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Institutional Analysis in Reforming Social Health Insurance Systems towards Universal Health Coverage: Philippines and Viet Nam

Original title: Enhancing Governance of Social Health Insurance Systems in the Philippines and Viet Nam: Lessons Learnt and Implications for Policy and Institutional Reforms

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Abstract

Governments worldwide have committed to global development agendas such as achieving Sustainable Development Goal 3 (Health lives for all), which aims to improve health outcomes and promote well-being for all. Progress towards better access to and quality of basic health services of countries across the globe has been uneven – underscoring the importance of effective policy coordination and operating mechanisms at multi-level governance systems. Middle-income countries such as the Philippines and Viet Nam are strengthening their social health insurance (SHI) systems as a key strategy to achieve Universal Health Coverage (UHC) and SDG 3.

Here two country case studies exhibit divergent outcomes towards health financial risk protection. VietNam case suggests clear progress towards UHC while the Philippines regresses, although health financing for SHI has increased recently. These phenomena are explained by incremental institutional change (displacement, layering, coversion and drift), varying governance and accountability structures, and reform sequencing – or the lack thereof – by government towards improving health financing and better design of SHI.

The structure of government, decentralized health system, and central and local government relations – and the tension between them – affect the design and implementation of SHI. Central government territorial interests tend to dominate SHI and decentralization reform processes, which reflect its priorities of shifting individual to collective interests in general and health sector in particular towards UHC. Reformers may not give sufficient attention on governance and institutional arrangements for health financing and SHI systems due to the potential backlash they might bring, thereby creating an environment for existing "rules" to be self-reforcing and path-dependent.

Fragmented health systems, inadequate service providers and information asymmetry limit individual access to and use of SHI and health services. Impact of SHI institutions is yet to be measured to capture effects of recent reforms. The relationship between insurer and service providers as a critical factor for improved accountability of SHI remains to be established. A network analysis of key actors is necessary to better understand their relationship prior to suggesting supply-driven solutions to improve transparency and accountability of SHI. Resource pooling and purchasing functions of SHI as well as government regulation on prices require attention at the country level.

Keywords: social health insurance, multi-level governance, de/centralization, policy

coordination, historical institutionalism

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1. Introduction

In the past two decades, low- and middle income countries have been pursuing institutional reforms to advance their social health insurance (SHI) towards Universal Health Coverage (UHC). The desired goals for UHC are clearly articulated in the literature, country health sector reform strategies, and diagnostic frameworks (e.g., McIntyre & Kutzin 2016; Mathauer & Carrin 2011) from a health financing expenditure framework.

Worldwide trends on health financing expenditure and role of SHI indicate a considerable gap between high income and low- to middle income economies. From the experience of eight countries[1] with developed SHI schemes, Carrin and James (2005) identified key factors affecting transition from SHI towards UHC as income level, population distribution (growth and demographic structure), economic structure, administrative capability to manage SHI, and levels of solidarity[2] within society. The speed of transitioning SHI towards UHC varied considerably.

International experience has shown varying lessons on good practices and critical ingredients in health financing towards the expansion of health coverage. They include, among others, the substantial and sustained financial investment into the health sector (e.g., Chile, Thailand), good governance through transparency and accountability (Costa Rica, Viet Nam), developed health information technology and system, network of primary health care facilities, and proper sequencing of reforms (see Gottret, Schieber and Water 2008, 27-56).

The literature on impact of SHI is analyzed in terms of *access and use*, *distribution* (equity), and *financial risk protection*. Most studies focus on financial risk protection by looking at reducing out-of-pocket spending (OOPS) and incidence of catastrophic payments and

[1] Germany, Austria, Belgium, Luxembourg, Israel, Costa Rica, Japan and Republic of Korea (order based on speed of transition).

[2] This is related to the role of social capital in understanding context-specific considerations towards sustainable universal health coverage at the community level; see Mladovky and Mossialos 2007.

impoverishment among the poor (e.g., Bredenkamp and Buisman 2015; Somanathan, Dao and Tien 2013, Wagstaff 2007). This is also an argument that access to insurance is related to income and type of employment at the country level. Analysts caution that exogenous factors may affect behavior, frequency of use, and costs to beneficiaries and providers. There is a gap in understanding 'how' SHI changes healthcare-seeking behavior on quality, type and composition when evaluating its impact (Escobar, Griffin, & Shaw 2010, 22).

The impact of SHI on UHC is still understudied; limited investigations noted methodological issues and factors that 'diminish' the impact of health insurance. 'Heterogeneity' in schemes and design explains why SHI may not always increase financial risk protection and reduce catastrophic costs in across countries and within country (ibid., 26). At any rate, a review of carefully selected impact studies provide a "compelling case" to support that SHI improves access and use of healthcare, and lessen exposure to financial risks associated healthcare; however, these are very sensitive to how SHI is designed (see Escobar, Griffin, & Shaw 2010).

Governance and institutional arrangements of health financing and SHI systems have not been given much attention in policy reforms as well. The number of health insurers, and the relationships between insurer/s and providers (purchasing function) are considered as the two critical factors for improved governance and accountability of SHI (Savedoff and Gottret 2008). There is a gap in explaining the extent to which change in outcome/s of interest (i.e., UHC goals) are consequential to prior institutional reforms and transitional processes of SHI over time.

This paper advances two hypotheses. First, the fragmentation or policy divergence of and poor institutional arrangements for health financing functions – revenue raising, resource pooling and purchasing – limit SHI's capacity to be a strong health service purchaser. Second, the transparency and accountability of purchasing function is a key factor in improving the

utilization of health services, quality of health care[3] and universal health protection (financial risk protection) to achieve UHC through SHI.

Against this backdrop, this research undertakes an institutional analysis of SHI design and organizational performance to test the above hypothesized causal mechanisms towards UHC in time and space. It draws evidence from two country case studies – Philippines and Viet Nam – as well as lessons and strategic areas for institutional reform to enhance governance of SHI systems. [4]

With health financing and SHI systems in the Philippines and Viet Nam as empirical phenomena, this adds policy-relevant knowledge by attempting to minimize some methodological factors that diminish SHI impact (e.g., endogeneity, time factor, inconsistent exposure; see Escobar, Griffin and Shaw 2010, 185-89) through temporal approach to explaining the degree of change in outcome/s of interest as a result of SHI institutional reforms. Thus, future analyses – and policy recommendations – become timely and relevant, and do not preclude the effects (or nil effects) of prior reforms in subsequent value decisions to enhance health financing and SHI systems towards UHC.

2. Approach and Methodology

Overall, this study employs within-case and historical institutional analysis approach to explain the causes and consequences of SHI institutional reform processes – revenue raising, resource pooling, and purchasing functions – towards UHC goals (outcomes of interest) as presented in Table 1. It characterizes the territorial interests (national and subnational),

[3] There are many factors the can influence access to and quality of care goal of UHC in general and SHI in particular. Among them include geographical location, human resources, infrastructure and facilities, and cultural or behavior of beneficiaries. This paper focuses on governance aspects on utilization of health services and health financing risk protection as discussed in section 3.

[4] Capuno (2006) was perhaps the first attempt to compare SHI for the poor programs in the Philippines and Viet Nam looking into the design features and implementation – revenue collection, risk pooling, purchasing, and adequacy and sustainability of resources – between 1995 and 2005. It is timely to review SHI of the two countries to explain the causes and consequences of earlier and subsequent rounds of policy reforms.

preferences and sources of ideas of key actors, groups and/or coalitions who dominate the reform processes in time. See Box 1 for historical institutionalism and gradual theory of institutional change as the study's theoretical lens.

Table 1: Analytical Framework for SHI Institutional Reform towards UHC

Function (reform areas)	**Indicators**	**Intermediate variables**	**Universal Health Coverage Goals** (outcomes of interest)
Revenue raising	General revenue Earmarked SHI contributions	Equity	**Utilization of health services** Quality of care **Universal health protection** (financial risk protection)
Resource pooling	Size Diversity Compulsory/ voluntary Fragmentation	Efficiency	
Purchasing	Benefits entitlements (rationing) Provider arrangements Organization structure and governance	Transparency and accountability	

Source: Based on McIntyre and Joseph Kutzin, WHO 2016.

This study considers the health financing functions as independent reform areas and their interaction (policy convergence or fragmentation) as key towards the attainment of UHC goals, particularly, the *utilization of health services* and *universal health protection* (financial risk protection) as outcomes of interest. As such, 'fragmentation' of the three functions and how SHI interfaces between purchasing and service provision are critical areas for analysis.[5] It also looks into the governance[6] dimension of purchasing function, more specifically *transparency and accountability*, *and* the multi-level governance structure at the country level where SHI operates.

Savedoff and Gottret (2008, 17-18) provide that *financial protection* looks into accessing health services despite costs, ensuring costs do not take over other needs, and individuals do not

[5] The authors recognize that purchasing quality health care services is key in improving individual and population health outcomes; however, it is beyond the scope of this study.

[6] Savedoff and Gottret 2008 suggest five governance dimensions towards mandatory health insurance (MHI) accountability to beneficiaries; government, supervisors and regulators; and employers and other non-beneficiary contributors. They are *coherent decisionmaking structures, stakeholder participation, supervison and regulation, consistency and accountability, and transparency and information* (28-32).

fall into catastrophic spending or impoverishment. Measuring good SHI performance considers the *breadth of coverage* as measured by the number of individuals eligible to receive benefits from health insurance (national health insurance, mandatory health insurance and private insurance; *depth of coverage* as measured by actuarial value of benefits package per enrollee, i.e., spending less fees of the number of users; and *financial protection* measured by out-of-pocket spending (OOPS) as % of THE or OOPS % of household consumption. OOPS shares reflect both *breadth* and *depth* of coverage or lack thereof

Box 1. Historical Institutionalism to explain institutional change

Historical institutionalism focuses on "*the process rather than equilibria*, and the key to understanding institutional evolution and change lies on precisely specifying the *reproduction and feedback mechanisms* on which particular institutions rest" (Thelen 1999, 266).

The *Theory of Gradual Institutional Change* recognizes 'power-distributional' implications of institutions (Mahoney and Thelen 2010). It suggests four modes of institutional change that explain when and how gradual change occurs – displacement, layering, drift and conversion. *Displacement* relates to removal of existing rules and the introduction of new ones, which include 'abrupt', 'radical-shift' and 'sudden break-down of institution.' *Layering* introduces new rules on top of or alongside existing ones. *Drift* refers to change/s in impact of existing rules due to shifts in the environment. *Conversion* pertains to changed enactment of existing rules due to their strategic deployment (ibid., 15-16).

Power-related explanation of path-dependence views that *institutional reproduction* "is supported by an 'elite group of actors' and the mechanism of change follow the "weakening of the elite group and strengthening of subordinate groups" (Mahoney 2000, 517). "Winners" or key actors of reforms of the first completed cycle will interpret the 'formal rules' and 'dedicate resources for enforcing them' based on varying interests. However, their preference/s may change when the meaning and enforcement of institution changes. Here the role of "ideas" and "knowledge" becomes very important.

The subordinate group or "losers" gradually or incrementally gain dominance as a result of built in characteristics of the institution leading to change processes in time, e.g., self-reinforcement gives way to inherent institutional conflicts, subordinate group successfully challenging reproduction of elite-supported institutions, institutions empowers the elite group

leading to its division (Mahoney 2005, 521-23). As Mahoney and Thelen (2010) pointed out, the role of 'ideas' and 'power distribution' can explain the processes of gradual institutional change.

Source: Drawn from TiuSonco, J. 2017. Explaining Decentralization Reforms in Post-Authoritarian Unitary States: Philippines and Indonesia. Kobe University: Unpublished Dissertation.

The study is guided by – and analytically builds on – World Health Organization's (WHO) health financing diagnostic framework[7] and attempts at World Bank's emphasis in analyzing how the insurer relates with beneficiaries and health providers for better governance and accountability of SHI. OASIS[8]-WHO Component 2 allows for detailed institutional-organizational analysis by looking into the broader health financing system and SHI's resource mobilization, membership registration, targeted subsidization, and target exemptions in each country case study.

Data are based on WHO Global Health Expenditure Database (1995-2014), and health financing sources (central and local government, SHI, private and other sources) from the ministries of health and statistics agencies of Viet Nam and Philippines; and SHI members' registration, health providers, accreditation (rural and urban), payment for purchases and utilization from the Viet Nam Social Security (VSS) and the Philippine Health Insurance Corporation (PHIC), respectively. Historical data before the institutionalization of SHI in each country are gathered from relevant studies and government reports.

3. Country case studies: Philippines and Viet Nam

This section has three parts. First, it discusses and compares the health financing performance of the Philippines and Viet Nam over time. It traces and explains the effects of prior policy reforms – and/or other factors – on selected indicators towards achieving universal

[7] See McIntyre, D. and Joseph Kutzin 2016. Health Financing Guidance No. 1. Health financing country diagnostic: a foundation for national strategy development. World Health Organization

[8] See Mathauer and Carrin 2011 for the Organization Assessment for Improving and Strengthening Health Financing (OASIS) of WHO.

financial protection. It establishes the trajectory of overall health financing systems and 'how' SHI contributes in the transition processes towards UHC – *level of funding, population coverage by SHI, equity, pooling of resources and financial risk protection.* Second, it provides some analyses on *multi-level governance* focusing on decentralization of health system and institutional arrangements, as well the governance dimension of SHI, particularly *transparency* and *accountability* in each country case study. Consequently, it assesses *cost-effectiveness, efficiency and equity of benefit packages* and *administration* of SHI. Thirdly, it infers lessons from policy reform processes for low- and mid- income countries in transitioning SHI to UHC. Tables 2 and 3 indicate comparative information on Philippines and Viet Nam as well as the institutional design of SHI systems.

Table 2: Philippines and Viet Nam - Comparative Information, 1995 and 2014

Information	Philippines		Viet Nam	
	1995	2014	1995	2014
Population (in thousand persons)	69,836	99,139	75,199	92,423
Income				
GDP per capita (2011 $PPP)	3,960	6,649	2,042	5,370
GNI per capita (2011 $PPP)	4,097	8,057	2,020	5,092
Health finance				
THE (% GDP)	3	5	5	7
THE per capita spending (US$)	37	135	14	142
GGHE (% GGE)	7	10	8	14
GGHE (% THE)	40	34	34	54
OOPS (% THE)	50	54	63	37
Health coverage				
Breadth of coverage (%)	48 (est.)	92	9 (est.)	71
Financial risk protection (%) (OOPS share of THE)	50	54	63	37
Degree of change				
Breadth of coverage (%)		92		689
Financial risk protection (%)		7.34 (negative change)		(41.52) (positive change)

Source: World Development Indicators, WHO Health Finance Expenditures, Philippine Health Insurance Corporation, and Viet Nam Social Security.
Legend: GDP=gross domestic product, GGE=general government expenditure, GGHE=general government health expenditure, OOPS=out-of-pocket health spending, THE=total health expenditure.

Table 3: Philippines and Viet Nam: Comparative Information on SHI institutional design

	Philippines	Viet Nam
Insurer	Philippine Health Insurance Corporation (PHIC)	Viet Nam Social Security (VSS)
SHI administrative structure	Centralized quality control and payment with deconcentrated functions to regional offices	Highly decentralized to provincial governments Provincial Social Security offices handle payment
SHI premium	2.5% of monthly salary base shared between employer and employee; salary cap 35000 pesos; Individual paying member: Php2400 with monthly income below Php 25000 and Php 3600 if over Php25000	4.5% of workers' salary where employers contribute 3% and employees contribute 1.5%; 4.5% of minimum salary on demand-side subsidies from government for poor, near poor and vulnerable
Overall enrollment scheme	Member groups: employed, sponsored program, individually paying, overseas workers, and lifetime members (retirees); individual members can enroll beneficiaries under certain conditions.	Members groups (25 groups, all citizens: civil servants and formal sector; pensioners, meritorious people, beneficiaries of social protection, and veterans; poor and near poor; children under six year of age; school children and students; all remaining members
Pro-poor targeting	Local governments with episodes of central government intervention; recently use NHTS-PR	Interaction between MOLISA (Ministry of Labor, Invalids and Social Affairs) and DOLISA (provincial Department of Labor, Invalids and Social Affairs)
Benefit package	Comprehensive for all insured.	Comprehensive for all insured.
Prioritizing Benefit Packages	Internal team with no clearly established third-party assessment (e.g., scientific community)	Set by MoH with involvement from VSS, MoF, and providers
Regulation and provider accreditation	PHIC regulates and accredits service providers (public and private) through regional offices; no penalty system	MoH regulates; VSS accredits service providers (public and private) through regional offices; only private service providers need accreditation to participate; no penalty system
Payment mechanism	Fee-for- service; transitioning to capitation and no balance billing payment scheme under NHIA 2013	Capitation-based mechanism applied in 481 out of 2094 health care facilities (private and public health), mostly in district level; fee-for-service for all secondary and tertiary hospitals, and some high cost services excluded in capitation payment; case-based payment and DRG piloted in some provinces
Referral and network	No referrals or gatekeeping	4 referral levels: free access at grassroots level (commune and district); Gatekeeping [(1)]: Outpatients: Without reference, no reimbursement; Inpatient: Without reference from district to provincial hospital: reducing reimbursement to 60% of total hospital fee; without reference from provincial to national hospital: reducing reimbursement to 40% of total hospital fee
System of accountability	Unclear due to structural issues (e.g., devolution, role of central government, targeting system); vulnerable information technology and database management systems; weak identification of insured people	Previously weak due to underdeveloped information technology system. Developing IT system in health sector and Healthcare Common Coding System (JCCS) linking health insurance data from all healthcare facilities to portals at MoH and VSS. Introducing unique health identifier for harmonized identification
Scientific research and third-party assessments	Low: Recently initiated empirical studies by Philippine Institute for Development Studies	Moderate: subjected to institutional assessments, empirical studies, case study

Source: Authors' research; Coltear et al 2015; Somanthan, Dao and Tien 2013. **Note:** [(1)] Gatekeeper: Changing from the beginning of 2015 with amended.

3.1. Comparative health financing performance assessment

Health system financing (HSF) indicators[9] have been established and standardized for policy analysis, policy formulation, monitoring performance as well as comparative purposes between and across countries, regions and levels of economic development. These indicators measure how a particular country or group of countries compares vis-à-vis the rest. For example, a country's HSF profile can be compared with another country or other income groups in the world, e.g., among low-mid income in the Asia-Pacific region. It is common to see comparisons at a particular point in time or time invariant indicators of select countries, inter-regions, and income sub-groups, but not on how the process of institutional reforms effect change over time.

One may ask: what is the value of a country's time invariant indicator/s being compared with another country or a group of countries? Are they really worth comparing for the purpose of generating within-country health sector reform policy agenda? Arguably, they do not mean much unless they are treated in more sophisticated empirical analysis; in-depth country analysis; and/ or if employed to explain how institutional and transitional processes cause change at a country level over time.

For instance, in 2014, the general government health expenditure (GGHE) as percentage of general government expenditure (GGE) was 10% for the Philippines and 14% for Viet Nam. The former's GGHE as percentage of gross domestic product (GDP) was low at 2%, while the latter's share was also considered low at 4%. Some low-middle income countries in west pacific region (WPR) tend to have higher GGHEs as percentage share of GGE and GDP (e.g., Micronesia, Kiribati, Vanuatu, Samoa, Somolon Islands). Are they performing better in terms of

[9] Commonly used indicators include the percentage of i) government health expenditure as percentage of GDP, general government expenditure, total health expenditure (THE); and ii) out-of-pocket spending (OOPS) as percentage of THE. See WHO Global Health Expenditure Database accessible at http://apps.who.int/nha/database/ViewData/Indicators/en.

health financing system in particular, and UHC goals in general? Firstly, these countries are not included in country case studies for better performing health financing and SHI systems based on carefully selected criteria and reputable empirical studies.[10] Secondly, they do not have established SHI systems, the size of their population is small, and they are relatively dependent on donor support.

Here we establish the pattern of select health financing indicators comparing Viet Nam and the Philippines from 1995 to 2014, and *periodized* as 1996-2000, 2001-05, 2006-10, and 2011-2014.[11] Looking at the *level of funding*, Figure 1 shows that VietNam's total health expenditure (THE) has increased from an average of 4.9% to 6.8% of GDP compared to Philippines' increase from 3.4% to 4.5% between 1996-00 and 2011-14. [12] Figure 2 indicates that the government of Viet Nam has increased its spending on health by 68.9% degree of change (from 7.7 to 12.5%) relative to a mere 9.9% (8.0 to 8.8%) in the Philippines for the same period. Overall, Viet Nam has been spending more for health and its government has prioritized health sector financing since 2006.

Figure 1: THE % of GDP

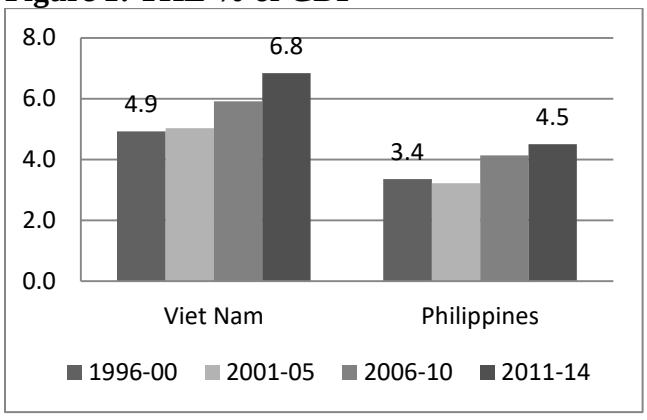
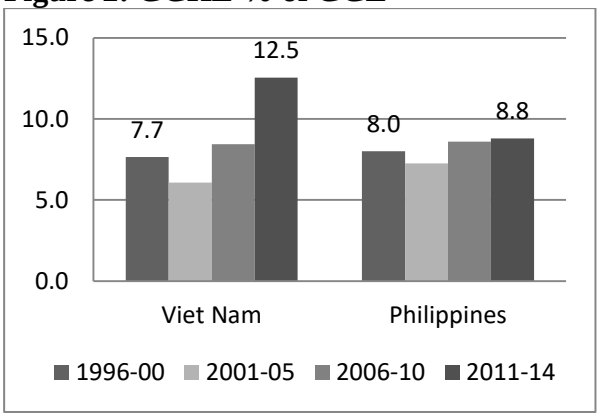


Figure 2: GGHE % of GGE



[10] See Gottret, Schieber and Water 2008 for eight good practices in health financing; Cotlear, et al. 2015 for the 24 Universal Health Coverage Studies Series (UNICO). Both studes are supported by the World Bank. See also Escobar, Griffin and Shaw 2010 of Brookings Instituttion.

[11] See also Annex 1 for the observed trajectories of these figures from 1995-2014.

[12] Measuring THE relative to GDP may not work well for the Philippines due to its economic structure and low GGE share in GDP.

Figure 3: GGHE % of THE

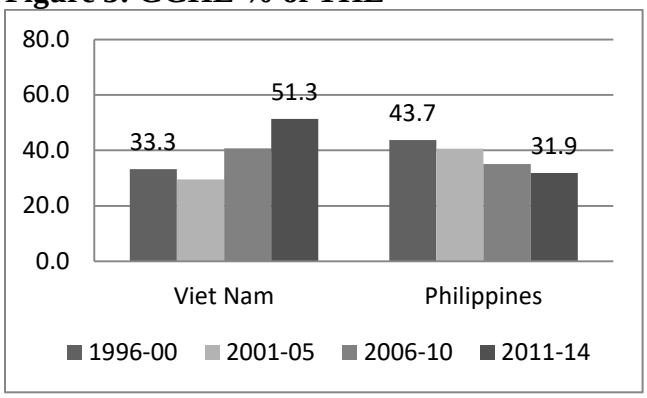
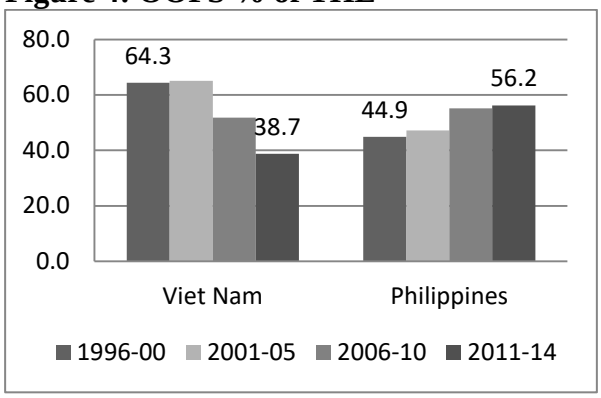


Figure 4: OOPS % of THE



Source: Authors' calculation based on WHO Health Expenditure database.
Legend: GDP=gross domestic product, GGE=general government expenditure, GGHE=general government health expenditure, OOPS=out-of-pocket health spending, THE=total health expenditure.

The Philippines' GGE and GGHE indicators are among the lowest in WPR when compared to GDP perhaps due to its unique economic structure. However, the *stable* or *consistently low* level of GGHE relative to GGE might be explained by the insignificant or negligible effects of policy reforms for health financing in the past two decades. Some observers might view this as: the health sector has not been a priority or not given much attention in the country's development strategy and expenditure framework.

Evidently, Viet Nam government's HSF expenditure share increased incrementally from 33.3% to 51.3% (54.2% degree of change), while households' out-of-pocket expenditure (OOPS) declined from an average of 64.3% to 38.7% (minus 40% degree of change) in 1996-2000 and 2011-2014, respectively. This suggests that households in Viet Nam benefit from greater health financial risk protection as the government spends more for healthcare over time. Conversely, the Philippines show the opposite trajectory where GGHE has gradually declined since 2000 and household OOPS as percentage of THE remained high (averaged 56.2% in 2011-14), implying *low* level of health financial risk protection.

At any rate, mere patterns of WHO-HSF are not optimized if not explained as to *when* and *how* the changes in the HSF indicators are consequential to deliberate health sector policy

reforms. Moreover, whether these divergent phenomena can be attributed to institutional reforms and transitional processes in SHI towards universal health coverage – or not – will be discussed in the Philippines and Viet Nam case study sub-sections.

3.2. Philippines: regressing from universal health financial risk protection?

The institutional origin of SHI in the Philippine can be traced to the adoption of the National Health Insurance Act (NHIA) of 1995 during the term of the President Fidel Ramos. NHIA "converting" the Philippine Medical Care Commission and the rules of the Philippine Medical Care Plan (Medicare) instituted in 1969. It established the Philippine Health Insurance Corporation (PHIC) to manage and develop a national compulsory health insurance program with the policy goal to provide *universal health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of the Philippines.*

NHIA likewise created a National Health Insurance Fund (NHIF) pooling members' contributions, balances of Government Social Insurance System (GSIS) and Social Security System (SSS) health insurance funds, appropriations and earmarked resources by central and local governments, and subsequent appropriations into a single fund. It also assigned PHIC with the responsibility of being a *purchaser* of health services, and prohibited it from undertaking service provision activities.

The implementation of the law was phased through ten years covering both the expansion of membership (population coverage), engagement of local governments through cost-sharing arrangements for the enrollment of the poor, assumption of Medicare function of GSIS and SSS for formally employed individuals in government and the private sector, and the expansion of benefits packages.

SHI membership has likewise evolved over time. Different studies have their own

categorization of members.[13] Recent membership can be categorized into formal and non-formal. Formal members include those who are employed in the government and the private sector – whose premium contributions are shared by the employer and the members – and the overseas Filipino workers. Non-formal members cover those enrolled in Sponsored Program[14] Individually Paying,[15] and Lifetime[16] members.

Subsequently, "layering" policy reforms were undertaken amending NHIA of 1995 in 2004, earmarking of revenues from Sin Tax Law for universal healthcare and SHI in 2011, and further amending NHIA in 2013. Table 4 indicates the reform areas, institutional forms and features as well as the supporting policies that phased the implementation of the law.

Table 4: Philippines – Institutional origin and evolution of SHI

Year	Reform area	Institutional forms	Features and phased implementation
1995	Risk pooling (population coverage), revenue raising, purchasing)	Conversion: National Health Insurance Act of 1995 (RA 7875)	• Indigent program with local governments (piloted in 1996) • Assumed medicare function of GSIS in 1997 • Assumed medicare function of SSS in 1998 • Launch individual paying program • Implementing rules and regulation in 2000 • New premium contribution rates in 2000 • Enrolled retirees and pensioners to non-paying program in 2001 • Implemented 43% increase in in-patient confinement of beneficiaries and launched enrollment of retirees and pensioners to non-paying members in 2002 • Increased benefit packages including room and board, dialysis, maternity care, SARS [severe acute respiratory

[13] For instance, Obermman et al (2006) categorized it into four, namely: formally employed workers, indigents, retirees, and individually paying members. Manasan (2011) classified NHIP's membership into five groups by program: employed sector, overseas workers, individually paying, sponsored, and non-paying.

[14] They are the poor or individuals whose income is insufficient for family subsistence. Previously, they were commonly referred to as 'indigents' under the local government identified and supported members. Premium payments are shared between local governments and central government. The latter's share ranged from 50-90% depending on the former's income classification. Subsequently, the Sponsored Program membership has been expanded using the National Household Targeting System for Poverty Reduction (NHTS-PR).

[15] This includes voluntary paying individuals who are self-employed, professionals on own practice, daily-wage earners, unemployed but not qualified as indigents or parents not qualified as dependent of members, personnel of civic and religious organizations and Philippines-based international organizations.

[16] Retirees and pensioners of GSIS and SSS prior to the enactment of RA 7875, and Philhealth members over 60 years old who contributed for at least 120 months. Recent policies expanded membership to include senior citizens.

Year	Reform area	Institutional forms	Features and phased implementation
			syndrome], and anti-tuberculosis
2004	Risk pooling (coverage)	Layering: Republic Act 9241 amending NHIA of 1995	• Inclusion of adoptive and step parents as legal dependents • Premium sharing between central government and local governments depending on tier and income level • Took over medicare for overseas Filipino workers in 2005
2011	Resource raising	Layering: Sin Tax Law of 2011	• Earmarked share from sin taxes earmarked for social health insurance to cover Sponsored Program of the poor/ near poor as targeted by the National Household Targeting System for Poverty Reduction (NHTS-PR)
2013	Risk pooling (coverage)	Layering: National Health Insurance Act of 2013	• Mandates government sponsored health insurance for all senior citizens and lifetime membership for retirees • Inclusion of foster children • Regulation to enroll various employees including drivers, *kasambaha*y (house help) • All case rate payment system

Source: Philippine Health Insurance Corporation annual report, 2015.

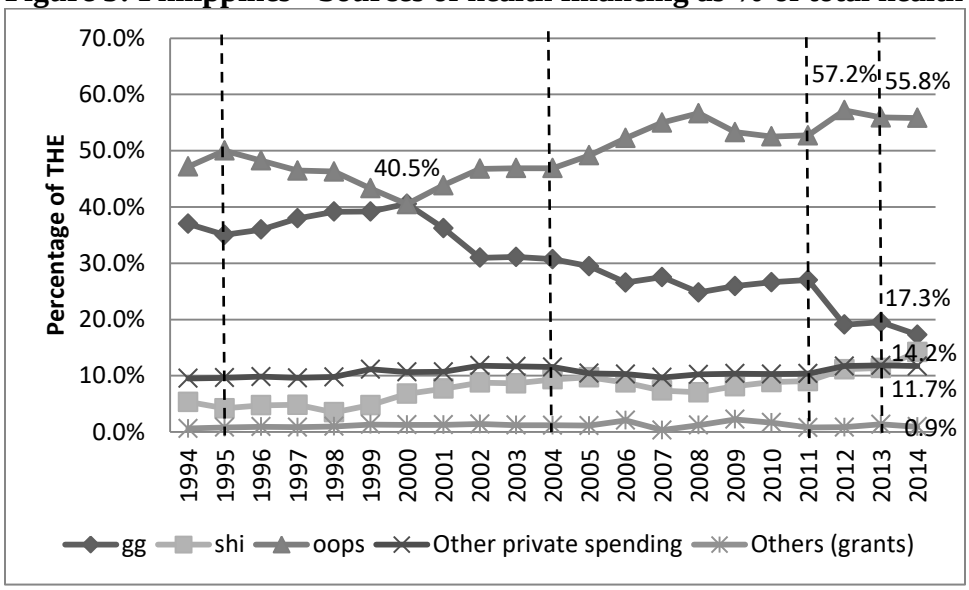
The Philippines established a single insurer for its SHI – ideal for a responsive and efficient manager of resource pool and associated risks. The relationship between the PHIC as purchaser, the millions of beneficiaries and the thousands of service providers across regions remains unclear and understudied. The administrative efficiency and effectiveness of SHI implementation depends on the organizational capacity of PHIC to manage not only the resources entrusted by its members and government subsidies, but also the integrity of information system and data management – fundamental in establishing accountable relationships.

3.2.1. Health financing and SHI coverage trajectories

The Philippines shows a unique pattern in its overall health financing structure by tracing the institutional origin of SHI to 1995 and its interaction with the implementation of devolution of health services from central to local governments implemented around the same time. On the one hand, the share of SHI in health financing has remained almost flat the past 20 years. On the other hand, the share of general government expenditure initially increased relative to OOPS for

health from 1996 to 2000, but it was never sustained. In fact, the government expenditure and OOPS significantly diverged from 2001 to date. Figure 5 indicates the trend of health financing sources as percentage of THE.

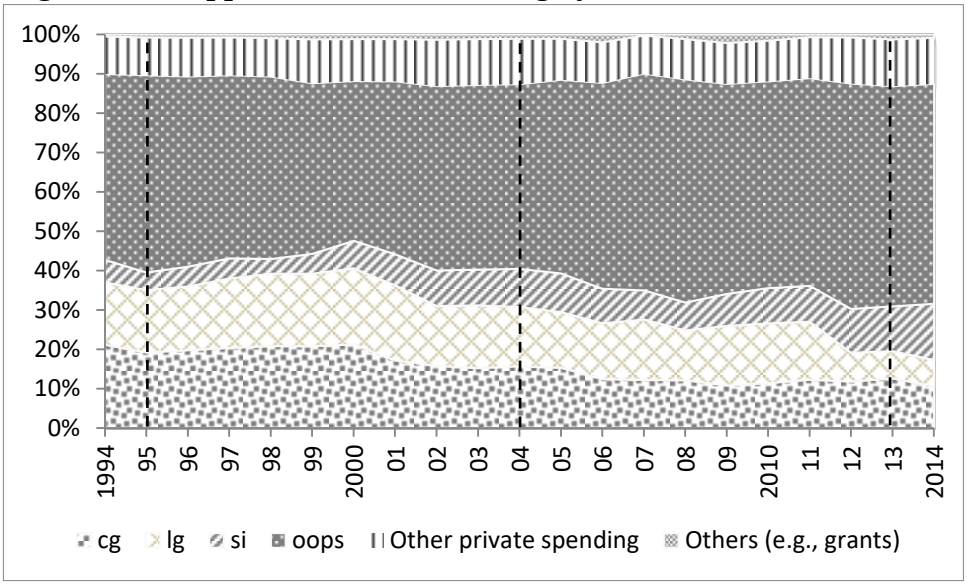
Figure 5: Philippines - Sources of health financing as % of total health expenditure



Source: PSA National Health Accounts.
Legend: gg=general government, shi=social health insurance, oops=out-of-pocket spending.

Critical information here is the continued high share OOPS, which represents about 83% of total private sources or 56% of THE in 2014. OOPS share has been steady in the past two decades (averaged 80%), implying low financing risk protection and dim prospects for UHC goal given the existing institutional arrangements. Figure 6 shows the trend of health financing sources for two decades – 1994-2014. Policy reforms in 1995 and 2004 seem to have not resulted in significant increases of SHI share in THE. However, SHI's share seems to crowd-out local governments' spending due to national targeting of and funding for indigents previously done by local governments.

Figure 6: Philippines - Health financing by source, 1994-2014



Source: PSA National Health Accounts.
Legend: cg=central government, lg=local governments, si=social health insurance, oops=out-of-pocket spending.

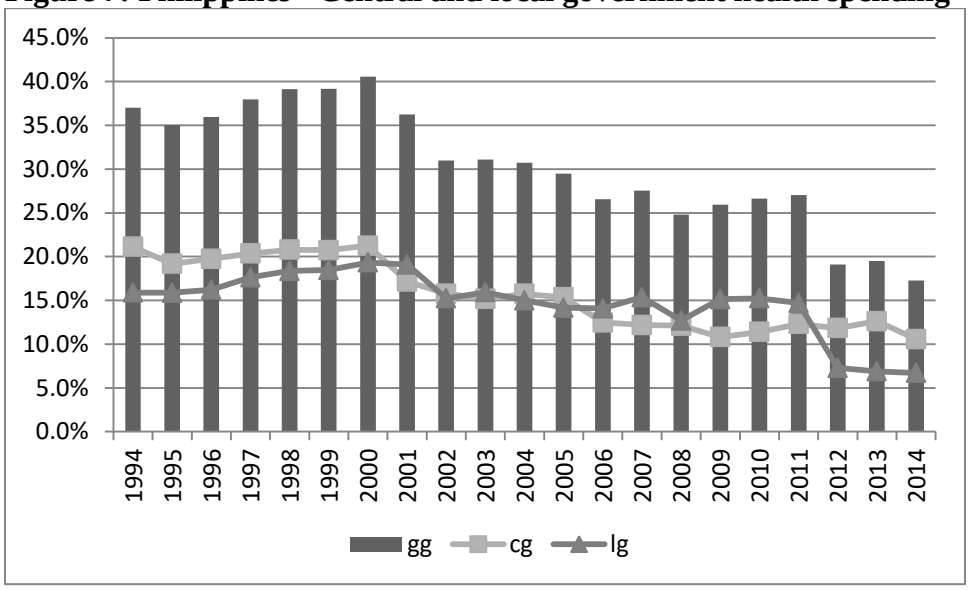
In spite of the faster GDP growth and better fiscal space in the past 5 years coupled with increased revenues for health financing with earmarked funds from the Sin Tax Law of 2011, general government health expenditure (GGHE) contracted relative to THE. There appears to be an increasing trend in SHI share which theoretically might be related to increasing income at the macro-institutional level.[17] Interestingly though, income level among the non-poor does not appear to be a barrier to obtain health insurance (Silfverberg 2014).What is clear is the increased insurance coverage of the poor and near poor through the Sin Tax revenues has had initial effects on the increasing trend of SHI in 2013-14. However, the potential effects of NHIA of 2013 remain to be observed on access and use of SHI and healthcare services in subsequent years.

Figure 7 shows the trend of GGHE as share of THE. Decomposed central and local government health expenditure, the spending shares at both levels have been declining. Most notably, local governments' health spending significantly declined from 14.7% in 2011 to 6.7%

[17] Carrin and James (2005) identified income and economic structure as two of five factors that affect transition from SHI towards UHC at the macro-institutional level.

of THE in 2014. On the one hand, this can be explained by the faster growth of OOPS than other sources of health financing relative to THE. On the other hand, local governments may have stopped payment for premiums of indigents due wide central government coverage for the poor under the Sin Tax Law of 2011.

Figure 7: Philippines - Central and local government health spending



Source: PSA National Health Accounts.
Legend: gg=general government, cg=central government, lg=local government.

In 2014, 86 million or 85 percent of the population are beneficiaries of PhilHealth. The World Bank (2016) pointed out that:

> the reform scaled up health care financing, nearly doubling the Department of Health's (DOH) budget in its first year of implementation and financing the extension of fully subsidized health insurance to the poorest 40 percent of the population. The number of the poor and near poor coverage by NHIP increased from 5.2 to 14.7 million in 2014 alone (1-2).

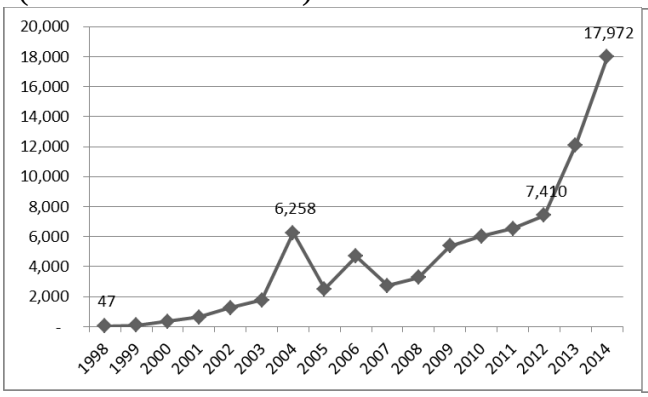
Recent membership categories show the shift in structure between formal and non-formal group members[18] since the adoption of the Sin Tax Law in 2011, which earmarked resources for health financing system. SHI significantly benefits from this with about 50% of revenues

[18] Formal group includes members employed by government, private sector as well as overseas Filipino workers. Non-formal group covers sponsored program, individually paying members, and lifetime members.

subsidize the Sponsored Program by targeting the poor at the national level.[19] Notably, the non-formal group's share in total membership shifted from 43.1% in 2010 to 58.5% in 2013. Due to the funding source and targeting system, there is a presumed regularity of the pattern of non-formal group both in terms of number of enrollees and contribution.

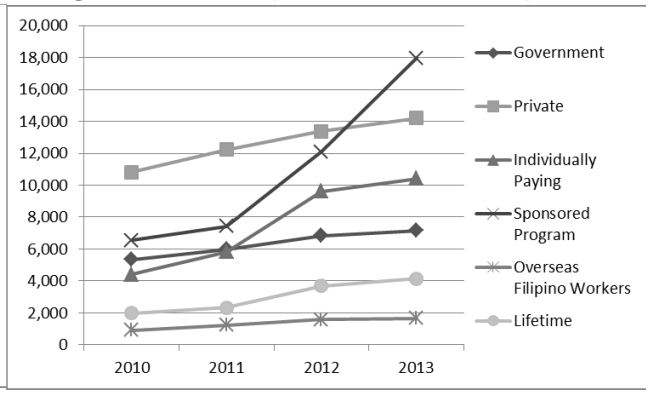
Previously, analysts raised the issue of 'political efforts' leading to large-scale enrollment of indigents, which pose serious challenges in subsequent years, e.g., Plan 5/25 Million in 2004, which increased SP members from 1.76 million to 6.26 million in 2004 before the general elections (Manasan 2011, Obermann et al. 2006, Capuno 2006).[20] Sponsored Program members then declined to 2.49 million in 2005 before increasing again to 4.67 million in 2006.

Figure 8: Philippines - Sponsored Program (in thousand members)



Source: Philippine Health Insurance Corporation.

Figure 9: Philippines - SHI Membership categories, 2010-13 (in thousand members)



Source: Philippine Health Insurance Corporation .

Note: Sponsored Program combines regular "indigents" covered by local governments and those targeted by NHTS-PR starting in 2012.

The erratic trends of Sponsored Program members can be observed in Figure 8 above, particularly between 2004 and 2009. Subsequently, the trend has been upward; soaring from 7.4 million in 2012 to 18 million 2014 Sponsored Program members, largely due to the expansion

[19] Previously, targeting of the poor or indigents was conducted and subsidized by local governments with cost sharing scheme with the national government.

[20] The program intended to enroll 5 million members or 25 million beneficiaries under the Sponsored Program during the term President Gloria Macapagal-Arroyo who ran for re-election. Philippine Charity Sweepstakes Office earmarked funds to cover for the premium contributions of indigent-members including the share of local governments.

of eligible members and earmarked revenues from the sin taxes for the social health insurance. The expansion of non-formal membership with subsidy from Sin Taxes immediately resulted in a high degree of change of 63% in 2011-12 alone as shown in Figure 9. Clearly, Sponsored Program and Lifetime members grew by 62% and 60%, respectively, owing to the targeting of the poor using the NHTS-PR of DSWD and inclusion of senior citizens for SHI coverage.

There was also remarkable growth of individually paying members by 32% and 65% in 2011 and 2012, respectively. More than income level, availability of accredited healthcare facilities at the provincial level seems to encourage voluntary enrollment in SHI. A recent empirical analysis among individually paying members using provincial data, Silfverberg (2014, 34) finds that: i) availability of health care services (beds and health professionals ratio to population) is strongly correlated with provincial coverage rate; ii) number "private" hospitals relates to higher coverage rates; iii) income levels are not a factor for insurance coverage; and, iv) size of certain sectors has significant effect on provincial coverage, particularly for sales, skilled-worker, services and mining.

Sponsored Program members grew 49% in 2013, while individually paying and lifetime members slightly by 8% and 12%, respectively. In spite of the significant increases in revenues for health care of DOH and for increased population coverage of SHI, it seems that there is disconnect between increased SHI coverage and health financing risk protection with the increasing OOPS over time. The next section analyzes the institutional design and organizational perform to explain this apparent divergence in policy outcomes, i.e., rapid increase in SHI membership coverage and the continuing decline in financial risk protection.

3.2.2. Challenges in institutional design and organizational performance

In assessing the challenges in institutional design and organization performance of SHI or

the NHIP, the paper looks into health financial risk protection, multi-level governance, and transparency and information systems towards UHC.

Health financial risk protection. Institutional analysis of SHI indicates gains in increasing population coverage and expansion of benefit packages. Evidence shows less financial risk protection from catastrophic payment and impoverishing health expenditure (see Bredenkamp and Buisman 2015). Institutional responses to mitigate catastrophic health expenditure through SHI are "disparate, untimely and inadequate" (Caballes 2013, 86). Over time, the overall health sector financing system has created a *regressive* environment towards universal health financial risk protection (Bredenkamp and Buisman 2015, Caballes 2013, Silfverberg 2013, Manasan 2011, Obermann et al 2006). To a certain extent, SHI funds a basic set of in-patient health services; however, it has a limited role in protecting the poor from catastrophic expenditure.

Earlier studies suggest "cross-subsidization" from the private sector to the poor (Capuno 2006, Obermann et al 2006). Analysts expect SHI to benefit from the windfall of revenues through earmarked share of Sin Taxes for health financing starting 2012. Consequently, the Indigents and Sponsored Program has been significantly expanded more than ever with a steady source of funding. Access of and utilization in terms of benefit payments for service providers are in a "black box" as to how the revenues generated will match the potential costs (actuarial) of increased membership – particularly the poor, senior citizens and lifetime members or retirees.

The case has shown the vulnerability of NHIP design to political interference and patronage both at the national and subnational level on its first 20 years. This resulted in slow growth of overall membership since its implementation in 1996 with erratic membership due to temporary pro-poor policy and problematic targeting. For instance, population coverage

significantly increased due to temporary coverage individual under Sponsored category only in 2004 through premium coverage by central government with resources form Philippine Charity Sweepstakes.

Since 2012, there has been a rapid increase in population coverage as a result of more informal members with the expanded sponsored program and lifetime members with support from central government. Increased membership of non-formal group may minimize financial risk due to risk pooling of function of SHI, "by spreading risk and adverse selection of members" (Capuno 2006). However, the expansion of population coverage – membership ratio to population – through SP enrollment does not guarantee access to healthcare services nor financial risk protection as evidenced by the persistently high and increasing OOPS.

On access and use of SHI, Obermann et al (2006) pointed out that the shortage of Philhealth accredited hospitals outside large cities and that a "good part of low utilization of medical care can be attributed to simple lack of facilities" (3181-82). Quimbo et al 2008 found "high level of insurance underutilization by insured patients" among a group of selected districts, which they associated with "lack of awareness of benefits, potentially high transaction cost relative to potential benefits, and cumbersome process claim or too many requirements" based on a national survey conducted in 2003 (3).

The results and impact of recent reforms, particularly to the targeted poor, remain to be observed. Methodology, tools and information systems are yet to be designed and developed for improved SHI governance through transparency and accountability of SHI. In doing so, the multi-level governance structure and administrative system at the country level should likewise be considered.

Multi-level governance. SHI operates in a decentralized structure of public health system

under the 1991 decentralization law (Local Government Code of 1991). While basic health services are 'supposedly' devolved to local governments[21] including rural health units. central government continues to play a major role in health service delivery. Local governments take part in financial performance and subsidization of membership categories, particularly the so-called "indigents." However, SHI coverage enrollment under devolution through local governments did not result in steady increase in population coverage over time. Local governments perform both as a financier and service providers of health services (Capuno 2006), which makes it difficult for PHIC to perform its regulatory function over them.

Data indicate that general government health spending has not been a government priority as it continued to decline from 1994 to 2014. In spite of the "devolution" of health in 1992, generally local governments do not have policy autonomy over the health sector as evidenced by the low and declining share of local governments in health expenditure. Prior reforms have not been able to shift the trajectory or decentralize the administrative responsibility to provide health services from central to local governments.

In addition, there seems to be limited functioning accountability mechanisms and measurement of health outcomes at the subnational level. It might even be asked: which level (central or subnational) should be held more accountable given the degree of health de/centralization in the Philippines in spite of 1991 decentralization law? To what extent has it really transferred authorities, responsibilities and resources for local health service delivery to local governments across tiers to hold them accountable?

There continues to be information asymmetry and unclear expectations between and among central and local government officials, policymakers, even development practitioners and academics on the degree of authority, responsibilities and resources local governments in the

[21] 81 provincial, 145 city and 1489 municipality, and 42,036 *barangays./*village units in 2015.

Philippines. Analyses of SHI system towards UHC seemed to be lacking. It only been until recently that the scientific community and/or third party have focused attention on this policy area, e.g., series of empirical studies conducted by Philippine Institute for Development Studies. This may partly explain why institutional reforms regarding SHI have remained weak.

Governance dimensions focusing on transparency and information. In 2015, PhilHealth reported 93.4 million beneficiaries with 40.5 million individual members and 52.9 dependents, which represents 92% population coverage. There are 15.3 million indigent members – targeted poor – whose premium payments are sponsored by government. With about 30.1 million dependents, they represent 49% of national SHI population coverage. There are 1,887 institutional healthcare providers across the country and about over 20000 professional health practitioners are accredited by PHIC. On the one hand, reported figures do not accurately show the level of completeness of accreditation of all eligible healthcare providers at the subnational level; on the other hand, the number of accredited providers does not indicate the level of adequacy or sufficiency of service providers to ensure access to healthcare and utilize SHI.

In 2014, PhilHealth coverage is estimated at 87% population coverage by SHI; however, a recent survey shows that only 61% of the population says that they have health insurance. The mismatch between population coverage claim and survey estimates suggests lack of information about individual members' coverage and their entitlement (WB 2015, 14).[22] Moreover, the "lack of awareness" about the benefits expansion through Benefit-Z package limits members' access to costly health services and expensive conditions (Caballes 2013, 85).

This situation also raises the issue of effectiveness and efficiency in matching resource requirements (based on actuarial studies) with expanded benefits (e.g., Benefit-Z) and the flow of

[22] This implies that many poor members are not aware that they have SHI coverage. Consequently, they do not utilize SHI benefits to access health services regardless of geographic location. There is increased population coverage due to national targeting of the poor for expanded SHI.

information to ensure that members are "aware" of the new benefits accorded – and the requirements – to access them. There is a need to facilitate transactions with streamlined forms and procedures, and more transparent in benefits selection and awards. Monitoring and further analysis are in order because Benefit-Z package seem to have increased OOPS as insured persons carry the burden of health care cost. Notably, OOPS spiked between 2012 and 2013 in spite of the expanded SHI coverage with earmarked funding and NHIA 2013 (see Figure 6).

Population coverage started to increase after the Sin Tax law of 2011 that obligated resources to cover the poor. This raises a governance issue on possible duplication of enrollment of indigents' identified by local governments and the NHTS-PR based enrollment. There is the risk of continued enrollment or double counting of SP enrolled households under the NHTS-PR targeting system, e.g., not in the list of poor household. The 2015 Commission on Audit disclosed critical deficiencies in its IT system, policies and procedures, and vulnerability to errors and risk of mismanagement.

3.2.3. Lessons from policy reform processes

The Philippines case suggests focus of SHI policy reforms relate to increasing population coverage, and expanding the types of health coverage. Population coverage showed fluctuating membership due to temporary program and poor targeting. There is disconnect between population coverage and health financial risk protection. With the rapid increase of SP membership, it remains unclear which membership group will benefit from enrollment expansion.

Prior evidence suggested that those in the upper quintile seem to have been benefitting from SHI more than the targeted poor. The utilization of SHI is affected by the supply-side of health services including those provided by local governments and information about benefits of

covered individuals. Subsequent empirical analysis is desirable to see the impact of the expanded population coverage and benefit packages post- Sin Tax law, which apparently create a more sustained SHI coverage of a significant portion of the population.

Governance structure and systems of accountability need to clearly establish intergovernmental arrangements – including fiscal relations – between central and local governments. For instance, the 100% premium contribution by central government seems to subvert the existing policy framework where local governments serve a financier for SHI. Moreover, coverage by local governments and central government under the NHTS-PR has to be reconciled and harmonized to avoid potential duplication and data inconsistencies.

Therefore, the roles and relationship between the purchaser and service providers should be analyzed for potential accountability risks, e.g., duplication of enrollees, leakage of government resources using SHI as venue, accreditation procedures and quality assurance, among others. Availability, adequacy and quality of service providers and their geographical spread in the regions, particularly rural areas should also be looked into.

3.3. Viet Nam: progressing towards universal health financial risk protection?

In 1986, the 'Doi Moi" (renovation) has displaced institutions in Vietnam from the subsidizing *centrally-planned economy into* the socialist-oriented *market economy creating significant* changes in both economic and social aspects. Four major reforms in the health sector were pursued including: user charges, health insurance, permission for private practice in health care, and opening of the pharmaceutical market. OOPS share of THE reached 71% in 1993 and continued to rise to 80% in 1998 (Tien et al 2011; Liebermann/Wagstaff, 2009).

As such, the government decided to reduce subsidies in healthcare and mobilize community resource in 1989. This led to the piloting of SHI in Viet Nam, which consequently

gained the support of the population. It created a new approach in applying economic measures towards health management. Table 5 indicates the reform areas, institutional forms and features as well as the supporting policies and implementation of SHI over time.

Table 5: Viet Nam – Institutional origin and evolution of SHI

Year	Reform area	Institutional forms	Features and phased implementation
1989	Introduced SHI (voluntary) in some provinces	Decision No 45 of Ministers' Committee (24/4/1989)	Piloting of voluntary non-commercial health insurance in some provinces
1992	Risk pooling: Implementation of SHI in all provinces	Displacement: First Decree No. 299 on the Article of Health Insurance (18/8/1992)	Enabling decree for SHI in Viet Nam SHI fund with two level scheme: one health insurance fund in each province and a national reserve fund Managed by Provincial Health Insurance Agencies and supervised by Provincial Health Departments SHI Fund covered all user fees for insured people; and patients did not pay any co-payment. Premium applied until 2005: for formal-sector workers at 3% of their salary, of which employers contributed 2% and employees contributed 1%; a flat premium for the informal sector without a government subsidy
1998	Risk pooling: Unifying all provincial health insurance funds into a single national health insurance fund	Layering: Second Decree No. 58 (13/8/1998)	Unified all provincial health insurance funds into a single national health insurance under management of MoH from 1998 – 2001. Enlarged coverage of health insurance scheme for members of Congress and People Council; pre-school teachers, meritorious people, socially protected people, dependents of army officer and soldiers and foreign students in Vietnam Increased compulsory groups; new regulation of co-payment (5% or 20%) SHI fees with most insured people Merged SHI agency for pension insurance; and SHI fund under management of Vietnam Social Security (VSS) from 2002 MoH serves as SHI policymaker while VSS as fund keeper and responsible for its implementation Poor exempted from paying user fees until 2002 and they can choose to enroll in HI scheme or access free health care covered by Health Care Fund for the Poor in 2002
2005	Risk pooling	Layering:	Ceased direct exemption policy

Year	Reform area	Institutional forms	Features and phased implementation
		Third SHI Decree No 63, (16/5/2005)	Poor and ethnic-minority people have to enroll in compulsory health insurance with 100% premium subsidy from government Increased benefits of insured card holders, Encouraged participation of volunteer groups by adjusting benefits for households or farmers Started private hospitals to join SHI scheme.
2008	Risk pooling (Layering)	Layering: First SHI Law in 2008	Enabling law harmonizing SHI policies
2009	Revenue raising; risk pooling	Layering: Decree No 62 Joint Circular No.09 Circular No.10 2009	Insured groups increase up to 25 Government to buy SHI card for the poor, revolution-related meritorious people and children under 6 New premium (until now): for workers at 4.5% of their salary, of which employers contributed 3% and employees contributed 1.5%
2014	Risk pooling	Layering: Amended SHI Law in 2014	SHI scheme compulsory for all Vietnamese citizens including the army and police forces Regulation for family-based enrollment of households with HI contribution reduced to 70%, 60%, 50% 40% with first member's contribution

Source: Tien et al 2011; Liebermann/ Wagstaff 2009.

From 1992 to August 1998, the government pursued the implementation of Decree 299 with SHI scheme aimed at increasing health care accessibility for the poor. During this period, there were observations on incompleteness and inconsistencies of SHI regulation. SHI followed a multi-funded model where the provinces managed SHI funds separately with independent accounting with no compensation. The Fund covered all user fees for insured people with no co-payment by patients. Consequently, there was over-utilization of SHI funds leading to deficits in many provinces.

After one year of implementing Decree 299, the number of insured people was only above 3 million including primarily state employees (MOH 2007). This led the government to promulgate Decree No. 58 of 1998 with various improvements in the regulation. This marked the

beginning of the second round of policy development of SHI. It initially unified all provincial SHI funds into the National SHI Fund to be managed by Ministry of Health (MoH). MoH also absorbed all SHI tasks in managing the revenue and expenditure of SHI fund.

In March 2003, MoH handed over the management of SHI fund to Vietnamese Social Security (VSS), previously used to only keep Social Insurance Fund. Subsequently, notable changes in SHI policy ensued, e.g., increase in compulsory groups, new regulation of co-payment of 20% or 5% SHI fees with most insured people. By 2005 SHI population coverage reached 23% or increasing 6 times compared to coverage in 1992 (MOH 2007).

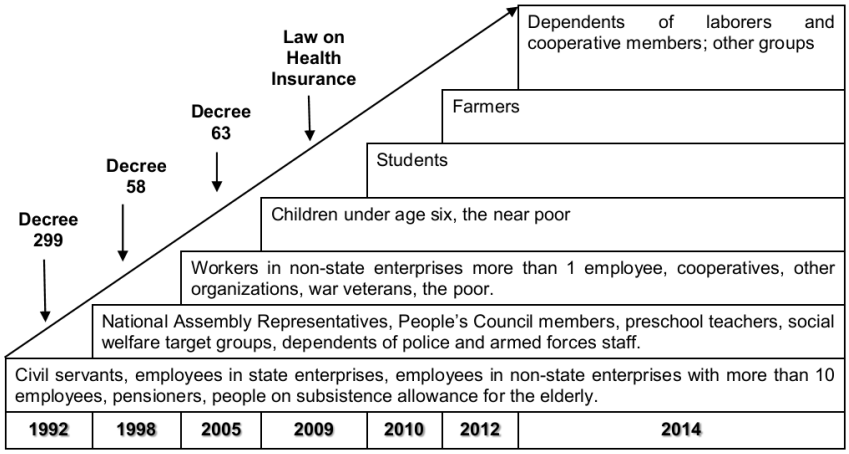
From 1994 to 2002, the poor were exempted from paying user fees. With the introduction of Health Care Fund for the Poor (HCFP) in 2002, they can choose either to enroll in SHI scheme or be covered by HCFP. The poor complained about being discriminated against and that they do not enjoy the full benefits of the policy. They perceived the previous health insurance coverage as better financial risk protection when seeking healthcare compared, particularly the direct exemption. Moreover, some provinces tended to transfer sickly poor to the health insurance, resulting in adverse selection and increase average per capita expenditure for the insured poor. While the preferred option for the healthier poor was to provide them with user fee exemptions (Liebermann/Wagstaff, 2009).

In 2005, the promulgation of Decree No.63 enlarged SHI coverage, putting a halt to the direct exemption policy. It stated that all poor have to enroll in compulsory health insurance with government funds subsidizing their premium. It further increased benefits for insurance card holders, and encouraged participation of some volunteer groups by offering reasonable benefits for households and farmers. By 2008, the number of insured people increased to 39.7 million or 46% coverage of the population. SHI policy achieved a higher degree in the breadth of coverage.

Consequently, the government saw the need for a more harmonized SHI sector through legislative action. The Vietnamese Parliament passed the Social Health Insurance law on 28 October 2008 after three years of drafting and revisions. It was followed by a series of supporting regulations in 2009 including the Decree No 62 with specific clauses guiding the SHI Law, Joint Circular No.09 guiding the implementation of SHI scheme, and Circular No.10 2009 guiding registration of initial examination and treatment for health insured people.

Article 51 provides the most important highlight regulating the timing when different social groups are responsible to participate in SHI, thereby providing a roadmap toward universal insurance coverage (SHI Law 2008). Supporting regulations covering insured individuals increased the number of groups up to 25; further providing for the government to subsidize SHI membership for the poor, revolution-related meritorious people, and children under 6 years of age. Figure 10 shows the expansion of health insurance coverage by group from 1992 to 2014.

Figure 10: Viet Nam - Expansion of health insurance coverage of insured groups



Source: Joint Annual Health Review 2011, The Ministry of Health 2011.

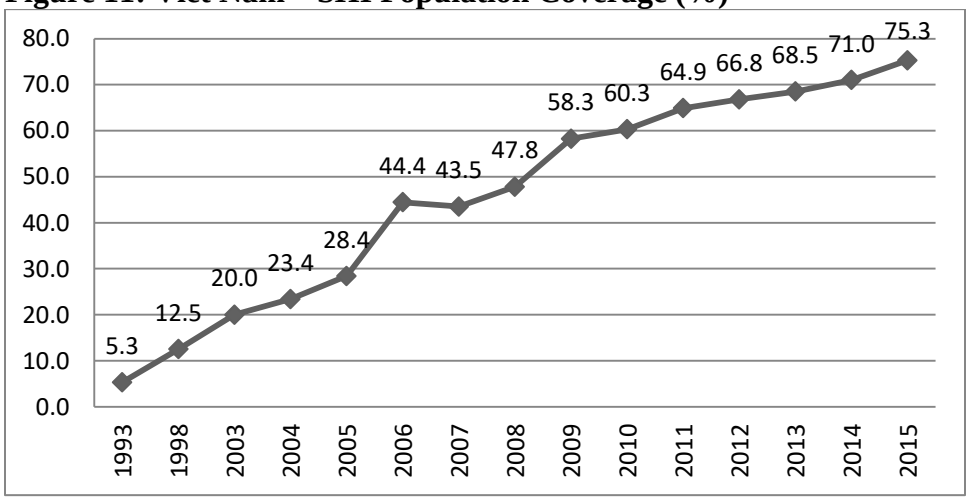
In 2014, the SHI Law of 2008 was further amended with the end view of all providing health insurance coverage for all Vietnamese citizens. SHI coverage continued to increase and was recorded at 75.3% of population in 2015. Implemented in 2015, it provided that enrollment in SHI scheme is compulsory for all Vietnamese citizens including the army and police forces. It

changed family-based enrollment for households with SHI contribution by reducing to 70%, 60%, 50%, 40% following first member's contribution. It also increased SHI benefit for insured groups by reducing co-payment for near-poor from 20% to 5%.

3.3.1. Health financing and SHI coverage trajectories

The Viet Nam case study shows that enabling laws and regulations reflect the steady increase of SHI population coverage from mere 5.3% in 1993 to 75.3% in 2015. Figure 11 shows the trajectory of SHI population coverage from 1993 to 2015. Notably, population coverage shifted its growth trajectory consistently in parallel with the incremental expansion program in 2005 and the enactment of 2008 SHI law shown in Figure 10 above. Growth slowed down in 2007 and 2008 when the SHI law was being drafted and deliberated upon.

Figure 11: Viet Nam – SHI Population Coverage (%)

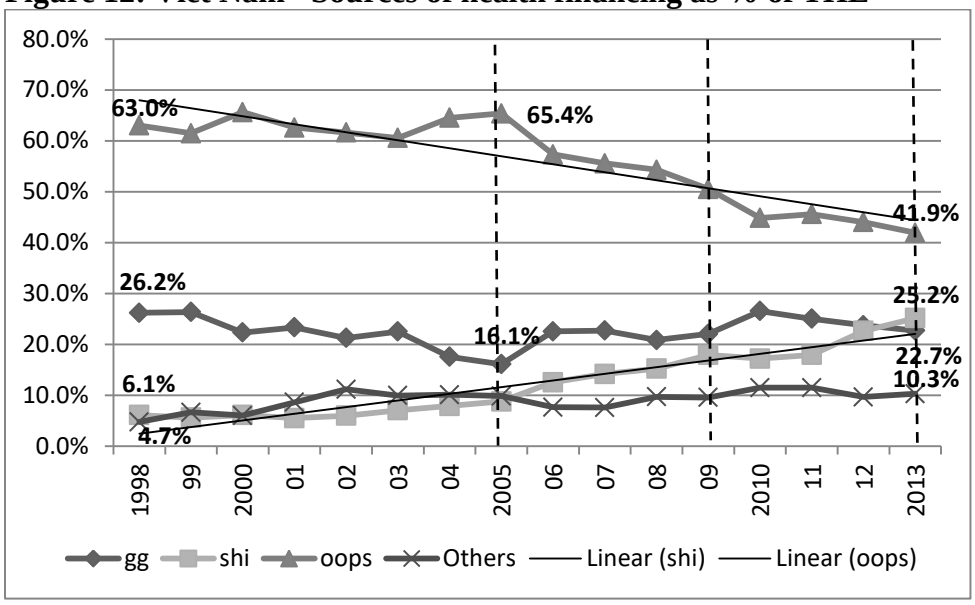


Source: Viet Nam Social Security.

Viet Nam exhibits empirically observed trajectory towards health financial risk protection with the declining OOPS share of THE from 63% in 1993 down to 42% in 2013(see Figures 12 and 13). SHI share of THE has increased from 6.1% in 1998 to 25.2% in 2013. General government health expenditure has had a varying trend relative to THE, but was overtaken by SHI in 2012. It is interesting to note that SHI's share shifted to a new trajectory as OOPS

continued to decline after the 2005 SHI regulation directing transition towards UHC.

Figure 12: Viet Nam - Sources of health financing as % of THE

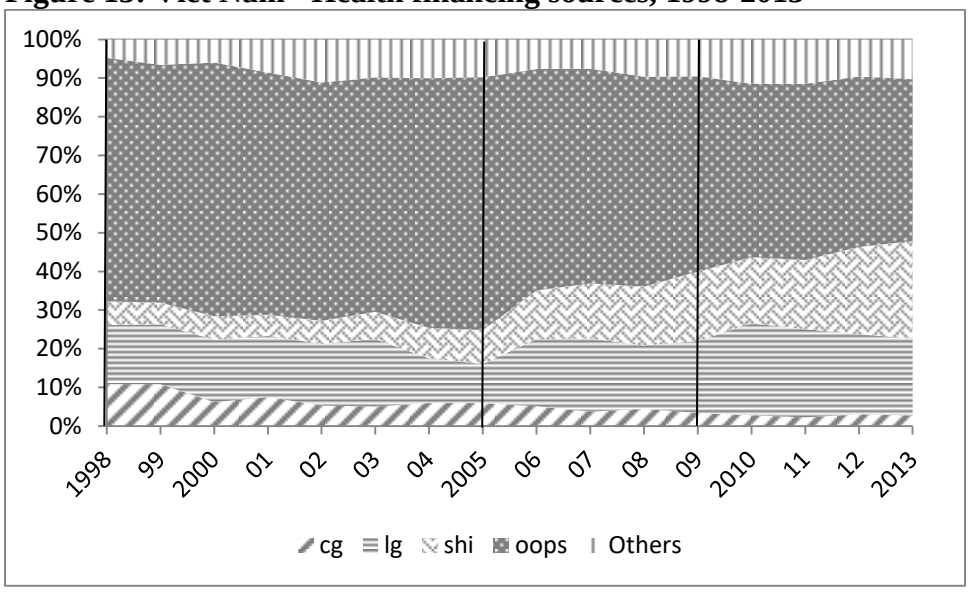


Source: National Health Account.
Legend: gg=general government, cg=central government, lg=local government, shi=social health insurance, oops=out-of-pocket spending, others=grants, ODA, social organizations.

In fact a strong relationship can be established here. Population SHI coverage is positively correlated with SHI expenditure share of THE. It is negatively correlated with OOPS as % share of THE.[23] The results suggest causal relationship of institutional reforms undertaken in expanding SHI coverage and transitioning SHI towards UHC. It may further be inferred that the observed trajectory of population coverage in Figure 11 above reflects a deliberate attempt of expanding coverage linked to the institutional design of SHI. [24] In Viet Nam, improved health financial risk protection and expansion of health insurance coverage as outcomes of interest are *endogenous* to or consequential of the processes of SHI institutional reforms over time.

[23] Simple regressions show results as statistically significant at .001 levels with Adj R-squared of .9171 and .8781, respectively.
[24] This is contrary to the erratic observation of SHI coverage in the Philippines.

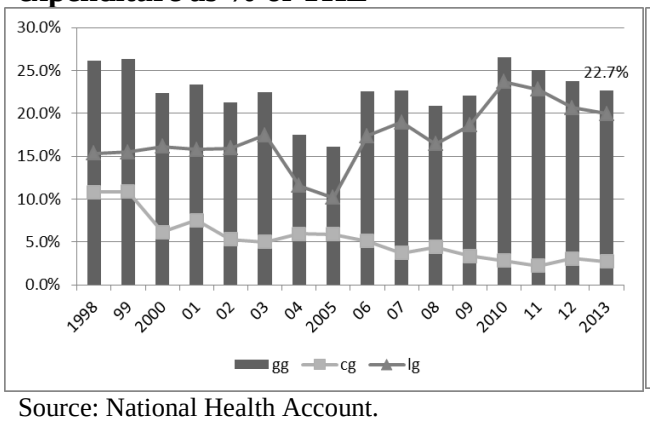
Figure 13: Viet Nam - Health financing sources, 1998-2013



Source: National Health Account.
Legend: gg=general government, cg=central government, lg=local government, shi=social health insurance, oops=out-of-pocket spending, others=grants, ODA, social organizations.

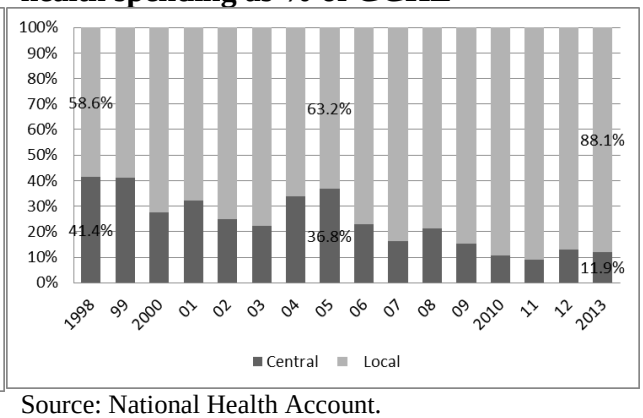
The varying trend in general government expenditure as described earlier can be attributed to the heath financing performance of local governments as shown in Figure 14. Conversely, CGHE has been declining since 1999 that coincided with the implementation of Decree 58 of 1998 (refer to Table 5 and Figure 10). Figure 15 shows the expenditure share of central and local governments in GGHE.

Figure 14: Viet Nam - Government health expenditure as % of THE



Source: National Health Account.
Legend: gg=general government, cg=central government, lg=local government.

Figure 15: Viet Nam - Central and local health spending as % of GGHE



Source: National Health Account.
Legend: GGHE= general government health expenditure.

Overall health sector financing reforms resulted in the shift towards greater health expenditure decentralization as well. The share of local government expenditure increased from 58.6% in 1998 to 88.1% in 2013, moving alongside the trajectory of SHI's share to THE as shown in Figure 12. The next section looks into the institutional and organization challenges of SHI in Viet Nam now that it has advanced quite significantly towards financial health risk protection and SHI population coverage.

3.3.2. Challenges in institutional design and organizational performance

Viet Nam' overall financial health system and population coverage in the above section showed much progress in transitioning SHI towards UHC in time. Earlier reviews (e.g., Somanathan, Dao and Tien 2013; Tien et al 2011) were conducted and/ or used data prior to or close to the adoption of the 2008 SHI Law and its subsequent enforcement and supporting regulations in 2009. Although they provide institutional and organization reviews of HSF and SHI systems, the consequences of the next round/s of reforms after 2005 are not captured. There is limited exposure to the SHI institutional reforms. As such, this section looks into earlier analyses and provides updates based on recent data from National Health Accounts.

Health financial risk protection. As established in the preceding sub-section, Viet Nam has achieved much in terms of expanded population coverage by SHI from 28.4 in 2005 to 75.3 in 2015 and increased financial risk protection as evidenced by the decline OOPS from 65.4% in 2005 to 42% in 2013. Here the improvement in financial risk protection and expansion of health insurance coverage as outcomes of interest are endogenous to or caused by the processes of SHI institutional reforms over time. The empirically observed trajectories will have to be captured by subsequent empirical analyses in measuring the impact on access and use of SHI and health services, particularly the targeted poor.

Somanathan, Dao and Tien (2013, 10-12) pointed out that there remains to be impediments towards the *effective coverage* of the poor towards UHC, particularly the "high degree of fragmentation of pooling and revenues exacerbated by the capitation-based system" (11). This has implications on pooling and equity, i.e., it leads to limited pooling of risks between rich and poor, it leads to limited pooling of risks and revenues across provinces, and it results in under-provision of services to the poor and other vulnerable groups. To what extent these have been addressed in recent reforms have to be analyzed empirically.

Multi-level governance. The governance and management of SHI scheme in Vietnam is assigned to several sectoral agencies at different levels. At the ministry level, the MoH serves as steward in implementing SHI with specific tasks of developing policy and strategy for achieving universal SHI including the design of benefit packages; maintaining reimbursable SHI drugs list; and, providing tools and solutions to balance the SHI Fund. The Ministry of Finance is responsible in developing SHI financing and working with other sectors. Other ministries also take state management responsibility for SHI within their scope of work. For instance, the Ministry of Labor, Invalids and Social Affairs (MOLISA) is responsible in identifying social target groups and listing the beneficiaries under the SHI scheme. At the subnational level, people's committees monitor the implementation of the SHI Law both at the provincial and district levels. They are also responsible in securing sufficient budget to cover for SHI premium of eligible individuals. However, the delineation of responsibilities between the people's committees and the state management as regards SHI law is unclear leading to ineffective implementation.

Vietnam Social Security (VSS) is the implementing agency of SHI. It serves as SHI fund keeper and ensures reasonableness of prescriptions and settlement of accounts claims of

healthcare providers. There are 63 provincial Social Security units to implement SHI policy in the subnational level. Healthcare facilities provide health care services for insured patients and receive SHI payment. In spite of specific responsibilities, there is lack of consistency in governing SHI at all levels and duplication/overlap of duty in implementing SHI policy between inter-ministries and VSS (MOH of Viet Nam 2012).

Central VSS assigns targets for SHI implementation, which are not aligned with provincial development plans. Many local authorities are not active in covering for new SHI beneficiaries as a target of their socio-economic development. They have limited authority in dealing with any conflict arising from healthcare service facilities and the provincial VSS. Restrictions arise from the administrative "vertical system" arrangement (MOH of Viet Nam 2012) and SHI design as discussed below.

Governance dimension focusing on transparency and accountability. Governance issues of SHI emanate from SHI membership scheme under the current law; that is, fragmented with 25 individual membership categories. This has both pragmatic and administrative efficiency implications – vertically and horizontally –among government ministries, local governments, people committees, VSS, and mass organizations. It can also confuse targeting the poor, children of poor family, dependents of military personnel and public security officers as well as those who move from the informal sector to the formal sector (Tien et al 2011).

On the one hand, fragmented membership has negative implications on members. First, the 100% premium coverage for children below 6 years old could have easily been covered through a family-based schedule; and second, it complicates enrollment procedure and contribution collections for individual families, the VSS and other relevant government agencies. Overall, there is low coverage rate for the formal sector employees recorded at 53.4 in 2010

(ibid., 21), particularly among private enterprises. This can be attributed to low enrollment compliance among private enterprises recorded at around 20-30% as a result of inadequate monitoring and inspection, weak enforcement and high level adverse selection at the subnational/ provincial level (ibid., 16-17).

On the other hand, fragmented membership has implications on data collection efficiency, management and accuracy of information as well. Earlier observations indicated that "the information environment under SHI is weak with little strategic or systematic use of data" (10). Recent reforms focusing on developing Viet Nam IT-system for the health sector and SHI with corresponding policy action from the Prime Minister are underway.

The government considers health information system (HIS) as essential for assessing healthcare needs, monitoring implementation of tasks, and evaluating impact of intervention in the health sector. Its Five-year Health Sector Plan 2011-2015 provides for the development of broad macro-level HIS called "HIS Comprehensive Plan" in 2014-2020. Considered as the first methodically and scientifically designed HIS in Vietnam, it aims to harmonize health statistical reporting forms including indicator system, report forms and guidelines for health information. MoH issued its "Plan for Information Technology Application and Development in 2016-2020" in 2016 providing for the investments in overall improvement of HIS-IT system architecture towards strengthening governance.

However, the development of information sub-systems and implementation of regulations remain weak. Among the implementation and organizational issues include (i) weak oversight and leadership for implementing HIS plan with fragmented steering committees; (ii) key health information systems not functioning effectively, e.g., death registration, cause of death statistics, and chronic disease registries, leading to inadequate information for health sector planning; (iii) inadequate patients records and absence of a unique health identifier to ensure continuity of

care, avoid adverse selection and duplication; iv) underutilization of HIS data due since are not disseminated to researchers for analytical work to inform planning, policymaking and health system reforms; (v) no regular and comprehensive data reporting from private health sector (MoH of Viet Nam, 2016).

To improve the information system of SHI, the Government has implemeted the project "Applying IT in management of health treatment and examination, and implementing online reviewing and reimbursement payment" in 2015. Under this policy, health facilities at all levels are expected to apply Healthcare Common Coding System (JCCS) and send their health insurance data to portals at MoH and VSS. Once completed by the end of 2017, it is expected to have better acuracy and transparency in SHI system.

3.3.3. Lessons on policy reforms processes

Viet Nam case study has shown that empirically observed trajectories towards improved population coverage (breadth of coverage) and financial risk protection are associated with and endogenous to the layering of SHI institutional forms and transitional processes. The remaining task is to continually monitor, review and put forward adjustments in ensuring that prior institutional reforms are implemented well and follow the current path.

Continuously measuring and observing the causes and consequences of SHI reforms is key to more accurate assessment of impact and utilization of SHI and healthcare services towards UHC. Earlier findings and observations (e.g., Somanathan, Dao and Tien 2013, Tien et al 2011) on financial risk protection as basis for impact of SHI, recommending future policy and institutional reforms seem to be outdated. For instance, the observation of "persistently high OOP payments" and "inability to control OOP payments" as well as other so-called "design flaws" may no longer hold. Measuring the impact of – and progress – SHI on population health

outcomes, individual health seeking behavior, access quality of health services is in order.

HIS and JCCS are underway for improved transparency and accountability of HSF and SHI systems. However, the extent to which such systems are useful will depend on "how" they are used in monitoring and assessing the relationship between the insurer, beneficiaries and service providers. Furthermore, the system should also go beyond internal procedures and reporting flows between and among concerned agencies. Insured persons have to be aware of their benefits and entitlements to improve access to SHI and healthcare services. Equally important, information systems should be able to provide reliable information for empirical analyzed and be made accessible to the scientific community and/or third party researchers for better analysis of impact towards the development of policy-relevant knowledge.

4. Multi-level governance: Interaction of SHI, decentralization and health service delivery

The Philippines and Viet Nam case studies show that SHI policy and institutional reforms towards access to and utilization of SHI can be explained by three factors: First, the targeted poor and non-poor members largely financed by government subsidy of SHI premiums. Second is the governance structure and degree of administrative decentralization where healthcare system and SHI operate. Third is the availability of information and transparency on SHI benefits and packages. In addition, adequacy of resources (e.g., hospitals, bed and doctor to population ratio, and facilities) may facilitate use of SHI and healthcare services on the ground.

Targeting the poor and vulnerable in SHI reforms. Integrating the poor into SHI has been the driving force in expanding coverage rather compulsory and/or voluntary enrollment. Philippines and Viet Nam have pursued increased enrollment towards full coverage of the population, particularly the poor and vulnerable. Despite the differences in their trajectories

towards financial risk protection as measured by OOPS, they have both achieved a considerably high population coverage in recent years. However, catastophic expenditure and impoverishment among the poor remains a challenge in both countries; the high cost of medicines is a major factor of OOPS (Bredenkamp and Buisman 2015, Somanathan, Dao and Tien 2013).

Governance and administrative structure. The structure of government, decentralized health system, and central and local government relations – and the tension between them – affect the design and implementation of SHI. National territorial interests tend to dominate SHI reform processes, which reflect the priorties of central government in general and health sector in particular towards UHC. Governance and institutional arrangements for health financing and SHI systems have not been given much attention by SHI reformers due to the potential backlash they might bring. Futhermore, reforms pursued are oftentimes influenced by the pragmatic approach of key actors either in ensuring that policy proposals get through the political processes of the legisture or in pursuing the interest of central government executives, particularly the health ministry/ department.

Regardless of the type of state and legal framework for decentralization (i.e., devolution), this study has shown that Viet Nam is far more decentralized than the Philippines in terms of administrative responsibility and resources over the provision of health services.[25] This further suggests that local governments have more policy autonomy[26] to decide on policy and health spending priorities at the subnational level; local officials might more accountable of health services in their jurisdiction. Within the context of de/centralized services (i.e., value for allocative efficiency), how has this improved access to and utilization of quality health services

[25] Consistent with this observation, Tien et al (2011, 5) notes that "the health service delivery system is undertaking 'hospital autonomy reform' that will help performance…."

[26] Here health policy autonomy is measured as subnational share of health expenditure relative to central government drawing on broader measure for administrative decentralization and policy autonomy (e.g., Blume and Voigt 2011, Rodden 2004, Schneider 2003)

in Viet Nam? Has it improved governance and accountability of SHI performance and health service delivery?

In Viet Nam, Health Care Fund for the Poor (HCFP) is administered in a highly decentralized manner, which appears to have helped administrative efficiency in the implementation and targeting of for health financing (Gottret, Schieber and Water 2008). Decentralized structure appear to more effective in targeting the poor for coverage through the MOLISA and DOLISA interaction. While in the Philippines, PHIC has a highly centralized quality control and payment function with support from its regional offices/ centers in the accreditation of service providers. Observations related to the 1991 decentralization law (Local Government Code of 1991) seem to be negative including politicization of enrollment and targeting of the poor, cases of non-remittance of local government contributions for indigents, and having a "fragmented" public health system, among others (Manasan 2011, Capuno 2006). PHIC finds it difficult to perform its regulatory function over local governments given their dual role as both a financier and service provider (Capuno 2006, 347).

Asymmetric expectations from decentralized health service delivery hinder administrative efficiency and effective implementation of SHI. In the case of the Philippines, it might be asked once more: which level of government (central or local governments) should be made more accountable in the delivery of local health services? This brings us back the institutional design of decentralization under the 1991 decentralization law. To what extent has it devolved the delivery of health services from central to local government? Apparently, central government continues to play a bigger role, which requires heightened *policy coordination* with and support from subnational governments towards achieving the policy goals of UHC – utilization of health services, quality care and financial risk protection – at the country level.

Information and transparency towards SHI accountability. Lack of awareness and information limit access to and utilization of SHI and health services among insured patients (e.g., Bredenkamp and Buisman 2015, Quimbo et al 2008). However, the mechanisms and systems of accountability showing relationships between the purchaser, beneficiaries and service providers are yet to be established. Given the voluminous transactions handled in managing SHI, it requires a well-developed information technology (IT) and database management system. Quality systems design and development are key to ensuring reliability, accountability and integrity of membership data, coverage as well as accreditation and payment for service providers. This requires policies for standardized terminologies/ accounts of indicators, flow of information (vertical and horizontal), and protocols for data sharing, privacy and security.

For transparency, accountability as well as analytical purposes, there seems to be missing information to establish the relationship of the insurer, beneficiaries and service providers. For instance, the ratio of accredited institutions relative the number of hospitals and health units as well as the ratio of beneficiaries relative to health professionals at the subnational level, i.e., regions and local governments should be collected and analyzed. These have important implications as to the access of health service providers in regional and provincial centers. The targeted poor are largely situated in rural areas with limited access to transportation. As such, subnational level analysis would provide critical inputs for subsequent institutional reforms in overall health financing expenditure framework and design of SHI towards UHC.

5. Conclusions and research implications

This paper sheds light to expectations for “miracles” to happen towards better health outcomes and achieving broad development agenda set at the global arena by being more transparent and accountable in administrative operations. Some fundamental questions had to be

asked to understand the causal mechanisms towards achieving SDG 3 (healthy lives for all) and improving health outcomes and promote well-being for all: to what extent did institutional reforms create new pathways towards financial health risk protection as a goal of UHC? When and how did they occur so that outcomes and impact may be associated with SHI institutional reforms?

Two country cases exhibit divergent outcomes towards health financial risk protection. VietNam case progresses towards attaining UHC policy goal while the Philippines regresses. This is explained by modes of institutional change and sequencing of reforms – or the lack thereof – by government towards increasing government health spending and better design of SHI. It also suggests either the persistence of self-reinforcing mechanisms leading to institutional *reproduction/ stability* or SHI institutional reforms and transitional processes over time towards health coverage and financial risk protection. The role of ideas and policy-relevant knowledge were observable as the processes of SHI reforms unfold.

Multi-level governance and accountability of SHI towards UHC may benefit from a more in-depth analysis of the interaction between health financing framework with SHI, decentralization reforms and local health service delivery. Within the context of de/centralization at the country level, which level of government – central or local governments – should be held more accountable in the delivery of health services at the subnational level?

The impact on access and use of SHI and healthcare services are yet to be measured and analyzed in time. Measuring impact and/ or utilization using time-invariant data may not be able to capture the consequences of institutional reform. Earlier attempts at measuring them were conducted a bit early to attribute the effects of reforms (e.g., Bredenkamp and Buisman 2015, Tien et al 2013). Temporal and spatial (e.g., subnational/ regional, local jurisdiction) dimensions

are likewise critical in analyzing impact; going beyond macro level information.

A comprehensive analysis of the purchasing function of SHI should be given more emphasis at the country level (national and subnational) in future studies. Network analysis in establishing the relationship between the purchaser and service providers would be useful in determining gaps that have implications for policy and institutional reforms, including the development of IT-based solutions to improve flow of information towards transparency and accountability of SHI.

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Annex 1 – Selected Health Financing System Indicators

Figure 1: Total Health Expenditure as % of Gross Domestic Product

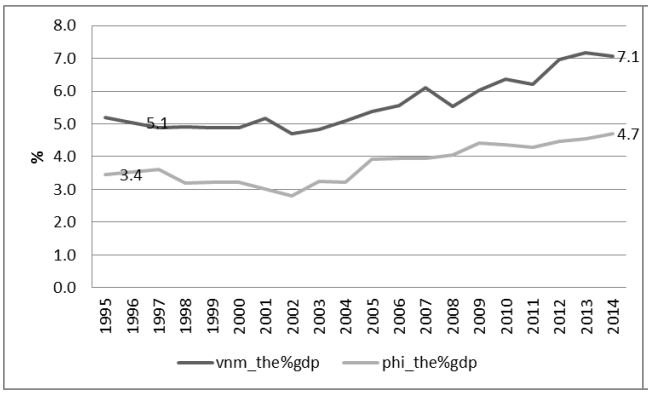


Figure 2: General Government Health Expenditure as % of General Government Expenditure

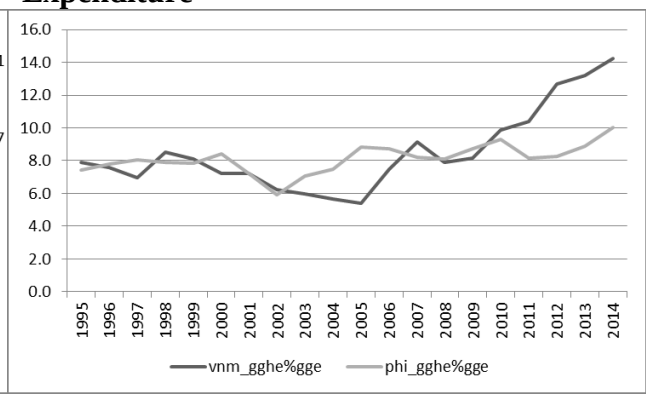


Figure 3: General Government Health Expenditure as % of Total Health Expenditure

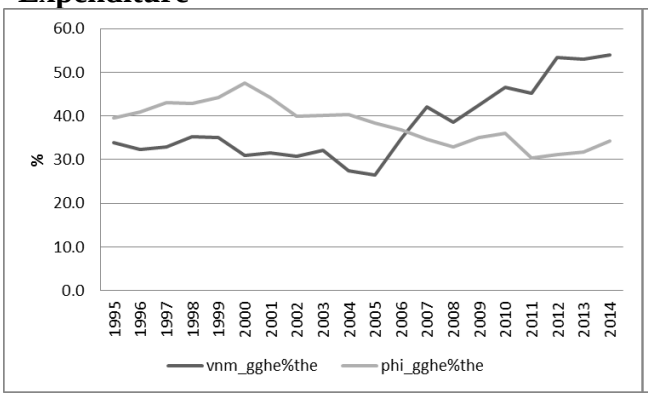


Figure 4: Out-of-Pocket Spending as % of Total Health Expenditure

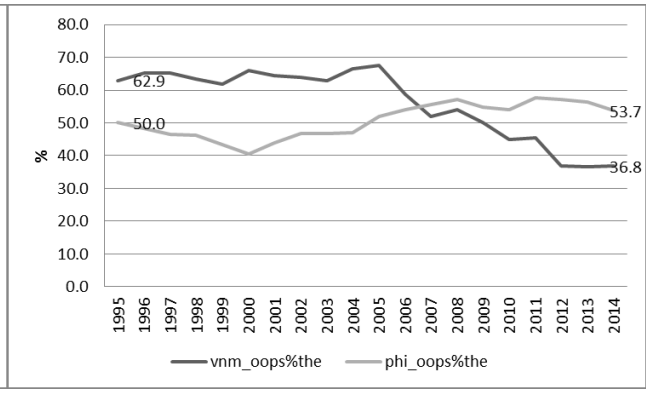
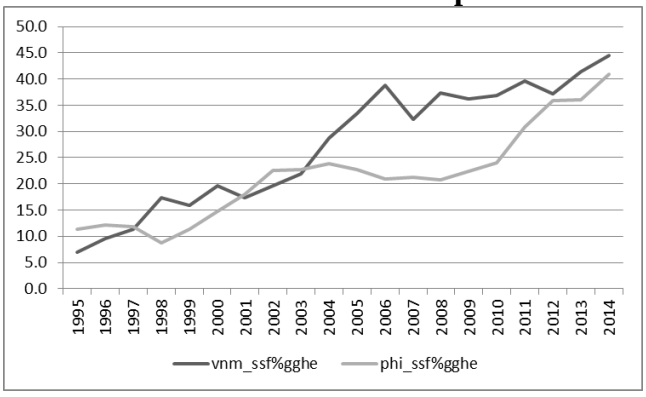


Figure 5: Social Security Fund as % of General Government Health Expenditure



Source: WHO global health expenditure database.