The growth of non-state hospitals in Vietnam: Implications for policy and regulatory options

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INTRODUCTION

This paper summarises the results of studies of the non-state hospital sector in Vietnam undertaken by the Health Strategy and Policy Institute, Ministry of Health, Vietnam, with the support of the Health Policy and Health Finance Knowledge Hub at the Nossal Institute for Global Health, University of Melbourne. The paper forms part of a broader examination of the role of non-state hospitals in middle income countries of Asia, with further in-depth country studies also in Indonesia. The aim of these studies was to examine the recent growth of hospital services in selected countries of the Asia-Pacific region, to identify factors contributing to and impacting on this growth and to explore the potential regulatory and policy responses. This paper examines the findings from Vietnam in the light of contemporary international literature and policy concerns.

The role of the private sector in health systems in low- and middle-income countries has received considerable attention in international policy discussions and in the literature. Some commentators have criticised the growth of the private sector as an ineffective means of providing services efficiently and equitably (Hanson, Gilson et al 2008, Marriot 2009). Others have actively explored the potential for private sector provision to contribute to expanding access of services by the poor (Loevinsohn and Harding 2005, Lagomarsino, Nachuk et al 2009). Currently, the private sector contributes significantly to the provision of health services in many Asian countries, including services to the poor. A number of studies have identified the use of private providers for primary or ambulatory care, although there is less information on their role in provision of hospital services (Hanson and Berman 1998, Hanson, Archard et al 2001, Mills, Brugha et al 2002).

Some commentators have linked the growth of the private sector with increasing commercialisation of the health sector. The World Health Report 2008 identified commercialisation and hospital centrisim as key challenges for health systems. It argued: ‘Unregulated commercialized health systems are highly inefficient and costly: they exacerbate inequality and they provide poor quality and, at times, dangerous care that is bad for health’. (WHO 2008). Nishtar (2010) postulates a ‘mixed health systems syndrome’ that compromises the quality of health services and equity of access.

Vietnam’s health system displays some of the characteristics of commercialised mixed public-private health systems, notably a high proportion of out-of-pocket expenditure, the imposition of user fees in state facilities and a degree of dual practice (Trieu, Tien et al 2009). However, state-funded service provision remains strong and effective. This has been contrasted with commercialisation in China, where funding for the state system has been reduced to a much greater degree, creating higher dependency on user fees (Huong, Phuong et al 2007). As Vietnam moves towards universal coverage and attempts to reduce out-of-pocket payments, it will need to consider both an appropriate role for the private sector (private sector hospitals in particular) and the appropriate regulatory framework to encourage the private sector to adopt this role.

In the light of these policy challenges, the Health Strategy and Policy Institute, in collaboration with the Nossal Institute for Global Health, analysed available data and conducted case studies on non-state hospitals in Vietnam. These studies contribute to the information on the growth and current role of non-state hospitals in Vietnam and identify the policy issues and options that need to be addressed.

The specific objectives of the studies were to:

- describe the number, distribution and growth of non-state hospitals;
- describe the role of non-state hospitals in terms of services provided and management of resources;
- describe the regulatory framework and identify gaps or weaknesses in regulatory enforcement;
- identify issues for policy consideration.
THE METHODOLOGY

The questions addressed by this study were:

1. What role do non-state providers play in the hospital sector in Vietnam, and what contribution do they make to achievement of key health system objectives?

2. How does the regulatory framework address the role and activities of non-state providers? What are the gaps or weaknesses?

3. How could the regulatory framework be improved to address the gaps or weaknesses identified?

The study began with a review of the international literature to identify key issues and conceptual thinking around the role of non-state providers in health systems. A mapping exercise of non-state hospitals in Vietnam was completed along with a review of the regulatory structure. Case studies were carried out in three localities (representing central, provincial and district levels and urban and rural areas). Analysis of the case studies focused on the issues identified from the earlier mapping and regulatory reviews. The analysis involved a comparison of the services provided and target populations between state and non-state hospitals in each location, how this related to the human resources and facilities available and how management officials viewed the priorities governing the hospital’s development. The findings from these three sources were used together with two key analytical frameworks identified in the literature: the characteristics of commercialised mixed health systems; and market reforms for hospitals as a policy to improve performance.

LITERATURE REVIEW

The literature review focused on articles, commentaries and conceptual papers together with a limited review of primary research papers. Papers were identified using search engines including PubMed using terms including ‘private hospitals’, ‘non-state hospitals’, ‘commercialisation’, ‘markets’ and ‘regulation’ in conjunction with ‘Asia Pacific’, ‘developing countries’ and ‘low and middle income countries’. Health-system-related websites were also searched, including the World Health Organisation, Eldis and the World Bank topics. A review of Vietnamese legal, planning and regulatory documentation was also carried out.

MAPPING STUDY

The mapping study compiled information on the number, size, type (general or specialised), staff numbers and activities (number of admissions, Out Patient Department (OPD) visits) of state and non-state hospitals throughout Vietnam. Information was collected from Ministry of Health (MoH) annual reports, and a questionnaire was sent to all provincial health bureaus (PHB) and known non-state hospitals. All facilities that provided curative care and had inpatient beds were included, while polyclinics without inpatient beds were excluded. Of 82 identified non-state facilities, 65 returned completed questionnaires (the remainder appear to have been hospitals under establishment and not fully functioning). There was some inconsistency in data on non-state facilities from the different sources; for this reason, the Ministry of Health data were cross-checked with data from the PHB and the completed questionnaires from the non-state facilities themselves.

REVIEW OF REGULATIONS

The regulatory review identified and summarised official decrees, ordinances and instructions from the legalisation of private providers in 1993 to the present. These regulatory items were analysed according to the five aspects of the market identified by Bennet, Dakpallah et al (1994): market entry, quality and safety, quantity and distribution, price and public information.

CASE STUDIES

Case studies were undertaken in three localities to examine the respective roles of and interaction between state and non-state hospitals at each level of the health system. Locations selected included Ho Chi Minh City (two hospitals), Da Nang City (two hospitals) and Thai Binh Province (a non-state hospital in the provincial capital and a similarly sized state hospital nearby). The studies examined the population groups served by each
facility, the resources required, the services provided, compliance with regulations and the factors influencing non-state hospital management decisions. Data on services provided, hospital workforce and structure were collected through a questionnaire sent to each hospital and to the respective PHB. These data were supplemented by a review of the annual reports of each hospital. In-depth interviews were undertaken with each hospital and local health bureau director, and focus group discussions were held with senior managers and doctors from two selected departments in each hospital.

BACKGROUND

Key Issues in the International Literature

Two concepts of particular relevance to the development and role of the non-state sector in Vietnam were identified from the literature. The first, commercialised mixed health systems, views the issue not so much as distinguishing between state and non-state providers and deciding on appropriate roles for each but rather as the pervasive use of market transactions throughout the health system in both state and non-state facilities. The second is market-based health system reforms that seek to introduce greater market exposure and more use of market-based organisation in an effort to improve the efficiency and responsiveness of health systems.

Commercialised mixed markets

Several commentators have noted that it is becoming increasingly difficult to distinguish between ‘state’ and ‘non-state’ facilities in many health systems, and that the border between state and non-state has become ‘blurred’ (Bloom, Standing et al 2008, Lagomarsino, Nachuk et al 2009). The latter authors observe that the structure of health markets is complex, with the lines between public and private often unclear, making strict public-private distinctions difficult and overly simplistic. Mackintosh and Koivusalo (2005) introduce the term ‘commercialised mixed health systems’ which they define as:

the provision of health care services through market relationships to those able to pay; investment in and production of those services and of inputs to them, for cash income or profit, including private contracting and supply of publicly financed health care; and health care finance derived from individual payments and private insurance.

Mackintosh (2007) further refined the concept of commercialisation as a combination of the following processes:

- marketisation: the shift from provision and input supply without fee payment to fee-for-service provision and cash payment for inputs;
- commoditisation: the specification of items of service provision in a form capable of being sold on a market;
- privatisation: the shift of an asset from government ownership into private hands; and
- liberalisation: removal of constraints on private provision of health care services and purchase and sale of inputs.

Mackintosh distinguishes between different patterns of commercialised health systems, with different mixes of public and private and different types of private providers, from a predominance of small scale unregulated primary health care providers to a predominance of corporate providers, as well as different situations for state services, from an underfunded, poor quality, subsystem for the poor, to a widespread, universal access, high standard system. In a south Asian context, Nishtar (2010) has postulated a similar concept, referred to as the ‘mixed health systems syndrome’, and suggests that this syndrome compromises the quality of public services and equity of access. The syndrome is characterised by:

- insufficient state funding for health;
- a regulatory environment that allows the private sector to deliver social services without an appropriate regulatory framework;
- lack of transparency in governance.
WHO (2008) notes that commercialised health systems and hospital centrisms are the key challenges currently facing health systems.

**Health sector market reforms**

In some cases, commercialised health systems arose through the progressive development of public and private sectors. In others they arose from intentional decisions by policy makers to introduce market incentives and impose greater discipline on health care providers in order to improve performance. Jakab, Preker et al (2002) provide a good summary of the rationale and approach recommended for market-oriented organisational reforms. They note that the performance problems of public provision of health services include:

- technical inefficiency: resource waste, poor morale, high staff numbers, equipment not used;
- allocative inefficiency: high budget allocation to hospitals serving urban elites and neglect of more efficient interventions;
- inequity: hospital services not available for the poor;
- poor responsiveness to clients, especially the poor.

In this situation, they suggest that market organisational reforms can improve efficiency and responsiveness, but are unlikely to improve inequities of access and financial protection. Such reforms need to address two aspects: internal organisation of hospitals and external operating environments. Aspects of internal organisation that require attention include:

- autonomy: the extent to which management have the right to make decisions on aspects of hospital function, including inputs (labour as well as capital and investment), outputs and process (user fees);
- market exposure: the extent to which the hospital is subject to competition from other suppliers, both in the product market (production of outputs and delivery of services) and factor markets (obtaining inputs such as physicians and capital);
- residual claimant status: this reflects an organisation’s degree of enforced financial responsibility, both the ability to keep savings and responsibility for financial losses (debt);
- accountability: the extent to which the hospital is held responsible and answerable for performance to patients, payers, owners or regulators;
- social functions: the extent to which the hospital is explicitly or implicitly required to provide services to patients where the revenues earned do not cover the costs, but there are social benefits to the community or public.

In terms of the external environment, they identified the following areas for reform:

- government oversight: the extent of government oversight in formulating health policy by defining vision and direction for the sector, regulating the actors in the health system and collecting and using information;
- organised purchasing: the hospital’s relationship with the collective or organised purchaser(s) determines the financial incentives embedded in the payment mechanisms and the extent of competitive pressures on hospitals from organised collective purchasers;
- market pressures: the hospital’s relationship with its consumers (market-driven purchasing) determines the extent of competitive pressures the hospital is subject to from unorganised individual consumers exercised through choice and user fees;
- ownership (governance): commonly defined as the relationship between the owner and management of an organisation, good governance is said to exist when managers closely pursue the owners’ objectives rather than their own.
Health System Context

Despite strong economic growth in recent years, a significant proportion of Vietnam’s population remains in poverty. Socio-economic and health-status disparities between populations in urban and rural areas and between northern and southern regions are significant. Table 1 lists key health and socio-economic indicators.

Vietnam has performed well in health outcomes, generally achieving outcomes in excess of those expected from a country with a similar economic status and comparing well with countries in the region. With an under-five mortality rate of 24/1000 live births and maternal mortality rate of 56/100,000 births in 2008, it is on track to meet MDG goals four and five. It is also doing well in the control of malaria, Tuberculosis and HIV-AIDS, although the rate of HIV in pregnant women is above the target level (Trieu, Tien et al 2009).

However, inequality by wealth and region remains a problem, and improvement in health outcomes has been greater in the wealthier quintiles, resulting in an increase in the degree of inequality between 1997 and 2002 (Lieberman and Wagstaff 2009). The other major health challenge is the growing burden of non-communicable disease, responsible for 34 per cent of the total burden of illness in men and 43 per cent in women in 2006 (Trieu, Tien et al 2009).

Vietnam has a well-developed system of government health facilities, ranging from commune health stations to district hospitals, provincial hospitals and central hospitals. Population coverage is broad: 99 per cent of all communes have a health station, 65.9 per cent of communes have a medical doctor and 84.4 per cent of villages have active village health workers. There is also a strong private sector, with some 35,000 facilities, which provide an estimated 35 per cent of outpatient care in urban communities and 23 per cent in rural communities. In one study, it was estimated that two-thirds of outpatient care was provided by the private sector (Trieu, Lieu et al 2008). In hospitals, however, state services predominate, private hospitals providing only 4 per cent of all hospital beds and only 1.65 per cent of inpatient visits.

Government spending on health remains relatively low at 2.1 per cent of GDP, despite recent investments in social health insurance, which now covers 42 per cent of the population. Out-of-pocket expenditure, which makes up 90 per cent of private health expenditures, is 56 per cent of total health spending. This has resulted in high rates of catastrophic expenditure among poor households, with an estimated 15 per cent of households spending more than 25 per cent of their expenditure on health and 5 per cent of households more than 40 per cent in 1998. As indicated by the 2002 National Health Survey, as much as 70 per cent of household out-of-pocket payments are spent on inpatient and outpatient treatment (in both public and private facilities), the remaining 30 per cent being spent on self-medication and procurement of health-related materials (Lieberman and Wagstaff 2009).

Table 1. Socio-Economic and Health Indicators, Vietnam

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP/capita (USD PPP, 2009)</td>
<td>2790</td>
</tr>
<tr>
<td>Poor as % total population (2008) (&lt;$1 PPP/day)</td>
<td>21</td>
</tr>
<tr>
<td>Life expectancy in years (2007)</td>
<td>72</td>
</tr>
<tr>
<td>Maternal mortality /100.000 live births (2008)</td>
<td>56</td>
</tr>
<tr>
<td>Health expenditure per capita (USD) (2008)</td>
<td>76</td>
</tr>
<tr>
<td>Total health expenditure as % of GDP (2008)</td>
<td>7.2</td>
</tr>
<tr>
<td>Public health expenditure as % of total health expenditure (2008)</td>
<td>38.5</td>
</tr>
<tr>
<td>Out-of-pocket expenditure as % of total health expenditure</td>
<td>55.5</td>
</tr>
<tr>
<td>Out-of-pocket spending as % of private health spending</td>
<td>90.2</td>
</tr>
<tr>
<td>Population covered by SHI as % of total population</td>
<td>42</td>
</tr>
</tbody>
</table>

Source: NHA database, WHO
Vietnam has a relatively high ratio of hospital beds to population and very high rates of utilisation, especially in provincial and central hospitals (Table 2). The average bed occupancy rate across all public hospitals was 118 per cent in 2006, 122 per cent in 2007 and 125 per cent in 2008. The highest rates were in central hospitals (130 per cent). Provincial hospitals had a rate of 114 per cent, and the rate fell below 100 per cent only in district hospitals in remote regions. The average length of stay in 2008 was 7.2 days.

Major health system challenges identified in the Joint Annual Health Sector Review of 2009 (Trieu, Tien et al 2009) include:

- difficulties in formulating an appropriate public-private mix and in controlling private investment in joint ventures to finance medical equipment in public hospitals, which threatens patient safety and costs;
- controlling rising expenditure on health, which is estimated to have more than doubled from US$21 in 2000 to US$45 in 2006 and US$55 in 2008;
- regulating and improving the quality of care provided;
- weak patient voice and regard for patient rights;
- shortage of health workforce in preventive programs, at grassroots and in remote and mountainous regions;
- overload of patients at provincial and central hospitals, where patients bypass district facilities and present directly.

### RESULTS OF THE NON-STATE HOSPITAL STUDIES

#### The Regulatory Framework

The involvement of the private sector in health service delivery was encouraged through two mechanisms: investment in non-state health delivery facilities; and investment in state health facilities. Non-state providers were officially recognised as part of the Vietnamese health system by the state ordinance on private medical and pharmaceutical practices in 1993 (Ordinance 26-PL/CTN/1993). In 1998 there were 19,836 non-state health providers of different types, and the number had grown to 30,836 by 2005 (including 21,600 pharmacies and distributors, 48 hospitals and 3000 polyclinics).

The recognition and regulation of the non-state sector forms part of a broader policy framework of the Vietnamese government, the concept of social mobilisation. This commenced in 1996, with the idea that while the government retains the leading role, ‘the people, business community, social organizations, individuals and international organizations should be encouraged to work together to solve social issues’ (Villith Party Congress, 1996 as reported in Trieu, Lieu et al 2008). The concept was further developed by Decree No. 73/1999/ND-CP, which allowed and encouraged non-state organisations and individuals to invest in health facilities, provided that the operation was not for profit.
The growth of non-state hospitals in Vietnam: Implications for policy and regulatory options

Government Resolution No. 46/2005/NQ-CP states that social mobilisation has two major aims: (1) to bring into play the intellectual and physical potential of the people and involve the entire society in developing education, health care, culture and sports; and (2) to create conditions for the entire society, especially policy beneficiary target groups and the poor, to enjoy the increasing benefits from achievements in education, health care, culture and sports.

This resolution also set out the following objectives for social mobilisation for health (quoted in Trieu, Lieu et al. 2008):

- Continue to invest more government resources in health, including ensuring financial resources for public health, provision of basic health care for policy beneficiary target groups, the poor and children under six years of age.
- Strengthen activities for the care and protection of the people’s health. Urge every community member to play a role in the care and protection of their own health.
- Accelerate the pace of development and improvement in the quality of health insurance. Strengthen and expand health insurance with a view to diversifying forms of health insurance to meet people’s health care needs.
- Pursue reform of the hospital user fee system based on accurate and comprehensive calculations of direct service costs. Gradually switch from providing recurrent budgets to service providers towards providing direct subsidies to users in the form of health insurance.
- Encourage the opening of private hospitals, clinics and family doctors. Mobilise contributions from communities in society for the development of public services, to gradually replace the role of state budget subsidies.

**Investment in non-state health care facilities**

Investment in non-state facilities was further clarified through Resolution No. 46-NQ/TW and Decree No. 69/2008/ND-CP in 2005. These specified incentives for investment in non-state health facilities, including provision of free land, exemption from income taxation for the first four years and then 50 per cent exemption for the next nine years. The Master Plan for Health (2001-10) provided targets for the growth of state and non-state hospital beds. By the year 2010, the total hospital beds/population ratio was to reach 20.5/10,000 and by 2020 25 beds/10,000, of which the target for the non-state sector was 2 beds/10,000 by 2010 and 5 beds/10,000 by 2020.

Further regulations (Ordinance 07/2003/PL-UBTVQH11 and Decree 103/2003/ND-CP) specify the licensing requirements for non-state facilities. All non-state hospitals are required to have infrastructure, equipment and staff equivalent at least to district hospitals and to have at least 30 inpatient beds. If these conditions are satisfied, the MoH will grant licences for non-state health facilities and pharmaceutical manufacturers, while the PHB grants licences for private clinics.

The licensing requirements have been revised based on the Law on Medical Examination and Treatment of 2009 (Law No. 40/2009/QH12). This requires a non-state facility to obtain establishment permission (business or investment certificate) from the relevant state body and an operation permit from the MoH. Requirements for the operation permit cover the premises and facilities, medical waste disposal, health workforce and that the director of the facility has been practising in the medical sector for at least 36 months.

According to Ordinance No. 07/2003/PL-UBTVQH11 and Decree 103/2003/ND-CP, only the director of the non-state health facility requires an individual licence to practise from the MoH or PHB. Government health staff who work at the non-state facility do not require a licence, but may work only outside of their normal office hours and only with the permission of the director of the relevant state hospital.

**Non-state investment in state health care facilities**

Non-state investment in state health facilities was facilitated through decrees granting financial autonomy to state facilities, partial user fee collection and mobilising resources for the state health care system. The
Table 3. Selected Characteristics of State and Non-State Hospitals in Vietnam

<table>
<thead>
<tr>
<th>Indicator</th>
<th>State Hospitals</th>
<th>Non-State Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of hospitals (2008)</td>
<td>1081</td>
<td>82</td>
</tr>
<tr>
<td>Growth in hospital beds per annum 2004-08</td>
<td>1.2%</td>
<td>27%</td>
</tr>
<tr>
<td>Average number of beds per hospital (2008)</td>
<td>127</td>
<td>77</td>
</tr>
<tr>
<td>Total staff/bed</td>
<td>1.06</td>
<td>1.63</td>
</tr>
<tr>
<td>Number of beds/doctor</td>
<td>4.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Nurse/doctor ratio</td>
<td>1.20</td>
<td>1.16</td>
</tr>
<tr>
<td>Outpatients treated/bed</td>
<td>181</td>
<td>295</td>
</tr>
<tr>
<td>Inpatients treated/bed</td>
<td>72</td>
<td>51</td>
</tr>
</tbody>
</table>

Policy for financial autonomy was included in Resolution No. 05/2005/NQ-CP to ‘Convert public institutions operating under the subsidized and bureaucratically managed public services to autonomous units providing not-for-profit public services without excessive subsidies’. Initially, Decree No. 10/2002/ND-CP provided limited financial autonomy, allowing recovery of operating costs, reducing staff and increasing income (through payment of ‘additional salary’ from surplus revenues) for workers. The extent of autonomy was subsequently extended through Decree No. 43/2006/ND-CP, which provided for autonomy and accountability in operations, organisation, human resources and financing in all public services.

The mobilisation of resources for investment in state health services is currently being undertaken in accordance with MoH Decision 2194/2005/QD-BYT in two main forms:

- joint ventures and business collaborations for the upgrading of medical equipment in public hospitals;
- development of ‘elective’ services in public hospitals, for which patients pay additional fees in return for better quality services, for example, shorter waiting time, better quality room, higher technical equipment (Trieu, Lieu et al 2008)

Prices for health care services are regulated by Ordinance ND 59/CP/1994, which sets the ceiling prices for public providers. A joint circular by the MoH and Ministry of Finance (MOF) sets the service price for both public and private providers, but private providers can charge extra for non-medical services or medical services if patients are willing to pay. The ceiling price for health services has not been revised since 1994.

Mapping

The number of non-state hospitals grew by 47, from 35 in 2004 to 82 in 2008, and accounted for 7 per cent of all hospitals by 2008. In comparison, the number of state hospitals increased by 60, or 1.5 per cent, to 1081 over the same period (Table 3)

In bed numbers, non-state hospitals are smaller on average than state hospitals; 68 per cent of non-state hospitals have fewer than 50 beds, and only eight have more than 100 beds. Non-state hospitals contributed 4.4 per cent of total hospital beds in 2008.

While 75 per cent of the non-state hospitals are general hospitals, the proportion of specialised hospitals increased from 17 per cent in 2004 to 25 per cent in 2008. Non-state specialised hospitals have focused on non-communicable diseases and high technology services (eye, plastic surgery, trauma/orthopaedic), while state specialist hospitals focus more on diseases of public health significance (TB, mental health, traditional medicine, leprosy-dermatology).

Just over 50 per cent of non-state hospitals are in the southern region of Vietnam, with about 25 per cent each in the northern and central regions. However, growth in the period between 2004 and 2008 was greater in the northern and central regions. In all regions, non-state hospitals tend to be in urban areas and in provinces with higher population densities and richer economies.
Table 4. Sources of Revenue among Investigated Hospitals (%)

<table>
<thead>
<tr>
<th>Source of revenue</th>
<th>Ho Chi Minh City</th>
<th>Thai Binh</th>
<th>Da Nang</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public hospital</td>
<td>Private hospital</td>
<td>Public hospital</td>
</tr>
<tr>
<td>State budget</td>
<td>19.1</td>
<td>0.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Health insurance</td>
<td>35.1</td>
<td>12.4</td>
<td>78.3</td>
</tr>
<tr>
<td>Hospital fee</td>
<td>45.1</td>
<td>87.6</td>
<td>10.0</td>
</tr>
<tr>
<td>Other</td>
<td>0.7</td>
<td>0.0</td>
<td>0.3</td>
</tr>
</tbody>
</table>

The ratio of staff to beds is higher in non-state than state hospitals, and this difference is more marked for doctors per bed (Table 3). Most of the doctors (70 per cent) and pharmacists (90 per cent) work full time in non-state hospitals, suggesting that 30 per cent of doctors work part-time, potentially also working in state facilities.

By 2008, 6.9 per cent of outpatients and 3.2 per cent of inpatients were treated in non-state facilities, compared to 4.8 per cent of outpatients and 1.0 per cent of inpatients in 2004. Non-state facilities have higher ratios of outpatients per hospital bed and lower ratios of inpatients per hospital bed than state facilities.

**Case studies**

The case studies paired state and non-state hospitals from three locations: Ho Chi Minh City (HCMC) in southern Vietnam, Da Nang city in central Vietnam and Thai Binh province in northern Vietnam. In these locations, non-state hospital numbers range from 31 out of 87 in Ho Chi Minh City, to 4 of 15 in Da Nang and 1 of 13 in Thai Binh. However, even in these locations with relatively high numbers of non-state hospitals, they contributed only 14-16 per cent of inpatient admissions in Ho Chi Minh City and Da Nang and 1 per cent in Thai Binh.

While the three state hospitals have been established since at least the middle of the previous century, the three private hospitals were established only in 2005, 2007 and 2008. The non-state hospital in HCMC was founded by joint investment of a group of senior doctors and a pharmaceutical group; that in Da Nang is one of a network of hospitals run by a corporate group; the hospital in Thai Binh was founded by a group of retired state doctors.

The state hospitals provide general acute services and, in the case of the state hospital in HCMC, referral services for a variety of high technology services (including cardiac, cranial and spinal surgery). The three non-state hospitals have specialised in certain areas: the hospital in HCMC specialises in haemodialysis, assisted reproductive technology, ophthalmology services and intensive care, while the hospital in Da Nang has focused on acquired cardiac diseases, obstetrics and gynaecology and intensive care, and the hospital in Thai Binh has specialised in endoscopy.

The non-state hospitals obtain the majority of their income from user fees (52-88 per cent of total revenue) and the remainder from health insurance reimbursement. The level of health insurance reimbursement varies depending on the involvement of the hospitals with insured patients, the hospital in HCMC having only limited involvement. Table 4 summarises the revenue sources for each of the hospitals in the study. The state hospitals received a contribution from the government of 11-19 per cent of revenue. The proportion from user fees and health insurance varied, with a higher proportion of user fee revenue in HCMC and a much lower proportion in Thai Binh.

The non-state hospitals’ involvement in care of health insurance patients was low. The number of health insurance patients as a proportion of total patients was less than 15 per cent in the studied non-state hospitals in HCMC and Da Nang, but 43 per cent in Thai Binh. Hospital fees were the major source of income, nearly 90 per cent in the non-state hospitals in HCMC and Da Nang (Table 4). However, the number of insured patients as a proportion of total patients was higher in the state hospitals in all three cities (47-64 per cent). The non-state hospitals did, though, provide a much higher number of diagnostic tests, especially X-rays and CT scans,
The growth of non-state hospitals in Vietnam: Implications for policy and regulatory options

Table 5: Services Provided by Investigated Hospitals (% of city total)

<table>
<thead>
<tr>
<th>Hospital services</th>
<th>Ho Chi Minh City</th>
<th>Thai Binh</th>
<th>Da Nang</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public hospital</td>
<td>Private hospital</td>
<td>Public hospital</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>2.9</td>
<td>0.6</td>
<td>8.3</td>
</tr>
<tr>
<td>Hospital admissions</td>
<td>35.7</td>
<td>2.1</td>
<td>23.8</td>
</tr>
<tr>
<td>X-rays</td>
<td>5.9</td>
<td>1.4</td>
<td>2.2</td>
</tr>
<tr>
<td>CT scans and MRI</td>
<td>10.1</td>
<td>3.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

than would be expected based on the number of patients treated. The single non-state hospital in Thai Binh, which treated only 1 per cent of admissions and 3 per cent of outpatients, provided 9 per cent of X-rays and 23 per cent of CT scans in the province (Table 5).

Bed occupancy rates for the non-state hospitals ranged from 72 per cent to 107 per cent, compared to rates of 112-265 per cent in the state hospitals (Table 6). Explanations for the lower rates in non-state hospitals included: fewer patients with complex and serious conditions; patients reluctant to stay longer in hospital because of fees; and fewer health insurance patients, who tend to stay longer. The non-state hospitals tended to have more staff per bed and particularly more doctors per bed, than the state hospitals. Compared to the MoH standard for state hospitals of 1.4 staff per bed, the non-state hospitals in the study had 1.5-3.3. However, compared to the MoH standard of 3.0-3.5 nurses per doctor, non-state hospitals had 1.7-3.0 nurses per full-time doctor.

An important difference was that, while all state hospital doctors are full-time, a significant proportion of the doctors in non-state hospital were part-time. The proportion of part-time doctors in the non-state hospitals varied considerably. There was also a relatively high proportion of retired doctors, particularly among the more senior doctors. While the Da Nang non-state hospital had no doctors in dual practice, 49 per cent of the doctors in non-state hospitals at HCMC and 11 per cent at Thai Binh were engaged in dual practice.

Key factors in determining investment decisions on services in non-state hospitals were:

• availability of specialised workforce (specialist doctors);
• level of demand for the service in the community and competition from state hospitals;
• potential for revenue from provision of the service through either fee payment or health insurance.

Thus, the medical specialisations of the non-state hospital in HCMC were decided on the basis of factors including the availability of retired specialist doctors, the demand (notably for haemodialysis, which was overwhelming state facilities in HCMC) and the agreement of the insurance agency to pay haemodialysis fees. In Da Nang, the focus on acquired heart disease complements the state hospital, which focuses on congenital heart disease. Similarly in Thai Binh, the focus on endoscopy arose because some doctors at the state hospital had been trained in endoscopy but could not practise there due to lack of equipment.

Only limited cooperation between state and non-state facilities was observed in these locations. The non-state hospitals in HCMC and Da Nang had memorandums for technical assistance with state hospitals for particular services (intensive care or emergency) and the non-state hospital in HCMC had an agreement to receive transfer of secondary health insurance patients from state hospitals where they were registered. Despite this cooperation, there were no mechanisms for referral of patients between state and non-state hospitals, reporting from the non-state hospitals to the MoH or PHB was limited, and there was little supervision of the non-state hospitals by the PHB. In HCMC and Da Nang, however, there was some exchange of information on professional development workshops and training updates.
Despite government regulations providing free land for investment in non-state health facilities, the non-state hospital managers complained that land was not provided. Monitoring and compliance with other regulations were also weak. Despite these being requirements for licensing, neither state nor non-state hospitals complied with minimum space per bed or medical waste disposal procedures. Monitoring of quality of care was hindered by the focus of the current regulation on administrative requirements and the lack of supervisory oversight. Despite the requirement that staff working in dual practice obtain permission from the hospital director, none of the state hospitals had a list of staff working part time in private practice. Although the decree allowing non-state hospital operation stipulated that hospitals should operate as not-for-profit entities, none of the non-state hospitals in the case studies or identified in the mapping operated on a non-profit basis.

**DISCUSSION AND KEY POLICY ISSUES**

These case studies illustrate the current contribution of non-state facilities to the provision of hospital care and their services, resources and roles in three selected locations. While this is not a representative study and the findings must be viewed with caution, the findings can be viewed in the light of three key questions raised by the study objectives.

**Health System Objectives**

What role do non-state providers play in the hospital sector in Vietnam, and what contribution do they make to key health system objectives?

The studies confirm that the health system has many of the characteristics of commercialised mixed health systems described in the literature. In particular, the following features apply:

- private providers allowed to provide services;
- state services given autonomy and allowed to compete in the market;
- money as part of most health care transactions;
- high out-of-pocket expenditure;
- blurred boundaries between public and private sectors;
- weak or poorly implemented regulatory framework.

However, non-state hospitals occupy only a very small proportion of the ‘market’ and contribute a small proportion of total services. Despite the incentives provided, it seems unlikely that the non-state sector will achieve the target set by the national Master Plan of providing 20 per cent of all hospital beds by 2020. However, within this small market share, the non-state providers demonstrate some of the characteristics of private providers, occupying niche positions responding to local market demand and providing a higher share of certain high technology services (such as CT scans and MRI) than their share of hospital beds would suggest.

Health system objectives to which the non-state sector could contribute include: availability of resources for the health sector; efficiency in use of resources; providing services of high quality and responsive to users; and equity in access to and use between rich and poor.

**Availability of resources**

The non-state sector has contributed to increased investment in health by private/non-state finance and to increased availability of services and technology in the locations and service areas of focus. This has assisted some cities, notably HCMC, to reach the MoH standard for the ratio of beds to population and to increase the availability of technologies such as MRI and CT. However, non-state hospitals tend to specialise and to provide services with higher profitability, often involving high technology, as well as services for which there is a demand and where the medical skills and specialists required are available.
Even so, these services may not be those most needed to improve health status in the population. Increasing the availability of resources in the non-state sector risks diverting resources away from the state sector, particularly resources in short supply, such as hospital specialists. However, the non-state hospitals in Vietnam have made fairly limited use of dual practice and have tended to adopt more flexible arrangements, either employing doctors full time in the private facility (as in Da Nang) or using retired doctors (as in HCMC and Thai Binh). This suggests that there is less risk of negative impact on state hospitals.

**Efficiency**
Non-state hospitals demonstrate more flexibility in their use of the health workforce and adaptation to different funding opportunities. The non-state hospitals use different combinations of full-time, part-time and retired doctors in different circumstances, and they use different combinations of user fees and insurance reimbursement. In general, non-state hospitals have shorter average length of stay and higher utilisation by outpatients compared to inpatients than in state hospitals. However, in terms of allocative efficiency, there is a risk that non-state hospitals direct investment to services that are most profitable and not those most likely to address population health needs. This could lead to over-investment in high technology diagnostic services and, through use of state-subsidised insurance payments, increase state funding for high tech and hospital level services at the expense of primary health care.

**Quality and responsiveness**
Unfortunately, the lack of data meant it was not possible to measure the quality of care or health outcomes. Nonetheless, the non-state hospitals in the study demonstrated lower bed occupancy rates, higher staff-to-bed ratios and better amenities than MoH norms, which implies a capacity to provide higher quality care. However, the lack of coordination between state and non-state hospitals, particularly in regard to cross-referral, suggests there may be problems with quality and responsiveness for patients who need to transfer between hospital types.

**Equity of access and financial protection**
The studies demonstrate that non-state hospitals do not contribute to improving equity of access to services but rather focus on services for those who can pay and in urban and richer areas. Indeed, they may increase inequity by encouraging health workers to move from rural to urban areas. However, in appropriate areas non-state hospitals do provide services for those covered by social health insurance and thus contribute to services for the poor.

**The Regulatory Framework**
How does the regulatory framework address the role and activities of non-state providers? What are the gaps or weaknesses?
The government has provided a policy framework and guidance for the development of the hospital sector as a whole, and the non-state sector in particular, through setting targets for bed-to-population ratios and through regulation of market entry. However, there are a number of aspects of the regulatory framework recommended in the literature that have not been applied (see, for example, Jakab, Preker et al 2002). These gaps in the regulatory framework include the availability of services, efficiency, quality and responsiveness and equity.

**Availability of services and relationship between state and non-state services**
The Government of Vietnam has provided incentives for the construction and operation of non-state health care facilities to encourage both the achievement of bed-to-population targets and the involvement of the private sector in the construction and operation of health facilities. However, there is no regulation of the type or location of services to be provided. Preker, Harding et al (2000) suggest that non-state providers are more suited to provision of certain types of services, particularly those that are easy to measure and allow for market competition. However, the suitability of services to be provided is not considered within the current regulations. The policy and regulatory framework regarding the relationship between state and non-state providers is also limited and relates mainly to the regulation of dual practice: the regulations require that state-employed doctors obtain approval from state hospital directors for work in the private sector and undertake this work only outside of normal duty hours in state hospitals.
The case studies demonstrated that this regulation was not fully enforced. There are currently few regulatory requirements for non-state providers to contribute to broader social benefits, such as to provide services of public health benefit or not to discriminate against particular patients. There is a requirement to treat emergency cases and to provide annual reports according to MoH formats. Otherwise, there is no policy or regulatory requirement to consider the availability of state hospitals or services when approving new non-state facilities, or any requirement for state and non-state facilities in the same areas to coordinate their services.

Efficiency
While it is not explicitly stated in the regulations, government policy makers have expressed the expectation that the non-state sector would contribute to efficiency through competition with the state sector (personal communication, study visit to Melbourne, 2010). Most questions related to internal organisational aspects are covered by the requirements of company law in Vietnam, while some areas are regulated by health law.

Government regulations limit the flexibility of hospital managers in the management of resources by setting standards for bed-to-workforce ratios and for prices. However, these standards do not appear to be enforced for private providers. While the government has provided policy direction and some regulatory framework regarding the external operating environment, there are few arrangements for organised or collective purchasing of services, such as through contracting or collective purchasing by health insurers. Purchasing and payment are essentially on an individual fee-for-service basis. The government has established standards and regulation for market entry through licensing of providers and facilities, although there are some concerns that there is insufficient ongoing monitoring and maintenance of standards once licensing is acquired.

Jakab, Preker et al (2002) have described the various internal and external policy and regulatory issues that need to be addressed in order to achieve efficiency gains from exposing state and non-state providers to market pressures. However, as a result of the regulatory gaps and weaknesses in Vietnam, there is little competitive pressure to increase efficiency, and there may be incentives for over-servicing.

Quality and responsiveness
Regulation of service quality and client responsiveness are at an early stage of development in Vietnam. The new Law on Examination and Treatment provides a framework for the establishment of an accreditation system for hospitals, sets out the rights of health care consumers and proposes a system for receiving, investigating and responding to complaints. However, this has yet to be translated into practice. The case studies found that quality was considered only in relation to input requirements (bed floor space ratios, workforce ratios) and administrative requirements, but was not extended to systematic measurement of the standards of services or outcomes. Some concerns were expressed about possible over-servicing and inappropriate prescription of more expensive medications. The tendency to compete on the visible and marketable aspects of quality was noted in these studies. However, it is difficult to assess the quality of services provided because current quality regulation, monitoring and reporting lack measurements of clinical standards of care.

Equity
The government has not introduced regulations or policy either directing or limiting non-state providers to particular locations or services, despite having the option to direct or limit incentives. As well as distribution, there is the more difficult issue of ensuring equity in the standard of care received by rich and poor. Despite the existence of the dominant state health system that could provide the expected standard for service delivery, there are significant concerns about the quality of some aspects of the state system, particularly services in rural and remote areas. While the MoH has attempted to address this through Decree 1816, which requires central and provincial hospitals to rotate staff to lower hospitals to build their capacity, there has been no requirement or incentive for non-state providers to participate in this program or to provide ‘public benefit’. Yet it is likely that the providers in at least some non-state facilities do have a public benefit motivation, at least in part. There is potential to identify public benefits that non-state providers could provide, such as a teaching and support role for lower level providers, and to provide appropriate incentives and remuneration for their participation.
Addressing the Gaps in Regulation
How could the regulatory framework be improved to address the gaps or weaknesses identified?
Together with Ensor and Weinzierl (2007), we adopt the view that regulation extends beyond legislative and bureaucratic procedures to include a full range of incentives, sanctions and mechanisms to address failures in the existing public and private health care system and promote current policy objectives. The regulatory framework for non-state providers could be improved by addressing two aspects: improving implementation of existing regulations; and expanding the range of regulatory mechanisms employed.

Improving implementation of regulation
The case studies showed that non-state hospitals often failed to comply with regulations and that compliance was not enforced. Shortcomings included the failure to comply with floor space and workforce ratios, medical waste disposal requirements and reporting of dual practice. Underlying problems included the reluctance by local agencies to enforce regulations (regulatory capture), lack of information or monitoring due to infrequent supervisory visits and administrative constraints, such as the lack of appropriate tools to measure and monitor standards of care. These problems are similar to those identified in the literature (Tangcharoensathien, Limwattananon et al 2009). While increased supervision and resourcing for regulators and provision of appropriate monitoring tools could improve implementation, another approach is to increase the use of other regulatory mechanisms that could support the legal and bureaucratic approach.

Increasing the use of alternative regulatory approaches
Self-regulation, financial incentives and public information are among the alternative approaches that could help to improve the situation.
Self-regulation or co-regulation involves the delegation of regulatory authority to professional associations and independent evaluation bodies. Typically, this approach is used for the accreditation of health service facilities or health workforce education facilities and the certification of providers as competent at different levels, such as specialised practitioners. Bloom, Standing et al (2008) suggest that such methods can also develop trust and build norms of probity and charity as well as promote needed collaboration between government and civil society groups and refer to this as the ‘co-production’ of regulation. The new law on treatment and examination provides the opportunity to explore self-regulation, but one of the limitations in the Vietnamese situation is the lack of civil society organisations such as medical professional associations to which regulation could be delegated and the lack of mechanisms for dialogue between state and non-state sectors.
Financial incentives and payment mechanisms range from encouraging competition through expanding market entry by new providers to contracting, collective purchasing, payment for results and performance incentives. Despite fund pooling through the social insurance scheme, purchasing and payment mechanisms have not been used to encourage targeted provision of services or improvements in quality. Existing subsidies provided by the government could also be better targeted to encourage provision of non-state services in locations and for services that have greater needs.
Increased public information on the availability, quality, price and risks of services could strengthen public demand for quality and thus drive competition. Additionally, improvements in the management and investigation of consumer complaints, as proposed in the new law, could improve responsiveness to public expectations and encourage competition to improve quality and efficiency. The high level of demand for hospital services and the high levels of education among the public suggest that this could be a useful approach.
CONCLUSION
These studies demonstrate some positive impacts from the opening of the health sector to non-state hospitals, particularly in terms of garnering private investment to deliver profitable services in areas of demand with an efficient use of resources. However, despite government incentives, the non-state sector still contributes only a very small share of hospital services nationally and is unlikely to achieve the master plan targets. Non-state hospitals have not contributed to increased equity of access to hospital services.
While these studies are only indicative and provide a snapshot of the role of the non-state sector, they do suggest a number of issues that require attention by policy makers. These include:

- more targeted use of incentives and more control over investment in high technology in order to steer non-state investment towards locations and services in need;
- addressing gaps in the regulatory framework in market operation, maintenance of quality and equity of access;
- moving from reliance on command and control regulatory mechanisms, despite evidence of weak capacity, towards more use of purchasing and payment mechanisms, self-regulation and public information and consumer voice.

The role of the non-state sector in Vietnam needs to be seen as part of the broader social mobilisation policy, with links to changes in state hospitals as well. Overall, this policy can be seen as encouraging marketisation or commercialisation of the health sector. Such a policy approach needs to be accompanied by an appropriate regulatory framework that is properly enforced in order to ensure the adequate, efficient and equitable provision of services to the whole population.
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