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Options for Developing a Collective Payment System and Co-payment Mechanism for Antiretrovirals using the Vietnamese Health Insurance Fund

Lessons for Domestic Resource Mobilization/Donor Transition Initiatives

September 2016

What follows is a draft proposal submitted by Health Finance & Governance (HFG) to local partners to present policy options for centralized reimbursement and co-payment. In this way, HFG provides much needed technical support to the Ministry of Health and other government agencies in Vietnam. Furthermore, this proposal illustrates the means by which HFG, through the Sustainable Finance Initiative (SFI), is facilitating domestic revenue generation and strengthening public financial management in support of HIV/AIDS treatment and care.

We address several issues that are likely to be relevant to other PEPFAR priority countries. In particular, it is important to bear in mind that it is one thing to advocate successfully for increased DRM for HIV/AIDS programs or services but quite another to address issues in the health system that may limit the program's ability to spend those resources effectively. For example, as noted in the proposal presented here, existing systems may require reorganization (e.g., the health insurance scheme nonpayment for currently free medications), or required systems such as a Central Procurement Unit (CPU) may not exist. Systems currently planning Social Health Insurance (SHI) of some sort (e.g., Nigeria, another SFI country) need to keep these complexities in mind as they design schemes that include malaria, HIV/AIDS, family planning, and immunizations – any services for which donors may currently pay the bulk of commodity costs.

I. Objective

Develop legislation to:

- Guide collective payment for antiretrovirals (ARVs) using the SHI
- Budget for the provision of ARVs free of charge to HI cardholders who are people living with human immunodeficiency virus (PLWHIV) so that they can obtain free ARV and be eligible for additional HI benefits

II. Proposed Legislation and Legal Framework

1. MOH Proposals Pending the Prime Minister's Approval:

- Permission to implement a payment structure for ARV collective purchasing contracts using the HI fund
- Budget for subsidizing PLWHIV purchases of HI cards
- Budget to fund the structure (state or local budget, estimated budget, payment) to absorb co-payments for HI cardholders who are also PLWHIV receiving ARV treatment

2. Government Decrees or Ministry of Health (MOH) Circulars [in consensus with the Ministry of Finance (MOF)] to stipulate the mechanism for:

- Guiding the structure of ARV collective payments from the HI fund
- Absorbing HI co-payment costs for PLWHIV receiving ARV treatment (e.g., support from state or local budget, budget estimation, etc.)

3. Challenges:

- The Health Insurance Law, Decree 105/2014/NĐ-CP dated November 15, 2014, and Inter-ministerial Circular # 41/2014/TTLT-BYT-BTC dated November 24, 2014 do not have any specific provisions stipulating that Vietnam Social Security (VSS) can make direct payments for ARV treatment at the central level from the SHI fund to the supplier.
- Nor are there provisions stipulating that VSS can make direct payments to the focal point, Vietnam Administration HIV/AIDS Control (VAAC), for medications used by PLWHIV.

III. Current Structure/Policy

1. Collective bidding for ARVs purchased by the SHI fund from VAAC's National Target Program (NTP) mainly applied for first-line regimen medications. The President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund (GF) provide medications in-kind for first- and second-line regimens and hand them over to VAAC for overall coordination of ARVs from all three sources. SHI has not yet been involved in this system.

   MOH has not yet established a CPU. Once established it will take time to develop a national system for collective purchasing of medication. Therefore in the intermediate period, VAAC will still handle collective bidding for ARV purchasing.

2. The co-payment system has yet to apply to PLWHIV because according to VSS regulations, free medications provided by the NTP (both state budget or donor aid sources) are not eligible for SHI payment.

   Current SHI funding does not cover ARVs, therefore current PLWHIV HI cardholders are responsible for co-payments.

   PLWHIV are currently obtaining ARVs 100% free-of-charge from donor facilities. If the co-payment is no longer subsidized once the system for SHI-paid ARVs is operational, coverage will drop to 80% of ARV costs for PLWHIV SHI cardholders. "Poor" patients will be covered at 100% and the "near-poor" will be covered at 95%.

   The policy for ARV co-payment by PLWHIV can be applied when Vietnam achieves its universal health insurance target.

3. Challenges:

In the development of the new system, one of the main incentives for PLWHIV to become SHI cardholders is for them to gain more benefits or at least retain existing benefits, especially regarding ARV use (e.g., they will not be responsible for co-payments).

Therefore, exempting "non-poor" patients ("normal" and "near-poor" insured by the SHI Fund) from co-payment is key in the new policy to ensure PLWHIV maintain their benefits.

Alternatively, Vietnam could consider the option of abrogating the current policy that allows the uninsured free access to ARVs. The weakness of this option is that it goes against the current social welfare policy and might ignite adverse social reaction.

IV. Options for developing a system of collective bidding for 2016-2020; contracting, reimbursing ARV expenses; administration and distribution of ARV; system for budget estimation and payment for the subsidized ARV co-payment for PLWHIV HI cardholders.

HFG recommends that VAAC continue to procure first-line ARVs from domestic suppliers through domestic bidding; however, it should also seek strategic partnerships with foreign sources (pharmaceutical companies) for fixed dose combinations (FDCs),

specifically formulated pediatric ARVs and second-line ARVs. The ARV procurement agency must go beyond merely fulfilling the purchasing element and have a detailed understanding of the entire procurement and supply management (PSM) chain to ensure ARV supply meets population demand. As a result, we recommend that in the short term, VAAC should maintain control of ARV procurement.

Option 1

SHI would directly reimburse contracted suppliers for the entire cost of ARVs for Vietnam in accordance with VAAC's ARV pricing agreements. Conceivably, these ARVs would then be distributed to health facilities for use. The MOH should allow for competitive procurement of more cost-effective ARVs, such as the TDF/3TC/EFV triple and TDF/3TC double combination tablets.[1] Procurement should be opened to foreign manufacturers at the lowest possible cost through local bidding (national competitive bidding in Vietnamese[2]). While donor support is still available, VAAC should establish framework agreements with local suppliers to cover at least the zidovudine-based formulations (preferably from domestic manufacturers).[3] This framework could be expanded to include TDF formulations once funding is available (either through the Ministry of Finance or VSS) and bulk purchasing (to benefit from economies of scale). This, in turn, would open up procurement to a larger group of suppliers, reducing prices and improving drug quality.

1. Drug Administration of Vietnam (DAV) and Department of Planning and Finance (DPF) should approve the tender plan, which will allow VAAC to secure local supply contracts for TDF/3TC/EFV tablets manufactured by Indian sources.
2. VAAC should improve coordination with donors on ARV procurement to avoid interruptions of HIV treatments or duplication that may waste valuable donor resources.
3. VAAC, DAV, and DPF should begin formalizing and using the legal pathways (e.g., Pharmacy Law Article 38) to allow the importation of ARVs, which could account for 99% of first-line (TDF/3TC/EFV and TDF/3TC) and 99% of the second-line (LPV/r or ATV/r tablets[4]) drugs.
4. For products not yet registered with the DAV, the DAV should fast-track applications to meet regulatory requirements for safety, efficacy, and quality. Under laws regulating the importation of non-registered drugs for Vietnam's NTP, a permit to import non-registered drugs is valid for up to one year after its signing (PM Decision No. 151/2007/QD-TTg of September 12, 2007).
5. Vietnam's SHI fund should cover first-line ARVs, and the VSS should pilot payment/reimbursement mechanisms for first-line ARVs among the 30-40% of PLHIV enrolled in SHI.

VSS is amenable to this option, though it is not preferred by DPF, the DHI, or the DAV. This option is preferred by VAAC and drug suppliers and is driven by existing evidence that VAAC has greater capacity to predict ARV needs than do facilities. But financial risk would be entirely borne by VSS under such a payment system. It does not encourage allocative or technically efficient spending, and it takes a step backward from output-based payment systems and targeted contracting (based on quality and costs). At present, VSS is not legally allowed to forward funding (especially such large quantities) to a third party.

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[1] SCMS indicated that they are not seeking to use the double. Further comment from VAAC would be helpfuL

[2] The Planning Dept. is in charge of this process in VAAC, which is largely based on the World Bank Standard Bid Document (SDB) and a pre-approved bidding plan (including state-funded budget), signed by the Vice Minister. Bid advertising is per law for a minimum of 20 days, and a team with representatives from VAAC (Care/Treatment), DPF, and DAV (VAAC Task Force) does the evaluation. Results are published via MPI Gazette. The process is subject to internal and independent audits.

[3] A draft RFP is attached

[4] A recent case study published by CHAI here (http://www.clintonhealthaccess.org/content/uploads/2015/08/Case-Study_ATVr_Uptake.pdf) could be considered by Viet Nam VAAC to phase in ATV/r in second line (one tablet per day compared with two times two tablets LPVr per day) with additional potential cost savings in the longer term (currently still quite limited, approximately 1.5 USD per patient in second-line per month)

Option 2

SHI would forward a large portion (~80%) of ARV funding to contracted health facilities. Those facilities would purchase ARVs from suppliers in accordance with the VAAC's drug pricing framework. Past experience suggests that pharmaceutical vendors negotiate prices with a national body (VAAC, CPU) under the expectation that they will sell a pre-agreed quantity of drugs. However, health facilities may alter their demand for those drugs based on real-time need, and the quantities purchased at the end of the year may be less than the anticipated quantity. For this reason, drug suppliers need confidence that they can sell at least 80% of the agreed-upon quantity. Hence, health facilities need this revenue up front in the event that they do not reach the expected purchase volume.

6. This reimbursement option accounts for health facilities' limited technical capacity to forecast ARV needs and financial resources to advance payment for ARVs. Because it is similar to a prospective, capitation-based payment mechanism, this method takes a step forward toward a more output-based payment system in Vietnam and could eventually be integrated into a capitation or Diagnosis Related Groups (DRG)-based payments for health services.
7. However, VSS – not health facilities – would currently incur most of the financial risk. To avoid solvency issues, this reimbursement method will require VSS to adjust the risk of payments based on facility needs and characteristics. Better information systems and facility-level data are needed. In their absence, VSS may under-reimburse some facilities (creating supply issues) while over-reimbursing others. For the latter group, there will be little incentive to improve performance or allocate ARVs efficiently.

Comment

- **Option 1** is similar to HFG's suggestion.
- **Option 2** would be feasible if the MOH faces difficulty in obtaining a structure for collective payment from the SHI fund to the supplier. An issue that needs further development and structure in Option 2 is the estimated budget and reimbursement for the amount of co-payment from the provincial budget to antiretroviral therapy treatment facilities.

About HFG
A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a five-year (2012-2017) global health project. To learn more, please visit www.hfgproject.org.

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