



Key Indicators	
Population (2015, est.)	94.3 million
Per capita GDP (2014, current USD)	\$2,051
Income classification	Lower-middle
Health Financing (2013)	
THE per capita (USD)	\$111
THE as % of GDP	6.6%
GHE as % of THE	41.9%
GHE as % of GGE	6.6%
OOP as % of THE	49%
DAH as % of THE	4.4%
Pooled private as % of THE	9%
HIV Financing (2012)	
Adult HIV/AIDS prevalence (2014)	0.5%
DAH for HIV/AIDS as % of TAE	68%
TAE per PLHIV (USD)	\$381
GAE as % of GGE	0.15%
GAE as % of TAE	32%

Source: World Bank, 2015; Somanathan et al., 2014; WHO, 2015; UNAIDS, 2016.

THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure.

Overview

Vietnam became a lower-middle income country (LMIC) in fiscal year (2007/08). Total health expenditure (THE) as a percentage of gross domestic product (GDP) has been consistent, at about 6%. Since 2006, the per capita amount spent on health has doubled (U.S. constant dollars), as the economy has grown for the last several years. Government health expenditure (GHE) as a percentage of general government expenditure (GGE) is near the average for LMICs, at 6.6%. Out-of-pocket (OOP) expenditure as a percentage of THE is below the average amount for LMICs, at 49% (Figures 1 and 2). The level of GHE has contributed to reduction of OOP expenditure, although it is still 85% of total private expenditure. There is room for nongovernment-funded insurance; however, the absolute level of OOP expenditure also has been falling. Vietnam is committed to achieving universal health coverage (UHC) and has made significant progress (Somanathan et al., 2014). The 2013 data show the country is likely on target for reaching its explicit goal of reducing OOP as a percentage of THE to 40% by 2020. There is little reliance on financing through external sources, at about 4.4% of THE.

Some features of health financing are as follows:

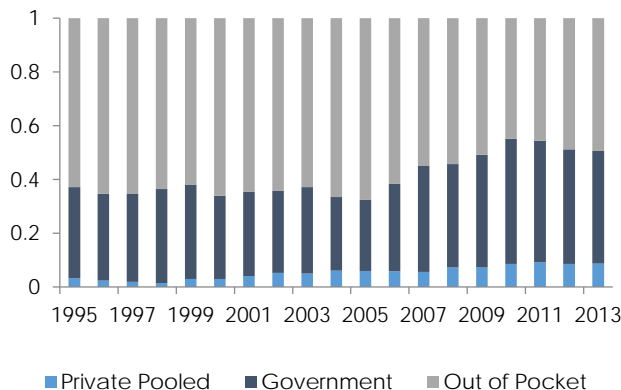
- Introduction of a mandatory contributory insurance program in 1989 for the formal sector and subsequent extension in 2009 of social health insurance (SHI), with free enrollment offered to the poorer population.
- An effort to guarantee that insurance coverage reaches 70% by 2015 and 80% by 2020; SHI coverage was 65% of the population in 2011 (Somanathan et al., 2014).

Health Financing Functions

Revenue contribution and collection

Healthcare financing is funded primarily through domestic resources. In recent years, Vietnam has been efficient at collecting revenue, at a level far higher than most LMICs. Given its projected high-level economic growth, it may be able to increase its health funding both through engaging the private sector via mandatory enrolment and increasing funding for SHI. Currently, achieving health insurance targets for the entire population is one of the top priorities on the health agenda of the government of Vietnam.

Figure 1: Share in THE



Source: WHO, 2015.

As part of the implementation plan for UHC, Vietnam will develop a basic health services package (BHSP) before 2018 to control healthcare costs, ensure service quality, and respond to health policy priorities (USAID, 2015).

Pooling

In 2014, health insurance coverage had reached 71% of the population. For formal sector workers, for whom health insurance is mandated, the enrollment rate was lower (GoV, 2015). Near 80% of those eligible for SHI have enrolled. SHI for the poor was put in place in 2003 after a free healthcare card program was found inoperable and used by only a third of those eligible for the program. SHI was offered without premiums or copayments at the point of accessing care. SHI is largely financed through tax subsidies; from 2006 to 2010, the government share of SHI revenues increased from 29% to 50%. Early evaluations of the SHI showed improvement in protection against catastrophic expenditure and utilization of care, although with only marginal improvement in reducing OOP expenses (Wagstaff, 2007).

Purchasing

The full list of services in the proposed BHSP includes basic and specialist treatment, medication, and preventive and primary healthcare, regardless of who provides them and their sources of financing. The list would apply to the SHI scheme as well as those funded through other means, such as mandated care. HIV and AIDS services would be included in the basic package; however, it would be costed separately from the BHSP. While the Ministry of Health is in charge of SHI policy formulation and BHSP revisions, Vietnam Social Security (VSS) manages the SHI fund, issues health insurance cards, and purchases services for its members based on fee-for-service. In 2014, VSS contracted with 1,627 public and 484 private providers. VSS reimbursements only partially cover the SHI benefits package; facilities charge patients user fees to cover the remainder.

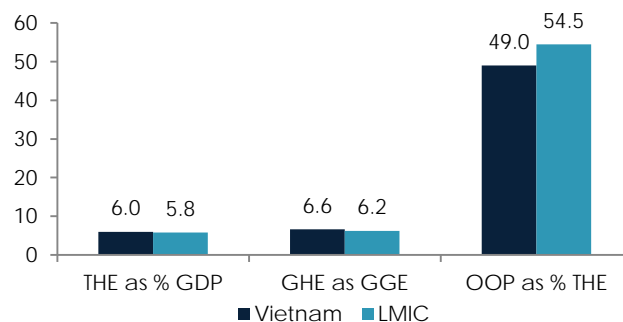
HIV Funding

In 2014, it was estimated that people living with HIV (PLHIV) numbered nearly 250,000. The HIV response is heavily donor dependent, with donors contributing 78% of the overall financing. PEPFAR and the Global Fund to fight AIDS, Tuberculosis and Malaria fund approximately 95% of the antiretroviral drug requirements. In 2012, an estimated US\$136 million was spent on HIV in Vietnam. The total public expenditure for HIV and AIDS as a proportion of GGE amounts to 0.15%, amounting to 2.35% of the public expenditure on health, which mostly includes government revenue expenditure. There is considerable scope for increasing this coverage. Vietnam aims to increase treatment coverage to 190,000 PLHIV by 2020. The costs of antiretroviral drugs alone could amount to US\$37–40 million. It is expected that the public sector would assume more than 60% of this cost, most of it funded through the SHI scheme. If SHI coverage increases to 80% by 2020, an estimated 52% of HIV treatment payments could potentially be covered through SHI (USAID, 2015).

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Figure 2: Comparative Health Expenditures (2013)



Source: WHO, 2015.

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