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Sustainable Financing of HIV/AIDS services for PLHIV in Vietnam – the contribution of Social Health Insurance

A Pilot Model for Ninh Binh and Dong Thap Provinces

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Abt Associates - USAID/HPI Vietnam , 72 Xuan Dieu - Tay Ho, Hanoi, Vietnam

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Acronyms

ADB	Asian Development Bank
ALT	Alanine Aminotransferase
ARV	Antiretroviral
ART	Antiretroviral Therapy
CCRD	Center for Community Health Research and Development
DFID	Department for International Development
DHI	Department of Health Insurance
DSS	District Social Security
GVN	Government of Vietnam
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NTP	National Target Program
NVP	Nevirapine
OI	Opportunistic Infection
OPC	Out-Patient Clinic
OOP	Out-of-pocket
PAC	Provincial AIDS Center
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PI	Protease Inhibitor
PLHIV	People living with HIV
PSS	Provincial Social Security
SHI	Social Health Insurance
TDF	Tenofovir
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
USAID	United States Agency for International Development
USAID/HPI	United States Agency for International Development/ Health Policy Initiative
VAAC	Vietnam Administration for HIV/AIDS Control
VSS	Vietnam Social Security
WHO	World Health Organization

I. EXECUTIVE SUMMARY

Over the past decade, Vietnam has achieved remarkable results in their national HIV/AIDS program. Since 2005 in particular, the number of PLHIV treated with Antiretroviral (ARVs) has risen sharply. According to epidemiological reports and forecasts there will be 300,000 people living with HIV/AIDS (PLHIV) in Vietnam by 2015¹. Demand for care and treatment for PLHIV will continue to increase, especially when the World Health Organization (WHO) recommends raising the threshold for Antiretroviral Therapy (ART) or when early ARV treatment becomes accepted protocol.

International donors have provided significant funding for HIV/AIDS prevention and control programs in Vietnam in the past and most ARV drugs (98%) are still fully financed by international funds². Statistics on contributions of each donor for the period from 2008-2012 show that the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funds account for 68 % (the highest proportion) of total international support. Total expected financing for the period from 2013 to 2020 is estimated at 9,952 billion Vietnamese dong (VND), which will only cover 37% of the total expected expenditures for HIV/AIDS prevention and control for that period. These financing sources remain uncertain and very much depend on the future financial ability and commitments of funders.

The current financing model is clearly not sustainable in the long term and efforts are being made to develop a road map towards an increasingly nationally funded program. The Ministry of Health (MOH) of Vietnam developed and proposed a Plan on Financing HIV/AIDS Prevention and Control Activities for the period 2013-2020 to the Government of Vietnam (GVN). The Plan emphasizes the following combination of (1) fund mobilization from diversified sources and (2) effective usage and management of mobilized financial resources. Effective integration of HIV/AIDS services for PLHIV in the existing national Social Health Insurance (SHI) scheme is one of the financing mechanisms recommended by the plan.

Vietnam already has a functioning social health insurance scheme, which is managed by Vietnam Social Security (VSS). A legal and policy framework exists to support the roll out and management of SHI both at central and provincial level. However, most of these documents are written for the general population and our analysis (see section 3.4) found that for PLHIV there can be distortions in interpretations or bottlenecks to effective inclusion of PLHIV and their treatment into the scheme as it currently exists. On the supply side these include the type of establishments which can be contracted by VSS to provide services. On the demand side, SHI card holders are required to choose a primary care provider at community level, where HIV services are not available in most cases.

¹ Government of Vietnam. "Vietnam AIDS response progress report 2012". National Committee for AIDS, Drugs and prostitution prevention. 2012

² Vietnam Administration of HIV/AIDS Control. "Report on Vietnam National AIDS spending assessment 2008 – 2009". Vietnam Administration of HIV/AIDS Control, 2010

In order to assist PEPFAR and the Government of Vietnam in this endeavor to provide and sustain long-term care and treatment for PLHIV, the PEPFAR funded USAID/Health Policy Initiative project (USAID/HPI) managed by Abt. Associate Inc. supported an evidence-based process to develop a pilot model on health insurance for health care of PLHIV. This process included an assessment on social health insurance amongst PLHIV led by the Center for Community Research and Development (CCRD) in Ninh Binh and Dong Thap. A summary of the results can be found in section VI. The results from these assessments, as well as an extensive bibliographical and policy review were used to inform the pilot model for implementation of social health insurance for PLHIV in section V.

This pilot model proposes the objective of enabling PLHIV “to receive medical care and effectively access SHI benefits at any eligible health facility”. This stated objective would facilitate a wider choice of health providers and better access to health services instead of concentrating on care provided at HIV/AIDS Out Patient Clinics (OPC). The model also recommends two alternative service packages to be covered by the SHI fund during the pilot period, and provides an outline of its implementation plan for a two year period. All evidence suggests that the GVN and MOH are already in agreement that PLHIV and their health care should be effectively included in the SHI scheme as part of Universal Health Coverage (UHC) in Vietnam. For this reason, it is reasonable to expect that the pilot should remain as close to the national financial realities as possible³.

³ Partners for Health Reformplus. August 2004. *The Role of Pilot Programs: Approaches to Health Systems Strengthening*. Bethesda, MD: PHRplus, Abt Associates Inc.

II. INTRODUCTION

Since the Doi Moi (“renovation”) reforms of the 1980s, Vietnam has made important achievements in the economic and health sectors, among others. Poverty has dropped significantly, from 64% in 1995 to 21% in 2008⁴, and most of the Millennium Development Goals – particularly in health – have been achieved or are within reach⁵. The Government of Vietnam (GVN) has prioritized Universal Health Coverage (UHC) establishing the government managed social health insurance law (SHI) in 2008. While the goal is to ensure UHC by 2014, further health financing mechanisms will need to be evaluated to offset the high costs associated with providing comprehensive care to most-at-risk populations and people living with or affected by HIV/AIDS (PLHIV). Even with UHC, out of pocket payments (OOP) and indirect costs, such as transportation and medical costs, remain significant barriers and directly impact the availability and affordability of HIV/AIDS related health services. Many agencies, both national and international, are involved in exploring options for diversifying funding sources, identifying efficient programs and prioritizing interventions.

Specifically, PEPFAR partners including USAID and US Centers for Disease Control (CDC) have been actively involved in activities with their implementing partners to assist the GVN in making SHI coverage effective for PLHIV. Although theoretically, PLHIV can receive SHI benefits if they are card holders, our research found that in effect, they use their cards for non HIV specific health needs for the most part. This may be for a combination of two reasons. PLHIV are sometime subject to disease related stigma⁶ and as such may prefer not to be identified with their disease when registering for care. Also, the current care and treatment system in Vietnam provides ARVs free of charge, so there is no incentive to claim benefits for that service. Furthermore, many of the HIV/AIDS out-patient clinics (OPCs), do not meet the criteria of a standard “examination and treatment health facility” regulated by the MOH. As a result they cannot provide reimbursable services under the VSS SHI scheme.

Analysis of the data from the assessment of the SHI situation amongst PLHIV attending HIV/AIDS OPCs in Dong Thap and Ninh Binh provinces conducted in early 2013 shows favorable factors related to including PLHIV into the SHI scheme. A legal framework and related policies do exist to regulate the use of SHI for treatments, including HIV/AIDS services. Approximately half of PLHIV interviewed already hold SHI cards even if they do not use them to cover ARV treatments. Furthermore, other stakeholders including medical practitioners are demonstrably in favor of effectively including PLHIV into the SHI scheme for their health needs.

⁴ Operational plan 2011-2015, DFID, Vietnam, July 2015 Vietnam

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67371/vietnam-2011.pdf

⁵ Ibid.

⁶ HIV/AIDS-Related Stigma and Discrimination in Vietnam, USAID/HPI Policy Brief, July 2013, Vietnam

III. BACKGROUND

Vietnam has been coping with HIV/AIDS epidemic for over 20 years. According to 2011 sentinel surveillance, by December 2011 there have been 249,660 reported infections and 197,335 PLHIV are still living⁷. An estimated 15,000 new HIV infections are expected every year. According to epidemiological forecasts, Vietnam will have a PLHIV population of between 250,000 and 300,000 by 2015, and the demand for care and treatment for PLHIV is estimated to reach 200,000 patients by 2020. Demand is expected to further increase when the WHO recommendation for a gradual raise in the ART threshold is implemented, and when the provision of early ARV treatment immediately after detection of HIV infection becomes an accepted protocol.

The Vietnam Administration for HIV/AIDS Control (VAAC) believes that HIV transmission among high-risk groups will remain a significant portion of the PLHIV population for the next ten years. In addition, it is expected that vulnerable high-risk groups such as intravenous drug users, female sex workers, and men who have sex with men, will continue to account for a major proportion in new HIV infections. However, the increasing trend of sexual transmission of HIV raises concern about the epidemic's spread to the community, including people with low risk behaviors. This fact is likely to cause more challenges in HIV/AIDS prevention and control.

Development of the HIV/AIDS epidemic in Vietnam remains complicated and continues to expand geographically. The distribution of HIV cases remains heavily concentrated in urban centers. However, over 77% of communes, 98% of districts and 100% of provinces and central cities had PLHIV populations by the end of 2011. Despite increased political commitment and leadership and a high availability of international aid, coverage of HIV/AIDS health care services in Vietnam remains low. In 2012, the VAAC/MOH reported 308 HIV/AIDS treatment facilities were established nationwide with 72,705 PLHIV under ARV treatment, among them 68,883 adults and 3,822 children. It is estimated that ART services cover only 55% of PLHIV currently eligible for treatment⁸.

3.1. National Strategy on HIV/AIDS Prevention and Control

In response to the continuing challenges of the HIV/AIDS epidemic, the Prime Minister issued Decision No. 608/QĐ-TTg (25th May, 2012) endorsing the *National Strategy on HIV/AIDS Prevention and Control to 2020, with Vision to 2030*. The strategy emphasized that "HIV/AIDS is a dangerous pandemic, a threat to people's health and life and the future of the nation." The strategy sets a general objective to "control the rate of HIV infection in the community under 0.3% in 2020, and to decrease the impacts of HIV on socio-economic development." Specific targets regarding care and treatment for PLHIV set by the Government are as follows:

⁷ National Committee for AIDS, Drugs and Prostitution Prevention and Control "Vietnam AIDS response progress report 2012". UNAIDS, Hanoi, 2012

⁸ idem

- Coverage of ARV treatment for eligible PLHIV increased to 70% by 2015, and to 80% by 2020;
- PLHIV continuing to receive ARV after 12 months of treatment maintained at 80%, from 2015 onward;
- PLHIV diagnosed with tuberculosis (TB) receiving ARV and TB treatment simultaneously increased to 80% by 2015, and to 90% by 2020;
- Early ARV treatment coverage of pregnant women infected with HIV and their children increased to 90% by 2015, and to 95% by 2020;
- Coverage of community-based care and treatment of PLHIV increased to 70% by 2015, and to 80% by 2020.

3.2. HIV/AIDS program financing

With substantial effort by the GVN, and strong support from international donors, the number of health facilities providing ARV treatment has increased in all provinces and cities, rapidly expanding the number of PLHIV treated with ARV since 2005. According to reports from VAAC/MOH, ARV drugs are currently provided free of charge to patients. However, the cost of most ARV drugs (98%) is fully subsidized by international funding through PEPFAR (accounting for 62% of the ARVs) and Global Fund (36%). ARVs supplied by the National Target Program (NTP) on HIV/AIDS Prevention and Control only account for 2% of the national total. In short, the majority of funding for HIV/AIDS prevention and control programs has come from international donors, including bilateral/multilateral sources and international non-governmental organizations (NGOs).^{9,10}

Within the HIV/AIDS funding provided by international donors from 2008 to 2012, PEPFAR funds accounted for the 68% of the total. The World Bank and DFID together contributed 9%, and the remaining funding was contributed by the Global Fund (7%), Asian Development Bank (6%), the Governments of Denmark, Australia and the Netherlands (4%), UN organizations (1%), and many others (5%)¹¹.

According to the MOH, estimated 9,952 billion VND have already been mobilized for the 2013 to 2020 period from the following sources:

- International aid committed until 2018 is projected to be approximately 2,923 billion VND;
- Central government budget contribution is projected to be 2,956 billion VND, and provided through the NTP;
- Local government budget contribution is projected to be about 2,725 billion VND;

⁹ Vietnam Ministry of Health. "Draft of Plan for health insurance coverage of HIV/AIDS treatment services from 2012-2015 and 2020." Vietnam Ministry of Health, 2013

¹⁰ Vietnam Administration of HIV/AIDS Control. "Report on Vietnam National AIDS spending assessment 2008 – 2009". Vietnam Administration of HIV/AIDS Control, 2010

¹¹ Vietnam Administration of HIV/AIDS Control. "Report on Vietnam National AIDS spending assessment 2008 – 2009". Vietnam Administration of HIV/AIDS Control, 2010

- Social Health Insurance (SHI) reimbursements are projected to cover 400 billion VND of care and treatment costs;
- OOP payments from the general population are estimated at 617 billion VND;
- Employing organizations will contribute an estimated 330 billion VND (this funding will be used for HIV prevention and control activities for their own employees).

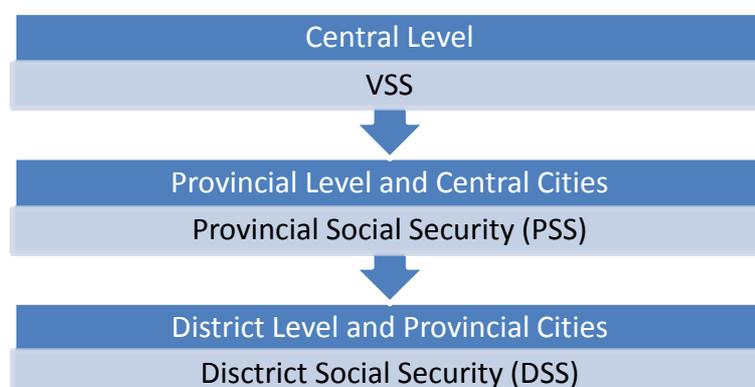
However, estimated funding from sources remains tentative, and would only cover 37% of the total estimated expenditures required for HIV/AIDS prevention and control in the same period. Contributions from local and national budgets will largely depend on the balance of revenue and expenditure across all programs in both provincial and central government levels. Committed budgets from international donors may still vary depending on availability of funds and donor priorities.

Under these circumstances, the MOH has developed and proposed the *Plan on Financing the HIV/AIDS Prevention and Control Activities for the period 2013-2020*. This plan emphasizes the need to mobilize of funds in combination with the effective use and management of financial resources. One of the plan’s main recommendations is to effectively integrate HIV/AIDS services for PLHIV and the existing national SHI scheme. Given the favorable current policy frameworks for SHI and HIV/AIDS prevention and control programs in Vietnam, integration of PLHIV into the SHI scheme is especially relevant and highly feasible.

3.3. The Vietnam National Social Insurance System

The Vietnam Social Security (VSS) was established according to *Decision No. 20/2002/QĐ-TTg* of the Prime Minister (24th January, 2002). On the 6th December, 2002, the Government issued *Decree No. 100/2002/ND-CP*, which provided stipulations regarding the functions, authorization and organization of VSS, including a health insurance component. Since 2002, central and provincial Social Security offices have implemented a comprehensive policy for mandatory and voluntary SHI for workers and community members at all levels.

The VSS is organized and managed hierarchically:



The national SHI is an integrated part of the VSS and its budget is dependent on two main sources:

- The state budget provides subsidies for specific populations such as retirees, national devotees, children under six, the poor, near poor and others. About 90% of the country's poor currently hold a subsidized SHI card¹².
- Contributions from individuals and institutions that purchase SHI cards, through mandatory subscriptions usually paid by employers for their employees, and voluntary subscriptions paid by individuals.

The Vietnamese Social Security establishes contracts with health facilities according to existing policies and norms of the national SHI scheme, and reimburses card holders for health care services provided by health facilities under contract.

3.4. Policies affecting coverage and implementation of SHI for PLHIV

The legal framework and policies guiding the effective implementation of SHI coverage for PLHIV, consists in a multitude of laws, decrees, circulars and decisions. The most important elements of the existing policy system are summarized below.

Law No. 64/2006/QH11 on HIV/AIDS Prevention and Control (29th June, 2006)

The Law on HIV/AIDS Prevention and Control has several articles that cover the right to health care and medical treatment, including access to ARV drugs.

- Article 4 – Rights and Obligations of HIV-infected people: states that PLHIV have the right to health care and medical treatment;
- Article 39 – Access to ARV drugs for PLHIV: While the State budget is insufficient to meet the total demand for ARV drugs, the Law has clearly identified the beneficiaries who are entitled to priority access to free ARVs. Free ARV drugs will be provided to PLHIV at HIV/AIDS treatment facilities;
- Article 40 – Participation in the social health insurance scheme by PLHIV: stipulates that people covered under health insurance who are infected with HIV are eligible for reimbursement for medical examination and treatment expenditures from the SHI fund. This is a remarkably new progress in comparison to the 1995 Ordinance¹³.

¹² General Statistics Office. "Data Result from the Vietnam Household Living Standards Survey 2010".

¹³ Ordinance on the Prevention and Control of Human Immune-Deficiency Virus and Acquired Immune-Deficiency Syndrome (HIV/AIDS), dated 31st May, 1995

Prime Minister approving the National Strategy on HIV/AIDS Prevention and Control until 2020 and vision until 2030, Decision No. 608/QĐ-TTg (25th May, 2012)

The *National Strategy on HIV/AIDS Prevention and Control until 2020 and vision to 2030*, approved by the Prime Minister, set a specific target to increase the proportion of ARV treatment for eligible PLHIV who are eligible to 70% by 2015 and to 80% by 2020. One strategic component of the strategy notes that international resources are declining rapidly, especially for ARV drugs, and will begin to decrease as early as 2014. Additionally, financial support for PLHIV health care services through the SHI system remains limited. Recommended solutions under this component include: “increase domestic resources for HIV/AIDS care and treatment, especially for ARV drugs,” and “ensure sustainable access to ARV treatment with reasonable quality and costs.” This includes the recommendation for “implementing activities that help to increase the ability to pay for medical examinations and treatments of PLHIV through SHI system.”

Examples of such activities include:

- Develop and issue documents regulating the minimum service package of HIV/AIDS treatment paid through the SHI system;
- Develop and issue guidance on payment for minimum service package of HIV/AIDS care and treatment through the SHI system;
- Provide training to health insurance staff on HIV/AIDS care and treatment knowledge and skills, including ARV treatment;
- Provide guidance to health facilities on SHI agreements related to HIV/AIDS care and treatment;
- Organize workshops on long-term benefits of SHI for HIV/AIDS care and treatment;
- Develop and disseminate promotional communication messages on benefits of the SHI, with focus on PLHIV;
- Review and assess the poverty levels among PLHIV at community level HIV/AIDS health facilities;
- Coordinate with organizations and agencies to implement the Government’s policy on health insurance subsidies for poor and near-poor households;
- Mobilize resources to establish a fund to subsidize SHI cards for PLHIV.

In addition, this document also recommends that the system of HIV/AIDS care and treatment service provision needs to be further improved in accordance with the existing regulations of the MOH by “transferring the provision of HIV/AIDS care and treatment services from non-curative health facilities to facilities that can perform medical examinations and treatment” and by “implementing the provision of HIV/AIDS care and treatment services at health facilities with a curative function.”

Law No. 25/2008/QH12 on Health Insurance (14th November, 2008)

The *Law on Health Insurance* provides the framework for the national SHI regime and related policies. This includes premium rates and payments, SHI cards, eligible

beneficiaries, medical care for covered by SHI, the SHI fund, and rights and responsibilities of parties involved in SHI. Article 21 related to the coverage of SHI benefits includes, "medical examination for screening and early diagnosis of some diseases."

Decree 62/2009/ND-CP dated July 27 2009 issued by Prime Minister and its accompanied inter-ministerial Circular No.09/2009/TTLT-BYT-BTC of the Ministry of Health and Ministry of Finance guiding the implementation of Health Insurance Law (14th August, 2009)

Article 8 of the Circular specifies SHI benefits in specific medical examinations for screening and early diagnosis of certain diseases (as prescribed in Clause 1, Article 21 of the Law on Health Insurance) shall be implemented under the guidance of the MOH. For example, if HIV screening and diagnosis tests are included under the guidelines of MOH as a "medical examination for screening and early diagnosis of some diseases," then the cost of this service will be covered by SHI for card holders.

Article 16 of the inter-ministerial Circular also provides guidance on "fee-for-service" payment, which is defined as "payment on the basis of costs of medical services, medicines, chemicals, and medical supplies provided for diagnosis and treatment of patients in health facilities." This Circular also specifies that fee-for-service based payment be applied for those who are insured by the SHI scheme, but are not registered at the health facility as appointed by the SHI.

The basis for fee-for-service payment calculations includes:

- Costs of medical services to be paid according to the standard health facility's price list, as approved by authorities and in accordance with the law on hospital fee collection;
- Costs of drugs, chemicals and medical supplies to be paid according to the procurement prices issued by the health facilities;
- Costs of blood and blood products shall be based on the standard prices issued by the MOH.

Law No. 40/2009/QH12 on Medical Examination and Treatment (23rd November, 2009)

The *Law on Medical Examination and Treatment* regulates the rights and obligations of patients, the conditions and professional and technical requirements for medical practitioners, medical examinations, and treatment facilities. It also provides detailed regulations on the application of new techniques and methods in medical examination and treatment, as well as conditional provisions for medical establishments. Under Article 2, a medical establishment is defined as "a fixed or mobile facility possessing an operation license and providing medical examination and treatment services."

Article 42 of the *Law on Medical Examination and Treatment* regulates the operating conditions for medical examination and treatment facilities as: "having an establishment decision issued by a competent state agency for medical examination and treatment facilities set up by the State..." and "possessing an operating license granted by the

MOH, the Ministry of National Defense or the by Director of Provincial Health Department.”

Circular No. 09/2011/TT-BYT on the technical conditions and scope of services of health facilities providing ARV treatment for PLHIV (26th January, 2011)

Circular No. 09/2011/TT-BYT from the MOH provides standards for health facilities providing ARV treatments that want to be eligible for participating in the SHI. Specifically, it regulates the conditions of human resources, equipment, infrastructure and their ability to provide services. The circular also regulates laboratory tests from health facilities with ability to provide ARV treatment (both first-line and second-line) for PLHIV. This Circular also stipulates the tasks of health facilities which provide first-line ARV and second-line ARV treatment for PLHIV.

Directive No. 16/CT-TTg of the Prime Minister on Strengthening HIV/AIDS Prevention and Control (22nd May, 2012)

In order to strengthen HIV/AIDS prevention and control, the Prime Minister issued *Directive No. 16/CT-TTg* stipulating that the responsibilities of the MOH are to “lead and coordinate with ministries and sectors to develop, revise and complete policy and guideline documents on health insurance for medical examinations and treatment relating to HIV/AIDS, in order to ensure the rights of the insured who are infected with HIV in accordance with the Law on HIV/AIDS Prevention and Control and Law on Health Insurance and in line with the current mechanism of management, care and treatment for PLHIV.” This Directive also requires “VSS to coordinate with MOH to strengthen and expand the provision of medical care and treatment services for PLHIV through the health insurance system.”

Prime Minister’s Decision approving the Scheme for Implementation of the Universal Health Insurance period 2012-2015 and through 2020 - Decision No. 538/ QD-TTg (29th March, 2013)

The specific objectives of this decision are to:

- Increase the number of people under SHI, maintain the current population of insured people, and expand coverage to other target beneficiaries in order to achieve a national SHI coverage of 70% in 2015 and 80% in 2020;
- Improve the quality of medical examination and treatment services covered by the SHI scheme; ensure the rights of insured people as prescribed by law and meeting the medical examination and treatment needs of those insured.

This Decision sets forth the general objective of scaling up SHI through the following measures: enhancing communication on health insurance laws and policies, advocating for stronger participation, improving the attractiveness of SHI scheme, and organizing the network of SHI agencies to ensure that people in need can access information about SHI and that participation is convenient to them. The Decision also suggests some specific measures to include groups which have low subscription rates to SHI,

such as mechanisms for household participation in SHI, and subsidized premium rates for SHI cards for employees working in informal sectors.

3.5. Access and use of SHI among PLHIV

Prevention, care and treatment services related to HIV/ AIDS in Vietnam are largely financed through international donor funding, with support from the state budget. The costs associated with HIV/AIDS treatment currently covered by SHI are a very small proportion of the total. In most cases, outpatient treatment for PLHIV is not reimbursed through the SHI fund, due to a lack of clarity and implementation of policies on medical examination and treatment for PLHIV covered by SHI. Unclear interpretation of policies is compounded by situations like the following:

- Many health facilities do not seek reimbursement for HIV screening or confirmation tests under SHI due to inconsistent regulations and guidelines. A similar situation affects the HIV/AIDS diagnosis and treatment;
- Article 23, clause 11 and 12 of the *Law on Health Insurance* regulates cases not eligible for SHI benefits, which include medical examination and treatment related to drugs, alcohol and other addictive substances, and medical examination and treatment for physical or mental injuries caused by law-breaking acts of the injured. However, many PLHIV in Vietnam acquired HIV by engaging in sex work or sharing needles when injecting drugs. Therefore, these regulations may lead to difficulties in reimbursement of medical services for SHI card holding PLHIV;
- Article 24, clause 1 and 2 of the *Law on Health Insurance* stipulates that SHI-covered medical examination and treatment facilities are provided by health facilities that signed a medical care contract with the VSS. These may include commune health stations and the equivalent, maternity houses, general and specialized clinics, general and specialized hospitals. Currently, HIV/AIDS Out-Patient Clinics (OPCs) that are not managed by hospitals face difficulties in signing a contract with VSS or being reimbursed for medical examination and treatment of PLHIV because they fall under the category of “prevention” facilities;
- Article 41 of the *Medical Examination and Treatment Law* regulates organizational types and standards of medical examination and treatment facilities. However, to date the MOH has not specified guidelines or clearly designated Health Centers (prevention) or Provincial AIDS Centers (PACs) as medical examination and treatment facilities. Therefore, these facilities including HIV/AIDS OPCs, do not have the required legal status allowing them to sign contracts with VSS and be authorized, reimbursed, providers to SHI card holders;
- Article 26 of the *Law on Health Insurance* regulates registration at the health facilities by insured people stating primary registration either at commune and district or equivalent levels. Although SHI card holders may change their registered health provider at the beginning of every quarter, their choice is restricted to commune and district levels. However, the majority of HIV/AIDS OPCs are currently located at provincial level. Thus, PLHIV face long travel times compounded by complicated referral procedures when they come for treatment at HIV/AIDS OPC at provincial level, which may be the only facility providing ARV services;
- Although Article 27 of *Law on Health Insurance* regulates patient referral, it requires certain procedures be followed including a reference letter. ARV treatment for

PLHIV is long term and PLHIV have to visit HIV/AIDS OPC monthly to receive care and medicine. Furthermore, specific characteristics of PLHIV include low self-esteem and vulnerability to stigma and discrimination make PLHIV hesitant to use health facilities close to their place of residence. Therefore, this regulation would also require review to ensure effective SHI for this target population.

Care and treatment of PLHIV with ART in Vietnam is currently provided free of charge through HIV/AIDS OPCs. Therefore it is common practice that PLHIV who hold SHI cards do not use their benefits for HIV care and treatment services at the HIV/AIDS OPCs.

IV. KEY FINDINGS FROM THE ASSEMENT IN NINH BINH AND DONG THAP ON ACCESS AND USE OF SOCIAL HEALTH INSURANCE AND HEALTH SERVICES BY PLHIV

In order to obtain updated information about access and use of SHI of the PLHIV for development of pilot model on SHI in provinces where there is no or very little foreign assistance, an assessment study was conducted in Dong Thap and Ninh Binh provinces in early 2013. This section presents key findings of this study.

4.1. Overview of the HIV epidemic in the two provinces

As of 31st December 2012, the cumulative number of PLHIV in Dong Thap was 4,663, of which 2,265 were AIDS cases. In Ninh Binh, cumulative data was 2,301 PLHIV and 818 cases of AIDS.

Box 1

Assessment findings

- The percentage of PLHIV holding SHI cards is close to the national average (about 50%);
- PLHIV use both OPC services and other (public) health facilities for health care;
- HIV testing occurs when there are other major health events (e.g. surgery);
- PLHIV do use their SHI cards at public facilities for the services they don't get for "free" at the OPCs;
- PLHIV are willing to participate in the SHI scheme and there is even WTP for cards;
- PLHIV would prefer to register their primary care provider at district rather than commune level to limit stigma and discrimination.

According to statistics from their respective of PACs, men accounted for the majority of PLHIV in Ninh Binh and Dong Thap. There is a different transmission mode between the two provinces. In Ninh Binh the majority of PLHIV were infected by drug injection (70.2%). In Dong Thap, sexually transmission is the main mode of transmission accounting for 92.4% of PLHIV.

However, looking at the epidemiological trend of both provinces over the years, data shows that proportion of women infected with HIV has increased significantly, especially women who were infected with HIV through unsafe sex with husbands/ partners who are PLHIV.

4.2. Medical care and treatment system for PLHIV in Ninh Binh and Dong Thap

Understanding the current organization of medical care and treatment for PLHIV is essential to designing a robust pilot model which will effectively bring this group into the Vietnamese SHI insurance system. Outpatient clinic services for PLHIV vary extensively between provinces, and Ninh Binh and Dong Thap represent two of the most common models which currently exist in Vietnam.

4.2.1. System of HIV/AIDS outpatient clinics

According to data from PAC, the numbers of patients being treated at HIV/AIDS OPCs in Dong Thap and Ninh Binh are 690 and 579 respectively. Thus, only about 25% PLHIV in Ninh Binh and 15% of PLHIV in Dong Thap are currently being treated at provincial HIV/AIDS OPCs, lower than the estimated national coverage (at about 30%). There is a major difference between two provinces related to HIV/AIDS OPCs system.

1. In Ninh Binh, there are only two HIV/AIDS OPCs, all of them are categorized within the preventive medicine system, including one HIV/AIDS OPC at the PAC which currently manages one point of ARV distribution at Hoa Lu and another HIV/AIDS OPC at Kim Son District Health Center.
2. In Dong Thap, there are three HIV/AIDS OPCs which are a part of the treatment system located in public hospitals (Dong Thap Provincial General Hospital, Hong Ngu General Hospital and Sa Dec General Hospital).

4.2.2. Inpatient treatment facilities for HIV/AIDS patients

HIV/AIDS patients who need inpatient treatment are admitted to infectious disease or other specialized departments of a Provincial or District Hospital. Results from the assessment show that 17.4% of PLHIV registered at HIV/AIDS OPC had inpatient treatment in Ninh Binh in the last 12 months and 11.2% in Dong Thap.

4.2.3. Medical care and management of HIV/AIDS patients

In general, the process of PLHIV management and medical care in the two provinces comply with MOH directives. Accordingly, clients with HIV-positive results are referred by health workers to HIV/AIDS OPCs for registration for examination and treatment, since currently HIV/AIDS OPCs are the only facilities which can follow up and manage PLHIV in accordance with the technical process, and more importantly they are the only facilities providing ARV drugs.

Three patterns emerge when HIV/AIDS patients visit health facilities:

1. PLHIV registers at an HIV/AIDS OPC for outpatient examination and treatment. The patient receives a clinical stage evaluation and CD4 count to ensure appropriate treatment protocol. If the patient is eligible for ART, ARV drugs are free of charge and the patient is provided with follow up services and receive medicines at a doctor's appointment on a regular basis (often monthly). If the patient is not yet eligible for ART, then he/she is included in the observation list and receives CD4, liver and kidney tests periodically. In May 2013, approximately 25% and 14.8% of PLHIV in Ninh Binh and Dong Thap respectively used services at HIV/AIDS OPCs.
2. PLHIV chooses both to register and receive services (mainly ARV) at a HIV/AIDS OPCs but also use other health facilities for non ARV medical care. Currently in two provinces nearly 30% of patients managed under HIV/AIDS OPCs are using medical

services at both types of facilities, and 14% of HIV/AIDS OPC patients have used inpatient treatment services in hospitals within 12 months prior to the survey.

3. PLHIV chooses not to visit HIV/AIDS OPCs for various reasons, either because he/she does not need to (feels healthy, with a high CD4 count) or due to concern regarding stigma and discrimination. When this group has non-HIV related health problems, they usually access other public health facilities for medical examination and treatment like any individual of the general population. Currently, the provinces do not have any data on the number of PLHIV who are eligible for ART (CD4 = < 350) but do not attend HIV/AIDS OPC.

4.2.4. Access and use of SHI among HIV/AIDS patients in the two provinces

As indicated in Section 2.4. on policies that affect coverage and implementation of SHI for PLHIV, the Government's *Decree No. 62/2009/ND-CP* dated 27th July, 2009 and its accompanied *Circular No. 09/2009/TTLT-BYT-BTC* dated 14th August, 2009 jointly issued by the MOH and Ministry of Finance have provided concrete guidance for implementing SHI at all levels of eligible health facilities. In overall both Ninh Binh and Dong Thap provinces have implemented SHI strictly in accordance with these existing policies, including organization of the SHI system, issuing SHI cards, organizing health care, and the SHI scheme reimbursing eligible services.

The current estimated average percentage of insured PLHIV in the two provinces is nearly 54%. Notably among the insured, nearly 25% paid for voluntary subscriptions to SHI. Together with the number of PLHIV who indicated their intention of participating in the SHI scheme, this is an important indicator predicting the feasibility of increasing the number of PLHIV covered by SHI. There is evident gender difference in access to SHI in both provinces. The proportion of women with SHI cards living with HIV is higher than that of men (58.5% compared to 51%).

There are also differences between two provinces in using SHI cards and in implementation of SHI policy for reimbursement of medical expenses for insured PLHIV (in general or ART only).

Ninh Binh

The proportion of PLHIV who have SHI in Ninh Binh is quite high (69.2%), almost equal to national levels for the general population. However, almost all insured PLHIV are enrolled in the poor and near poor health categories of SHI (83%) where the premium rates are subsidized 100% by the state (central and local). The number of PLHIV who subscribed to SHI under the voluntary category in Ninh Binh only account for 16% of insured PLHIV. In addition, when stratified by gender, there was a notable difference between men and women accessing health insurance, where most female PLHIV do have SHI, but health insurance coverage among male PLHIV is only 62%.

Currently, 77.7% of insured PLHIV are registered at commune health centers, 15.7% at district health centers and nearly 6% registered at the provincial hospitals. However, survey data showed that almost all PLHIV who buy SHI cards through voluntary subscription registered at district level and above. Furthermore, the majority of PLHIV

who indicated willingness to pay for SHI cards (70%) also stated that they would prefer to register at district level or above.

Social Health Insurance cards are used by insured PLHIV in different ways for health care:

- *Inpatient treatment.* In Ninh Binh, amongst the insured PLHIV in the survey sample who had been admitted for inpatient treatment services in the last 12 months, up to 75% used SHI cards every time, 3.1% used some of the time and about 22% did not use their SHI card when hospitalized.
- *Outpatient treatment.* Two distinct types of health facilities provide outpatient services to PLHIV. Non HIV/AIDS specific facilities provide general services to PLHIV, as well and HIV related examinations and treatment including Opportunistic Infections (OIs). These “treatment” facilities have contracts with VSS and PLHIV have the possibility of using their SHI card benefits. Up to 85% of insured PLHIV used their SHI cards for all of their visits to health facilities for outpatient treatment and only 10.5% patient did not use their SHI card. HIV/AIDS OPCs provide ARV treatment covered by the Global Fund, where 100% of insured PLHIV did not use their SHI at time of service.

In Dong Thap

The assessment results show that the proportion of PLHIV who have SHI cards in Dong Thap is about 39%, much lower compared to Ninh Binh or the national average. Although most insured PLHIV in Dong Thap subscribed to SHI are also in the poor and near poor categories, this province differs from Ninh Binh in that the proportion of insured PLHIV who have subsidized SHI cards (for the poor and near poor) is much lower (67%). The proportion of insured PLHIV who subscribed to voluntary SHI was more than double that of Ninh Binh (about 36%).

Another difference with Ninh Binh is that 62.1% of insured PLHIV in Dong Thap are currently registered at commune health centers, 24.2% registered at district health centers and only 10.5% registered at the provincial hospitals. When stratified by poverty status or by voluntary subscription, most of insured PLHIV who are non-poor subscribed for voluntary insurance and registered their cards at district levels of health care or higher (70%), which is quite similar to Ninh Binh.

While use of SHI cards for inpatient treatment in Dong Thap was similar to Ninh Binh, there was significant difference in SHI claims/reimbursements between the two provinces regarding treatments at the HIV/AIDS OPC. Insured PLHIV in Dong Thap could and did use their SHI cards for ARV treatment since all HIV/AIDS OPCs in Dong Thap are located in hospitals which have contracts with VSS and can facilitate the SHI administrative process. PLHIV in Ninh Binh do not enjoy their SHI benefits when they come to HIV/AIDS OPC for ARV treatments because these facilities of Ninh Binh are located in the preventive system, and therefore not eligible for signing agreements with VSS, according to the current policies. Concretely:

- *Inpatient treatment: In Dong Thap*, 77% of insured PLHIV who both registered at HIV/AIDS OPC and had inpatient treatment in the last 12 months used their SHI card for all hospitalization episodes and only 23% of them did not their SHI card when hospitalized. This data is similar to that of Ninh Binh province.
- *Outpatient treatment: Similarly to Ninh Binh*, two different scenarios exist. With non ARV related outpatient treatment (PLHIV who come to health facilities other than HIV/AIDS OPCs for general medical services, examinations and treatment for diseases, including OIs), only 38% of insured PLHIV used their SHI cards for all medical care visits and 62% patient did not use their cards. For outpatient treatment related to ARV treatment at HIV/AIDS OPCs, even though the use of SHI is higher than Ninh Binh, only 30% of insured PLHIV in Dong Thap used their SHI cards at the HIV/AIDS OPC. Expenses covered by SHI are also limited to a few services which include general health examination, blood and liver (HbG) tests, X-ray, OI prevention and treatment.

4.2.5. Sources of funds for HIV/AIDS OPCs operation:

There are also major differences in the way which OPCs are financed in the two provinces. These differences influence whether the SHI scheme is legally allowed to reimburse providers. Legislation prevents donor funded services from being reimbursed by the VSS through SHI (since that would amount to double payment).

	Ninh Binh (HIV/AIDS OPC in preventive system)	Dong Thap (HIV/AIDS OPC in treatment system)
Financing sources for Care and Treatment		
CD4 Test (regular test)	Patients receive free CD4 test, financed by Global Fund administered by PACs.	Patients receive free CD4 test at PAC: 1. Biological: paid by VAAC 2. Incentive: paid by National Targeted Program (NTP)
ARV drugs	Covered by Global Fund	1. Provincial General Hospital and Hong Ngu HIV/AIDS OPC: paid by Global Fund 2. Sa Dec HIV/AIDS OPC: paid by NTP
OI prevention drugs (Cotrimoxazole)	Covered by Global Fund	1. Provincial General Hospital and Hong Ngu HIV/AIDS OPC: paid by Global Fund 2. Sa Dec HIV/AIDS OPC: out-of-pocket payment
Opportunistic Infection treatment drugs	Out-of-pocket (OOP) payment	OOP payment
Other routine tests	OOP payment	1. Patients with SHI card: paid in accordance with regulations 2. Non-insured patients: out-of-pocket payment

	Ninh Binh (HIV/AIDS OPC in preventive system)	Dong Thap (HIV/AIDS OPC in treatment system)
Salaries, consumable supplies, utilities, etc.	State budget	State budget
Incentives	Global Fund	Global Fund
Other expenses	NTP	NTP

Clearly the current HIV/AIDS service delivery system through HIV/AIDS OPCs is unable to fully meet the growing demands due to their limited number (as there are only two or three HIV/AIDS OPCs per province), which also limits geographic accessibility (most facilities are at provincial level). With the current proportion of less than 30% PLHIV or about 55% PLHIV in need of ARV treatment are actually being treated at HIV/AIDS OPCs in the whole country, there still be a significant number of PLHIV whose health status are not managed systematically and might not timely receive treatment regimens.

Financing for HIV/AIDS OPCs especially those located in the preventive system comes from various sources which are often not in line with the national health financing system (higher salary levels, different reporting systems). This is also true for provinces that have no or little foreign assistance for HIV/AIDS care and treatment. Moreover, OPCs in many provinces including Ninh Binh are registered as “preventive” facilities and as such are not able to sign contracts with VSS and therefore are ineligible for SHI payments. Our assessment studies showed that application of SHI benefits for PLHIV attending HIV/AIDS OPCs is limited and erratic. Each province does what they can but in the absence of governance framework which is applied to the policies they implement¹⁴.

V. PROPOSED PILOT MODEL

The MOH of Vietnam has developed and proposed a *Plan on Financing HIV/AIDS Prevention and Control Activities for the period 2013-2020*. The Plan emphasizes the following solution methods: (1) Fund mobilization from diversified sources; (2) Ensure effective usage and management of mobilized financial resources. Effective integration of HIV/AIDS services for PLHIV into the existing national SHI scheme is one of the major recommendations in the plan. A pilot for this integration is an important step to ensuring the effective roll-out of the national policy.

Inclusion of PLHIV into the national UHC initiative in Vietnam through the SHI scheme is a logical next step to ensuring a sustainable HIV/AIDS control program. It has the potential to contribute substantially to a long term solution which will ensure PLHIV have access to general health services as well as ARV treatments in particular, especially in the context of declining donor funding.

¹⁴ USAID/HPI, *Assessment Results from Ninh Binh and Dong Thap*, Hanoi, Vietnam, unpublished report, September 2013.

A concrete legal framework for coverage of care and treatment for PLHIV within the government sponsored SHI scheme exists. This framework serves as the basis for MOH and SHI to continue the implementation of a comprehensive and sustainable health insurance program for PLHIV. The draft of MOH's *Plan for health insurance coverage of HIV/AIDS treatment services from 2012-2015 and to 2020*, which is currently under consideration by the Vietnamese Government is an important step towards effective and timely inclusion of PLHIV into the SHI scheme.

Findings from the assessment analysis conducted in Dong Thap and Ninh Binh provinces in early 2013 also revealed the following factors in favor of SHI for PLHIV:

- Current SHI coverage among PLHIV in the two study areas is similar to that of the general population, estimated at 50% on average, ranging nationwide from 39% to 69%;
- PLHIV do use their SHI cards for non-ARV health services, including both inpatient and outpatient care in health facilities;
- Although subsidized subscriptions to SHI for the poor account for the majority of insured PLHIV, there is a considerable proportion of PLHIV who either already subscribed to the SHI scheme voluntarily or are willing to contribute to the purchase of a subscription;
- Currently, the state budget does cover essential expenses of HIV/AIDS OPCs such as human resources, management and other recurring expenses. Therefore, if the SHI pays for medicine and other costs of HIV/AIDS treatment in the same way as it does for other diseases, HIV/AIDS OPCs should be able to sustain their operations and ensure the compliance of HIV/AIDS treatment;
- Some HIV/AIDS OPCs located in health facilities are already receiving SHI payments for medical care and treatment for insured PLHIV (such as the case of Dong Thap) and this model can be replicated at other sites.

5.1 Rationale

Pilot projects play a fundamental role in testing new initiatives on a small scale before determining whether reforms can be scaled up to a national level. In the case of Vietnam, the political decision to partially finance HIV/AIDS care and treatment through SHI appears already to have been taken.¹⁵ The purpose of this proposed pilot would be to test out specific modalities and provide answers to some remaining questions which remain about this important initiative (see box 2). The provinces of Ninh Binh and Dong Thap are suggested as the pilot areas because they represent provinces where the current implementation of HIV/AIDS care and treatment is minimally distorted by international donor funding.

¹⁵ Vietnam Ministry of Health. "Draft of Plan for health insurance coverage of HIV/AIDS treatment services from 2012-2015 and 2020." Vietnam Ministry of Health, 2013.

International best practices¹⁶ identify essential elements to a successful health systems pilot. Not only it is important that the objective of the pilot be clearly stated but also that specific study questions be articulated at the outset and a robust monitoring and evaluation (M&E) framework be included in the project design to ensure that pertinent data is available at project close. In our draft, we propose some study questions and provide input for M&E. It should however be noted that due to time constraints (end of USAID/HPI project) this proposal is a draft and still require find tuning and consensus building, a process with is outlined in the section on next steps (section VI).

This proposed pilot model is based on the current application of SHI scheme for HIV/AIDS services, and the existing organizational structure and operational model for HIV/AIDS care and treatment service delivery in Ninh Binh and Dong Thap provinces. The model was designed with extensive reference to experiences in other provinces and cities across the country. On-going health insurance-related proposals, projects and initiatives by the MOH and provinces/cities have also been taken into account.

5.2 Objectives of the model

‘PLHIV will receive medical care and effectively access SHI benefits at any eligible health facility’

The overall objective of this model is to contribute to the effective implementation of the “National Plan for Health Insurance of HIV/AIDS treatment services period 2012-2015 and to 2020” by piloting a model in Ninh Binh and Dong Thap provinces, which represent provinces with no or little donor assistance for HIV/AIDS care and treatment.

Box 2

Indicative study questions

- What are the current and future costs a defined essential (NTP) packet of services for PLHIV
- What is the current/expected breakdown of spending for HIV services provided (who pays for what? NTP, Ministry of Health, OOP, facility funds)?
- Which are the most important barriers to hospitals being reimbursed by the VSS for PLHIV care and treatment?
- What are the major problems faced by PLHIV in accessing HIV services at public hospitals and using their SHI cards effectively to cover the cost?

The specific objectives to be reached by the pilot model by the end of 2015 include:

- Strategic targets of SHI coverage for PLHIV achieved, specifically:
 - 50%-70% of PLHIV will have SHI cards;
 - 60%-80% of insured PLHIV will effectively use their benefits for medical services including ARV drugs, OIs, and inpatient treatment;
 - Local VSS institutions will provide insurance benefits for insured PLHIV in accordance with the regulations.
- Feasibility and appropriateness of the proposed model of HIV/AIDS service delivery and SHI coverage for PLHIV validated in the

¹⁶ Partners for Health Reform*plus*. “The Role of Pilot Programs: Approaches to Health Systems Strengthening”. Bethesda, MD: PHR*plus*, Abt Associates Inc., August 2004.

two pilot provinces through independent evaluations.

- Detailed master plan for the roll out of SHI coverage completed for PLHIV according to the desired timeline as set out in the National Plan.

5.3 Beneficiaries

The direct beneficiaries of this model include all PLHIV in Dong Thap and Ninh Binh who want to participate in the SHI scheme and who require medical care in the two pilot provinces. All PLHIV will be entitled to benefits from the SHI scheme under the same modalities the general population under existing health insurance policies of Vietnam.

5.4 Service provision and care packages

HIV/AIDS related laboratory tests as well as care and treatment services should be made available at all health facilities that are qualified to provide such services. HIV/AIDS patients in need of medical care should be permitted to access the qualified health facility most convenient to them. This aspect should attenuate the current geographic accessibility issues which affect PLHIV currently receiving treatment and specifically ARV treatment.

Once the policy barriers have been removed, VSS agencies will be able to sign contracts with all health facilities qualified to provide HIV/AIDS examination and treatment services, including the current HIV/AIDS OPCs. In this manner all HIV care and treatment facilities will be eligible for reimbursement of services from the SHI funds. Subscriptions for SHI cards for PLHIV will be facilitated through existing mechanisms including subsidized cards for the poor and near poor, or voluntary health insurance.

Social Health Insurance card holding PLHIV will follow normal channels and qualify for insurance benefits like any other SHI cardholder and in accordance with cost norms and other regulations for HIV/AIDS care and treatment.

A key element to the effective operation of this model is that all HIV/AIDS OPCs, including HIV/AIDS OPCs in the preventive system are acknowledged as health service providers and permitted to sign contracts with VSS like any other health facilities qualified for the national SHI scheme. Once this model is implemented, financial sustainability of HIV/AIDS

Box 3

Guiding principles for the development and implementation of the model

- Ensure the rights and welfare of PLHIV and ensure the convenient access to HIV/AIDS services for PLHIV in need;
- Reduce stigma and discrimination against PLHIV;
- Limit the changes and disruptions to existing service delivery system and the established SHI scheme;
- Ensure the feasibility and sustainability of the SHI fund;
- Reduce the burden of PLHIV's out-of-pocket expenditures;
- Focus on ARV care and treatment, taking into account its long term nature.

OPCs for providing HIV/AIDS care and treatment services will be more stable and these providers will remain attractive options to insured PLHIV seeking health services, which will allow for supply of services to more adequately meeting existing, and future, demand.

Proposed treatment services packages

Based on MOH and VAAC regulations on care and treatment for PLHIV as well as current cost of care, HIV/AIDS service provision in Vietnam and the existing health insurance policy framework, we are proposing two service package options for PLHIV in this model. The major difference between the two packages is mainly on the elements covered by SHI benefits. While Package 1 - Comprehensive Treatment proposes full coverage by SHI for the range of PLHIV treatment needs, the Essential Package (Package 2) does not include ARV drugs based on the assumption that current practice of free ARV drugs will be continued by the GVN in the future.

The intention of giving two model options is so the pilot can be implemented differently in two sites providing actual costing data and sustainability projections for both options. It is especially important to assess the financing ability of the SHI according to different treatment options. The pilot will document the financial impact of each service package facilitate the decision making by policy makers related to final choice of a national care and treatment package for PLHIV for ultimate scale-up.

Service Package 1: Comprehensive package

This package includes: ARV treatment and services which are currently provided by the HIV/AIDS OPC, as well as hospitalization and outpatient treatment for OIs and for other HIV/AIDS related medical issues.

Under this service package, the SHI scheme is expected to cover the medical expenses for all essential health care needs, including ARV treatment, outpatient care and inpatient treatment. Although at present HIV/AIDS patients may have to pay for routine laboratory tests in provinces where there is no donor support, ARV treatments are nonetheless provided free of charge. Therefore it is envisaged that once this “comprehensive” package is implemented, SHI will cover the costs of ARV treatment, including ARV drugs and routine laboratory tests.

As regulated by the MOH, ARV treatment and services at HIV/AIDS OPCs include:

- Examinations and clinical assessment to periodically monitor treatment;
- Counseling (pre-ARV treatment and adherence of ARV treatment);
- ARV drugs (1st line or 2nd line)
- Other routine testing: before and after treatment and once per 6 month since starting treatment:
 - CD4 counts
 - Formula blood test/Hbg

- Alanine Aminotransferase (ALT) if treatment regimen includes Nevirapine (NVP)
- Creatinine when using regimen include Tenofovir (TDF)
- Virus load test if possible
- Lipid and fasting blood glucose when using Protease Inhibitor (PI) regimens or other regimens: once a year or when patients show signs of lipodystrophy
- Prophylaxis prevention of OIs with cotrimoxazole or other drugs for OI treatment.

The major strength of Service Package 1 is the “comprehensiveness” of SHI coverage for its card holders. Reimbursements from the SHI scheme to providers for the services included in this package will ensure that PLHIV receive all essential health care once they have cards. At the same time it helps to free the HIV/AIDS care and treatment system from the heavy bureaucratic procedures as well as uncertainty in request of Government funding for ARV drugs which is currently done on an annual basis. A comprehensive benefit package would make it highly attractive for PLHIV voluntary participation (higher premium).

However, the limitation of the package is that it will significantly increase the financial burden on the SHI scheme, which may affect the feasibility of the model in the long term. It is expected that careful testing of the model in different economic settings will provide accurate data for decision making on scaling up the model to national level in the future.

Service Package 2: Basic Package

The benefits to be covered by SHI under this service package would include: ARV treatment (but excluding ARV drugs), the services currently provided at the HIV/AIDS OPC and hospitalization. For the Basic Treatment Package SHI will not pay for costs of ARV drugs or for outpatient care in health facilities other than HIV/AIDS OPCs. This package in fact will only create minor increase of SHI payments for medical care of PLHIV in relation to the present situation. It must be noted that given the high costs of ARV drugs and the difficult socio-economic situation of PLHIV, the GVN will need to continue to provide ARV drugs free of charge until the full range services under Package 1 can be implemented.

According to the MOH’s standard protocol, covered aspects of ARV treatment and services at HIV/AIDS OPC level include:

- Medical examination and evaluation of clinical stage for monitoring for treatment
- Counseling (pre-treatment counseling and treatment adherence counseling when starting ARV treatment)
- Routine laboratory tests: to be done before treatment and biannually from the start of treatment, including:
 - CD4
 - Formula blood test/ HbG
 - ALT (Alanine Aminotransferase) if the treatment regimen includes NVP (Nevirapine)

- Creatinine if the treatment regimen includes Tenofovir (TDF)
- Viral load test, if possible
- Lipid and fasting blood glucose when using PI regimens or other regimens: once a year or when patients show signs of lipodystrophy.
- OIs prophylaxis using cotrimoxazole and other OI treatment drugs.

The principal advantage of the Basic Treatment Package is that the minimum costs to be covered by SHI would make it highly feasible in most, if not all settings. However, the limited services and benefits to be covered by SHI would greatly affect the sustainability of ARV treatment for PLHIV and therefore make it not very attractive to PLHIV to participate. For this reason this service package is proposed only as a temporary solution in case the budget of VSS faces a serious short-fall and cannot afford the Comprehensive Service Package. The ultimate, long-term solution should be the Comprehensive Treatment Package (Package 1).

Cost estimates based on currently available data are available in the annex for both treatment packages.

5.5 Implementation

While this model is designed to be piloted in Ninh Binh and Dong Thap provinces, it could also be piloted in other provinces presenting similar situations.

- *Implementation duration:* Two years, from 2014 to 2015
- *Implementation strategies:*
 - In order to be able to make comparison and draw experiences and lessons learned in a consistent manner, each province should pilot one of the two packages proposed above;
 - Eligible provincial and district hospitals will be permitted to provide care and treatment for PLHIV by the Provincial Department of Health under the official direction of the MOH. Dong Thap province starts with a more favorable situation since the HIV/AIDS OPCs are currently managed and operated as an integral part of the treatment system. In this case, the Provincial Health Service will only have to extend permission to additional eligible district/provincial hospitals to provide health services to HIV/AIDS patients;
 - Those HIV/AIDS OPCs that are currently operating as part of the preventive health system will need assistance in signing contracts with VSS/DSS for reimbursement of the services they provide. Increasing the number of eligible providers will not only increase services to PLHIV who need care and treatment, but, funds from SHI will contribute to the sustainable financing of health services for PLHIV;
 - During the pilot period, drug procurement should be pooled by one responsible party, the MOH or other, for all ARV drugs and OI medicines to be covered by

SHI. This option is more cost effective, because larger numbers of patients and orders of medications means lower prices. Furthermore, provincial systems do not currently have the capacity to procure and distribute these medications efficiently.

5.5.1 Main components

Policy reinforcement

In order to effectively implement the SHI model for PLHIV, certain regulations and guidance documents must be modified or updated. For example:

- Guidelines and decisions on HIV/AIDS related health care registration, reference and treatment services covered by SHI, must be applied consistently to all HIV/AIDS OPCs at all levels for PLHIVs with SHI cards;
- Provisions in the existing legal documents related to PLHIV's access to health care services need to reflect their effective inclusion in the SHI benefit package;
- Revision and/or update legal documents related to the functions, responsibilities and technical scopes of health facilities at district level and of those in the preventive system, which have functions of providing health care for PLHIVs, is needed in order to make them eligible for signing contracts with the SHI fund.

The policy component, must emphasize that the health financing policy framework should be thoroughly and comprehensively studied from the perspective of a comprehensive and long-term strategy aiming at consolidating and strengthening the sustainability and enhancing the quality of health care services for PLHIV. On this basis, the development and completion of the system of legal documents and technical guidance will be implemented in a systematic and logical manner to minimize the overlap, omissions, or vagueness in the policy framework.

Improving service provision

Supporting existing providers to providing and processing HIV/AIDS related health care services and ensuring a timely and efficient SHI payment process for HIV/AIDS care and treatment services PLHIV is essential to a successful pilot. Possible activities could include:

- Implementation capacity building activities based on rapid assessments. These capacity building activities for newly identified health facilities to provide care and treatment could include modules including staffing, clinic and service organization, refresher courses on HIV/AIDS examination and treatment, as well as awareness raising to address stigma and discrimination issues.
- Facilitation of clinic-based PLHIV monitoring and management process with linkages to the community.
- Provision of guidance and supportive supervision for the implementation of SHI reimbursement for care and treatment services to health facilities.

The suggested expansion of HIV/AIDS care and treatment services to all qualified health facilities including HIV/AIDS OPCs only requires minimal changes in the health care system since most health facilities from district level and above already have adequate conditions to provide medical services for PLHIV. However, those health facilities that newly undertake care and treatment services for PLHIV would need careful preparation and supportive supervision of human resources, facilities and expertise to ensure quality of services. Even existing HIV/AIDS OPCs would benefit from additional investments to fully meet the standards of eligible health facilities for SHI as currently regulated.

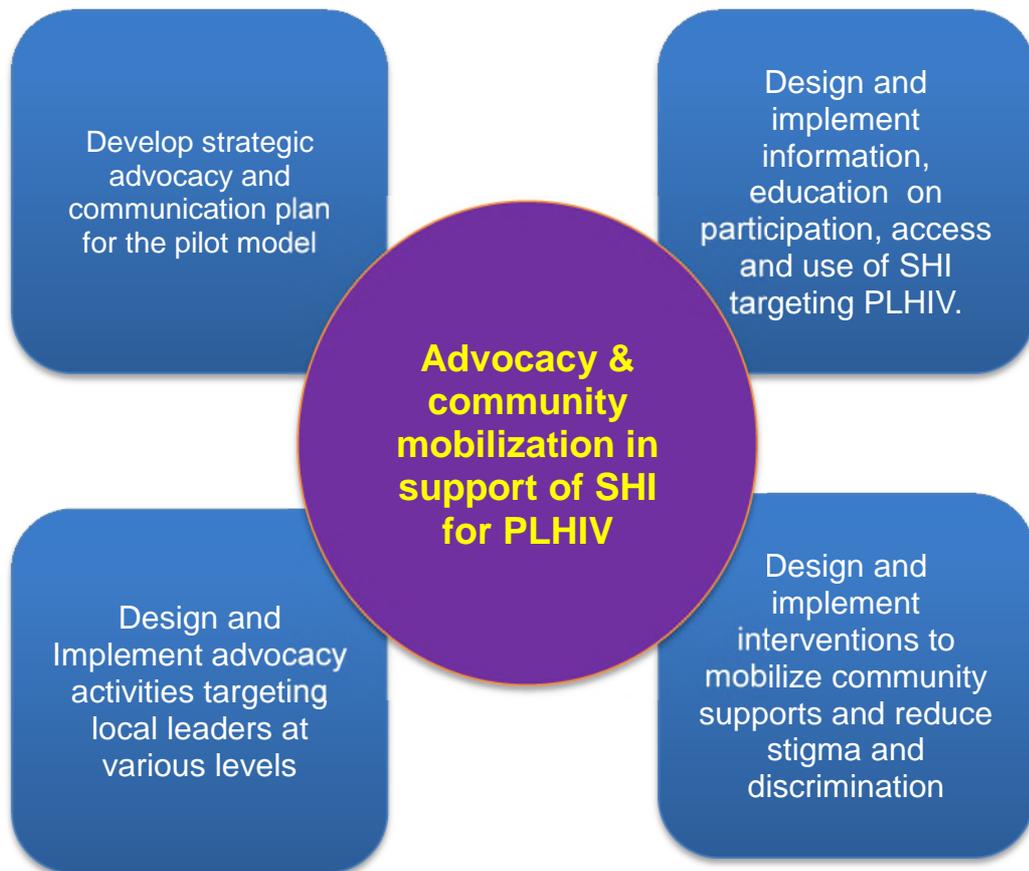
Advocacy for supporting PLHIV to participate in SHI

These activities must be implemented from the very beginning of the pilot. Although the percentage of “voluntary” SHI participants is low, the number of PLHIV who are willing to purchase SHI cards was found to be fairly high in Ninh Binh and Dong Thap. Therefore, under the pilot model, improved public and community-based information and advocacy for PLHIV to participate in voluntary SHI is essential where PLHIV are not eligible for poor and near poor subsidies. In addition, local health services will require support for their promotional activities targeting PLHIV so that they will be adequately and timely informed of significant changes in provision of health care and new SHI payment policies. These elements are key to increasing PLHIV access to health services with their SHI cards.

Under this pilot model, advocacy activities to support PLHIV to participate in SHI could include:

- Support provinces in developing strategic advocacy and communication plans. These strategic plans on advocacy, information and education for the implementation of SHI at local level should not merely include a list of activities with estimated budget and division of responsibilities, rather there should be necessary steps and elements of a strategic communication program;
- Implement advocacy activities for local leaders to inform them of the benefits to and the requirements of participating in the pilot model, and at the same time call for the attention and specific commitments of leaders of related agencies for the implementation of the pilot;
- Provide information and counseling for PLHIV on accessing SHI, participation and utilization. These activities should use various forms and multiple channels of communication, including the government system and mass organizations. These behavior change and communications packages should provide information on the revised service delivery system, the process and procedures of SHI registration and utilization, benefits of PLHIV with SHI cards, and advocacy for participation in SHI.

Advocacy and community mobilization components



Resource mobilization for the implementation of the model

Resource mobilization will focus on the following areas: a) financial resources for subsidizing SHI cards for PLHIV; b) securing adequate supplies of ARV and OI drugs; c) capacity building for health facilities, including HIV/AIDS OPC; d) funds for implementation of the pilot model's activities.

For effective resource mobilization, the pilot model implementing agencies should develop an overall financial plan for all of the areas mentioned above, as well as identify sources and mobilization approaches. One important aspect in developing an effective financial plan is appropriate coordination of resources and strengthened integration with existing sources.

Monitoring and evaluation

The objective of a pilot is to provide a testing ground for future scale up. Robust M&E is essential to insuring that the outputs of any pilot feed back into policy reform and future

implementation.¹⁷ Monitoring is a regular activity which follows data on a continual basis, which is just as important as the evaluation of the pilot as a whole.

A simple but effective monitoring and supervision system should be developed by the implementing agency at the beginning of the pilot. Indicators should be readily available through existing data collection and adhere to SMART criteria (Specific, Measurable, Available, Relevant and Timely). It is recommended that the indicators of pilot model include elements of quality of service provision as well as the degree of policy changes for implementation of SHI. The monitoring system, which provides information on a regular (monthly or quarterly basis) will help managers to detect and correct critical problems throughout the implementation period. A robust monitoring system will also provide reliable data to policy makers, macro-level planners which will allow for informed decisions to be made. The monitoring systems should closely follow data which tracks the objective of the pilot (effectively providing SHI coverage to PLHIV for care and treatment) while providing inputs to answer the study questions.

At local level, each HIV/AIDS treatment center will monitor their clients and carefully record and report information related to the services provided, and their financing. It is equally important that each local SHI agency monitor the number and amount of services reimbursed. The SHI for PLHIV management unit must be responsible for collecting, synthesizing and making periodical reports to the central level. It is also vital that the entire M&E system will be designed as a two-way flow in order to ensure timely feedback from national level on the quality and process of implementation. Local level staff are far more likely to collect quality data in a timely manner if they get feedback on the information they are sending to higher levels.

It is highly recommended that baseline data be established at the beginning of the pilot against which the objectives will be measured at the end of the pilot period. Information from the assessments undertaken by USAID/HPI in Ninh Binh and Dong Thap¹⁸ should be an integral part of this baseline. An external evaluation, would prove useful in determining the success of the pilot, and provide an unbiased source of information.

5.5.2 Strengths and challenges

The proposed pilot model is faced with both strengths and challenges. The strengths contribute to the high feasibility of the model since it builds on political will to include PLHIV into the national SHI program. Furthermore, it builds on the existing health system, and modest financial investments will ensure sustainable benefits of PLHIV and contribute significantly to the sustainable financing health services for PLHIV.

The implementing agency must pay adequate attention to meeting the stated objective while addressing the fundamental problems PLHIV face in using their SHI cards, as well

¹⁷ Partners for Health Reform *plus*. August 2004. *The Role of Pilot Programs: Approaches to Health Systems Strengthening*. Bethesda, MD: PHR *plus*, Abt Associates Inc.

¹⁸ USAID/HPI, *Assessment Results from Ninh Binh and Dong Thap*, Hanoi, Vietnam, unpublished report, September 2013.

as ensure that the principal service providers are aware and buy into the guiding principles (box 3).

Strengths	Challenges
<ul style="list-style-type: none"> ▪ PLHIV participation and use of SHI card is an integral part of the Vietnamese policy supporting the national goal of universal health coverage. ▪ All OPCs qualify to provide HIV/AIDS services covered by the SHI scheme and the number of HIV/AIDS care and treatment facilities will increase with only minor adjustments needed. ▪ Primary care registration at district level will facilitate better access to health care for PLHIV and reduce complicated referral procedures when using their SHI cards. ▪ Minimal changes in the current health care and VSS system of social health insurance enhances the ability of the SHI scheme to respond to the health care and treatment needs of PLHIV. ▪ SHI coverage for care and treatment will reduce OOP expenses for PLHIV and in the long-term ease the burden on the government budget (salary, management and facility) by including PLHIV into the national risk pool for universal health coverage. 	<ul style="list-style-type: none"> ▪ Removing policy barriers will take time (see brief overview in section 4.3.8). This policy work requires further detailed planning when developing the final implementation plan. ▪ Capacity at health facilities must be strengthened to ensure the quality of care and treatment services especially at health facilities that begin to provide HIV/AIDS treatment. ▪ HIV/AIDS OPCs which belong to preventive system will have to integrate into the current curative system. This change in management could lead to changes in performance. ▪ Training on how to process SHI benefits will be required, especially in those locations where SHI cards have not previously been used.

VI. NEXT STEPS

Given the keen interests from various stake holders from central level and from a number of provinces in the proposed pilot model of SHI for PLHIV developed with the support of USAID/HPI Vietnam, and taking into account the timeline of national master plan on SHI for treatment of PLHIV, the GVN and donor agencies should take prompt actions in moving forward to implementation of pilot model.

Outlined below are a number of key activities to ensure an effective implementation of the pilot model that need to be accomplished over the next 12 months:

	Steps	Indicative time frame
1	Discuss and develop existing pilot model further at national level (MoH-HID, VAAC, VSS, USAID), including scope, financing, time frame, implementing mechanism.	October 2013
2	Refine pilot model including study questions which still need to be answered by the pilot to contribute to a generalized roll out including 1) more robust costing of care and treatment packages 2) streamlining reimbursement to facilities by VSS to ensure timely payment so facilities limit cash flow issues.	November 2013 – January 2014
3	Develop a road map for removing policy bottlenecks at national level.	October 2013
4	Prepare tender documents and secure funding for piloting the model.	October- November 2013
5	Gather consensus with provincial level stakeholders.	January 2014
6	Secure the official decision from MOH for implementation of pilot model	January 2014
7	Establish a task force on SHI for PLHIV which will include MOH (DHI, VAAC, Treatment Department, Legal Department), VSS, donor(s) and PLHIV.	February 2014
8	Prepare a detailed implementation plan for the pilot model in two years 2014-2015	February – May 2014
9	Hold consultation meeting(s) on the detailed plan in order to identify possible bottleneck, barriers, requirements for pilot implementation.	March - June 2014
10	Revise detailed work plan and develop a detailed mapping of solutions addressing identified issues and barriers.	Upon identification of implementing partner
11	Last consultation meeting to finalize the detailed work plan and solutions mapping.	July 2014
12	Prepare a legal framework for pilot provinces. The task force	July-October 2014

	Steps	Indicative time frame
	will contribute to developing a “draft” legal framework and a list of all the necessary documents which will comprehensively facilitate implementation of pilot model in selected provinces. The preparation process will be done in close consultation with provincial level and other related stake holders including PLHIV.	
13	Draft necessary revisions or new policy documents as defined in the approved legal frame work at both national and provincial levels.	Starting July 2014
14	Obtain official approval for draft legal documents to be piloted in selected provinces.	Starting August 2014
15	Conduct series of provincial planning meetings in each pilot province.	April – May 2014
16	Obtain official approval of provincial plans and budget by national and provincial authorities.	June 2014
17	Start pilot implementation activities at provincial level.	September 2014

It is estimated that in order to have adequate time for significant assessment results of the pilot model, actual implementation at provincial level must take place for at least full 12 months, from September 2014 onwards. The final pilot evaluation should be conducted at the end of the period to provide data to inform the subsequent scale up to other provinces.

Parties directly involved in supervising and managing the entire piloting process at central level should include Health Insurance Department, VAAC, VSS, Treatment Department and the Legal Department of the MOH, as well as representatives of donor agencies who will support this process. The inclusion of PLHIV representatives is highly recommended.

VII. Annexes

Annex 1: Cost estimates for the proposed service packages

To facilitate the assessment of the feasibility and appropriateness of the two service packages, a need-based estimation of total costs for each package was made specifically for Ninh Binh and Dong Thap based on the available data sources of 2012, combined with assumptions on the annual changes of these data in the future years in the period from 2012 through 2020. This method of estimation could also be applied for other provinces if data available.

a) *Estimated need for HIV/AIDS treatments in two provinces:*

	2012	2013	2014	2015	2020
Estimated number of PLHIV					
Ninh Binh	2,301	2,521	2,741	2,961	4,061
Dong Thap	4,663	5,013	5,363	5,713	7,463
Estimated number of insured PLHIV					
Ninh Binh	1,588	1,739	1,919	2,073	3,249
Dong Thap	1,814	2,156	2,467	2,857	5,970
Estimated number of insured PLHIV who need 1st line ART					
Ninh Binh	399	502	615	720	1,422
Dong Thap	254	320	385	464	1,110
Estimated number of insured PLHIV who need outpatient treatment in other health facilities (outside HIV/AIDS OPC)					
Ninh Binh	768	842	929	1,003	1,572
Dong Thap	405	481	550	637	1,331
Estimated number of insured PLHIV who will be hospitalized					
Ninh Binh	324	355	391	423	663
Dong Thap	250	297	340	394	824

Data sources and method for estimation of PLHIV treatment needs

- Projected number of PLHIV and number of PLHIV who need ARV treatment are calculated based on an assumption that annual increase remain constant from 2012 through 2020 and is equal to the mean increase in each province in two years 2011-2012 (data were provided by PAC of Dong Thap and Ninh Binh)
- Projected proportion of insured PLHIV from 2012 is based on the survey results in Ninh Binh and Dong Thap
- Proportion of insured PLHIV period 2013-2020 is estimated based on the targets of the proposed model

- Estimated proportion of PLHIV using health care services from 2012-2020 is based on the survey results in Ninh Binh and Dong Thap with the assumption that this proportion remain constant through years

b) Estimated costs for HIV/AIDS treatments to be covered by SHI in two provinces:

Unit: millions Dong

	2012	2013	2014	2015	2020
Estimated total SHI reimbursements for Package 1					
Ninh Binh	2,889	3,408	3,984	4,510	8,163
Dong Thap	1,950	2,386	2,799	3,311	7,441
Average SHI reimbursement for a single card holder for Service Package 1					
Ninh Binh	1.82	1.96	2.08	2.18	2.51
Dong Thap	1.08	1.11	1.13	1.16	1.25
Estimated total SHI reimbursements for Package 2					
Ninh Binh	1,308	1,509	1,735	1,939	3,383
Dong Thap	947	1,147	1,334	1,567	3,439
Average SHI reimbursements for a single card holder for Service Package 2					
Ninh Binh	0.82	0.87	0.90	0.94	1.04
Dong Thap	0.52	0.53	0.51	0.55	0.58

Data sources for estimation of PLHIV treatment costs

- Estimated costs for inpatient treatment and outpatient care in health facilities other than HIV/AIDS OPCs is based on survey results conducted in Ninh Binh and Dong Thap
- The proportion of each type of SHI card among PLHIV is based on survey data from Ninh Binh and Dong Thap assessments, in order to estimate the total reimbursement costs for all card types
- Estimate costs for ARV drugs and OI drugs are based on 2011 World Bank report.

Assumptions for estimated PLHIV treatment costs

- The annual inflation rate is equal to 0%
- There is no difference in SHI coverage between PLHIV who currently registered at HIV/AIDS OPC and who are not registered
- All insured PLHIV come to the right level of health facilities and use their SHI card for health care
- Provincial health facilities will continue to only provide 1st line ART
- Salaries, depreciation and management fees are covered by the state budget, and are not included in this estimates

- PLHIV and SHI co-pay for costs under the current regulations for each type of health insurance card, of which SHI pays 95% for the poor, 80% for others (near-poor, volunteer, and compulsory). The remaining will be paid by PLHIV (or from other sources, if any).

Annex 2: Estimated needs for treatment of PLHIV in the whole of Vietnam and costs of each service package, period 2012-2020

Estimate of treatment needs of PLHIV in Vietnam period 2012 – 2020

Unit: thousand persons

	2012	2013	2014	2015	2020
Estimate of overall needs for HIV/AIDS treatments in Vietnam					
Estimated number of PLHIV	266,275	275,894	286,827	299,530	374,530
ART targets for adults	76,200	87,800	99,500	111,000	195,380
- First line ART: 97% of total ART needs	73,914	85,166	96,515	107,670	189,519
- Second line ART: 3% of total ART needs	2,286	2,634	2,985	3,330	5,861
Estimate of PLHIV who will need outpatient treatment in health facilities other than HIV/AIDS OPC	77,250	80,040	83,212	86,897	128,988
Estimate of PLHIV who will be hospitalized	37,966	39,337	40,896	42,707	61,123
Estimate of needs for HIV/AIDS treatments among insured PLHIV in Vietnam					
Estimated number of insured PLHIV	143,522	148,707	154,600	161,447	299,624
ART targets for insured adults	41,072	47,324	53,631	59,829	156,304
- First line ART: 97% of total ART needs	39,840	45,904	52,022	58,034	151,615
- Second line ART: 3% of total ART needs	1,232	1,420	1,609	1,795	4,689
Estimate of insured PLHIV who will need outpatient treatment in health facilities other than HIV/AIDS OPC	55,400	57,401	59,676	62,318	115,655
Estimate of insured PLHIV who will be hospitalized	19,987	20,709	21,530	22,483	41,726

Data source and method of estimating the national needs for HIV/AIDS treatment

- Number of PLHIV and number of PLHIV who need ART is based on VAAC's statistics in 2011 and 2012;
- Proportion of PLHIV using health care is based on the survey results in Ninh Binh and Dong Thap, 2013;

Estimate of total HIV/AIDS treatment costs in the whole of Vietnam to be covered by health insurance period 2012 – 2020

2.1. Service Package 1: Comprehensive treatment – estimates of costs and financial sources

Unit: millions Dong

	2012	2013	2014	2015	2020
Estimated total costs of Package 1 (including salaries, running costs, management)	821,536	914,258	1,009,068	1,104,305	1,842,883
	100%	100%	100%	100%	100%
Estimated total amount to be covered under health insurance scheme	279,538	311,015	343,205	375,546	899,916
	34.0%	34.0%	34.0%	34.0%	48.8%
Total amount to be covered from state budget	285,088	314,164	344,060	374,352	613,276
	34.7%	34.4%	34.1%	33.9%	33.3%
Total amount to be paid out of pocket of PLHIV (including co-payment from insured PLHIV and OOP from uninsured PLHIV)	256,909	289,079	321,803	354,407	329,690
	31.3%	31.6%	31.9%	32.1%	17.9%
Estimated total amount to be paid by health insurance in addition to the current payment	205,173	233,964	263,101	291,894	744,669
Average cost to be paid by SHI for a single card holder	1.95	2.09	2.22	2.33	3.00

2.2. Service Package 2: Essential Treatments – estimates of costs and financial sources

Unit: millions Dong

	2012	2013	2014	2015	2020
Estimated total costs of package 1 (including salaries, running costs, management)	519,304	569,940	622,405	675,751	1,099,863
	100%	100%	100%	100%	100%
Estimated total amount to be covered under health insurance scheme	127,627	138,699	150,199	162,031	362,049
	24.6%	24.3%	24.1%	24.0%	32.9%
Total amount to be covered from state budget	285,088	314,164	344,060	374,352	613,276
	54.9%	55.1%	55.3%	55.4%	55.8%
Estimated total amount to be paid by health insurance in addition to the current payment	106,319	117,078	128,146	139,367	124,539
	20.5%	20.5%	20.6%	20.6%	11.3%
Estimated total amount to be paid by health insurance in addition to the current payment	66,093	74,942	83,916	92,813	233,588
Average cost to be paid by SHI for a single card holder	0.89	0.93	0.97	1.00	1.21

Input data sources and methods of estimation:

- Unit costs for hospitalization and non-OPC outpatient treatment is based on results of survey in Ninh Binh and Dong Thap
- Unit costs for ARV and OIs drugs receiving ART is based on World Bank report 2011
- Percentage of insured PLHIV by types of cards is based on results of survey in Ninh Binh and Dong Thap

Assumptions:

- Inflation rate is equal to 0%
- All insured PLHIV will use their cards and use in the right facility as regulated
- There is no difference between patients having 1st line and 2nd line treatment in using outpatient treatment in other health facilities
- Rate of PLHIV receiving 1st line and 2nd line treatment remains constant throughout the years and based on VAAC estimates (97% is 1st line ART)
- Salary, running costs and management costs are covered by the state budget
- Co-payment of SHI fund and PLHIV according to the existing SHI regulations: SHI covers 95% costs for the insured poor, 80% for others (near poor, voluntary, compulsory).

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This document was produced for review by the United States Agency for International Development. It was prepared by:

Nguyen Mai Huong – Director, Center for Community Health Research and Development (CCRD)

Dang Thu Trang – Senior Researcher, Center for Community Health Research and Development (CCRD)

Nguyen Tri Trung – Senior Researcher, Center for Community Health Research and Development (CCRD)

Christine Ortiz – USAID/Health Policy Initiative Vietnam