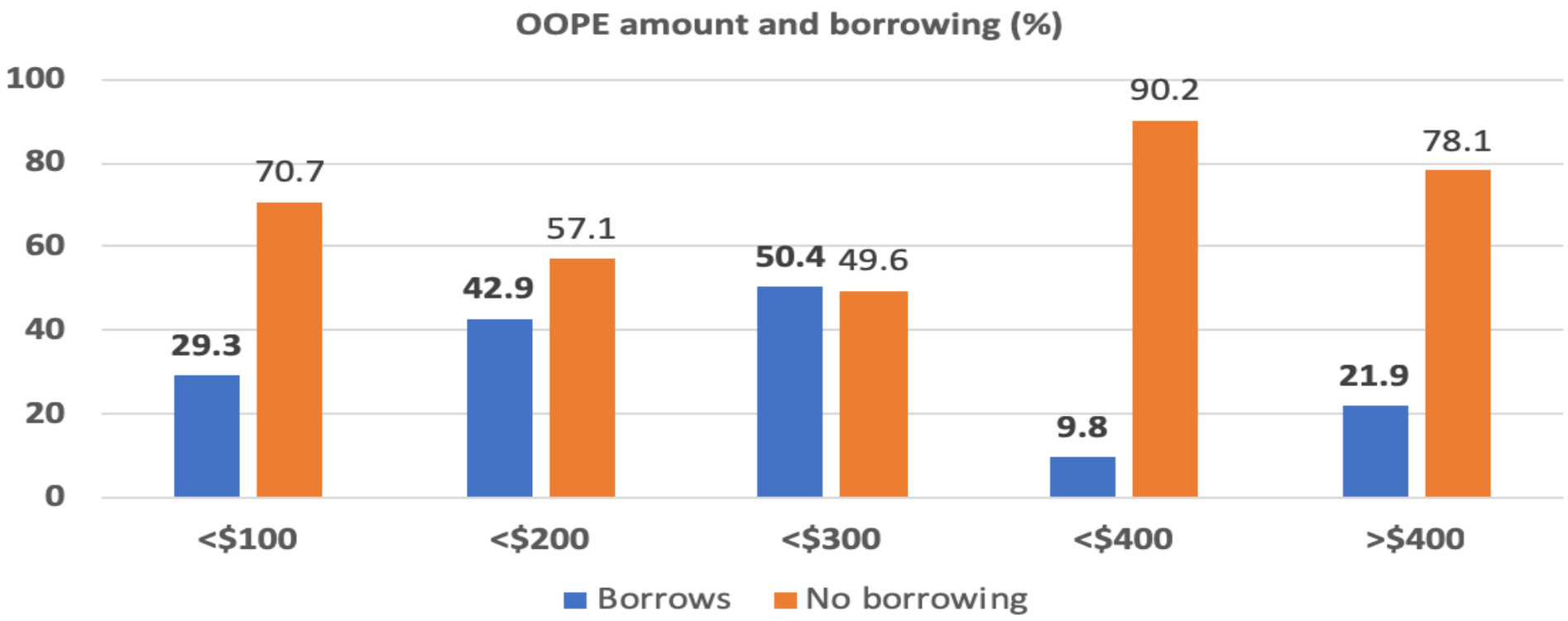
Results (3) Lumpsum OOPE per HH



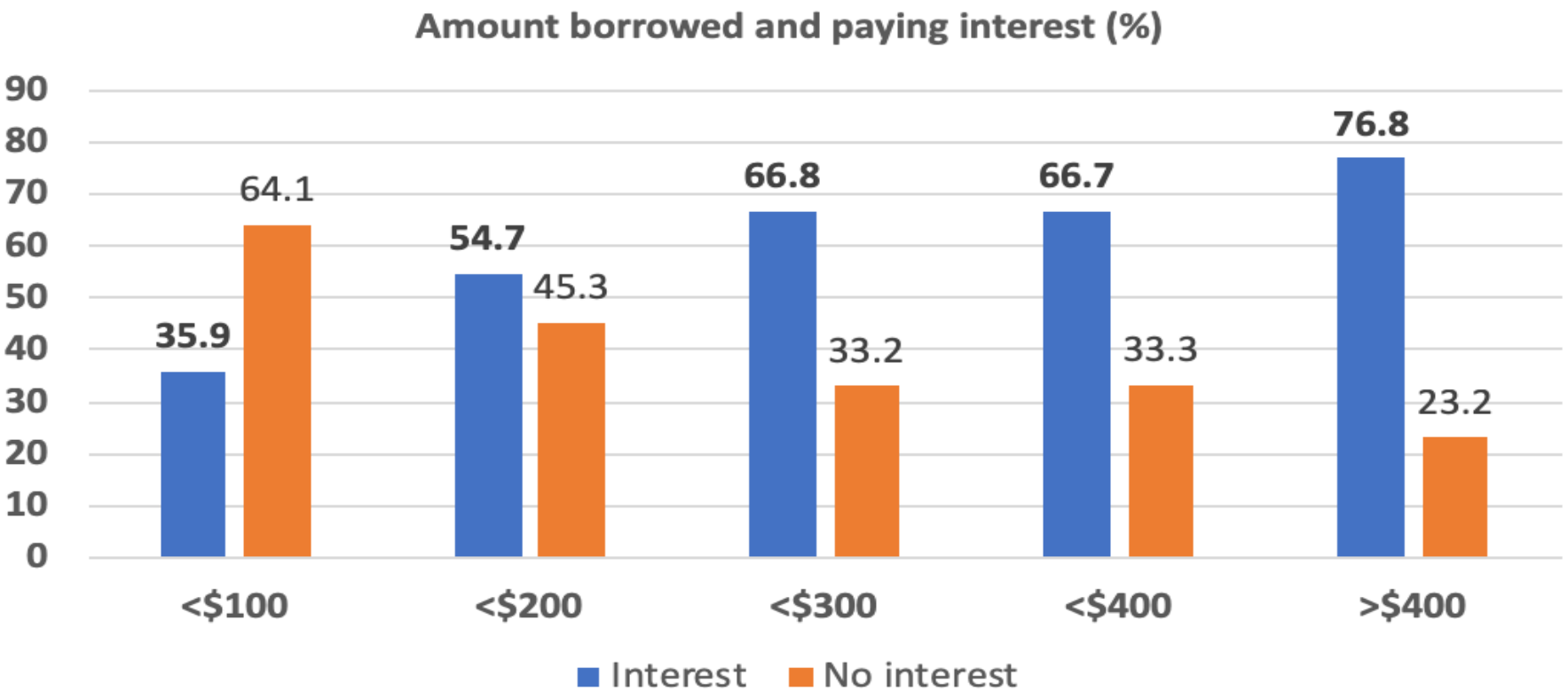
Results (4) Borrowing practices

- **28.1% borrows**
  - 15.4% with interest (median US$200)
  - 12.7% without interest (median US$75)
  - 5.6% still paying loan > 12 months

Results (5) Borrowing or not



Results (6) Amount and interest



Determinants distress financing

- household socio-economic status
- household size
- number of members aged 65 years or older
- number of members seeking outpatient consultation
- number of members seeking inpatient care
- type of health facility for outpatient consultation

Determinants distress financing (2)

- Socioeconomic status: Q1st (**6.1x**); Q2nd (**4.4x**); Q3rd (**3.4x**); Q4th (**3x**) than Q5th
- HH => 5 members **1.4x** than HH < 5 members
- HH => 3 members seeking OPD **1.5x** than those not
- HH with 2 and 3 members seeking IPD **11.6x** and **16x** times than those not
- OPD private providers/facilities only (**2.2x**) than public only
- OPD both private and public providers/facilities (**3.5x**) than public only
- HEF not protective
- Preventive services no hardship financing

Conclusion

- Poverty is a strong determinant of distress financing –the poorer the more likely to borrow
- Health equity funds cannot prevent distress financing
- [a] Household size, [b] IPD, and [c] OPD at private providers determine the risk of borrowing
- To ensure effective financial risk protection prioritize [a] poor and/or [b] large households, [c] inpatient care and [d] care seeking at private providers

Thank You

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P4H SOCIAL HEALTH PROTECTION NETWORK

China’s health reform at a glance

Qiao Jianrong

07 Dec 2018, Cambodia

World Health Organization

Huge Economic and Infrastructure Development

World Health Organization

Huge Human Capital Development

source: Sina

World Health Organization

Content

- Part 1. Health Status
- Part 2. Health in government and national development plans
- Part 3. Health care system and health care reform
- Part 4. Case sharing - health financing reform and medical insurances in China

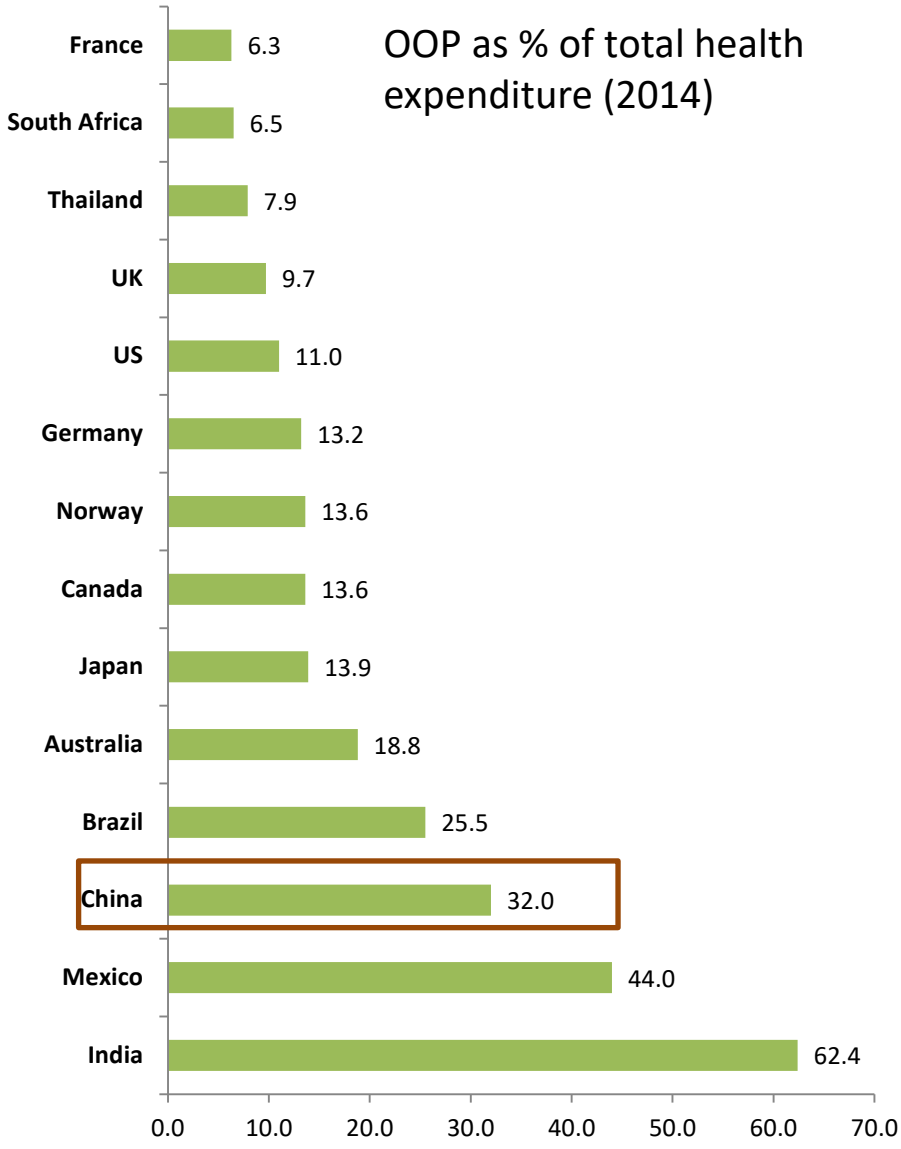
Part 1

HEALTH STATUS

Country Profile (as of 2016)

SOCIO-ECONOMIC		HEALTH EXPENDITURE			NCD BURDEN	
Population (1000)	GDP per capita in current USD	THE (billion, USD)	Health expenditure per capita (USD)	THE as (%) of GDP	Cardiovascular diseases mortality rate per 100 000	Diabetes mortality rate per 100 000
1 382 710	**7 972**	**648.36**	**494.9**	**6.23**	**300**	**15**

HEALTH WORKFORCE	ACCESS AND USE	HEALTH OUTCOMES			COVERAGE	
Physician, nurses and midwives density per 1000 population*	Average length of stay (ALOS)*	Life expectancy at birth (years)	Under-five mortality rate (‰)	Maternal mortality rate per 100 000 live births	Births attended by skilled health personnel (%)	DTP3 Immunization coverage among 1 year olds (%)
5.96	**10.0**	**76.34**	**10.2**	**19.9**	**99.9**	**99**



Country Profile

Declining Communicable Disease (mostly)

- 84% reduction in mortality rate of people with TB (1990-2013); Estimated TB incidence in 2015 down to 67 per 100 000 population
- 95.5% of population with access to improved water source in 2015
- 90 million people with Hepatitis B and 28 million in need of treatment

Increasing NCDs

- Over 80% of deaths are caused by NCDs.
- 3 million premature deaths every year
- 28% of adults smoke – that is 315 million people
- 4 in 5 adolescents don't get enough physical activity
- Poor air quality – 1 million deaths per year in China

Aging, urbanization and migration

- 2020: 250 million senior citizens (17% of total pop)
- 2035: 487 million (35% of total pop)
- 54% of China's population lives in cities (760 million people)
- Over 250 million migrant population
- "Two-child" policy introduced in 2015

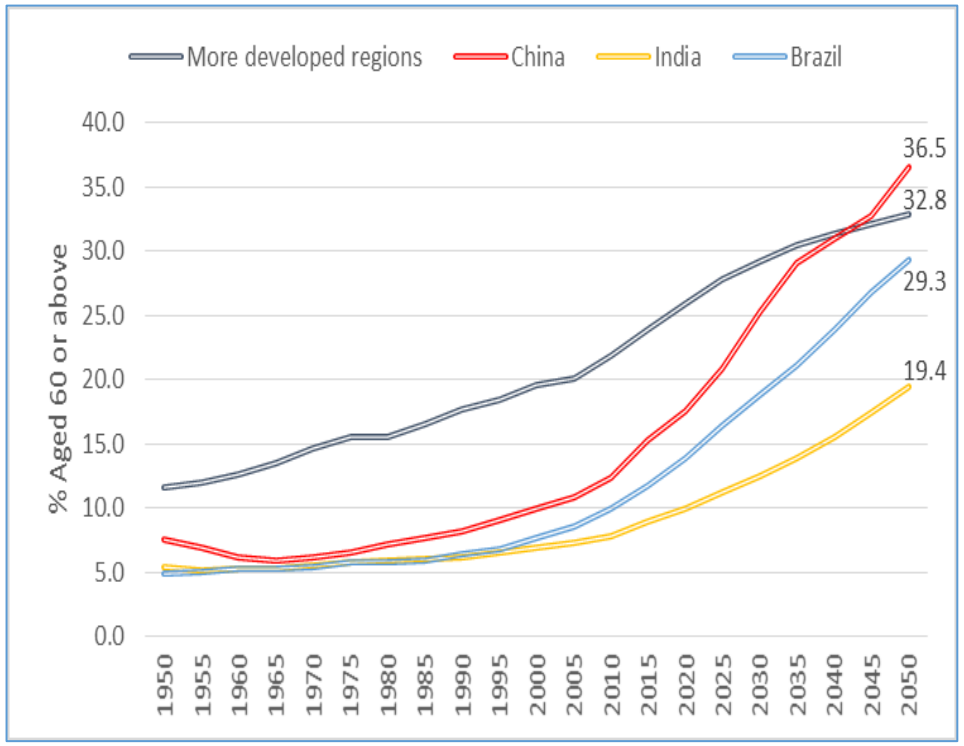
Increasing Non-communicable Diseases (lifestyle related)

Source: China Daily Shot by: Gao Hetao

- Over 80% of deaths are caused by NCDs.
- 3 million premature deaths every year
- 28% of adults smoke – that is 315 million people
- 4 in 5 adolescents don't get enough physical activity

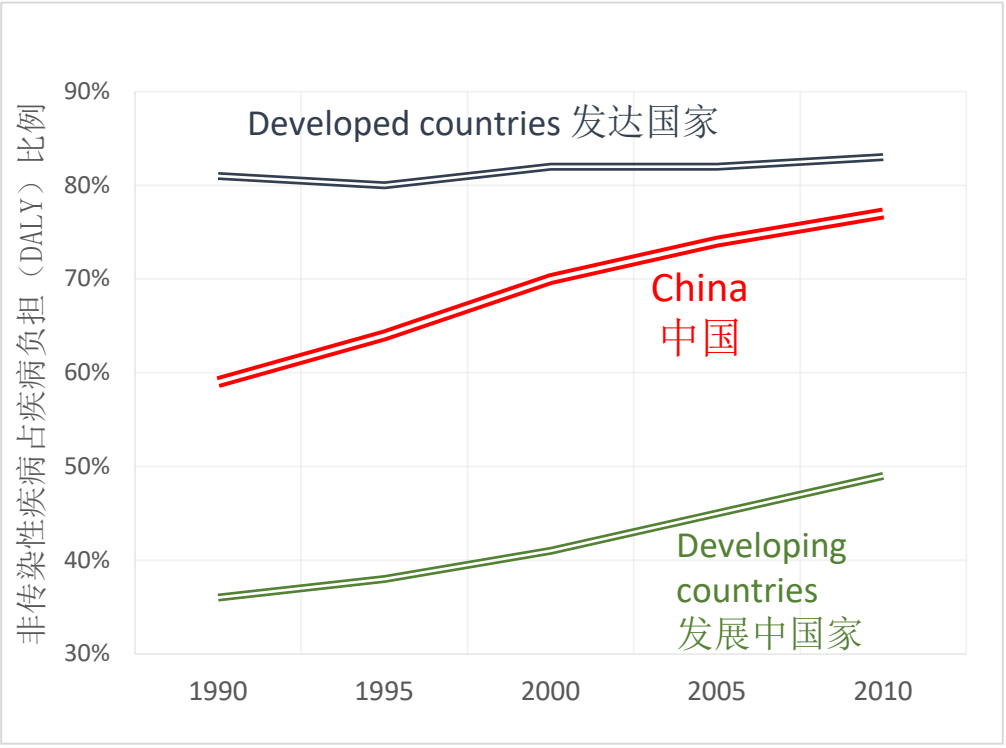
Changing Health Needs: Ageing and Non-communicable Diseases

Share of elderly in China will rapidly catch up with developed countries



Source: Population Division of the Department of Economic and Social Affairs of the United Nations World Population Prospects: The 2012 Revision.

China's Burden of Disease is increasingly from chronic conditions



Source: Global Burden of Disease, Institute for Health Metrics and Evaluation. Country group follows the WHO criteria.

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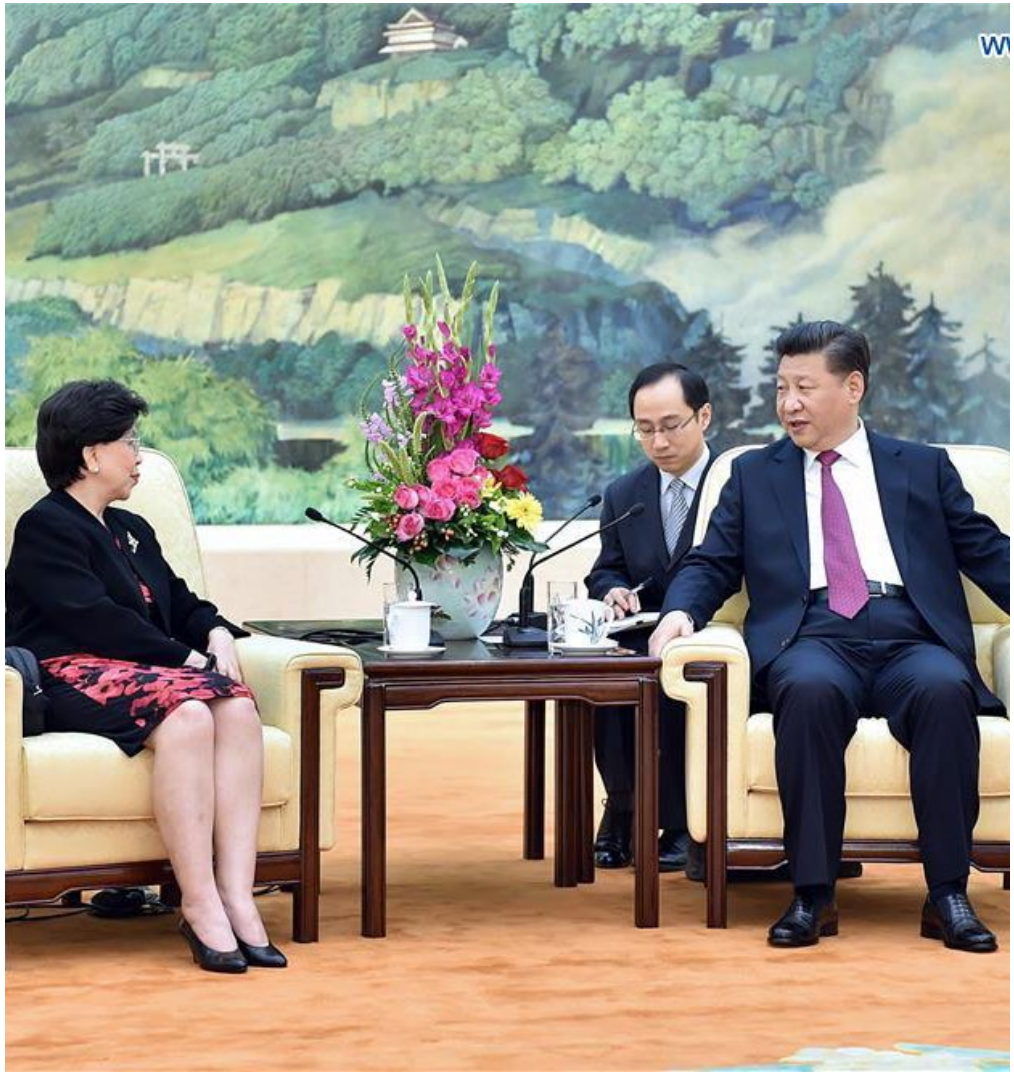
Part 2

HEALTH IN GOVERNMENT AND NATIONAL DEVELOPMENT PLANS

Political Commitment on Health is High



"Health is a precondition for economic and social development"

President Xi Jinping,
19 August 2016,
National Health Conference

World Health Organization

Outline of the Healthy China 2030 Plan

Co-drafted by over 20 government departments. The first medium and long term strategic plan in the health sector developed at national level since the founding of China in 1949.

Strategic targets

Maintain health indicators equal to the levels of high-income countries by 2030:

- Continuously improved health of the people - **an average life expectancy of 79.0 years in 2030**
- Major health risk factors under effective control
- Increased healthcare service delivery capacity
- Significantly expanded healthcare industry
- A well-developed health promotion system

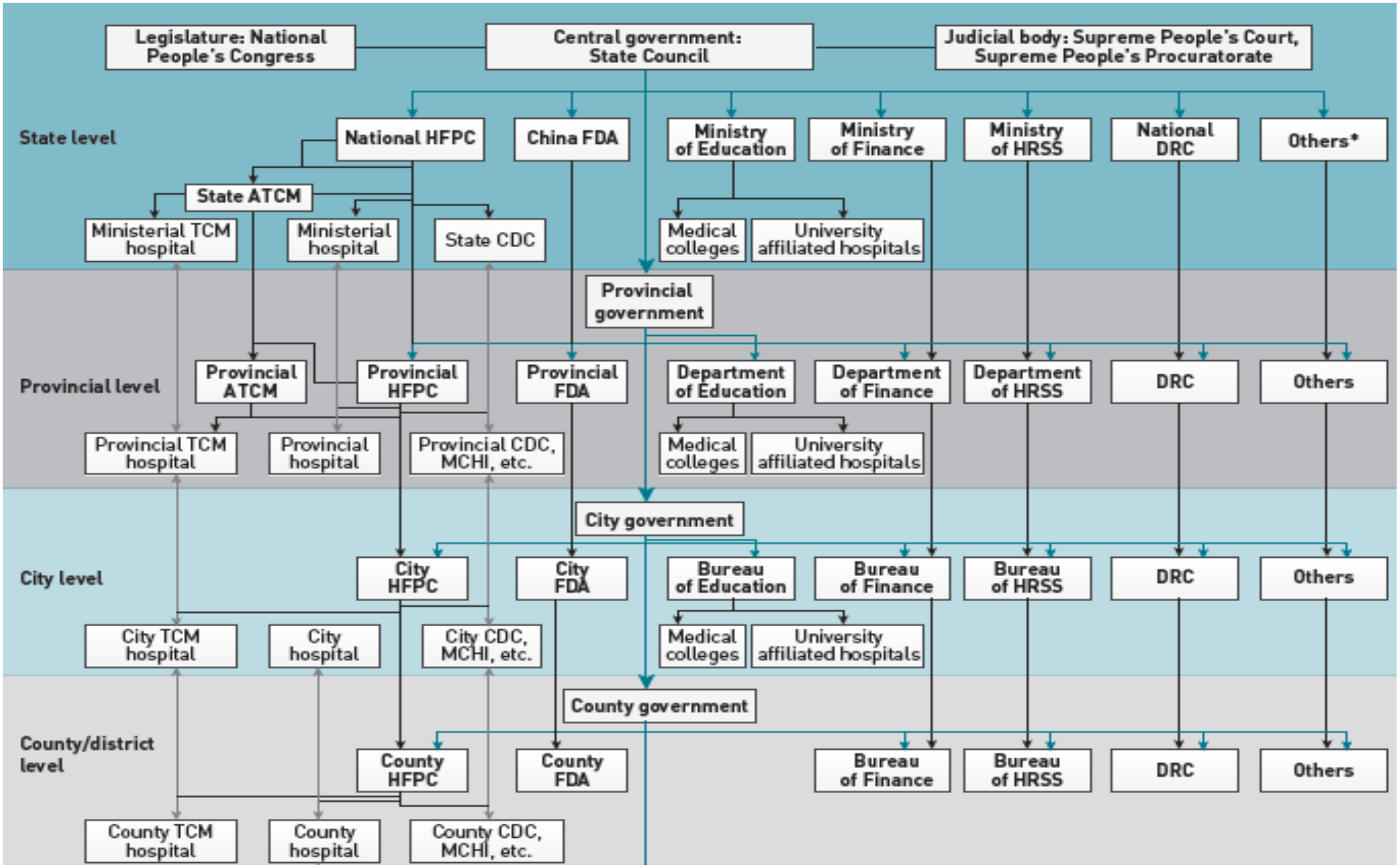
Key content

- **Healthy living for all**
  - Health education, healthy habits, physical fitness
- **Optimizing healthcare services**
  - Universal access, quality and efficiency, TCM, care to priority populations
- **Improving health security**
  - Health insurance coverage, drug supply security
- **Building a healthy environment**
  - Patriotic public health campaign, management of environmental factors, food and drug safety, public safety systems
- **Developing healthcare industry**
  - Pluralistic structure of health services, innovation, fitness, leisure, sports and medical industry

Part 3

HEALTH SYSTEM AND HEALTH REFORM

Organization of Chinese Health System



WHO. People's Republic of China health system review [Health Systems in Transition. Vol. 5 No. 7 2015]

2009: Major Health Reforms Launched

Five Pillars to Reform:

1. Increase health insurance
2. Strengthen primary health care
3. Improve medicine system
4. Equalise public health services
5. Begin public hospital reform

Health reform progress since 2009

The Progress

- Average life expectancy increases by 1.51 year in 2015 (76.34 yrs) compared to 2010
- Lowest % of OOP accounting for total health expenditure in recent 20 years (28.8% in 2017)
- Universal health insurance system is basically in place, covering over 95% of the population.
- Massive investment has been placed to support the infrastructure development at primary care facilities.
- Basic public health service package are provided to public for free.

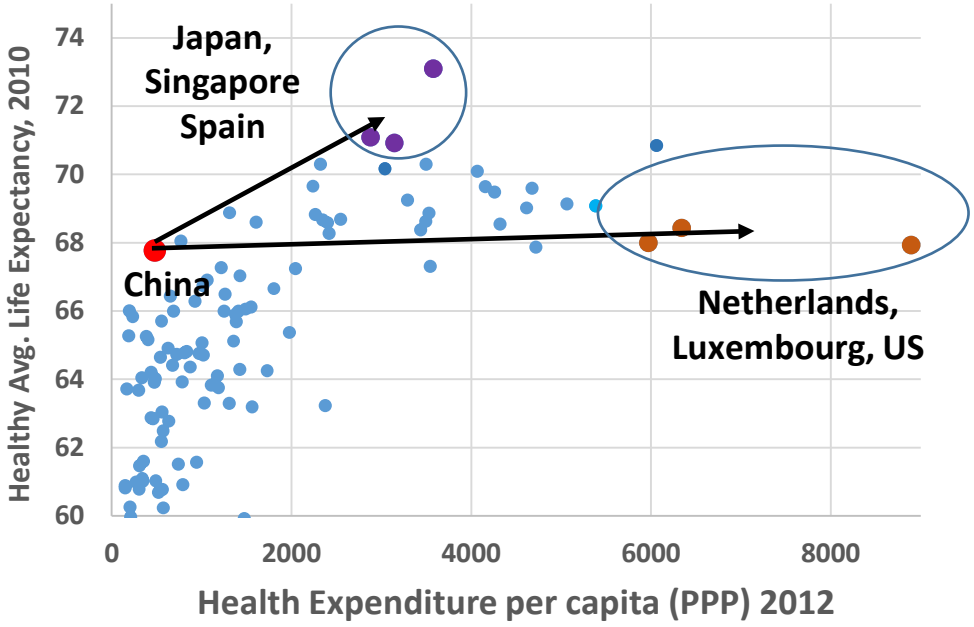
The Challenges

- Illness-related poverty– 40% of rural poor impoverished due to medical cost
- Insufficient primary care capacity – low quality, and 63% trained family doctors choose to work elsewhere
- Perverse incentives of public hospital financing – volume over quality
- Lack of coordination over drug policies - increasing concerns over Quality, Pricing, Supply, Access and Rational Use.
- Selective implementation at local level

China needs 21st century delivery system to address 21st century challenges

- Better health for the population
- Better quality and care experience for individuals and families
- With affordable costs for individuals and government

Two Paths to Better Health?



Source: World Bank, WHO Indicators

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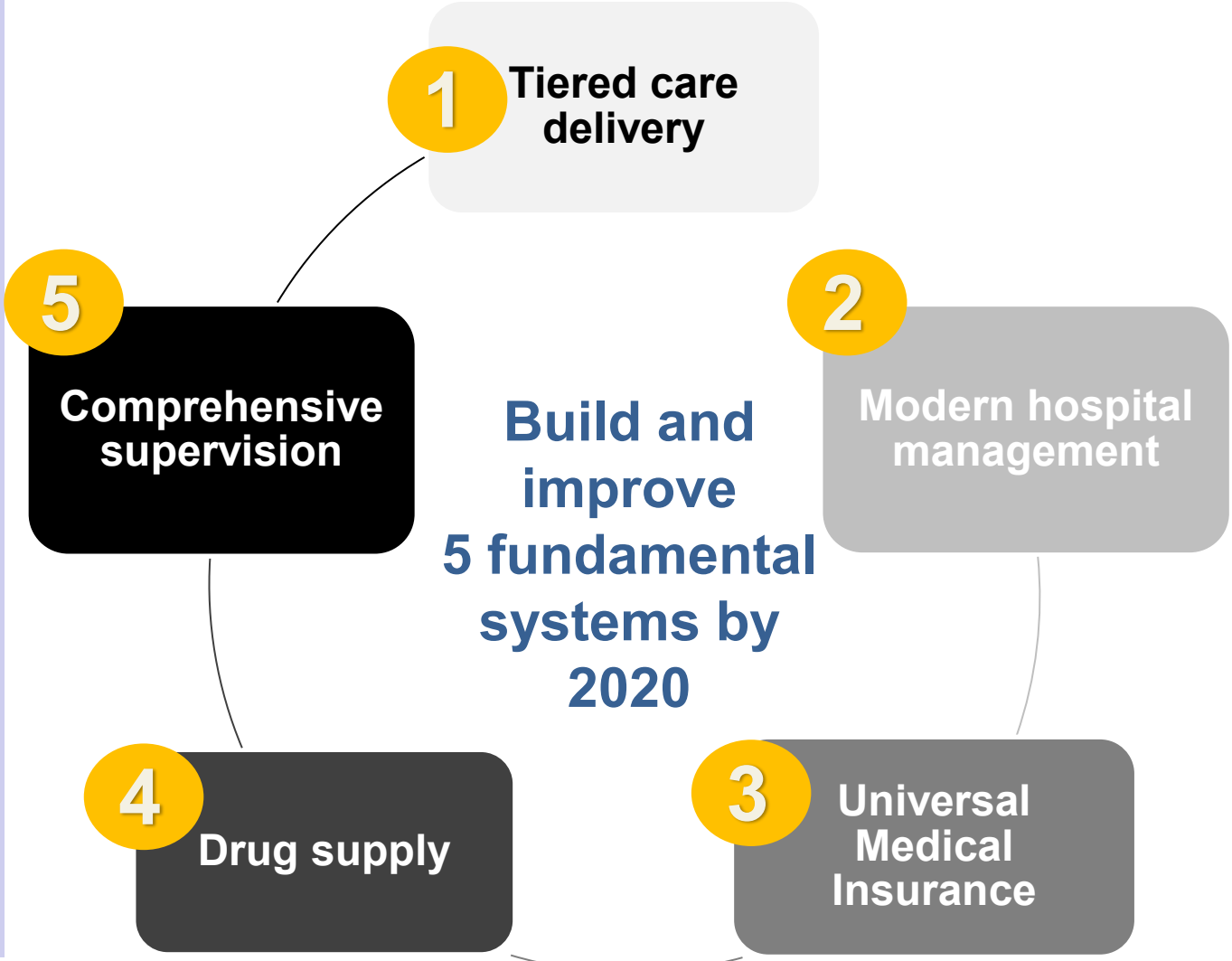
The 13th Five Year Plan on Health Reforms (2016-2020)

Key features

- People-centered, “contribute and share”
- Ensure basic health services and the public good nature of health service
- Combined Government-led and Market mechanisms
- **Coordinated reforms on medical care, medical insurance and medicine industry**
- Learn from successful pilots and promote to the nation



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Part 4

CASE SHARING - HEALTH FINANCING AND MEDICAL INSURANCES IN CHINA

The historical context of health system development in China

Planned economy period (1949-1978)

- Egalitarianism in income distribution and welfare provision
- Wide rural cooperative medical scheme coverage with low financial protection
- “Patriotic Health Campaign” to address major infectious diseases and public health issues

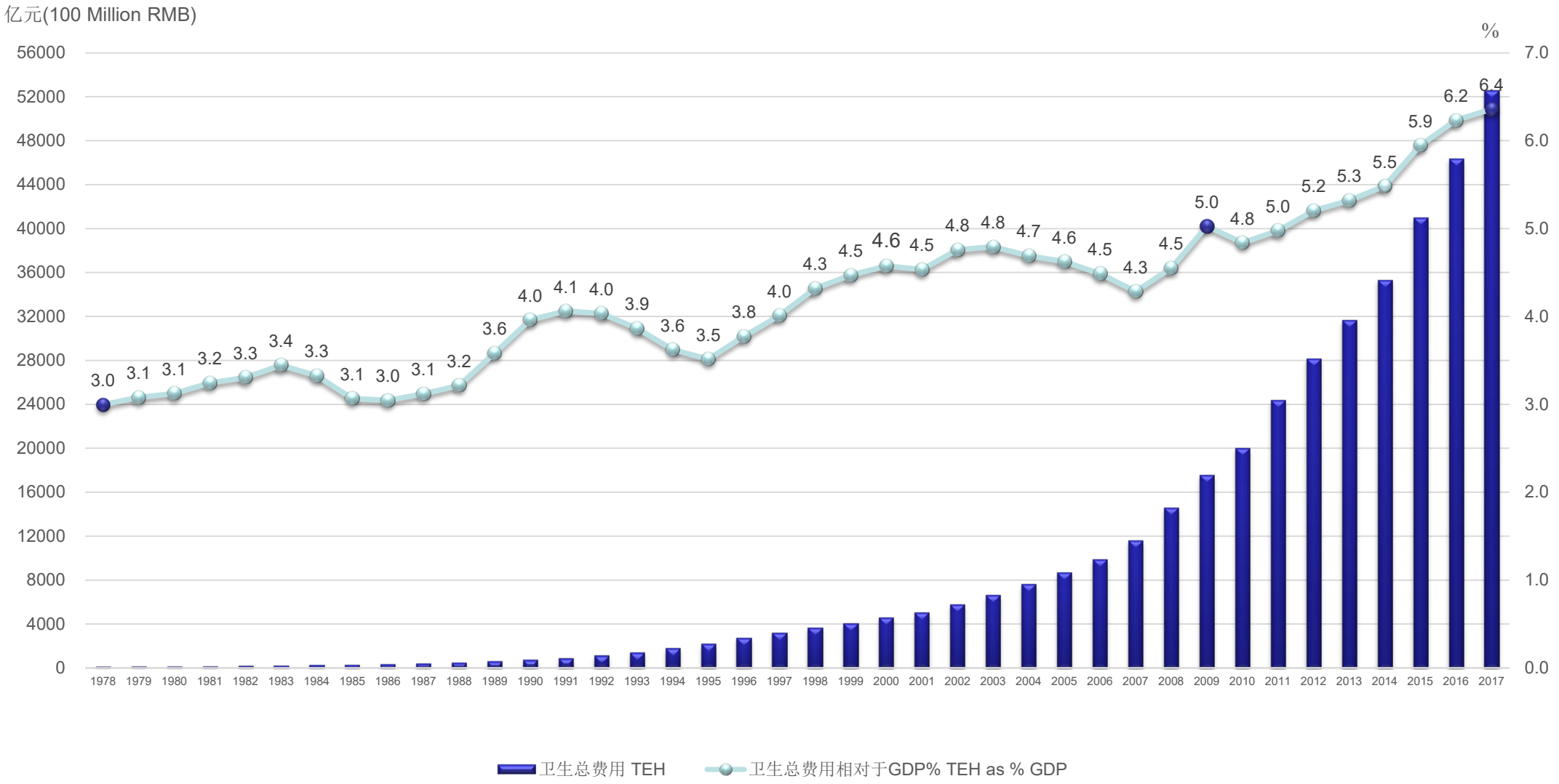
Initial stage of reform and opening (1979-2002)

- Financial system reform and market liberalization
- Health facilities became self-financed and profit-driven
- High OOP (60% of total health expenditure in 2001)
- Stagnation/decline of basic public health service provision

Deepening stage of reform and opening (2003- now)

- Reinvestment in public health and primary care after SARS in 2003
- Establishing the New Rural Cooperative Medical Scheme (NRCMS)
- Major health reform plan launched in 2009
- Healthy China 2030 outline launched in 2016

Health Expenditures grow since 1978 (annual rate 11.6%)



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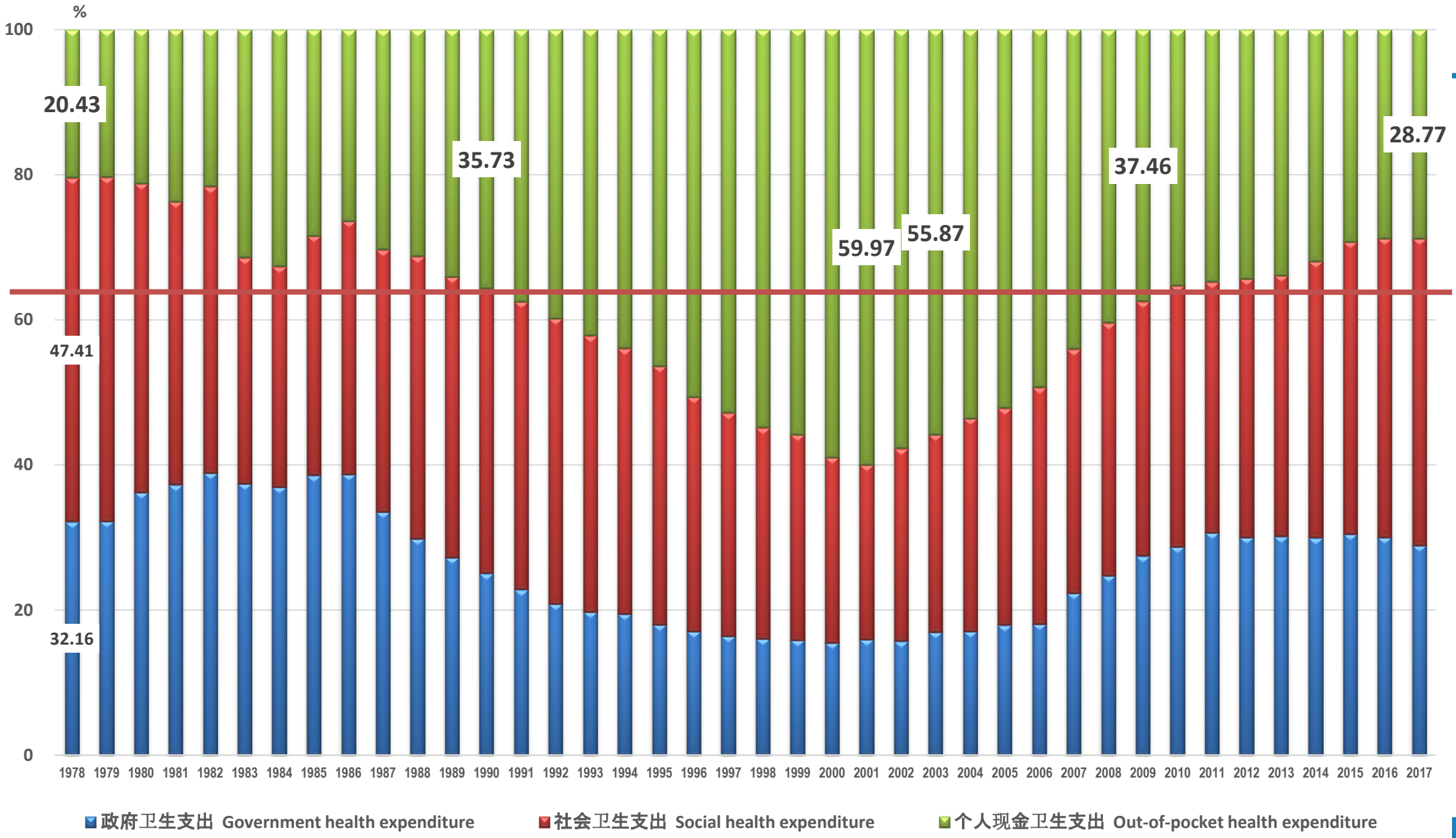
Structure of Total Health Expenditure in China (1978-2017)



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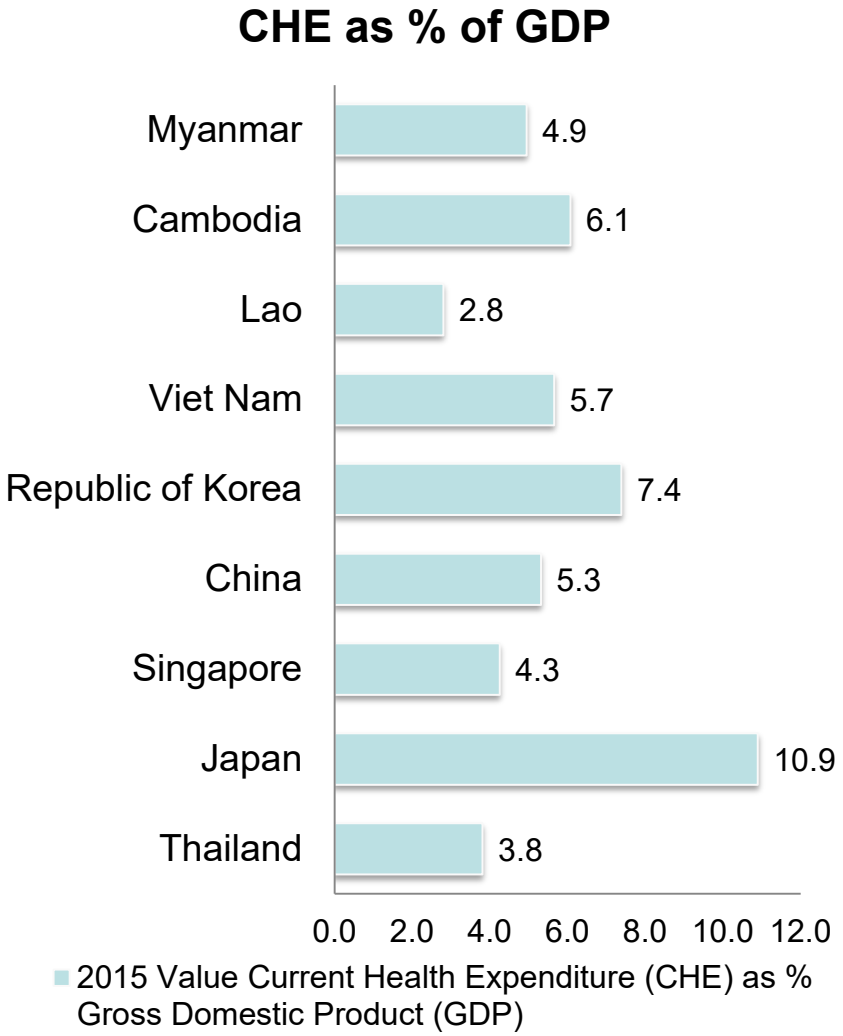
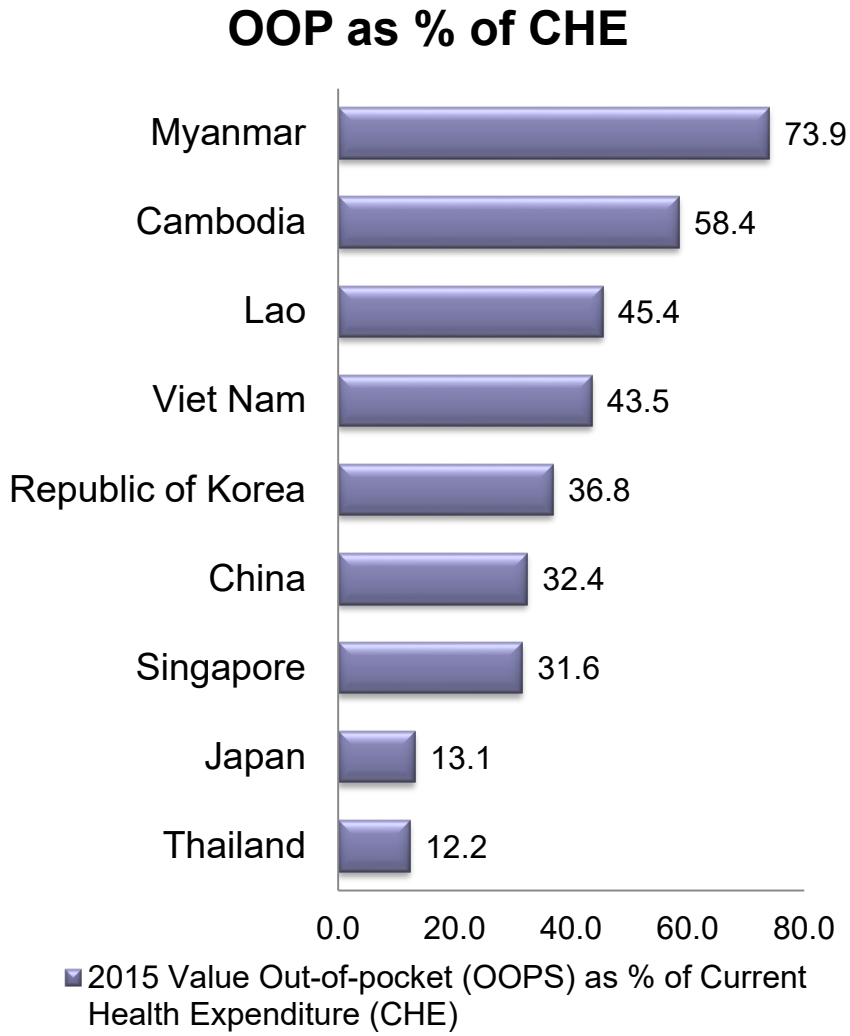
Comparing health expenditure data of selected countries in Asia





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The multi-layered medical insurance system in China

Commercial health insurance

Subsidy for civil servants (decreasing)

Supplementary insurance of enterprises

Critical illness insurance

Urban Employee Basic Medical Insurance (UEBMI) 1998

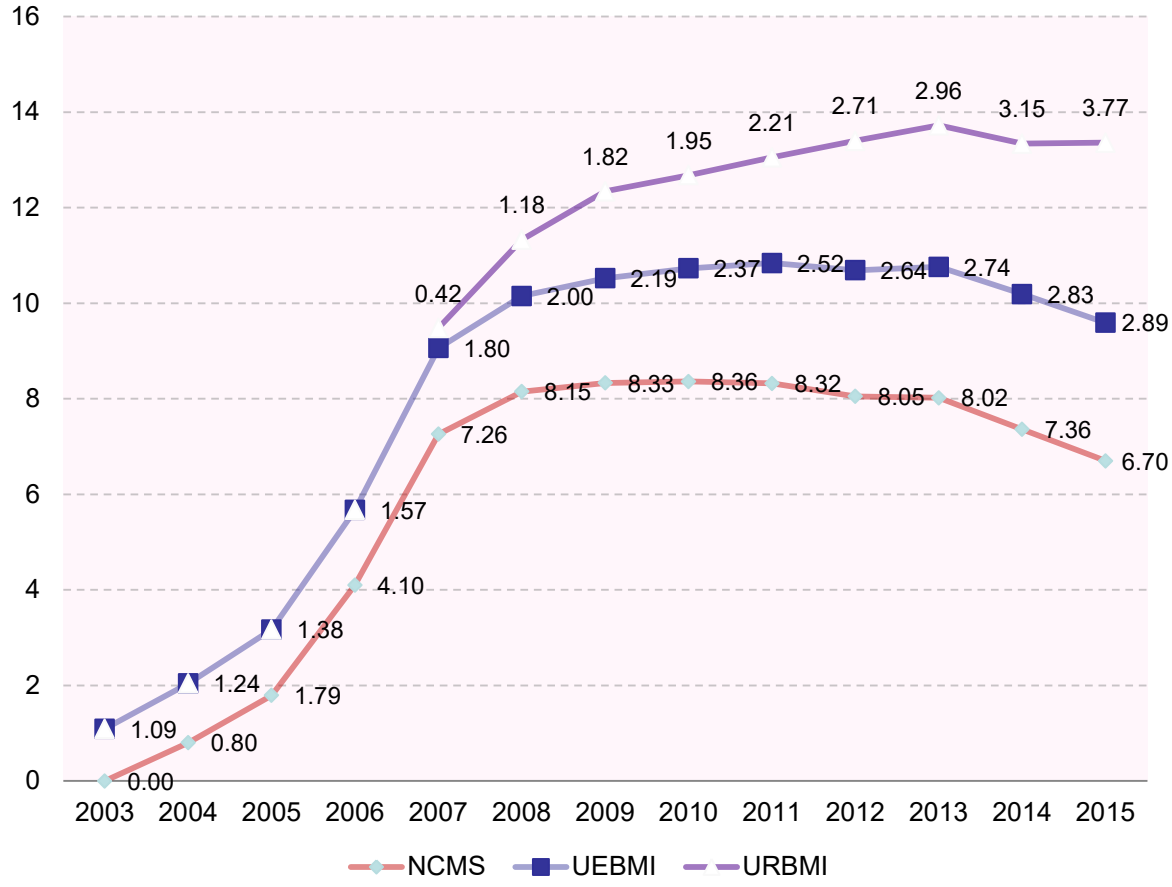
Urban Residents Basic Medical Insurance (URBMI) 2007

New Rural Cooperative Medical Scheme (NRCMS) 2003

Merging since 2016

Medical Assistance for the poor and emergency rescue

Population coverage by the three basic medical insurance schemes (100 million)



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Comparisons of the three basic medical insurance schemes (BMI) (2013)

	NCMS	URBMI	UEBMI
Inception year	2003	2007	1998
Eligible population	Rural, employed and non-employed	Urban, non-employed	Urban, employed
Number of people insured (millions)	802	296	274
Population coverage	98·7%	..	..
Source of funding	Government subsidy (80%) and individual premium (20%)	Government subsidy (70%) and individual premium (30%)	Contributory (8% of annual payroll, 6% from employers, and 2% from employees)
Per-capita fund (US$)	$61·2	$66·2	$424·7
Number of funding pools	2852 (counties)	333 (municipalities)	333 (municipalities)
Service package	Limited	Limited	Comprehensive
Annual admission to hospital rates	9·1%	7·1%	11·3%
Rate of physician visits for 2 weeks	12·5%	12·4%	13·4%
Number of drugs covered	800	2300	2300
Per-capita household consumption expenses ($)*	$1095	$2974	$2974
Proportion of health expenditures in total household consumption expenses*	9·3%	6·2%	6·2%

Data are from 2013 from the National Health Statistics Annual Report[18] and Xie and Zhang.[19] NCMS=new cooperative medical scheme. URBMI=urban resident-based basic medical insurance scheme. UEBMI=urban employee-based basic medical insurance scheme. *Household-based data, and URBMI and UEBMI data cannot be separated.

Benefit package and entitlement policies

- Central gov't defines benefit package and reimbursement policies, while local gov'ts have flexibilities to adjust the package according to local disease priorities and financial capacity.
  - E.g., central gov. first develops the national reimbursement drug list in 2000, including 1523 drugs. After three rounds of adjustment, the latest list contains more than 2500 drugs. Provincial gov'ts usually adding more drugs to the central list (within 15% flexibility space) to address local conditions.
- Benefit package include **medicines (positive list), diagnostics and medical services (positive list and/or negative list),** and is applicable to cover both **outpatient and inpatient** services, where **deductibles, copayment and ceilings** are set, varied by provinces/cities.
- Disparities in benefit package and entitlement policies also exist across 3 BMI schemes. In general, UEBMI enjoys better entitlements than URBMI and NRCMS (e.g., lower copayment and higher ceilings).
- With the increasing in financing, copayment rates for all 3 schemes have been gradually declined. As of now, average copayment rate has lowered to 50% in outpatient, and 25% in hospitalization within the policy scope. The actual copayment rate is higher when taking into account of deductibles and other OOPs outside of the reimbursement list.
- Differential copayment rates are set by levels of medical facilities with least copayment at primary care to guide patient flow.
- Portability remains big challenges due to low pool level. An interconnected reimbursement settlement platform is under development to ease the procedure of reimbursement claims of medical expenditure (for inpatient only) outside of the registered cities/provinces.

Medical Financial Assistance (MAF) Program

- MFA is run by Ministry of Civil Affairs, piloted since 2003, and launched in 2009 across the country.

Target population

- Households enrolling in the Minimum Living Standard Scheme (MLSS), a household-based cash aid program run by MOCA.
- Extremely poor residents (e.g., rural and urban residents with no income, labor capacity, or caregivers, or households defined as extremely poor the state).
- Low-income families not enrolled in the MLSS (LIF, identified by local government; the criterion is usually a monthly family income of between 100% and 120–150% of the local MLSS line).
- Persons who are identified by county government.

Benefit package

- Subvention for SHI enrolment. Target households are subsidized for their enrolment in SHI programs.
- Cash aid. Members of target households can apply for MFA cash aid from the county Bureau of Civil Affairs if their OOP exceeds the thresholds of the MFA. If they are enrolled in a SHI scheme, MFA cash aid is provided as a proportion of their OOP; if not, the MFA cash subsidy is provided as a proportion of their total medical expenditure

Funding source

- government budget
- lottery welfare fund
- society donations;
- County government normally sets up a special and independent MFA account within the SHI system, manages all funds uniformly, and takes full responsibility for its activities.

Case Sharing: Historical development of Cooperative Medical Schemes

	1955-1978 CMS	1979-1996 Collapse period	2003-present NRCMS
Fund collection	• Public welfare fund from agricultural cooperatives • Premium from enrollees • Revenue of village clinics	Only few areas still had traditional CMS, and some researches or pilots applied other kinds of health insurance in few areas, but in most areas of rural China, no any health security system.	• Subsidy from different levels of government • Premium from enrollees
Risk pooling	• Pooled at the village brigade level • In few cases, pooled at township level		• Pooled at county level
Benefit package	• Based on the fund level, firstly coverage preventive and outpatient services in village clinics; • Some areas partly covered referred hospital visits and referred hospitalization.		• NRCMS covers both outpatient and inpatient services in different level of health care facilities (with different reimbursement rates) • Catastrophic diseases are also partly covered.

Financing for NRCMS

- Financing source: subsidies from central and local gov’ts (majority), and household contributions (small portion)

Differentiation in gov’t funding strategies to address disparities across provinces

Year	Individual premium	Government contribution			Premium per capita
		central	local	total	
2003-2005	10	10	10	20	30
2006-2007	10	20	20	40	50
2008-2009	20	40	40	80	100
2010	30	60	60	120	150
2011	50	Western:124 Middle:108	Western:76 Middle:92	200	250
2012	60	Western:156 Middle:132	Western:84 Middle:108	240	300
2013	70	Western:188 Middle:156	Western:92 Middle:124	280	350
2014	90	Western:220 Middle:180	Western:100 Middle:140	320	410

Source: National NCMS policy,2003-2014.

The growth of NCMS premium from 2003-2014 by central gov, local gov and individual

Source: National NCMS policy, 2003-2014.

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Hospitalization reimbursement for NRCMS

- Deductibles were set according to the level of health care facilities and health expenditures (lower in primary care than in higher level hospitals)
- With the continued growth in financing, NRCMS's reimbursement ceiling has achieved 8 times rural residents' annual net income per capita in 2012, and was no less than 60,000 RMB.
- Copayment has decreased from 60-80% in the early stage to below 30% recently.

Deductible and ceiling for hospitalization in township hospital in Zhangqiu County, Shandong Province

Time period	Deductible (A)	Ceiling (B)	annual net income per capita (C)	A/C	B/C
Jul 2005-Jun 2007	1000	14000	5475	18.26%	2.56
Jul 2007-Jun 2008	1000	30000	7051	14.18%	4.25
Apr 2009-Mar 2011	700	35000	9190	7.62%	3.81
Apr 2011-Feb 2013	300	120000	11736	2.56%	10.22
Mar 2013-present	300	150000	15294	1.96%	9.81

Source: Zhangqiu NCMS policy, 2005-2013

Outpatient service reimbursement for NRCMS

- At early stage, outpatient services were reimbursed by using the household medical saving account with only 10-20 RMB per capita.
- Since 2008, more counties employed unified pooling funds to reimburse outpatient services. In 2012, the outpatient unified pooling funds were more than 50 RMB per capita.

Copayment and ceiling for outpatient services in village clinics in Zhangqiu County, Shandong Province

Time period	Copayment	Ceiling
Jul 2005-Jun 2007	85-90%	80
Jul 2006 - Jun 2007	70-80%	80
Jul 2007- Mar 2009	60-80%	80
Apr 2009- Feb 2013	65-75%	100
Mar 2013-present	60-70%	100

Source: Zhangqiu NCMS policy, 2005-2013

NRCMS has improved access to care and financial protection for rural residents

NRCMS coverage from 2004-2014

Year	No. of enrollees (100 million)	Average funding per capita (RMB)
2004	0.80	50.36
2005	1.79	42.09
2006	4.10	52.10
2007	7.26	58.95
2008	8.15	96.30
2009	8.33	113.40
2010	8.36	156.60
2011	8.32	246.21
2012	8.05	308.50
2013	8.02	370.59
2014	7.36	410.89

Rural residents' utilization of health care

year	Hospitalization rate (%)	Two-week clinical visit rate (%)	Two-week illness without clinical visit rate (%)
2013	9.0	12.8	16.9
2008	6.8	15.2	37.8
2003	3.4	13.9	45.8

Source: The 3rd NHSS in China (2003) , the 4th NHSS (2008), the 5th NHSS (2013),MOH

NRCMS actual reimbursement rate for hospitalization from 2004 to 2011

Source: China New Cooperative Scheme development report, 2002-2012, p81.

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Practical experience on expanding NRCMS schemes (I)

- Gov't playing a guiding role in the establishment of NCMS (financial and political incentives)
- Taking diverse measures to expand population coverage (unit of enrollment is households rather than individuals; door-to-door approach with sufficient communication)
- Ensuring enrollees' benefit as the key to maintain the attractiveness (gradually expand the benefit package and simplifying reimbursement procedures)
- Decentralization in scheme design to fit local conditions and piloting first

Practical experience on expanding NRCMS schemes (II)

- No perfect design at the beginning;
- Government funding is key to sustain the scheme though starting from very modest level of funding;
- Gaining the trust of local community on the scheme, through strong administrative support from local governments;
- An incremental approach on 1) benefit package; 2) population coverage; 3) innovation in special consideration for the poor through MFA scheme.

Case Sharing 2:
Equalization of public health services for all

The expansion of the basic public health package

Before 2009	2009	2011	2015	2017
Health records	Health records	Health records	Health records	Health records
Health education	Health education	Health education	Health education	Health education
Children's health	Children's health (0-3yrs)	Children's health (0-6yrs)	Children's health (0-6yrs)	Children's health (0-6yrs)
Maternal health	Maternal health	Maternal health	Maternal health	Maternal health
Vaccination	Vaccination	Vaccination	Vaccination	Vaccination
Infectious diseases and health emergencies	Infectious diseases and health emergencies	Infectious diseases and health emergencies	Infectious diseases and health emergencies	Infectious diseases and health emergencies
	Health for the elderly	Health for the elderly	Health for the elderly	Health for the elderly
	Hypertension	Hypertension	Hypertension	Hypertension
	Type 2 diabetes	Type 2 diabetes	Type 2 diabetes	Type 2 diabetes
	Severe mental illness	Severe mental illness	Severe mental illness	Severe mental illness
		Health Supervision	Health Supervision	Health Supervision
			TCM	TCM
			TB management	TB management
				Contraceptive service
				Health promotion

Funding for Public Health Services: earmarked and sustainable public funds

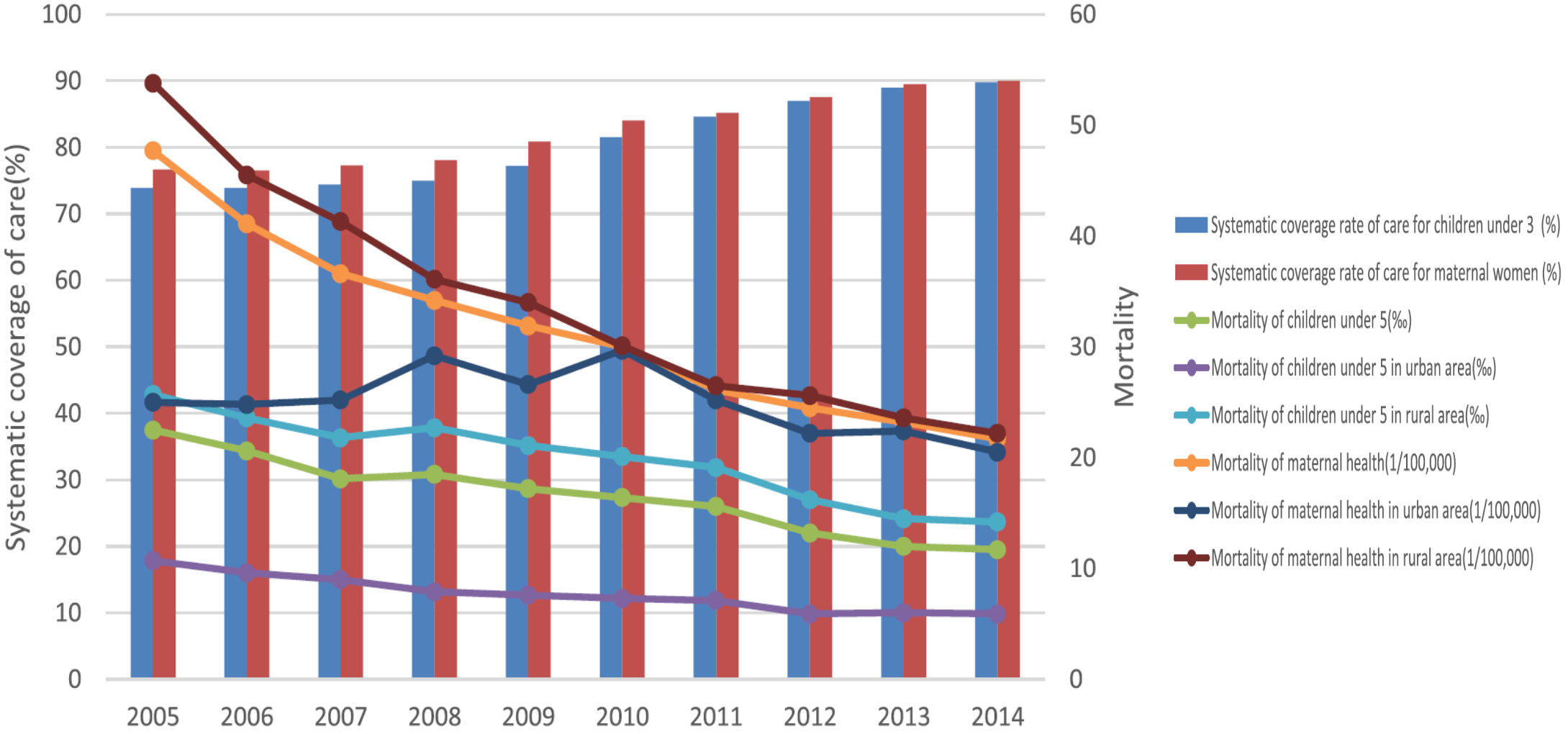
- Establishing a minimum funding level for basic public health service package with progressive gradual increases. Provincial gov’ts can increase the funding and services according to local capacity

Year	Minimum funding level
2009	15 RMB per capita
2013	30 RMB per capita
2015	40 RMB per capita
2018	55 RMB per capita

All levels of the gov’ts share responsibilities for funding, while central gov’t allocates more money to the less-developed regions by transfer payments.

- Public health funds are earmarked with unified accounting and strict allocation by capitation, to reduce payment delay or misappropriation.
- Pre-payment (e.g., 50%) in the beginning of fiscal year with subsequent top up according to performance.

Increased coverage rate and narrowed gap of health outcomes between urban and rural



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Implications for funding public health services

- Public health sector can develop stably and sustainably when the responsibility of government for financing is in place
- Earmarked funding and allocation by capitation can increase transparency of funding levels which can safeguard against the delay or diversion of funds
- It is essential to continuously expand public health service package as local conditions and fiscal capacity improve

From individual/family perspectives

- Urban

-health safety net in place: UEBMI(employees) enjoys better entitlements than URBMI (kids, unemployed), with on average of 72% actual reimbursement for hospitalization. actual reimbursement rate for URBMI is around 56% accordingly (data in 2016).

-good access to community health care, secondary and tertiary care

-core public health services free or nearly free at point of services

For urban poor, premium exemption and more subsidy to reduce co-payment

- Rural

-health safety net in place: NRCMS provides on average 50% actual reimbursement rate for hospitalization, comparing to 20% only in 2003

-good access to village, township and county level hospitals with much improved facilities and quality of services

-core public health services (EPI, medical check up, health records, institutional delivery etc) free or nearly free at point of services

For rural poor, premium exemption and more subsidy to reduce copayment

Ambitious government restructure to improve efficiency and accountability

Deputies to the 13th National People's Congress (NPC) listen to an institutional restructuring plan of the State Council at the fourth plenary meeting of the first session of the 13th NPC at the Great Hall of the People in Beijing on March 13, 2018. (Photo by Li Ge from People's Daily)

- One of the most ambitious government reshuffles since the "Chinese Economic Open Up" in 1978
- 15 ministries and commissions were shut down or merged
- 7 new ministries were created
- **The establishment of National Health Care Security Administration (NHCSA)**

Institutional arrangements before 2018

MOF

- Funding for public health
- Funding for NRCMS and URBMI

NDRC

- **Pricing** on medicines and medical services

MOCA

- Medical Assistance Programme

NHFPC

- **Public hospitals**
- **NRCMS (rural)**
- **Essential Drug List (EDL)**
- **Drug bidding and procurement**

MOHRSS

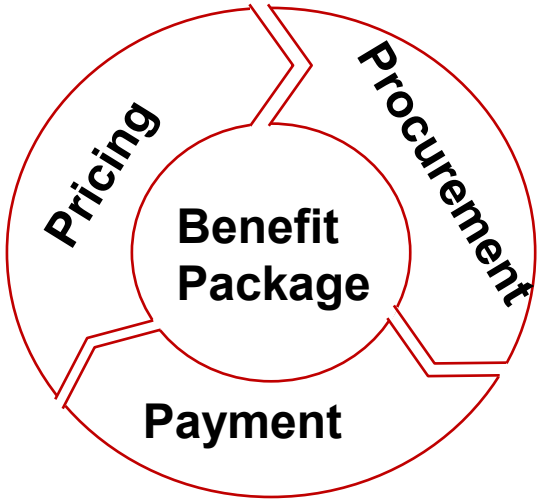
- **UEMBI and URBMI (urban)**
- **National Drug Reimbursement List (NRDL)**
- Catastrophic illness insurance

MOF: Ministry of Finance; NHFPC: National Health and Family Planning Commission
MOHRSS: Ministry of Human Resources and Social Security; NRDC: National Reform Development Commission
MOCA: Ministry of Civil Affairs

The establishment of National Health Care Security Administration (31 May 2018)

MOHRSS	UEBMI &URBMI &BP entitlements
NHC (NHFPC)	NRCMS & Procurement Policy
NDRC	Price Control on Drugs and Medical Service
MOCA	Medical Assistance Fund

NHCSA



- Designer of Benefit Package
- Price-setter and purchaser
- Practitioner of payment reforms
- Inspector of quality and cost

UEBMI: Urban employee basic medical insurance
URBMI: Urban resident basic medical insurance
NRCMS: New rural cooperation medical scheme

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Conclusions (I)

- Political commitment is key to put health at the heart of development. Not a linear process.
- An evolution, not a revolution. Different schemes for different population groups-no lose only gains and closing the gap over time.
- A mixer of tax financing and social health funding as the dominant source of funding to achieve UHC.

Conclusions II

- Policy choices made at 1998, 2003, 2009 for different political and technical reasons with flexibility and ability to adjust and correct along the implementation.
- Getting implementation right-governance and accountability are important, as shown in the recent institutional arrangements when ready to do so.
- Learning by doing, learning from others, learning from failures and success (enormous amount of research commissioned, consultations, and piloting approach)

A few reflections

- Social development is important as well as economic growth, and do invest in human development and health.
- Health reform never ends as population change their expectation and demands so there is no such a day that job is done, as shown in China.
- Based on the social and economic status, carefully examine your options and work out sequencing of the reform, encourage innovation, allow failures and learn from pilots.
- Comprehensive reform measures (which can be incremental but not piecemeal), is required to achieve Universal Health Coverage.

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Vietnam Health Financing for Universal Health Coverage

Cambodia UHC Forum
7 December 2018

Presented by: Nguyen Kim Phuong
WHO Vietnam Programme

Outline

- Health outcomes and financial protection
- Health sector reform process since 1990
- Key design features of SHI system and strategies to cover informal sector
- Challenges
- Dos and don't

Viet Nam

World Health Organization
Representative Office for Viet Nam

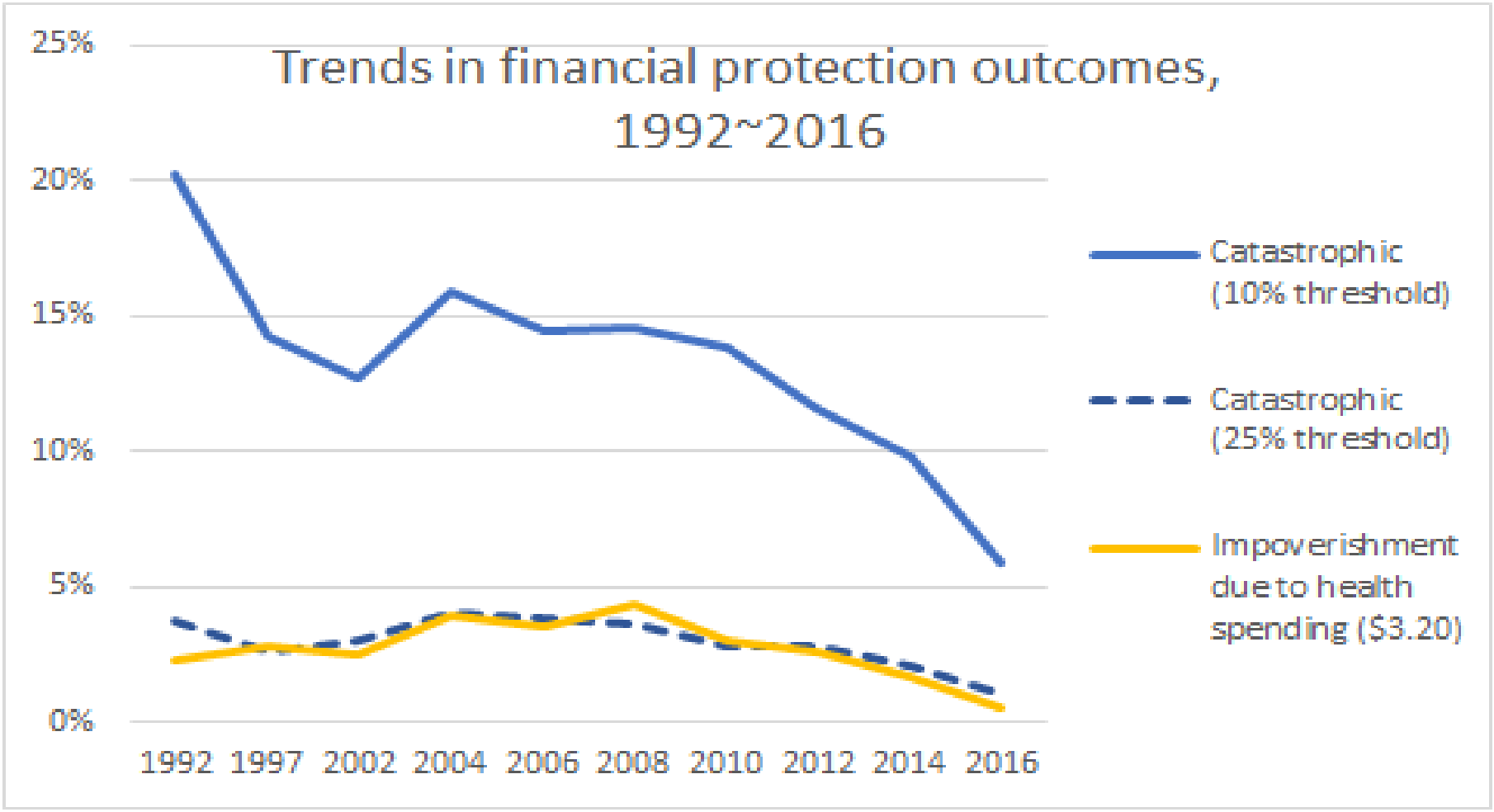
Key health outcome indicators

The basic health indicators of Viet Nam are better compared to other countries which have the same or higher GDP per capita

Country	Total population (millions) (2017)	GDP per capita (current USD) (2015)	THE %GDP (2015)	GGHE %GDP (2015)	OOP %THE (2015)	Skilled birth attendance* (%)	DPT3 coverage (%) (2017)	IMR (2017)	MMR** (2015)	Life expectancy at birth (years) (2016)
High income countries										
Australia	25	56,561	9.5	6.1	20	99.7	95	3	6	82.9
Japan	127	34,568	10.9	9.1	13	99.9	99	2	5	84.2
Germany	83	41,324	11.2	9.4	13	98.7	95	3	6	81.0
UK	66	44,306	9.9	7.9	15	N/A	94	4	9	81.4
Korea	51	27,105	7.4	4.2	37	100.0	98	3	11	82.7
Upper middle-income countries										
Malaysia	32	9,649	4.0	2.1	37	99.4	99	7	40	75.3
China	1386	8,069	5.3	3.2	32	99.9	99	8	27	76.4
Thailand	69	5,846	3.8	2.9	12	99.1	99	8	20	75.5
Lower middle-income countries										
Indonesia	264	3,335	3.4	1.3	48	92.6	79	21	126	69.3
Philippines	105	2,878	4.4	1.4	54	72.8	88	22	114	69.3
Vietnam	96	2,065	5.7	2.4	43	93.8	94	17	54	76.3
Lao PDR	7	2,159	2.8	1.0	45	40.1	85	49	197	65.8
Cambodia	16	1,163	6.0	1.3	59	89.0	93	25	161	69.4

Source: Worldbank and WHO Global health observatory

% of people suffering financial hardship due to OOP has fallen dramatically



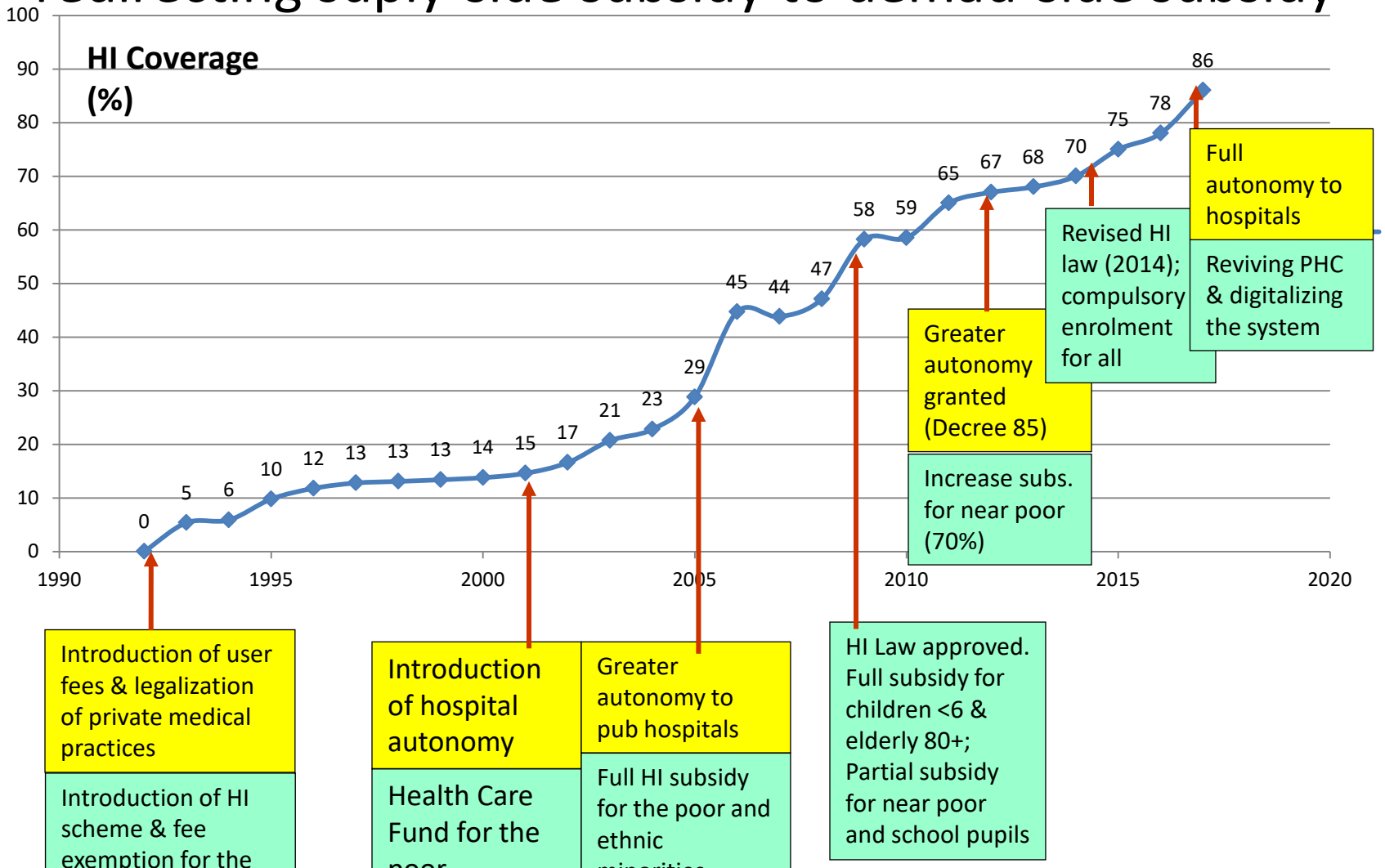
Source: WB VNM (HEFPI database and VHLSS 2016)

Health sector reform process (since post war)

1992	•Introduction of social health insurance (SHI) for gov employees and pensioners •Allowing for collection of user fees in public hospitals, with fee exemption for the poor •Legalization of private medical practice and pharmaceutical market
1995	User fee schedule issued for all public hospitals
2002	•**Compulsory SHI for formal sector** •Establishment of Health Care Fund for the Poor •Introduction of financial autonomy to central public hospitals (Decree 10) as conditions for performance improvement ("service dept"), and less reliance on gov budget subsidy
2005	•Health Care Fund for the Poor replaced by **full SHI subsidy for the poor & ethnic minorities** •Greater financial autonomy to the public hospitals (Decree 43): retained revenues
2008	**1st Health Insurance Law approved**; **subsidy extended to under 6 children, elderly 80+; partial subsidy for near poor and school children**; roadmap to universal health insurance coverage
2012	•Revised user fees schedule (fees increased) •Hospital autonomy fully implemented (Decree 85)
2014	**Health Insurance Law revised – compulsory SHI for informal sector with partial subsidy (30%??)**
2017	Moving from "fee" to "price" (full cost). Central Party Resolution 20 (Oct17): reviving PHC and standardizing/modernizing the system

Vietnam major reforms –

redirecting suply-side subsidy to demad-side subsidy



Key design features of SHI system- 25 years of development

- **Expansion of coverage:**
  - Including the poor and vulnerable in the SHI from early stage using full subsidy
  - Formal economy workers contribute a fixed % (now 4.5%) of their incomes (1/3 made by employee; 2/3 made by employer; individual enrolment)
  - Partial subsidy for school children, near poor, informal households
  - Prior to 2015: compulsory enrolment for formal workers and voluntary participation for the rest.
  - From 2015: compulsory enrolment for all
  - Make HI coverage in each province as one of key indicators of provincial government performance

Key design features of SHI system

- **Revenue collection:**
  - Being done by VSS (Vietnam Social Security) via VSS's district branches and commune people committee & commune health station
- **Pooling:**
  - Centralized fund management without clear pooling mechanism
- **Benefit package:**
  - Comprehensive, covers both inpatient and outpatients, with the list of about 1,000 medicines including some high cost cancer medicines
  - 20% co-payment is generally applied; reduced rate for the poor and near poor; higher co-payment for high cost medicines and high tech services
- **Payment methods and payment rate**
  - Basically FFS with overall global budget cap, which is set based on historical expenditure
- **Referral system:**
  - Referral system is applied though by-passing is allowed with higher co-payment (OP: 100%; IP: 40% at provincial and 60% at central facilities)

Key design features of SHI system

- **Medicines list, procurement, and price control**
  - The list is revised every 2-3 years by MOH committees
  - Medicine procurement is implemented at provincial & hospital level, via bidding. Central procurement has been introduced recently for the most frequently used/high value items, which has helped to reduce the price
- **Claim review**
  - Basically manual until 2017 when digitalized claim review center was created within VSS and all health care facilities are asked to use electronic health record system
- **Governance and accountability**
  - HI Agency was initially created from within the MOH in 1992; it was then separated and joined with pension (VSS) in 2002
  - The law indicates that the MOH to be responsible for making policy while VSS is responsible for the policy implementation →Accountability framework is not clearly defined
  - Changing roles of the MOH and VSS

Enrolment of informal sector and some pro-poor policies

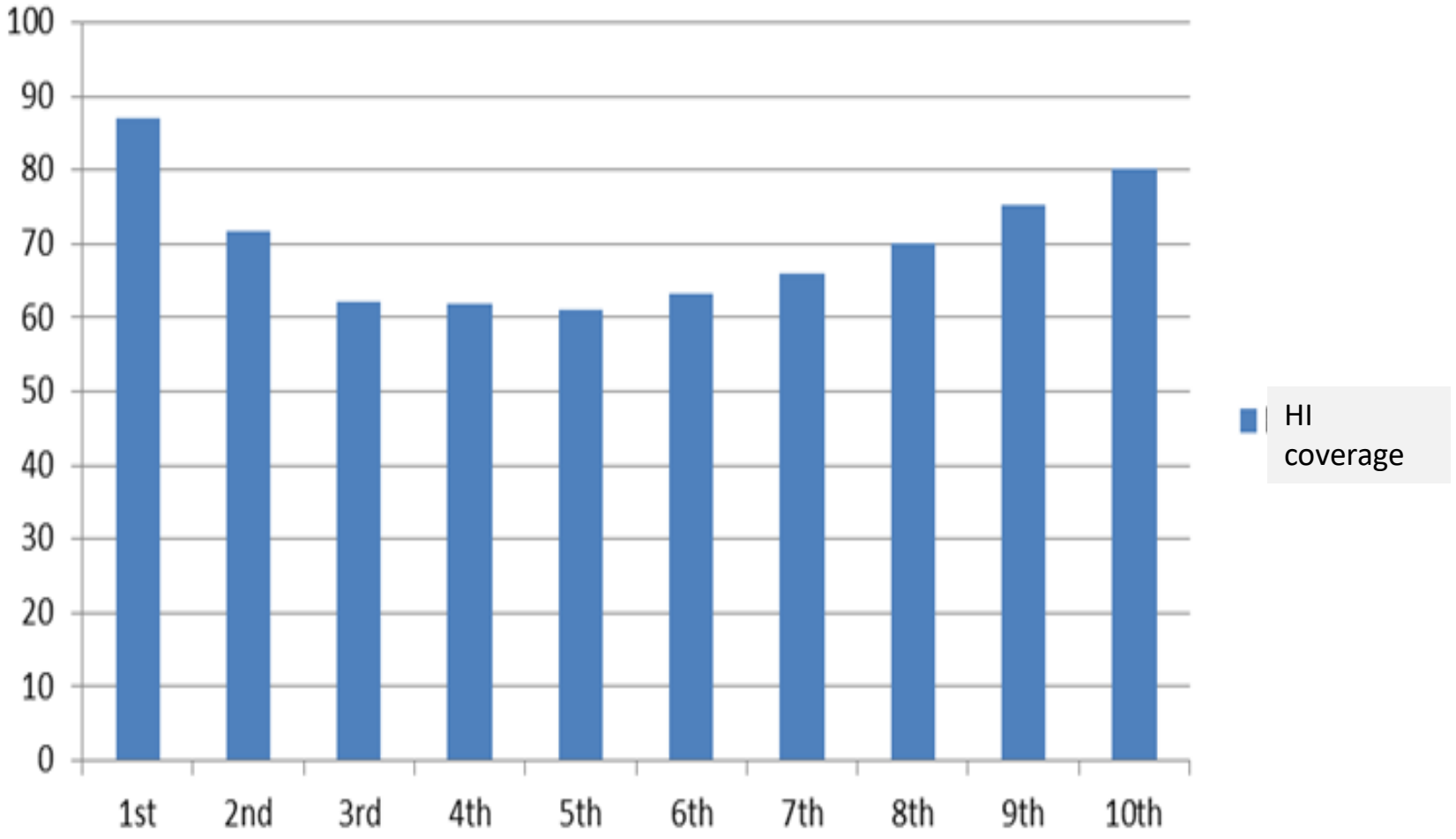
- Full subsidy for the poor and ethnic minorities
- Partial subsidy for near poor and informal households
- Co-payment rates vary by ability to pay
- Generous and unified benefit package
- Wide network of grassroots facilities providing care close to where people live
- Strong public health that prevents people from getting sick in the first place

About 70% of HI members receive some form of subsidy from the national and provincial government; the subsidy account for about 40% of total HI revenues

Subsidized population segments (mainly informal sector)	Rate of subsidy		Rate of Self-payment of premium	Registration
	National gov	Provincial gov		
Poor household	100%		0%	MOLISA and local Gov prepare the list, to facilitate fund transfer
Ethnic minority	100%		0%	MOLISA and local Gov
Under 6 children; older persons 80+	100%		0%	MOLISA and local GOV
Near poor household	70%	10-30%	0 - 30%	MOLISA and local Gov
Informal household	30%	10-30%	40 – 60%	Local Gov and VSS
School pupil and student	30% (*)	0-10%	60 - 70%	Schools prepare the list and collect premium

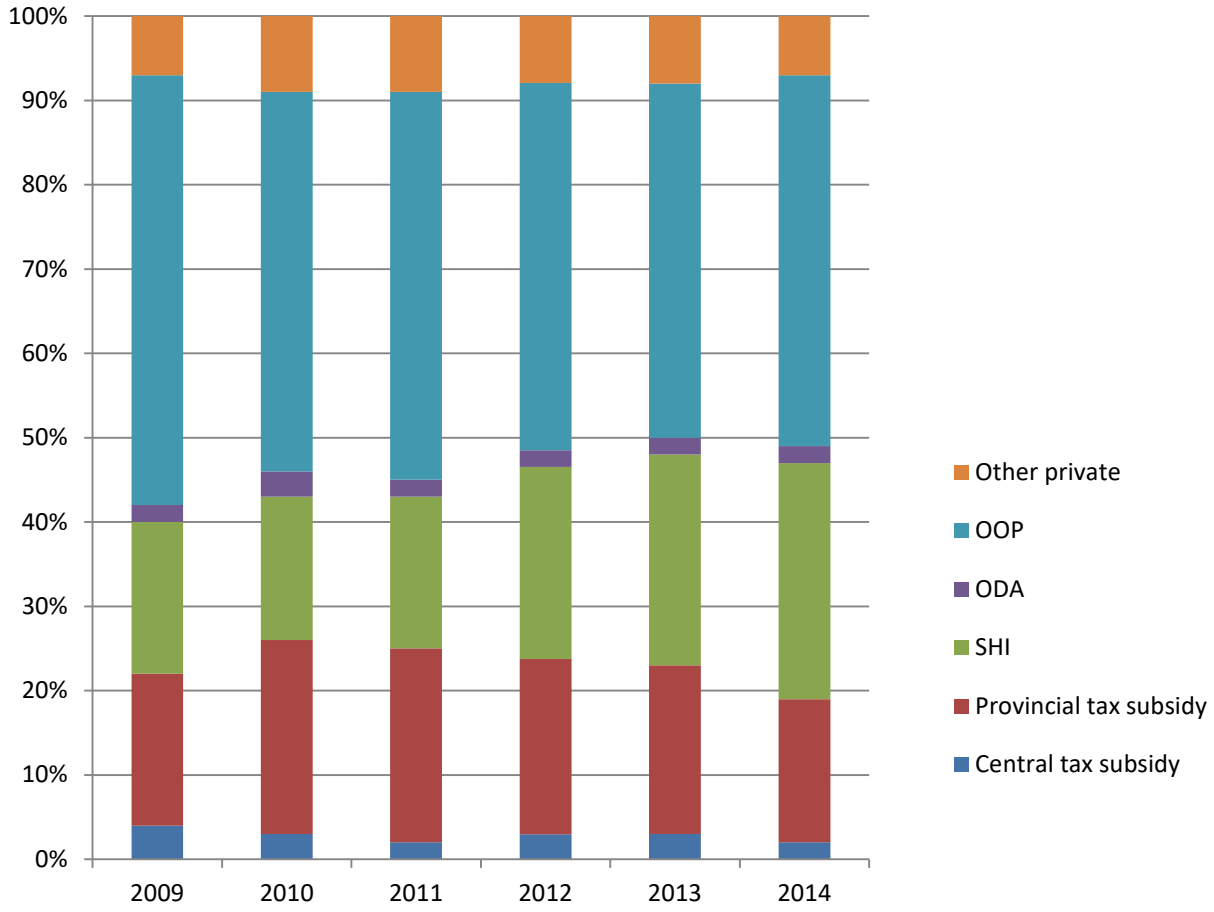
(*): it can be 100% subsidy if the children are living in poorest communes
(**): there is also a Decree calling the local government to fully subsidize people living with HIV

Challenges – missing the middle

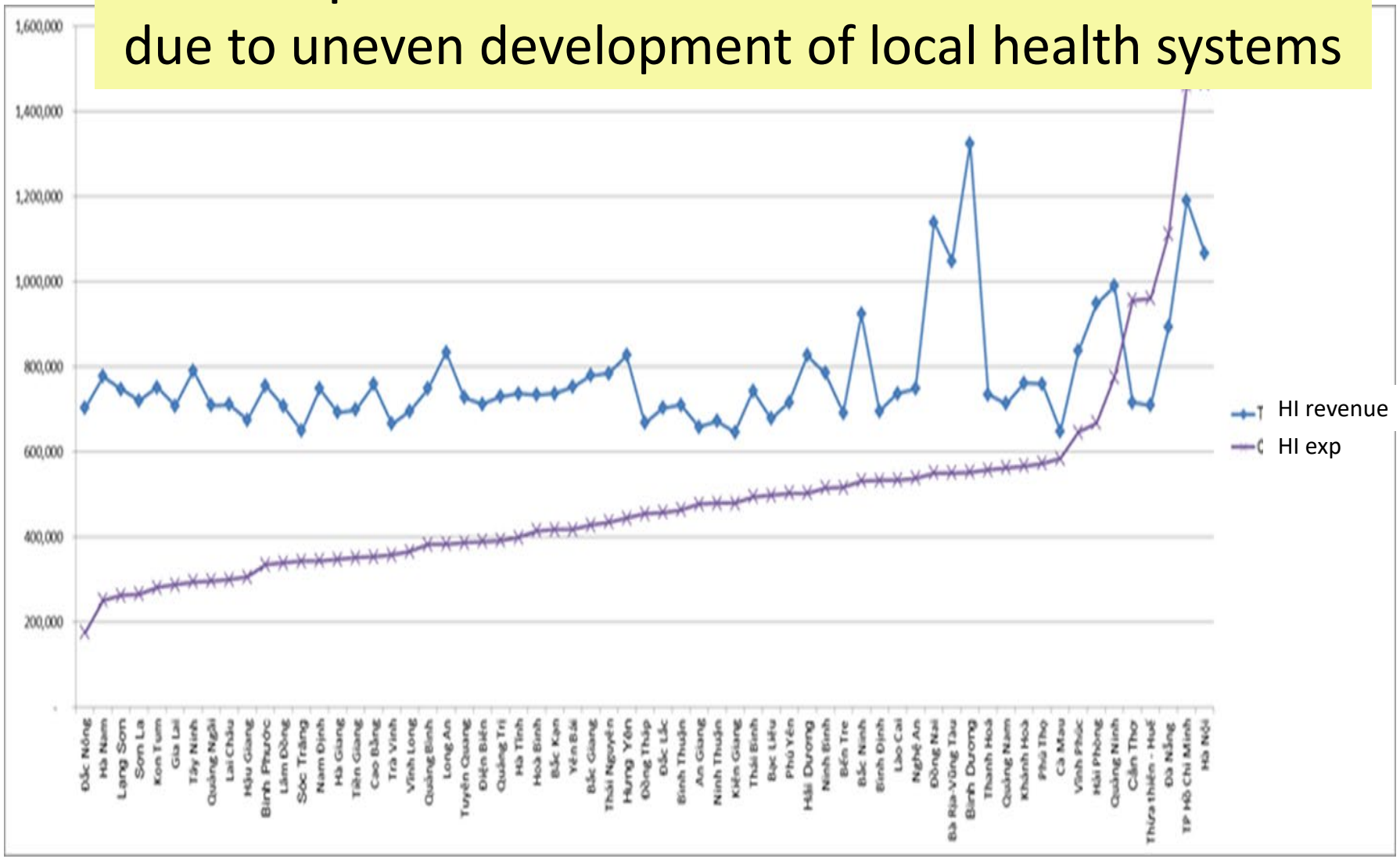


OOP remains high (2009 – 2014)

- OOP is reducing over time though remains high
- SHI is now 2nd biggest spender



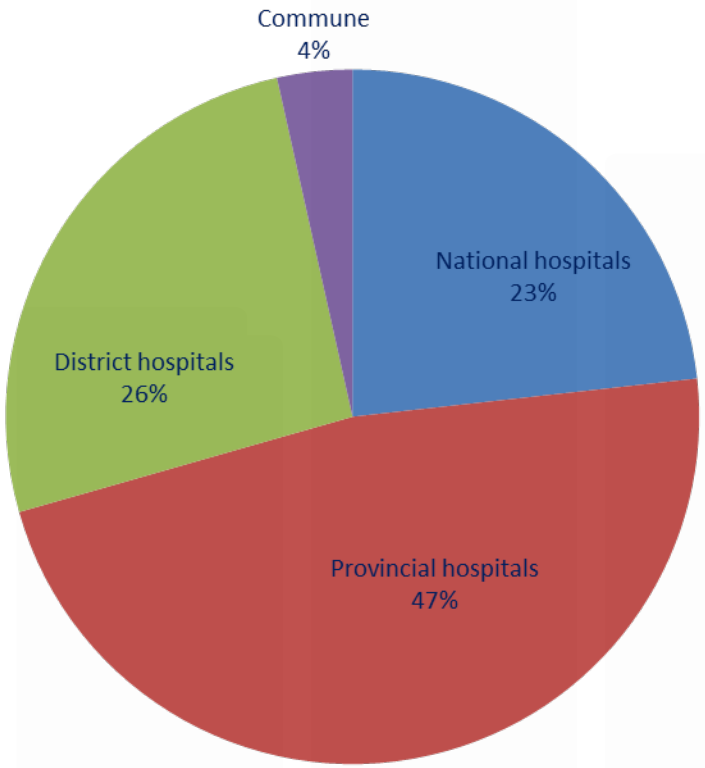
Inequitable distribution of resources - due to uneven development of local health systems



Source: VSS, 2015

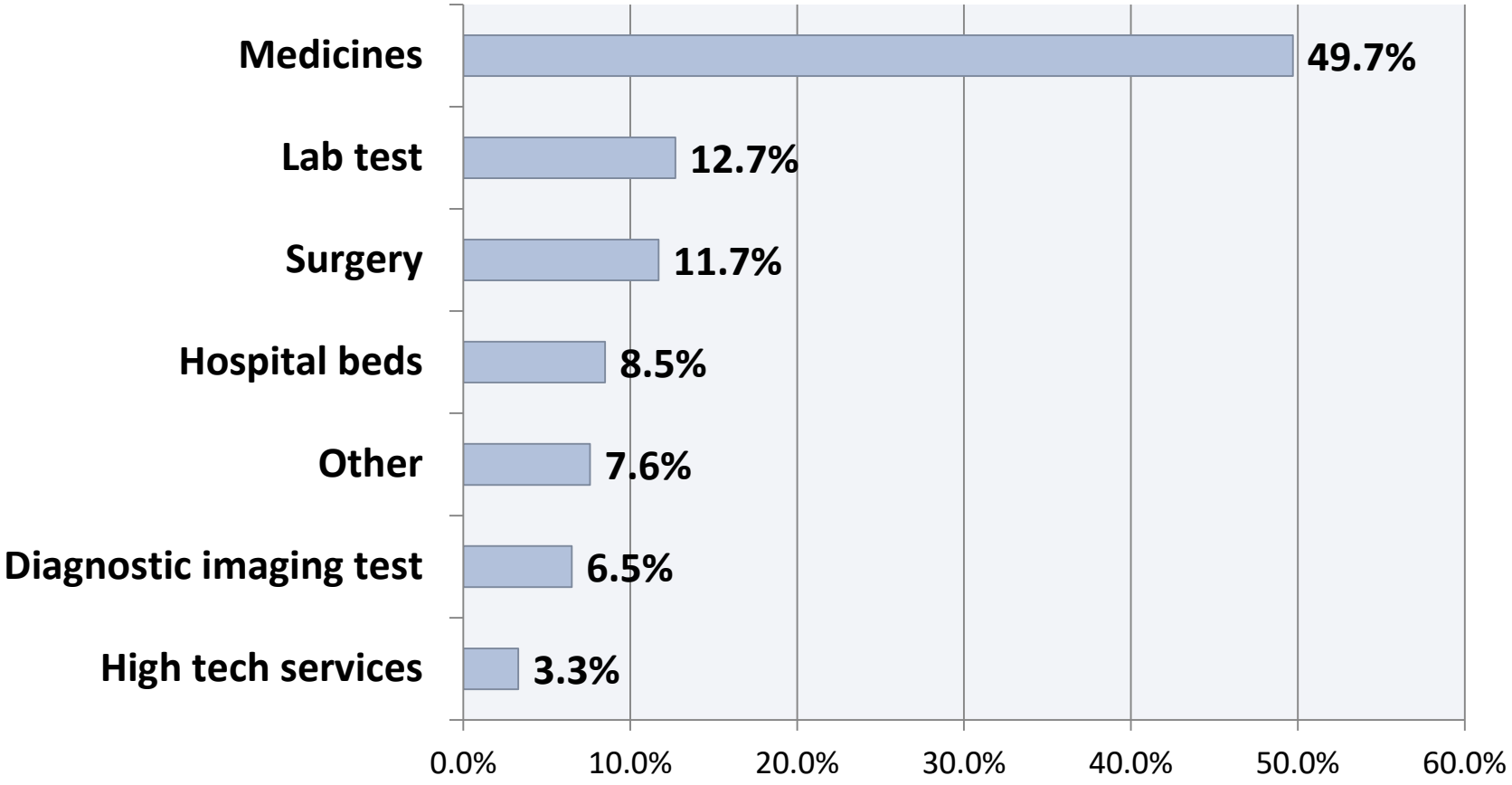
HI expenditure concentrated in hospitals, 2014

- Primary care is under-resourced
- 96% of resources go to hospitals



Source: VSS

High spending on drugs, labs and imaging tests



Source: VSS data, 2015

Lessons from VNM: Dos…

- Subsidize the poor and low income groups; subsidize also informal sector
- Design simple, attractive and easy-to-collect premium for informal sector
- **Enroll as a family from the start** where income earners pay according to ability to pay; dependents are included
- Think about **a single fund** (for stronger purchasing power) with mechanism for equitable pooling and resource distribution
- Get provider's **digital clinical data** system in place as soon as possible and link payment to providers' information/know what you pay for
- **Focus on PHC**, that will be both efficient and equitable – pay for the right service at the right place
- Keep eyes on list of **benefits**, including medicines
- Be **price and quality maker**
- **Governance** matters - think of the relationship, and division of roles and responsibilities among key agencies MOH - HI Agency – HI revenues collector – other actor

And Don’t…

- Rely on providers to set the price – prices should be revised when appropriate
- Allow tertiary hospital to provide much of PHC services for common illnesses
- Pay by FFS without regulation on price and quantity of services
- Overlook additional and extra charge (balance billing) – except in vey few/limited clearly specified cases

Thank you

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