Abstract—This article describes the lessons learned by USAID’s Health Finance and Governance project over three years of implementation of health system strengthening activities in Vietnam. The authors recount the project’s approach to supporting significant advancements in the government of Vietnam’s (GVN) efforts to transition the financing of HIV/AIDS from donors to domestic resources, while assuring adequate coverage and financial protection for people living with HIV. Through an adaptive method of technical assistance design and delivery, the project aligned early on with the GVN’s policy to finance HIV through Social Health Insurance and supported the Ministry of Health, the Vietnam Authority for AIDS Control, and the Vietnam Social Security agency in ensuring the long-term sustainability of HIV programs in the country. Major lessons included the importance of working within complex adaptive systems, the need to work within the country’s existing policy framework, and the aim of creating and disseminating evidence in a cyclical fashion to sustain deliberate, persistent advocacy activities to guide and support the relevant decision makers.

INTRODUCTION

To date, the HIV/AIDS response in Vietnam has been financed mainly by external donors, with the President’s Emergency Plan For AIDS Relief (PEPFAR) and the Global Fund providing the majority of the funding. Due to Vietnam’s rapidly growing economy and its evolution to lower-middle income status, development partners have been collaborating with the government of Vietnam (GVN) to advocate for increased domestic funding for HIV/AIDS prevention and treatment services.

Since 2014, in support of the GVN’s efforts to mobilize additional domestic resources for the national HIV response, the United States Agency for International Development’s (USAID) flagship Health Finance and
Governance (HFG) project has provided technical assistance and support to the Vietnam Authority for AIDS Control (VAAC), the Ministry of Health (MoH), the Vietnam Social Security (VSS) agency, the Office of Government, and the Ministry of Finance (MoF). These institutions were selected for cooperation based on their potential role in increasing domestic spending on HIV/AIDS. The VAAC is the policy and implementation arm of the MoH for HIV-related activities and general programming. The MoH, and especially its Department of Planning and Finance, played a major role in the inclusion of HIV services in a revised benefit package to be reimbursed by social health insurance (SHI). VSS, the agency tasked with administering the social pension and health insurance funds, approves any changes to the benefit list and related prices and signs contracts with health facilities that participate in the insurance scheme. The Office of Government advises the prime minister on social affairs issues, among many other topics, and the MoF has a very important say in any decision affecting the use of public funds. The HFG project, together with the USAID/Vietnam Health Office and other USAID partners in the country, designed and implemented a portfolio of activities to identify and remove the key obstacles to a financial and programmatic transition from donor-funded to government-funded HIV/AIDS services. These activities have included the following:

- Integrating donor-supported outpatient HIV treatment facilities into the public health system, with funding provided primarily through SHI.
- Expanding the population and service coverage of SHI.
- Shifting from donor-funded procurement to local procurement of antiretroviral (ARV) drugs.

This article, intended as a personal reflection and commentary, documents the role of the HFG project in the ongoing process of integrating HIV into the package of services paid for by the SHI scheme in Vietnam. Through its technical assistance, HFG had a unique opportunity to work with national and international stakeholders in improving the prospects for a sustainable HIV response in Vietnam. The authors want to also share the lessons they learned, drawn from documenting the project’s actions and decisions that had a tangible and positive reaction from GVN stakeholders. These lessons, mostly focused on general approaches to delivery of technical assistance, may also be applicable to other situations involving policy and health system strengthening work. Furthermore, HFG’s experience in Vietnam may suggest a replicable approach for adaptive technical assistance in countries with similar problems related to HIV/AIDS financing. To provide more context to the work, we provide here a brief summary of SHI in Vietnam.

**The Evolution of Social Health Insurance in Vietnam: A Brief Overview**

Until the economic crisis of the late 1970s, Vietnam’s health system, like that of other socialist countries, was largely financed by general government revenue. The beginning of the current health financing system of Vietnam can be traced to four major reforms that followed the beginning of the economic renovation (Doi Moi) period in 1986: (1) the introduction of user fees; (2) the introduction of health insurance (initially limited to the government sector); (3) permission for private practices to operate in the health sector; and (4) the opening up of the market for pharmaceuticals. As a result of this liberalization of the health “market,” Vietnamese citizens were exposed to increasing levels of out-of-pocket private expenditures.

In 1992, in part to contain the growth of out-of-pocket expenditures, a decree (No. 299/1992/HĐBT, dated August 15, 1992) was promulgated to extend health insurance coverage to civil servants, workers in the formal sector, pensioners, and other people in social support schemes. In 1998, all of the provincial health insurance funds were pooled into a national fund and coverage was extended to members of the National Assembly and People’s Councils, preschool teachers, meritorious people, socially protected people, dependents of army officers and soldiers, and foreign students in Vietnam. In 2002, VSS began to manage the national insurance fund. In 2005, decree 63 called for compulsory enrollment of the poor and near-poor, with their premiums (currently the approximate equivalent of 30 USD for the poor and 21 USD for the near-poor and students) to be subsidized by government funds. More recently, in 2012 the MoH introduced, and the prime minister approved, the Master Plan for Universal Coverage, in which the GVN committed to expanding coverage to up to 70% of the population by 2015 and 80% by 2020, while reducing patients’ out-of-pocket costs to less than 40% of total health care spending by 2015. The current estimates of SHI coverage, at around 80% in 2017, are exceeding the goal, and a new goal of 100% enrollment in SHI has been set for 2020. The most recent estimate of the out-of-pocket proportion of total health expenditures is 47%, as per MoH’s 2015 National Health Accounts, first draft, including patient co-financing of health insurance.
The system of reimbursing health care providers under SHI also underwent important revisions over time. Until 2009, fee-for-service (FFS) was the main payment method for inpatient and outpatient care provided by the SHI network. However, this payment system suffered from abuse and overprescription of services, creating financial strain on the SHI fund while not ensuring adequate quality and satisfactory performance. To address some of the weaknesses of the FFS method, the Law on Health Insurance of July 2009 recommended capitation as a principal method of payment for primary care, along with FFS and diagnosis-related group payment methods for inpatient care. Capitated payments are meant to control the cost of services provided, promote the use of lower-cost preventive services, and discourage higher-level, costlier treatment. The Joint MoH-MoF Circular 09/2009 provided additional guidance on applying different methods of provider payment; the circular indicated that at least 30% of primary health facilities should be paid via capitation by 2011, increasing to 60% in 2013 and 100% in 2015. However, the current version of the capitation mechanism has fallen short of expectations, due largely to its unconventional design. Though elsewhere capitation is primarily used for payment of primary health care services, in Vietnam the past and current capitation models also cover costly inpatient services and exclude prevention services. These features, plus a largely uncontrollable referral mechanism and the lack of a defined benefit package of services to be paid for by insurance, created a number of perverse incentives, misallocations, and inequalities in the system. The MoH has implemented pilots to test a revised capitation model as an improved and more equitable method of paying providers in Vietnam. As of today, provider payment reform is stagnating at best, because the recent pilots have not achieved the expected results. As for a diagnosis-related group system, the MoH has been testing small-scale pilots but as yet no large-scale adoption of such case-based payment systems has occurred.

MATERIALS AND METHODS

This article relies on practical and on-the-ground observations by the authors and experiences gleaned from three years of targeted policy advice based on delivery of ad hoc studies and analytical evidence provided by the HFG project in Vietnam. The descriptions and history of the Vietnamese health system and social health insurance scheme are based on desk and field-based review of documents and actors’ experiences. Deductions and interpretations, based on impact of evidence on decision makers and collective stakeholders’ feedback, are the authors’.

RESULTS AND DISCUSSION

Integrating HIV in the Social Health Insurance of Vietnam: The Challenges

The SHI Benefit Package

In theory, the benefit package is very comprehensive. For an annual premium of around 30 USD, the package covers inpatient and outpatient services, including rehabilitation services, screening, diagnostics, and transportation services in poor and mountainous areas. HIV has never been explicitly excluded from the benefit package, and the Government Circular 15 of 2015 states that people living with HIV/AIDS are covered by services including ARV treatment, other chemotherapies, medical supplies, HIV testing, and medical services for babies born to HIV-positive mothers, among others. However, the SHI scheme will not cover people already receiving treatment paid for by national programs, no matter how the national programs are financed. Given that PEPFAR and the Global Fund still provide over 90% of the drugs and tests administered in Vietnam as part of the national HIV/AIDS program, it is plain to see that the SHI scheme has historically had a very minimal role in financing the HIV response in Vietnam. It is only recently—with specific indications from PEPFAR of a major decrease in funding for ARVs expected in 2019—that the SHI scheme has taken on a whole new relevance vis-à-vis the HIV response in Vietnam. As PEPFAR continues to transition away from direct service delivery in Vietnam, the country urgently needs to take the lead in financing and managing HIV/AIDS programs, and the SHI fund is the single most important financing mechanism for the long-term sustainability of the HIV/AIDS response. However, even though SHI coverage in Vietnam has reached over 80% of the eligible population, the prime minister’s goal of achieving payment for HIV/AIDS prevention and control services through the health insurance system is far from being achieved.

Integration of HIV/AIDS Services

The VAAC, the VSS, and the MoH are working to remove several obstacles that have been identified on the path to integration of HIV services into SHI. Currently, only services provided in curative settings qualify for reimbursement from the SHI fund; however, a large number of HIV patients are currently served in single-function HIV-only health facilities,
mainly outpatient clinics, that are a part of the preventive medicine system. Even more significant from a financing perspective are the administrative challenges to pooling and paying for ARV procurement at the national level if SHI funds have to be used. Moreover, until very recently, estimates showed that roughly 40% of people living with HIV were enrolled in SHI, or about half the national enrollment average. Most people living with HIV will be expected to pay up to 20% in copayments once HIV care is provided to them through the SHI network. This is in stark contrast to the current free-of-charge environment, so it will be a deterrent to people seeking HIV care in the future.

**Donor Transition**

The transition from donor-supported to SHI-supported HIV services imposes a series of important changes to beneficiaries and providers (including facilities and facility staff). As an example, patients are asked to abandon a model in which modern, confidential, and supportive treatment, testing, and counseling are provided free of charge and to embrace public, fee-bearing, hospital-based services amid widespread concerns about quality, confidentiality, and social stigma. Providers and administrators will have to operate within an expected decreased capability of the GVN to ensure current levels of funding and financial rewards.

**Integrating HIV in the Social Health Insurance of Vietnam: The HFG Project Response**

The Health Finance and Governance project responded to the challenges by leveraging relationships, trust, and ongoing commitments with GVN actors to support the common goal of a successful and timely transition to the government of HIV/AIDS treatment and related services. Since 2015, PEPFAR–Vietnam has followed the Vietnam Transition Blueprint, which lays out the broad principles for transition of donor-supported HIV activities to the GVN. Within this broad guidance, the HFG project built a framework for technical support targeting the coverage of key populations affected by HIV, with the objective of supporting Vietnam’s commitment to universal health coverage. The approach, centered on financial and programmatic transition of HIV services from PEPFAR to the GVN, focused on four main priorities (see also Figure 1):

1. Increase enrollment of people living with HIV in social health insurance. At the outset of HFG’s work in Vietnam, estimates of SHI coverage among people living with HIV hovered around 40%. With such low enrollment, the strategy of using SHI to finance HIV services could not lead to the desired results. A key disincentive for People Living with HIV (PLHIV) to enroll was the uncertainty about the inclusion of HIV services in the SHI package. It was essential to remedy this situation as all of the other fiscal and administrative elements were put in place. To get changes to happen, a road map was prepared as a guiding document, to lead the development process for a basic health service package (BHSP) that included a comprehensive set of HIV/AIDS services and was paid for by health insurance. The road map included goals, including general and specific objectives for each phase; an analysis of the situation and the challenges to developing the package; principles and solutions for achieving the identified goals; timelines for each phase of the road map; and information on the roles and responsibilities of stakeholders. Therefore, the implementation time frame of the road map was four years, from 2014 to December 2017. The MoH led the implementation of the road map and coordinated with stakeholders to assign each party’s roles and responsibilities in developing and implementing the BHSP. As of end of 2017, the BHSP has been officially adopted by the MoH, although more analysis is needed to ascertain the extent of the real changes and improvements brought by this new document.

2. Integrate PEPFAR-funded outpatient clinics into the SHI network. The key administrative challenge at the point-of-service level, especially in the urban area of Ho Chi Minh City, was that almost 50% of the facilities offering HIV services in the PEPFAR program were single-function, preventative sites. Under the Law of Health Insurance, only those facilities providing curative functions were allowed to sign contracts with the SHI scheme. Either the law had to be changed or the facilities had to be equipped to provide curative
services as well. The program worked with various provincial directorates of health to address the challenge. Solutions included transfer of patients to eligible facilities and accreditation of previously ineligible facilities, without changing the SHI legal framework, and integrating administrative and management processes, in addition to revising the purchasing mechanism. As a result of these efforts across nine key provinces (Ho Chi Minh City, Hanoi, Hai Phong, Can Tho, Hoa Binh, Thai Binh, Dong Nai, Dong Thap, Phu Tho), 83 previously prevention focused facilities have signed contracts with VSS to allow provision of and reimbursement for HIV/AIDS curative services through the SHI fund (see Table 1). Technical support for these changes was delivered by grouping senior management and medical staff from facilities and allowing them to discuss and address the challenges they faced and the solutions that some of them had found. The additional value of the technical assistance was in following up on the progress of the various steps needed to achieve integration and supporting prioritization of the transition among the many tasks confronting provincial health staff in their day-to-day work. The collaboration was mainly guided by the Out-Patient Clinic (OPC) Integration Tool, a tool developed and tested by HFG and VAAC (see Figure 2).

3. Ensure financial sustainability for patients, health providers, and the SHI fund. The introduction of SHI to patients with HIV as the preferred mode for accessing services carries a financial burden for the beneficiaries: people living with HIV not classified as poor or near-poor would be expected to pay for a portion (up to 20%) of the care received in an SHI setting. Given the fact that only PEPFAR sites would be transitioning to SHI in the short to medium term, some people living with HIV would have to pay for their care, whereas others (those using Global Fund facilities) would continue to receive free-of-charge treatment and care. Besides the inequity, this might represent an unbearable financial burden to some of the beneficiaries. The financial sustainability of the fund itself also needed addressing, to reassure the VSS that it was affordable to add HIV services to the benefit package. The project helped prepare analytical evidence to inform local decision making of the sustainability of the financial transition:

- A national subaccount of HIV expenditures for the year 2013. The MoH Department of Planning and Finance successfully developed the system of national health accounts of 2013 using the World Health Organization’s system of health accounts methodology (SHA 2011). This report provided a retrospective analysis on health expenditures in Vietnam, with particular focus on HIV as a way to set a baseline of HIV financing ahead of the transition.
- An actuarial analysis of SHI claims to inform the MoH of potential efficiency measures to create fiscal space for HIV services. This analysis documented actuarial findings contributing to the development of the BHSP by providing evidence on frequency of utilization of specific services by age and gender. The study attempted to answer these key questions: (1) What is the disease burden, measured according to cost, for SHI in Vietnam? (2) What are the five most costly International Classification of Diseases, 10th edition, categories? (3) What are the key services used to treat these diseases? and (4) Does treatment vary significantly by level of health facility? The report then considered how these findings might possibly impact the development of the BHSP for SHI in Vietnam. MoH’s Department of Planning and Finance used the report to validate choices of inclusion of services in their BHSP document.
- An estimate of the HIV liability for the SHI fund, once the program is folded into the benefit package. In response to a gap in available data, this report provided financial forecasts on the funding amounts needed from SHI and other sources for HIV/AIDS treatment. It provided strong evidence to help VSS prepare the financial resources needed for SHI to reimburse HIV/AIDS treatment. It also included estimates of the resources needed from other sources for HIV/AIDS treatment to help the government plan and prepare. It

|                          | Year Ended September 2016 For Six HFG-Supported Provinces | Year Ended September 2017 For Nine HFG-Supported Provinces |
|--------------------------|------------------------------------------------------------|-----------------------------------------------------------|
| Treatment facilities with SHI contracts | 0                                                                         | 24/86 (28%)                                                |
| Treatment facilities providing SHI-funded services for HIV patients (not ARV) | 0                                                                         | 14/86 (16.3%)                                              |
|                          | 82/114 (72%)                                                | 66/114 (58%)                                              |

**TABLE 1. Integration of HIV Outpatient Clinics into the SHI Scheme**
was the evidence needed by the Vietnam Social Security agency to accept the sustainability of including HIV in the SHI benefit package.

Additionally, these analyses have been used by VAAC in their advocacy efforts with lawmakers and, more critically, helped influence local authorities in the key provinces to commit public funds to provide subsidies for SHI premiums for all people living with HIV. The provincial people’s committees, with two main funds at their disposal—the “provincial fund for the poor,” and the “fund for medical examination,” also meant to defray health care expenses for the indigent—needed clear guidance to use the funds for people living with HIV. This was achieved by pairing a team of HFG experts with government experience with staff from the VAAC for targeted advocacy with the Office of Government and the prime minister over the issue of financial protection for people living with HIV. The messaging was centered on people living with HIV as one important piece of the universal health coverage puzzle and the potential epidemiological implications of lack of adherence to treatment due to high cost.

4. Increase domestic resource mobilization for procurement of ARV drugs. In terms of sheer money required, the procurement of ARV drugs will represent the largest share of the resources expected of the GVN as it takes responsibility for HIV. In addition to advocating for allocation of funds, the HFG project had to support the resolution of administrative and legal challenges such as the need to pool procurement without a centralized procurement unit at the MoH, support provision of a legal mandate to VSS to act as a procurement agency, and work out the relationship between VAAC and VSS in terms of supply chain responsibilities, among other issues. One of the overarching obstacles was related to the nature of the SHI fund, which was designed to provide reimbursement after the fact directly to providers, not to advance funding for services or goods. The project provided policy options for using the SHI fund

FIGURE 2. OPC Integration Tool
to pay for the HIV response in Vietnam in form of a brief, submitted by the HFG project to local partners. The document presented policy options for centralized reimbursement and copayment for ARVs and was considered to inform the GVN decision to allow the SHI fund to finance ARVs in the future.10

This work provided evidence for VAAC to successfully advocate for Prime Minister’s Decision No. 2188/November 15, 2016,11 that allowed the centralized procurement and reimbursement of ARVs through the SHI fund and the support for SHI premiums for Antiretroviral Treatment (ART) patients with local provincial funds. With help from the same HFG advocacy and legal team, the VAAC and VSS have developed a circular (Circular 28/2017/TT-BYT dated June 26, 2017,12 based on Decision 1288), regulating the central procurement of ARV drugs through the SHI fund. As a result, and according to VAAC plans, the first year of procurement will provide enough ARV treatment to cover 30% of people living with HIV, or approximately 44,000 patients. The MoH, on behalf of the prime minister of Vietnam, had requested that the HFG project present a proposal for the introduction of a central procurement unit for pharmaceutical products, including ARVs, offered in the public health system. In this policy brief, HFG presented reform options based on initial discussions with key government stakeholders and HFG’s experiences and expertise, which stem from global best practices, particularly in East and Southeast Asia.10 As of this writing, the integration is still lacking procurement and distribution of ARVs with SHI funds, a step that is expected in 2019.

CONCLUSION

When the HFG project started its work in Vietnam, there was no clear indication on how to make use of the SHI fund for sustaining the HIV program. As donors were signaling their impending decrease of funding for direct service delivery, the leading response was that of advocating for increased direct state funding. This was in direct contrast to Vietnam Prime Minister’s Decision 608/201213 to pursue SHI as the financing mechanism for HIV moving forward. It took most of the first year of HFG in Vietnam to make the argument and create evidence and consensus across partners, including within the MoH, for the SHI solution as the most feasible and worthwhile to pursue.

The technical work needed to approach sustainability and transition issues around HIV funding has not been fundamentally different from standard approaches to address fiscal space challenges. However, what has made a difference was the awareness and consideration of the existing political economy issues that endangered HIV as a priority among other priorities and work within those issues and related constraints. In countries such as Vietnam, where the epidemic is highly concentrated within populations that do not enjoy high political visibility or social consideration, it has worked best to advocate for funding under the large umbrella of universal health coverage. Working within the current policy framework, the idea of including HIV in a large and comprehensive basket of services has been (at least in Vietnam) more politically palatable than labeling HIV as a national health priority and trying to ensure vertical funding for it. For Vietnam, integration in the SHI scheme is seen not only as an efficient way of paying for HIV, but it is also a way to facilitate its political sustainability in the long term.

The experience of HFG in Vietnam is not necessarily replicable on a step-by-step basis but, in taking forward their work with GVN, those implementing the project have drawn a number of lessons on what has worked and provoked an impactful response from policy makers. Because the lessons mainly related to an overall approach to technical assistance, it is the authors’ hope that a number of them can be applied in other country contexts, not necessarily linked to HIV or social health insurance:

1. Providing technical assistance while working with complex adaptive systems: One fundamental lesson learned through the process has been that unique circumstances occurring within a specific time period allow for unique decisions based on unique opportunities. In other words, and admittedly without counterfactual proof, the decisions made and the results obtained are unlikely to be replicable in the exact sequence and through the same expediency in a different time and/or environment. Our experience with and within the Vietnamese health system supports the view that looking through “the lens of CAS [complex adaptive systems] opens up a deeper understanding of how to effect change in health systems, including the pathways for increasing and sustaining coverage of effective interventions.”14

2. The importance of working within national policy: With regard to roadblocks, the main source of delay in supporting GVN’s policy on HIV financing was the lack of clarity on policy objectives related to the ongoing health financing reform efforts. Though the National Assembly had clearly stated the need for Vietnam’s SHI fund to define a list of basic services
(Resolution No: 68/2013/QH13) accessible to all, the policy objectives and the way to proceed had not been clearly specified. As the MoH and other GVN institutions debated which objectives to prioritize (e.g., universal health care versus SHI fund preservation and comprehensive benefit package versus acceptable quality and availability of services), the discussion around HIV financing and inclusion of HIV services in the benefit package took a back seat on more than one occasion. Working within the MoH or VSS context, where, again, HIV was not always a top priority, we found that framing the discussion on HIV under the broad umbrella of universal health coverage allowed the project to get into the right meetings and to keep providing effective technical advice.

3. Being clear on the different stakeholder objectives makes it easier to identify the work needed: HFG Vietnam has focused on one “simple” (not easy) goal: increase domestic resource mobilization for HIV/AIDS services in Vietnam. By doggedly focusing on this goal, all decision making at the project level was suddenly much easier (e.g., Is that workshop useful to increase domestic resource mobilization [DRM]? Yes: consider; No: discard. Is the proposed collaboration going to increase our chances to create value for HIV? etc.). A corollary to this lesson is that the clearer the messages from key stakeholders, the better for all involved. Things really got moving once PEPFAR started providing deadlines and blunt estimates of decreasing funding.

4. Evidence delivered in simple and understandable ways is key successful advocacy: Over a three-year period, the HFG project has produced a number of studies and documents. However, it was the delivery of this information in simple language, often condensed to the essentials, in the local language, that led to acceptance of the SHI mechanism for HIV, approval of the BHSP road map, the definition of a new SHI benefit package, and inclusion of HIV services in the benefit package.

5. The need for evidence is cyclical, not linear: It is tempting at times to see the inputs of evidence and technical assistance as we view medical interventions: a shot of National Health Account (NHA), a few pills of international experience, an intravenous dose of health financing via PowerPoint presentations, and the “patients” will be cured of their weak capacity, lack of knowledge, and blurred long-term vision. In reality, our work alone cannot “fix” weak health systems. In order to have real, long-term impact, it has to be part of a continuous cycle of evidence-based evaluations, decision making, actions,
| Challenges                                                                 | Actions                                                                 | Expected Results by September 30, 2018 | Responsible Entities                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------|
| PEPFAR- and Global Fund–supported facilities are still offering free services, which may prevent newly accredited SHI facilities from attracting patients | Technical support to departments of health, provincial AIDS centers, facilities | Full integration (SHI contracts, service delivery, and reimbursement) of 80% of HIV treatment facilities; an efficient and effective system for tracking SHI claims and reimbursement for HIV services | HFG, Centers for Disease Control and Prevention Vietnam Program (CDC/Vietnam), VAAC |
| In some provinces (e.g., Ho Chi Minh City and Hanoi), management and facility staff may not wish to accept new patients because they do not see the urgency and do not want to deal with the burdensome paperwork and other details of SHI reimbursement | Technical support to departments of health, provincial AIDS centers, facilities | HFG, CDC, VAAC, | |
| Some preventive medicine center–based OPCs do not yet have SHI contracts | Technical support for preparation of facilities’ applications for dual-function (curative and preventive) or polyclinic status so they qualify for SHI contracts | HFG, VAAC, VSS | |
| Some facilities with SHI contracts are not yet obtaining reimbursement through SHI | Technical support to departments of health, provincial AIDS centers, facilities | HFG, VAAC, VSS, Provincial Social Security | |
| Expansion of HIV services covered under social health insurance | Technical support on revision of legal basis for ARV procurement; quantification of ARVs needed; preparation of bidding documents | Effective system of ARV procurement and supply chain management (operated by GVN), implemented in time to prevent any gaps in patients’ treatment | HFG, Procurement and Supply Chain Management (PSM) project, VAAC, VSS |
| Coverage of ARV drugs through the SHI fund has been delayed until 2019; it is critical that the timing of procurement and availability of ARVs through SHI be arranged to avoid any gaps in supply that could cause patients to lose treatment | Technical support on costing of these services and mechanisms for SHI coverage | VSS approval of coverage and mechanisms | HFG, CDC/Vietnam, VAAC, VSS |
| Basic health services package under SHI does not include voluntary HIV testing and counseling, viral load testing, or costs of shipping blood samples for testing | Technical support for development and costing of proposed package of HIV prevention services; return on investment analysis | Evidence to support the coverage of this package by SHI in the revision of the Law on Health Insurance | HFG, VAAC |
| Law on Health Insurance prohibits coverage of any prevention services or addiction treatment | Training for Community Based Organizations (CBOs) and community health workers | SHI coverage of 80% of PLHIV | HFG, Healthy Markets Project, CDC/Vietnam |
| Expansion of social health insurance coverage among PLHIV | Technical support on legal basis, mechanism, budgeting, and funds management procedures to support SHI premiums and copayments for PLHIV | Financing guidelines and tools for provincial support of SHI premiums and copayments in all provinces | HFG, VAAC |
| Gaps in SHI coverage remain, particularly among key populations such as drug users and sex workers | | | |
| Some patients with HIV may have to endure financial hardship through out-of-pocket expenditure as they move from free-of-charge OPCs to public health facilities | | | |

**TABLE 2. What Remains To Be Done**
and sudden changes due to governmental politics and moving targets is invaluable. Such flexibility has to be mutually agreed upon with the client (in our case, USAID) and well coordinated with the supported beneficiaries. The overall work becomes more intense and the only constant will be change, but it is worth the effort in the end.

7. Consider the political economy of context at all levels: Political commitment from the top is necessary but not sufficient. Champions at all levels are needed, but not all of them will be useful or fully engaged. In a situation defined by constrained resources, the implementer should focus on targeting the right people for advocacy, capacity building, and partnership. A pragmatic approach requires a deliberate effort to pursue and cultivate the right influencers—the champions who can get things done. The HFG project in Vietnam has relied on a systematic analysis of individual stakeholders and their potential roles as positive influencers. The diagram in Figure 4, refined internally within the project, synthetically describes the approach that has been applied (especially at the beginning of activities) to identify the counterparts most likely to exert and use their influence and capacity.

In conclusion, the vast amount of work described, and some of the successes documented here, should not give the false impression that all is proceeding perfectly and that the sustainability of HIV services in Vietnam is a done deal. Much still has to be done and the HFG project has planned for more activities and cooperation with the GVN in 2017–2018; see Table 2. The activities presented in the table are the result of joint planning between HFG and government stakeholders such as VAAC, VSS, and the MoH Department of Planning and Finance.

The results that have arisen from the work done by HFG and GVN partners in the areas of health financing and DRM for HIV have been notable. This was achieved in part because the HFG was able to contribute timely evidence on the cost of HIV services, levels of HIV expenditures, SHI enrollment, and other critical issues to strengthen VAAC’s advocacy to VSS and the prime minister for increasing DRM for HIV. HFG supported the MoH Department of Planning and Finance in defining an appropriate basic health services package to be reimbursed by SHI, making sure that HIV was included in it. A major part of the overall HFG strategy was to ensure that the work on behalf of HIV response sustainability was firmly rooted in Vietnam’s commitment to universal health care.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors report no conflict of interest.

ACKNOWLEDGMENTS

The authors acknowledge the work and support of Nguyen Thi Cam Anh, MPH, Health System Strengthening specialist of the USAID/Vietnam Health Office; Duong Thuy Anh, MPH, PhD, Head of Finance and Accounting Division, Vietnam Authority of HIV/AIDS Control, Ministry of Health Vietnam; and Dr. Tham Chi Dung, MD, PhD, Department of Planning and Finance, Ministry of Health, Vietnam.

FUNDING

This manuscript was funded by the U.S. Agency for International Development (USAID) as part of the Health Finance and Governance project (2012–2018), a global project working to address some of the greatest challenges facing health systems today. The project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., the Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc. This material is based upon work supported by the United States Agency for International Development under cooperative agreement AID-OAA-A-12-00080. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

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