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SOCIAL HEALTH

INSURANCE AS A MEANS TO ACHIEVING UNIVERSAL COVERAGE AND MORE EQUITABLE HEALTH OUTCOMES

Sub-report of Viet Nam

Prepared by DucAnh Ha MD, MSc, D.Ph.

Hanoi, June 2011

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List of Abbreviations

CHC	Community Health Centre
CHE	Catastrophic Health Expenditure
DALYs	Disability Adjust Life Year Lost
FGD	Focus Group Discussion
FSS	Fee for Service
GDP	Gross Domestic Product
GNI	Gross National Income
GSO	General Statistics Office
HCFP	Health Care For the Poor
HI	Health Insurance
HID	Health Insurance Department
IDI	In-Depth Interview
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
OOP	Out of Pocket Payment
VND	Viet Nam Dong
VSS	Viet Nam Social Security
WHO	World Health Organization

Executive summary

This technical assessment was carried out in order to 1) adapt the global requirements for phase two of the global survey to fit the context of Viet Nam and undertake a tailored survey in Viet Nam with the specific objective of conducting an analysis of the existing social health system in the country; and 2) to design and conduct a sub-set and complementary study together with the Health Insurance Department – Ministry of Health (MOH), for reviewing the implementation of the Health Insurance Law in Viet Nam with focus on marginalized groups including children under six, the poor and the near-poor and ethnic minority groups.

Overall, Viet Nam has made considerable progress in improving economic and social well-being such as reducing the absolute poverty rate and attaining rapid and sustained economic growth. Epidemiologically, Viet Nam has been experiencing a transition to that of a developing country with an increased prevalence of non-communicable diseases. Financially, key expenditures on health have been increasing. Specifically, total health expenditure as a percentage share of Gross Domestic Product (GDP) increased slightly from 4.9% in 1998 to 6.4% in 2008, mainly as a result of increases in government and social security expenditures on health. The poor and children under six have been considered vulnerable groups in health financing policies in general, and in health insurance, in particular.

Many policies have been issued to guide enrolment in health insurance the inception in 1992. The most important being the Law on Health Insurance which establishes a roadmap for universal coverage by 2014. Over the last two decades, health insurance coverage has been gradually increased and nearly reached 60% of the total population in 2010. However, the differences between targeted population and actual coverage in 2010 vary significantly. For example, 77.3% of the population fall into groups that are mandatorily covered by health insurance, yet only 69.8% of this population isenrolled. High coverage was found among civil servants, pensioners, meritorious people, foreign students, veterans, recipients of social allowances and the poor. On the contrary, the unemployed, part-time officers (at the communal level), and dependants of meritorious people have no coverage. Coverage of the near-poor is very low, at only 11%. Of the population that can voluntarily enrol in health insurance, only 21.1% had elected to do so. Among vulnerable groups, the poor and children under six, nearly 97% and 81% have achieved coverage, respectively.

In theory, the insured are entitled to a relatively comprehensive benefit package that is identical for all health insurance members regardless of the scheme they belong to. However, Viet NamSocial Security (VSS) data shows that the system does not achieve this objective as figures on health expenditures indicate that the use of health servicesby subsidized groups is much lower than by other populations. With respect to financial protection, average benefits received by the poor are much lower than the average benefits for all groups.The poor and ethnic minority people were found to receive less expensive services when compared to non-poor patients with the same disease, age and gender.The rate of Catastrophic Health Expenditure (CHE) increased slightly over time and is highest among the poorest quintile.

Regarding access to health services, health visits (inpatient and outpatient) among the insured increased slightly from 1.79 visits in 2008 to 2.07 visits in 2010, mainly due to the increase in usage of outpatient services.Utilisation at the district and community levelaccounts for two-

thirds of the total usage of outpatient services, while district and provincial health facilities account for nearly 90% of the services provided for inpatients. In 2008, only around 48% of insured people used their health insurance cards.Reported reasons include: indirect costs such as the cost of transportations the cost of caregivers and under the table payments,which are all much higher than what is reimbursed by health insurance agencies; cumbersome procedures involved in seeking health care services; the poor quality of public health services, especially for insurers; long waiting times; and unfair treatment. Moreover, ethnic minority people and workers of the informal sector were found to receive less expensive services when compared to non-poor patients with the same disease, age and gender.

In Viet Nam, the health care system is characterized by a mix of public and private providers. It is evident that the weaknesses of the health service system havebeen and will potentially be challenges for the universal coverage of health insurance. Notable issues include the failure of the health servicesystem to meet the increasing needs for convenient and quality health care of local people, as well as itsinability to ensure that the entitlements of insured people are fully met. In the latter case, this includes problems with the appropriateness of thelevel of clinical care, the quality of care, and the efficiency ofadministrative procedures. Moreover, human resources are insufficient (both number and skills mix) to meet the needs of health care services, given the context of a changing epidemiologic transition and the increasing need for effective primary health care services.

Key target populations for universal coverage are companyemployees, children under six, near poor people, students and pupils (compulsory scheme); and dependents of workers, farmers, the self-employed and members of cooperatives (voluntary scheme). In the current situation, universal coverage of health insurance is challenging for the following reasons. Firstly, the compliance of company employees is low because of i) weak labour registration and weak enforcement measures; ii) there is collusion between employees and employers in reporting lower than actual monthly salaries.. Secondly, low interest among near poor people has resulted in a low coverage among this group even with subsidized enrolment fees. Thirdly, accessing health insurance at the community level is difficult. Finally, knowledge and understanding of health insurance schemes and their benefits is relatively low, especially among the near poor.

Individual premiums for health insurance havevaried between 3-10% of the minimum wage since the introduction of health insurance in 1992. The median range is between 3-4.5% of the minimum wage. Currently, a premium of 4.5% of the minimum wage, allowance and pension salary is applied toworkers, of which two-thirds are paid by employers. The enrolment fee for students is 3% of the minimum wage.It is important to note that the state remains the biggest payer of health insurance contributions. Data from 2007-2009 shows that outlays exceed revenues in the compulsory and voluntary schemes. Moreover, adverse selection and supplier-induced-demand are making financial sustainability a further challenge for the development of health insurance in Viet Nam.

Fee-for-service (FFS) remains the most common method of payment used followed by capitation and case base methods. However, in the case of FFS, relatively weak regulatory and financial autonomy of public revenue provides incentives for the overuse of service, while there is concern that the capitation-payment method has inherent risks of under-servicing and quality skimping.

In conclusion, Viet Nam has made impressive progress in introducing and expanding health insurance over the last two decadeswith several important programmes to subsidize vulnerable groups such as the poor, ethnic minorities and the near poor. However, achieving universal coverage will be extremely challenging.Attention should be paid to mobilizing more resources for health insurance by, amongst other things, making the collection of social health insurance more effective so that all potential resources are collected from the obliged companies. Secondly, in order to expand the coverage,there must be a concerted effort and harmonized collaboration between ministries, local governments, VSS and the MOH. The depth of coverage should be taken into account by improving quality of care, removing unnecessary administrative procedures and encouraging business and employee registration and family coverage rather than individual coverage.Finally, containing health costs is highly recommended. To do that, the reimbursement methods should be effectively implemented in line with other dimensions of the health care system including the health information system and the regulation capacity of the authorities. The issue of supplier-induced-demand must be taken care of through improving quality of regulation and effective oversight of the sector.

I. Background/Introduction

Relieving financial barriers to accessing health care and preventing impoverishment of families from catastrophic health care costs, are essential components of Health System Strengthening transformation. Social health insurance is one means of achieving these objectives and Viet Nam has declared its determination to pursue universal health insurance by 2014 as stated in the Law on Health Insurance, which was appraised by the National Assembly in 2009 and put into practice on July 1, 2009.

Globally, UNICEF and the Rockefeller Foundation share a common concern for transforming health systems to make them more equitable and effective in delivering better health outcomes. A global survey on social health insurance has been designed by the two organizations to have a better understanding of how to best address the issue in different contexts and settings. This project explores and documents the current situation of risk-pooling health insurance entitlement and coverage for mothers and children in Africa and Asia, as well as the options for and constraints against increasing coverage, as a starting point for a) preparing an evidence-based advocacy case for the introduction of universal entitlement to social health insurance protection at the policy level, and b) providing targeted support to countries that choose to adopt and implement such policies.

The aforementioned global survey includes two phases: (1) Phase One was to conduct a rapid survey of its 71 country offices in Africa and Asia with a brief questionnaire, which assessed the existence and coverage rates of health insurance schemes providing protection for mothers and children (defined by UNICEF as aged 0-17 years). Phase One was implemented from April to May 2010 with the participation of Viet Nam; and (2) Phase Two is to conduct an in-depth analysis to explore the potential of expanding Social Health Insurance (SHI) coverage, or the feasibility and desirability of adding SHI as a policy where it does not currently exist in 13 tentatively selected countries based on the phase one analysis. These countries include Bangladesh, Burkina Faso, China, Ethiopia, Ghana, India, Lesotho, Malawi, Pakistan, Ethiopia, South Africa, Sri Lanka, and Viet Nam. Phase Two is expected to be implemented in quartersone and two of 2011.

At the same time, after more than one year of implementation of the Health Insurance Law in Viet Nam, the UNICEF country office and its national counterpart – the Health Insurance Department, MOHconsider it important to review the Law's implementation in order to make policy adjustments, especially for marginalized and vulnerable groups such as children under six, the poor, the near poor and ethnic minority groups.[1] The global survey, with an additional sub-set study, will provide important input into the policy review and subsequent adjustments.

The overall purpose of this study is to analyze key issues around the universalization of health insurance in Viet Nam in order to inform the policy response in general and the revision of relevant circulars and decrees on the implementation of the Health Insurance Law in particular.

Specific objectives include:

- To adapt the global requirements for phase two of the global survey to fit the context of Viet Nam and undertake this tailored survey in Viet Nam with a specific objective of conducting an analysis of the existing social health system in the country.
- Together with the Health Insurance Department, MOH, to design and conduct a sub-set and complementary study for reviewing the implementation of the Health Insurance Law in Viet Nam with focus on marginalized groups including children under six, the poor, the near-poor and ethnic minority groups.

II. Methodology

1. Desk review

A literature review was undertaken focusing extensively on legal documents; reports and administrative documents issued by the legislative bodies, government ministries and VSS; published and unpublished researchproject reports in Vietnamese and English;journal articles;reports from UN agencies;and statistics published by the General Statistical Office (GSO) and MOH. A qualitative technique called "snowballing" was employed to find referencesbased on founded references and potential experts who could provide additional information.

2. Qualitative study

This was composed of two elements:

1. In-depth interviews (IDI)using semi-structured questionnaires with key policy makers/ managers and beneficiaries at national and sub-national levels were conducted to collect additional information for the report. Some of the IDIs were recorded and quoted in the report.
2. Two focus group discussions (FGD) with key informants were conducted to prioritize issues and explore solutions to achieving universal health insurance coverage.

[1] Ethnic minorities are concentrated in the 5 Central Highlandsprovinces and the 7 most disadvantaged Northern Uplands provinces.

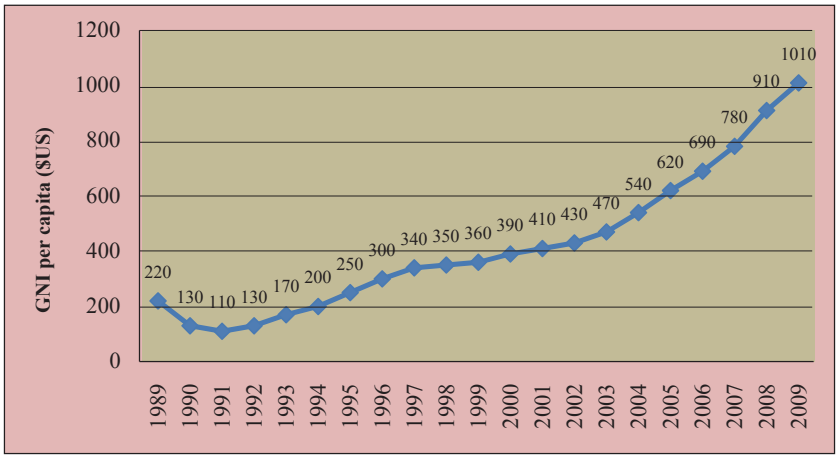
III. Results

1. Context of Viet Nam

Viet Nam is located in Southeast Asia and borders China to the north, and Laos and Cambodia to the west. The 2009 census reported that Viet Nam was home to 87.8 million people, of whom approximately 30% live in urban areas. Much of the population is concentrated in two main delta regions, the Red River Delta in the north and the Mekong River Delta in the south. Viet Namhas 54 ethnic groups, of which the Kinh, Viet Nam's main ethnic group, account for 73.6 million individuals, equivalent to 86% of the total population[1].

In 1986, the Government of Viet Nam launched an economic and social reform programme known as *DoiMoi*. Since then the country has been moving from a centrally planned economy to a market orientated one. Over the past two decades, Viet Nam has made considerable progress in improving economic and social well-being. The absolute poverty rate is now as low as 18% compared with around 75% in the mid-1980s, 58% in 1993, and 37% in 1998[2,3]. Economic growth has been rapid and sustained, averaging around 7-8 % per year[3]. Gross National Income (GNI) per capita was at around US$ 1,010 in 2009[2], well above the average of low-income countries (see Figure 1). As a result, Viet Nam is rapidly moving from a low-income country to a middle-income country. *DoiMoi* has led to, amongst other things, a series of profound policy shifts in the health care system during the late 1980s and early 1990s. Central among these were the liberalization of the health care and pharmaceuticals markets, the introduction of official user fees at public health facilities and, more importantly, the inception of health insurance[4].

Figure 1: Viet Nam GNI per capita 1989-2009



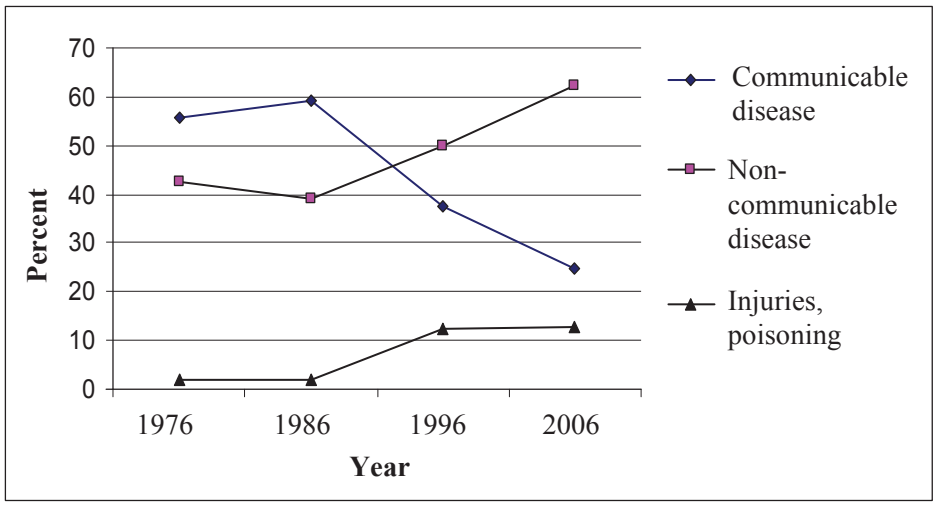
Source: IMF[1]

1.1. Epidemiology pattern

Data reported from public hospitals[5] shows significant changes in recent trends in morbidity and morbidity of non-communicable diseases (NCDs). Figure 2 introduces trends in morbidity by disease category over the past three decades in Viet Nam.

[2] IMF's website available athttp://www.imf.org/external/pubs/ft/weo/2007/02/weodata/weorept.aspx?sy=2004&ey=2008&scsm=1&ssd=1&sort=country&ds=.&br=1&c=582&s=NGDP_R%2CNGDPD%2CNGDPRPC%2CNGDPPC%2CNGDPDPC&grp=0&a=&pr1.x=67&pr1.y=11

Hình 2: Xu hướng bệnh tật theo danh mục bệnh ở Việt Nam, 1976-2006

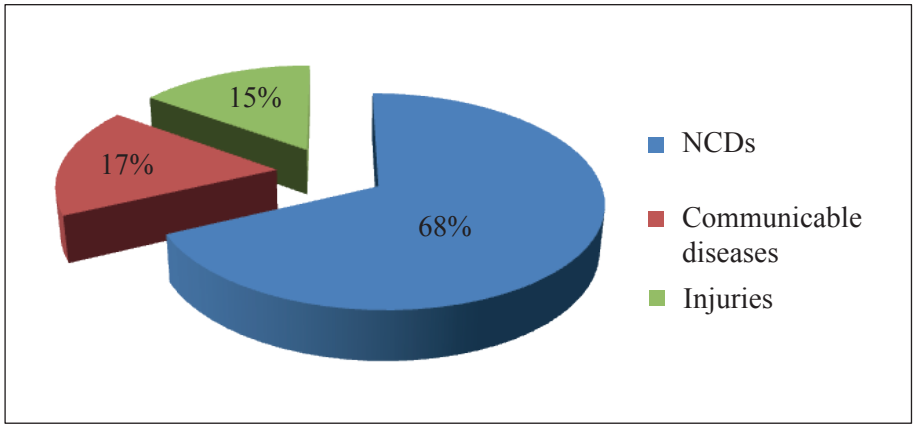


Source:MOH, Health statistics year book, 2006[5]

Surprisingly, the trend in morbidity from non-communicable diseases, to which cardiovascular diseasecontributes a significant share, has increased continually over the last several decades, surpassing communicable diseases since the early 1990s. In addition, Viet Nam has a very high injury burden, mainly as a result of road traffic injuries, prompting the concept of the triple burden of disease.

Results of a national study, Viet Nam Burden of Disease and Injury,conducted by the MOH, Hanoi School of Public Health (HSPH) and the Health Strategy and Policy Institute (HSPI) in 2011,reported that the total burden of diseases in terms of Disability Adjust Life Year Lost (DALY) in Viet Nam in 2006 amounted to 15.2 million DALYs. Like the share in morbidity, non-communicable diseases were responsible for more than two thirds of the total disease burden. Second to them were injuries that contributed to 17% of the total burden[6]. The remaining was attributed by communicable diseases (see Figure 3).

Figure 3: DALYs by major disease groups in Viet Nam 2006



Source:MOH, HSPH and HSPI, 2011[6]

1.2. Health financing

Table 1: Key expenditures on health, 1998-2008

(Unit: %)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total health expenditure as % of GDP	4.9	4.9	5.2	5.6	5.1	5.2	5.5	5.9	6.2	6.2	6.4
Total health expenditure as % of total consumption	6.3	6.5	7.2	7.8	7.2	7.2	7.7	8.5	9.0	8.8	8.7
Government expenditure on health as % of total government expenditure	7.6	7.2	5.4	5.7	4.8	4.8	4.3	5.2	6.9	7.4	10.2
Government expenditure on health as % of total health expenditure	35.0	35.2	31.0	31.5	30.5	32.1	27.5	27.2	36.6	38.2	42.9
Private expenditure on health as % of total health expenditure	65.0	64.8	69.0	68.5	69.5	67.9	72.6	72.9	63.4	61.9	57.1
Social Security expenditure on health as % of general government expenditure on health	6.1	5.6	6.1	5.5	6.0	7.0	7.9	8.8	12.5	14.2	17.6
External resources for health as % total health expenditure	2.8	3.3	2.6	2.7	3.3	2.6	2.0	2.3	1.5	1.3	1.9

Source:MOH, National Health Account, 2010[7]

Health financing in Viet Nam is comprised of two major sources. First, the state budget allocated directly to health care providers through the MOH and provincial health services, and the social health insurance fund. The second source is private expenditure on health that consists of mainly out of pocket payments for service providers,pharmaceuticals, transportation and caregivers.

Several key expenditures on health over the 1998-2008 period are presented in Table 1. Total health expenditure as percentage share of GDP increased slightly from 4.9% in 1998 to 6.4% in 2008. Total expenditure on health as percentage share of total consumption also went up over time. This was mainly a result of increases in government and social security expenditures on health, which increased from 7.6% and 6.1% in 1998 to 10.2% and 17.6% in 2008, respectively. As Viet Nam becomes a middle-low-income country external assistance sources have decreased, which is reflected in Table 1.

1.3. Birth registration issues

To implement the right to birth registration provided in Article 55 of the Civil Law[8] and Article 7 of the United Nations Convention on the Rights of Children[9], the Government issued the Decree on Household Registration in 1998[10]. According to the Decree and the Circular issued by the Ministry of Justice (MOJ)11, parents can easily apply for afree birth certificate for their children through their local People's Committee.

There have been no studies on birth registration but an in-depth interview with an officer responsible for birth registration indicatesthat birth registration has been successful in Viet Nam except for among ethnic minority groups.Ethnic minority people are not required to apply for registration immediately after a birth and it is only when their childrenreach school agethat they attempt toregister the birth because without birth certificates their children can not officially be enrolledin school.

> *I do not knowof any data related to birth registration. However, I think it has, to my best knowledge, been done relatively well forKinh people. But for some ethnic minority people,the importance of birth registration is not fully understood. As a result, these people do not apply for birth certificates for their children even it is free of charge. In some cases, children obtain a birth certificate only when preparingtheir applications for school.*
>
> IDI with an officer at General Office for Population and Family Planning.

1.4. Vulnerable groups

The poor and children under six areconsidered vulnerable groups in health financing policies in general, and in health insurance, inparticular. In 2002, the Prime Minister promulgated Decision 139/2003/QD-TTg establishing a Health Care Fund for the Poor (HCFP)[12]. All poor people, people residing in extremely disadvantaged communes and ethnic minority groups,as defined by Ministry of Labour, Invalids and Social Affairs (MOLISA), were provided free health care services. People were defined poor usingthe poverty line promulgated by the local government.Beneficiaries received either a 'free health insurance card' or a 'health care card for the poor'often referred to as the '139 card'.There issome difference between the benefit packages of the purchased health insurance card and the 139 card. Those with the 139 card receive services for free, and have access to a somewhat greater scope of services. Under the 139 card scheme, the provider is reimbursed by the HCFP, which each province is required to set up, and for which the central government provids 75% of funding. In 2005, with the promulgation of the Decree 63/2005/ND-CP, all beneficiaries of the Decision 139 were issued 'free health insurance cards'. As before, under the 2005 Decree, the local government defines the poverty line for each province; those falling under that line receive the card for free, while for those above the line, the cost of the card varies from 3 to 10 % of the minimum wage.

Table 2: Poverty line for the 2011-1015 period

	Income per capita per month (VND)	
Group	**Rural**	**Urban**
Poor household	400,000	500,000
Near Poor household	401,000-520,000	501,000-650,000

Source:Government of Viet Nam, 2011 [13]

It is important to note that in Viet Nam poverty lines are developed by the Government for a specific period of socioeconomic development rather than using those recommended by the World Bank. Over the last 10 years, Viet Nam has adjusted the national poverty line three times in 2005, 2009, and 2011. The most update poverty line regulated by the Government in Decision 09/2011/QD-TTg[13] is presented in Table 2.

With respect to the second vulnerable group, all children under six years of ageare entitled to free health care services using a free health care card under the provision of the Decree 36/2005/ND-CP promulgated by the Minister of Health in 2005[14] .In 2008, the implementation of the Law on Health Insurance converted all free health care cards into health insurance cards.

In 2010, there were 10 million children under six years old and 14 million poor people, of whom 81% and 96.6%, respectively were covered by health insurance. Additively, these groups make up 42.7% of total health insurance coverage.

2. Health insurance policies and coverage update

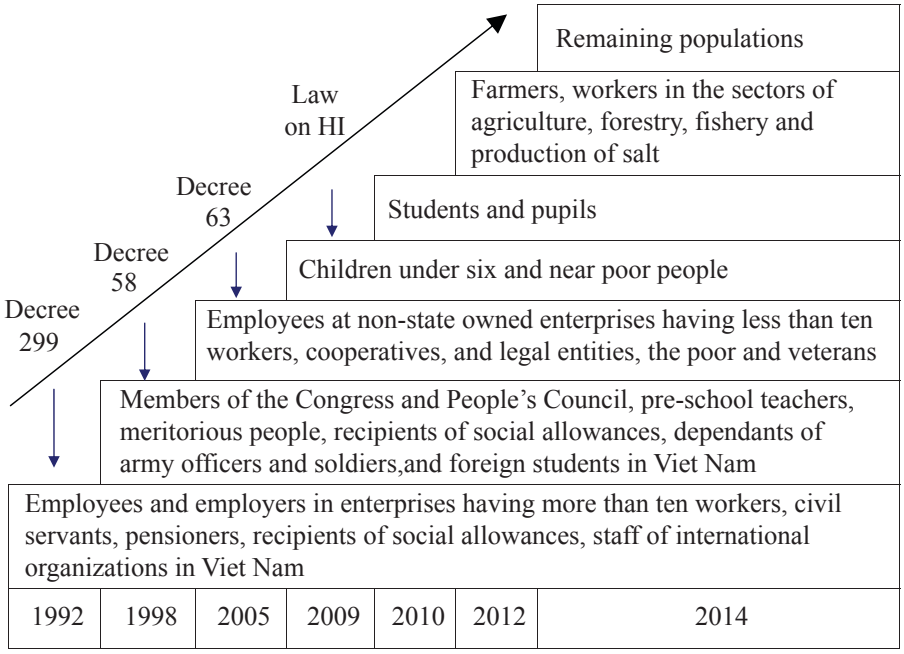
2.1. Recent health insurance policies and enrolment sequence

Figure 4 presents the successive policies that have influenced enrolment in health insurance. Since its inception in 1992, the development of health insurance in Viet Namcan be divided into four key periods.

1992-1998. Decree No. 299/HDBTwas issued by the Council of Ministers in 1992 and laid the foundation stone for health insurance15[15]. Throughout this period, health insurance enrolled mainly civil servants, employees and employers in state-owned enterprises and non state-ownedenterprises with more than ten workers, civil servants, pensioners, recipients of social allowances and staff of international organizations in Viet Nam.

1998-2005.During this period the Government of Viet Nam issued Decree 58[16], which added a few new member groups to the compulsory scheme by requiring those working for people elected organizations such as Congress and People's Council, meritorious people, foreign students and pre-school teachers to be covered by the compulsory health insurance scheme.

Figure 4: Roadmap for enrolment sequence of health insurance 1992 - 2014



From 2005-2009: An important point in this period was the promulgation of Decree 63 17. There were two new points set out in this decree. Firstly, it expanded the compulsory coverage

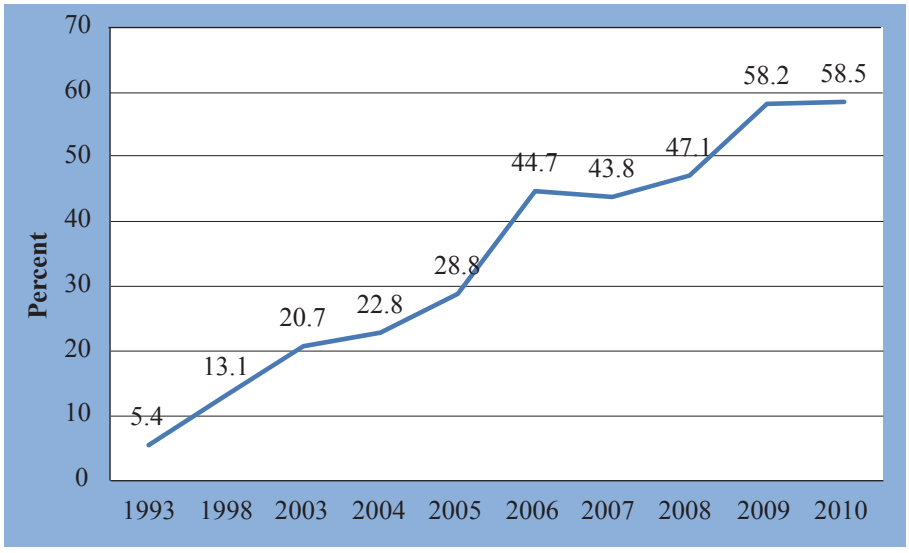
of health insurance to workers in non-state-owned enterprises having less than ten workers. Secondly, the decree expanded enrolment to poor and ethnic minority people who were entitled to benefits provided in Decision 139/2002/QD-CP. Another notable change in this period was made by the Joint Circular 06/2007/TTLB-BYT-BTC[18] that guided the implementation of voluntary health insurance in communes and schools where at least ten percent of members (households and students, respectively) could enrol.

2009todate: With strong political support, the Law on Health Insurance was passed paving a new path for the development of health insurance. Under the provision of the Law, all children under six years old and near poor people are compulsorily covered by health insurance. The Law also provides the roadmap for universal coverage with the enrolment of students and pupils since January 1, 2010; famers and workers in the sectors of agriculture, forestry, fishery and production of salt as of January 1, 2012; and all remaining groups as of January 1, 2014.

2.2. Health insurance coverage

Figure 5 below introducesthe trend in health insurance coverage since its inception in 1992 up to 2010. Over the first decade, the coverage rose to around one-fifth of the total population in 2003. However, it doubled after three years in 2006 with the launch of Decree 63 adding the poor, veterans and staff of non-state enterprises which have more than ten workers, into the compulsory scheme. Thecoverage rose further in 2009 when the Law on Health Insurance was promulgated adding children under six and near poor people into the compulsory scheme.

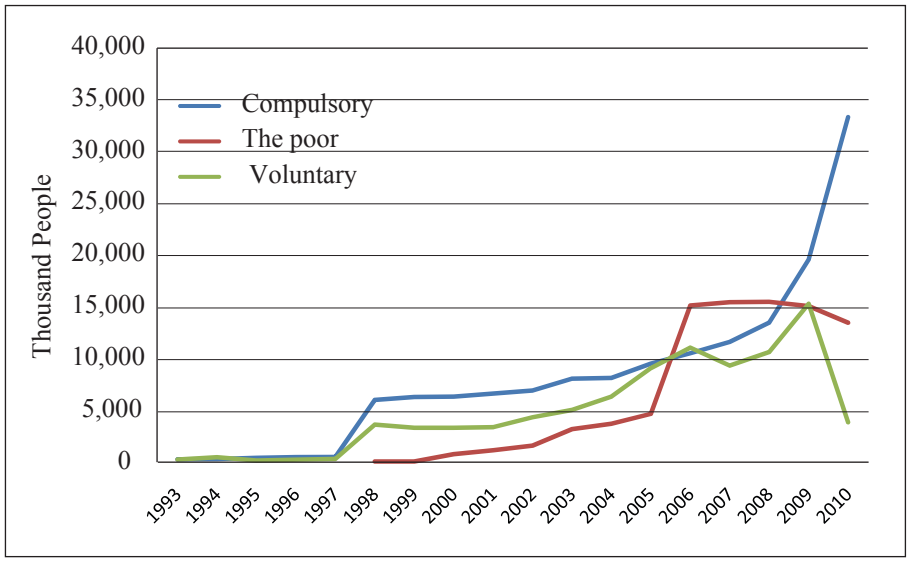
Figure 5: Trend in health insurance coverage, 1993-2010



Source: MOH, 2011[19]

Figure 6 breaks down the trend in health insurance enrolment into three groups - the poor, compulsory and voluntary schemes. Overall, the total enrolment number of health insurance increased between 1993 and 2010. Between 1998-2005 all three groups increased enrolment almost at the same pace. However, between 2006-2008the enrolment of the poor did not increase.

Figure 6: Trends in health insurance enrolment by different groups, 1993-2010



Source:MOH, 2006 and VSS, 2011 [20-22]

This could be due to the application of the poverty line for the 2005-2010 period, by which more people fell above the poverty line. There were important changes to mandatory and voluntary schemes in 2010. While the enrolment of the compulsory scheme went up dramatically, a reversed trend was recorded for the voluntary scheme. This is due tothe switch of pupils and students from the voluntary to the compulsory scheme as required by the Law on Health Insurance.

Differences between the targeted population and actual coverage in 2010 are presented in Table 3. As of 2010, 77.3% of the population falls into the groups that are mandatorily covered by health insurance, yet only 69.8% of this population were enrolled. Civil servants, pensioners, meritorious people, foreign students, veterans, recipients of social allowances and the poor have over 95% coverage. On the contrary, the unemployed, part-time officers at the communal level, and dependants of meritorious people have no coverage. Reasons for this include: i) these groups were newly required to have mandatory health insurance but the implementation at community level was reportedly poor; and ii) unemployed people are required to contribute unemployment insurance for at least 12 months to be covered by health insurance. Notably, coverage of the near-poor is very low, at only 11% in 2010. Of the population that can voluntarily enrol in health insurance, only 21.1% of the population had elected to do so.

Table 3: Differences between targeted population and actual coverage in 2010

Các nhóm đối tượng	Target population (thousand)	Covered people (thousand)	Percent covered (%)	Uncovered people (thousand)	Percent uncovered (%)
Total	**86,866**	**50,771**	**58.5**	**36,095**	**41.6**
Compulsory groups	**67,114**	**46,854**	**69.8**	**20,260**	**30.2**
Employees of enterprises and other companies	11,911	6,361	53.4	5,550	46.6
Civil servants	3,142	3,142	100.0	0	0.0
Foreign students	3	3	100.0	0	0.0
Part-time officers at communal level	182	0	0.0	182	100.0
Pensioners	920	920	100.0	0	0.0
Recipients of social allowances	1,305	1,254	96.1	51	3.9
Unemployed people	80	0	0.0	80	100.0
Local authorities	41	40	97.6	1	2.4
Meritorious people	2,113	2,113	100.0	0	0.0
Veterans	374	350	93.6	24	6.4
Members of National Assembly and People's Council	123	119	96.7	4	3.3
Privileged social groups	843	384	45.5	459	54.4
The poor	13,945	13,511	96.9	434	3.1
Dependents of meritorious people	869	0	0.0	869	100.0
Dependents of army and police officers	1,281	297	23.2	984	76.8
Children under six	10,103	8,183	81.0	1,920	19.0
Near poor people	6,081	692	11.4	5,389	88.6
Students and pupils	13,798	9,807	71.1	3,991	28.9
Voluntary groups	**18,552**	**3,917**	**21.1**	**14,635**	**78.9**
Relatives of employees	6,820	0	0.0	6,820	100.0
Farmers, self-employed and members of cooperatives	11,732	3,917	33.4	7,815	66.6

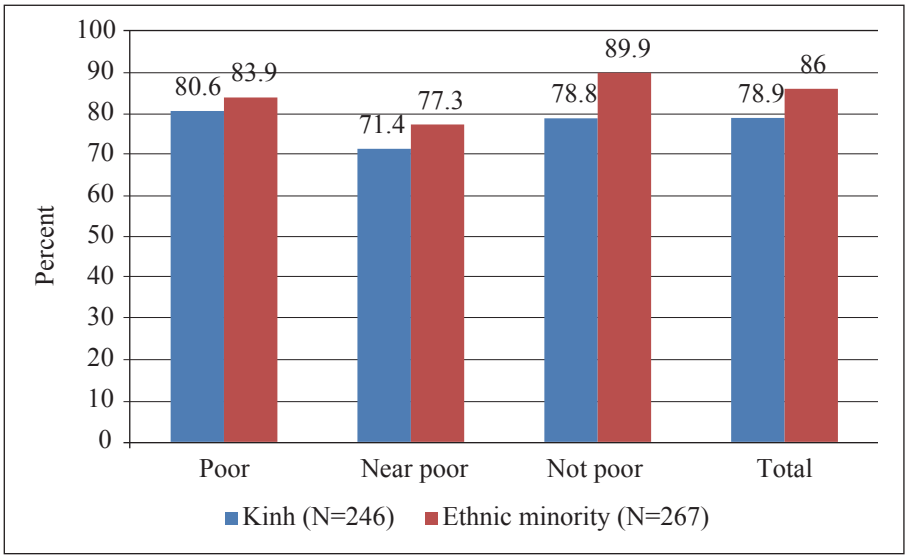
Source: VSS, 2010 and 2011 [22, 23]

Among vulnerable groups, the poorhad nearly 97% coverage and children under six had a coverage of 81%. The results for children under sixare similar to results found in a study conducted in five poor provinces by Loi and Liem in 2010 (see Figure 7)[24]. Qualitative results from this study showed that the majority of parents of uncovered children under six years of ages reported that they had applied for Health Insurance (HI) cards for their children but were still waiting for them. The reported time lag between birth and receiving theHI card, was quite long. Some parents reported that the HI card for their child could not be delivered upon request of an individual, and were told by local in-charge officers that cards were only being issued to a whole group of children.For relatively affluent Kinh parents,it is not a concern whether or not

their children have HI cards, because they only use private services and would rarely, if ever, consider going to public sector providers.For ethnic minority groups, anadditional reason for not having health insurance was poor knowledge of birth registration and policies related to health insurance enrolment and eligibility for children under six[25].

> *...I went to the Commune People's Committee to apply for health insurance cards for my children, one is eight months and the other is two and half years old. They asked me to do some paper work and submit copies of their birth certificates. However, I have not heard any news from them since September 2010. I called them a couple of times but received the same answer, "wait".*
>
> IDI with a mother in Hanoi

Figure 7: Coverage of health insurance among children under six by poverty status



Source: Loi et al., 2010[24]

In 2008, MOLISA issued Circular No. 29/2008/TT-BLDTBXHwhich instructed theissuing, managing and useof free health care cards for children under six years old in public health facilities[26]. According to the circular, local Commune People's Committees are responsible for issuing and distributing free health care cards to children under six years old living in the communes, including children with permanent and temporary residence status. In 2010, the Viet Nam Social Insurance Agency issued another document, No. 2147/BHXH-CSYT, to address the issue of the remaining uncovered children under six years, instructing the lower level Social Insurance to grant free health care services to children who do not have birth certificates but have an age certificate paper issued by a local People's Committee.

Circular No. 29/2008/TT-BLDTBXH was issued at the time when the Health Insurance Law was not promulgated. Document No. 2147/BHXH-CSYT was issued in 2010 *after* the HI Law became effective. Therefore the document 2147 could not refer to circular 29/2008, as the earlier circular fell under a different framework. However, it is interesting to note thatneither document mentions anything about the role of the health sector.As the 2008 circular instructs the Commune People's Committee to issue cards and the 2010 document instructs the Social Insurance Agency to issue cards, a lack of coordination between these two agencies could create challenges for the implementation of health insurance for children under six.

3. Key issues affecting universal health insurance coverage

3.1. Benefit packages

The insured are entitled to a relatively comprehensive benefit package that is identical for allhealth insurance members regardless of the scheme they belong to. Specifically, thecovered services are comprised of: medical consultations; diagnosis and treatment; x-ray and laboratory tests, functional examinations, imaging diagnosis; drugs approved by the MOH; blood and transfusion; surgery; antenatal examinations and delivery and transportation costs in the case of referrals for the poor, persons entitled to social subsidy and workers in remote areas.

In terms of coverage for accidents at the work place, in the formal sector, if an employee is enrolled in the VSS, accidents are covered by their social security plan.

The services that are not covered by health insurance include: tests,earlydetection of pregnancy, medical check-ups, family planningservices and infertility treatment, prosthesis and aesthetic surgery(such asartificial arms, legs, teeth, glasses, hearing-aids);occupational diseases(such as treatment for suicide, self-inflicted injuries, drug addiction, orinjuries resulting from crimes); medical appraisal, forensic appraisal, mental examinationor home care.

3.2. Financial protection

Financial protection is a key objective of health insurance. VSS data shows figures on health expenditures indicate that the use of health services by subsidized groups is much lower than by other groups. Table 4 presents benefits in terms of monetary unit per member. As seen in Table 4, average benefits received by the poor are between VND 144,570 in 2007 and VND 166,912 in 2009 and were lower than the average benefits for all groups which were VND 229,857 and VND 307,498 in 2007 and 2009, respectively.Thiscould be due to fewer visits to health facilitiesamong the poor. Moreover, the poor and ethnic minority people were found to receive less expensive services when compared to non-poor patients with the same disease, age and gender[27].

Table 4: Benefits per member, 2007-2009

	2007	2008	2009
Compulsory	393,477	436,862	611,752
Poor	114,570	123,181	166,912
Students	76,533	81,991	63,663
Voluntary	719,620	599,499	690,023
Children under six	-	-	69,492
Average benefit	229,857	257,402	307,498

Source: Author's calculation based on the secondary data[28]

However, the data in Table 4 must be interpreted cautiously, since financial protection is best assessed by more disaggregated indicators (such as the proportion of poor households, covered by HI facing catastrophic health expenditure). Low health expenditure of the poor can be caused by other factors than the HI scheme itself, such as the lack of availability of fully functional (e.g. staffed, equipped and supplied) health care facilities in remote, rural areas. Inability to access services would reduce spending by the poor as well. In Vietnam,

poor and ethnic minority people are also known to use lower level and thus less expensive, facilities, which also would reduce the per capita benefits they received. An issue here is also the quality of services received; as poor quality care may discourage the poor from seeking all services they are eligible for, and thus would also reduce the per capita benefits they receive. This highlights the need for a careful study to assess the importance of availability, quality and appropriateness of services received, to assess exactly why the poor seem to receive less benefits per capita than wealthier households.

As stated in the Law on Health Insurance[29], the Vietnam Social Security covers 100% of examination and treatment costs for children under six years of age, police and army forces, and meritorious people, and all treatment at commune health centres; 95% of examination and treatment costs are incurred by pensioners, beneficiaries of social allowances, the poor and ethnic minority people. All remaining populations are reimbursed 80% of examination and treatment costs when accessing health care services. It is worth noting that for expensive health care expenses, a capped level of 40 times the minimum wage is applied for all groups with a few exceptions such as female war heroes and veterans type B, the latter being defined as those who are veterans but who have not fought in wars.

Table 5: Catastrophic health expenditure by consumption quintile, location and geographic regions

	2002	2004	2006	2008
Consumption quintile				
1st quintile	5.5%	5.5%	6.9%	7.8%
2nd quintile	4.6%	6.1%	4.6%	6.0%
3rd quintile	4.7%	6.4%	4.6%	5.5%
4th quintile	5.0%	5.5%	5.2%	4.5%
5th quintile	3.6%	4.9%	4.3%	3.6%
Location				
Urban	1.9%	3.1%	3.0%	3.1%
Rural	5.6%	6.6%	5.9%	6.4%
Geographic region				
Red River Delta	6.2%	6.3%	6.2%	5.9%
North East	3.8%	3.8%	4.3%	5.7%
North West	6.4%	5.5%	3.4%	5.1%
North Central Coast	5.3%	6.7%	6.1%	7.3%
South Central Coast	3.6%	5.0%	4.9%	4.9%
Central Highlands	5.8%	6.6%	5.8%	4.7%
South East	2.7%	3.9%	3.0%	3.7%
Mekong River Delta	4.5%	6.7%	5.4%	5.8%
Overall	**4.7%**	**5.7%**	**5.1%**	**5.5%**

Source: WHO, 2010[30]

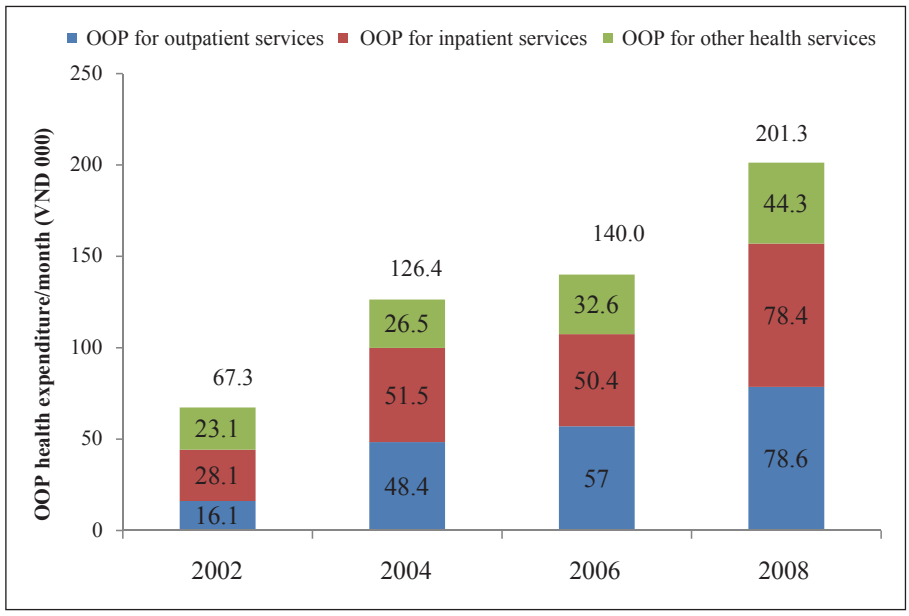
In this section, two aspects of financial protection including catastrophic expenditure and out-of-pocket payment are going to be discussed in turn. Note that in both cases, the data uses

current, and not constant, currency figures. A studyby the World Health Organization (WHO) and Hanoi Medical School (HMS)in 2010 defines Catastrophic Health Expenditure (CHE) as occurring when "a household's total out-of-pocket health payments equal or exceed 40% of the household's capacity to pay"[30].CHE by socioeconomic status, rural and urban areas and geographic regions is presented in Table 5. Overall, rates of CHE increase slightly over time and are highest among the poorest quintile, in rural areas and in the North Central Coast region.

Interpretation of the data again requires care. First, the data comes from the period of time before the current Law on Health Insurance was fully enacted. Second, as mentioned before, a more detailed study is required to assess what would be the incidence of CHE and impoverishment if health insurance was not available. On the other hand, it is important to note that even if the poor are more likely to have health insurance, they are at higher risk of impoverishment from several factors, such as the lack of disposable assets needed to overcome the loss of wages from an ill wage earner or the impact of indirect costs (for example, transportation for treatment) on household wealth.

The second aspect of financial protection examined is out-of-pocket (OOP)health payments, which refer to the payments made by households at the point they receive health services. Typically these include doctor's consultation fees, payments for medication and hospital bills. Although spending on alternative and/or traditional medicine is included in out of pocket payments, expenditures on health-related transportation and special foods are excluded in the figures below. Also note that OOP payments are net of insurance reimbursement.

Figure 8: Out of pocket payments made by households, 2002-2008



Source: WHO-HMS, 2010[30]

A recent analysis on out of pocket payments using the Viet Nam Living Standard Survey shows an increasing trend in out of pocket payments over time regardless of health services and expansion of health insurance coverage[30]. The mean of OOP was VND 67.3 thousand per household per month in 2002, but gradually doubled in 2004 and tripled in 2008. Again, these figures are based on current costs, and have not been adjusted for inflation. When

breaking down OOPsinto specific health services, OOP for outpatient services had the highest increase of nearly five times from 2002 to 2008, while the increase for inpatient services was approximately three times higher. OOP for other health services (such as self-treatment, drugs) doubled over the same period (see Figure 8).

The OOP mean isbroken down into consumption quintiles, urban and rural areas, and geographic regions (Table 6) based on reported payments for health care during the last 12 months. Results show reversed trends compared to rates of CHEs. OOPs are higher among more wealthy groups, urban areas and affluent regions such as the South East and Red River Delta regions.

Table 6: Mean OOP per household by socioeconomic status, location andgeographic regions

(Unit: VND 1,000)

	2002	2004	2006	2008
Consumption quintile				
1st quintile	21.7	32.8	40.4	58.9
2nd quintile	34.8	59.7	68.4	99.0
3rd quintile	52.0	88.1	103.3	147.2
4th quintile	75.6	124.6	163.6	204.9
5th quintile	151.7	313.3	319.7	479.7
Location				
Urban	94.2	184.2	192.8	275.9
Rural	58.7	106.2	120.3	172.7
Geographic region				
Red River Delta	64.1	105.7	132.1	170.5
North East	45.3	67.3	93.7	131.9
North West	44.8	97.5	69.6	120.3
North Central Coast	52.9	94.0	98.1	155.4
South Central Coast	67.3	110.8	130.8	169.5
Central Highlands	67.7	111.8	142.9	219.9
South East	91.5	219.4	214.0	308.7
Mekong River Delta	77.7	140.9	152.6	231.8
Overall	**67.3**	**126.4**	**140.0**	**201.3**

Source: WHO-HMS, 2010 [30]

Table 7 reports the trend in the percentage share of OOP in total expenditures on health over the 1998-2008 period. In general, the OOP gradually decreases overtime, but significant reduction was recorded between 2005 and 2008 from 65.4% to 52.2%. Matching this trend with the trends in health insurance coverage presented in Figure 5 and Figure 6, it can be seen that the coverage of health insurance significantly increased from 2005mainly because ofthe promulgation of the Decree 63 and the Law on Health Insurance thereafter. This is supported by results found in a recent evaluation of short-term impacts of the HCFP on out of pocket payment.[31]

Table 7: Percentage share of OOP in total expenditure on health, 1998-2008

(Unit: %)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Out of pocket payment	63.0	61.5	65.6	62.6	61.6	60.6	64.5	65.4	57.3	55.6	52.4

Source: MOH, National Health Account, 2010 [7]

3.3. Barriers to accessing health services

Table 8: Average health visits per person per year among the insured 2008-2010

Category	2008		2009		2010	
	Visit	Percent	Visit	Percent	Visit	Percent
Outpatient services	1.67	93.6	1.71	92.7	1.90	91.9
Inpatient services	0.12	6.4	0.13	7.3	0.17	8.1
Total visits	1.79	100	1.85	100	2.07	100

Source: Author's calculations based on the secondary data[28]

Table 8 shows the average health visits (inpatient and outpatient) among the insured since 2008 based on statistics provided by the Health Insurance Department[28]. On average, total health visits increased slightly from 1.79 visits in 2008 to 2.07 visits in 2010, in which the uses of outpatient services increased from 1.6 visits to 1.9 visits while the uses of inpatient services went up from 0.12 to 0.17 visits. In terms of total visits, outpatient visits make up over 90% throughout the period.

Table 9:Percentage of visits among insured people by level of service, 2008-2010

(Unit: %)

	2008	2009	2010
Use of outpatient service			
Central level	3.3	3.4	3.0
Provincial level	22.5	21.8	21.2
District level	41.6	45.6	41.8
Community level	32.6	29.3	34.0
Use of inpatient services			
Central level	9.3	9.6	8.5
Provincial level	43.4	43.2	44.7
District level	46.1	46.2	44.8
Community level	1.1	1.0	2.0

Source:Author's calculations based on the secondary data[28]

The percentage of peopleusing health services according to different levels of health care systems and types of services are presented in Table 9. The use of both outpatient and inpatient services at all levels remains stable overtime. For outpatient services, use at the district and community level accounts for two-thirds of the total use. However, for inpatient services, district and provincial health facilities receive nearly 90% of total use.

Table 10: Percentage of inpatients and outpatientswho have health insurance or a free health care certificate by income quintile, urban and rural, 2004-2008

(Unit: %)

	Total	Income quintile				
		Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Whole country						
2004	37.4	44.1	32.3	31.7	35.3	43.3
2006	57.4	71.0	52.9	49.0	53.5	60.9
2008	61.0	72.0	55.7	53.0	57.4	66.5
Urban - rural						
Urban						
2004	43.0	36.6	36.7	42.8	49.9	47.9
2006	62.1	58.6	57.8	61.3	65.8	66.7
2008	65.0	57.9	59.2	63.6	69.5	73.5
Nông thôn						
2004	35.4	46.0	34.0	30.7	31.6	35.1
2006	55.7	74.5	55.3	49.2	47.8	52.6
2008	59.5	74.4	59.8	52.3	53.8	57.2

Source: GSO, 2008 [32]

Table 10 presents the percentage of inpatients and outpatients who had health insurance or free health care certificates over the 2004-2008 period. The figures show that over time the percentage of inpatients and outpatients who have health insurance increases regardless of socio-economic status or whether they live in rural or urban areas. This is not surprising as the national coverage of health insurance increased from 22.8% in 2004 to 47.1% in 2008. A further look into urban and rural figuresshows that health users residing in urban areas are more likely to have health insurance regardless of income quintiles. The only outlier is the poorest group in rural areas who have slightly higher rates compared to those living in urban areas.

Table 11 shows the use of the health insurance card in 2008. Nationwide, around 48% of insured people used their health insurance cards in 2008. The rates were relatively low in the Red River Delta, South Central Coast and South East regions, but significantly higherin the Mekong River Delta when compared to the national average.

Table 11: Use of Health Insurance Card, 2008

	Red River Delta	North East	North Central Coast	South Central Coast	Central Highlands	South East	Mekong River Delta	Total
Yes	38.9	50.1	55.0	39.4	44.2	37.4	60.8	47.9
No	30.7	22.1	15.5	29.6	31.2	36.9	20.6	25.9
No visits	30.4	27.8	29.6	31.0	24.6	25.7	18.6	26.3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: calculations based on VHLSS 2008 [33]

TheMOH *Study on Feasibility of Universal Coverage of Health Insurance in 2011* revealed that although benefit packages have been improved significantly, the insured still face many challenges accessing health services[19]. In many cases, indirect costs such as the costs of transportation, caregivers and under the table payments are much higher than what is reimbursed by health insurance agencies. It was reported by the National Health Account that out of pocket payments account for 52.3% of total health expenditure in 2008[7]. This is one of barriers that prevents insured people from accessing health services, especially at district, provincial or central levels.

Secondly, the insured reported cumbersome administrative procedures when seeking health care services. For example, to be eligible for reimbursement of health expenditures, insured persons must submit all their invoices, receipts, vouchers, along with a certification from their service provider as to services received, to VSS. Thirdly, public health services are of a poor quality, especially for insurers, because of the limited treatment ceiling at community level services due to ashortage of human resources and lack of equipment. Finally, long waiting times and unfair treatment, in other words, discrimination between insured and uninsured patients, was also reported[19, 34].

> *I had a relative being treated in K Hospital (a central cancer hospital) in Hanoi. He had a health insurance card but chose the user pays mechanism as it helped to save both money and time. If he had used his health insurance card, he would have had to wait two days to be fully checked. But it took him a morning to receive the same services when he paid with his own money. The total cost for two days, including indirect costs and service fees, were much higher than what he would have been reimbursed by the health insurance agency.*
>
> *The waiting time is too long. You have to pay additional money if you want to be checked quicker. Saint Paul Hospital (a district-level hospital in Hanoi) permitted us to stay only 12 days, after that I was discharged and had to submit another referral letter if I want to be continuously treated.*
>
> FGD conducted by Department of Health insurance in Soc Son, Hanoi

Table 12:Last use of health facilities among insured by ethnicity, poverty status and ownership of health insurance card

	Kinh non-poor		EM non-poor		Kinh poor		EM poor	
	Without HI	With HI	Without HI	With HI	Without HI	With HI	Without HI	With HI
Private sector	70.7	22	51.3	10.7	42.4	14.7	43	8.9
CHC	13	45.7	17.8	55	29.8	54.3	36.6	66.7
District hospital	4.8	18.4	20.7	24	15.7	25.2	14.4	22.6
Provincial hospital	11.5	13.9	10.2	10.3	12.1	5.8	6	1.8
Number	**392**	**245**	**353**	**242**	**198**	**381**	**284**	**615**

Source: Loi et al., 2010[26]
Note: The differences among groups were statistically significant using Chi-squares

The 2009 study by Castel, Viet Nam health insurance use of health care services by the poor efficiency and equity issues in the province of Kon Tum[26] compared the most recent health care service use between insured and uninsured people and disaggregated the data by socioeconomic groups, ethnicity and types of health facilities. Results are presented in Table 12. The table shows that public facilities in general, especially community health centres, are the most frequently visited places among the insured. Regardless of ethnicity, the poor, especially those covered by health insurance, tend to consult community health centres more often than any other facility. These rates are significantly higher than those presented in Table 9 for insured people in general.

Castel, in her econometric analyses using data of a central highland province[35] found that the dual objectives of the subsidized health insurance programme for the poor and ethnic minority populations - equal opportunity in accessing and receiving health care - were far from being achieved.Similarly, this report has found that ethnic minority people and workers of the informal sector receive less expensive services when compared to non-poor patients with the same disease, age and gender. Their use of health care services was much lower than the rest of the population despite the fact that their lower spending on healthputs them at risk of higher spending when sick. More importantly,it was found that the financial barriers imposed by hospitals, rather than such conventional factors such as culture and distance, seem to be the most important factorexplaining the low use of health care service among the poor and ethnic minority people.

3.4. Service provision

In Viet Nam, the health care system is characterized by a mix of public and private providers, of which the public sector is the single most important provider, especially in prevention, research and providing health care services for insured people. The public sector is organized into four tiers - central, provincial, district and commune levels.

The central level is the Ministry of Health, which consists of departments and manages central hospitals, medical and pharmaceutical training schools/institutions, research institutions and

companies. According to the MOH Health Statistics Yearbook in 2009, there were 44 state curative care facilities at the central level managed by the MOH[36].

At the second level are provincial departments of health, which often manage provincial general hospitals and, in some big provinces, specialized hospitals, preventive medicine centres, centres for maternal and child health care and family planning, and provincial pharmaceutical companies. Every province has at least one general hospital with 200– 1,000 beds that typically has seven departments: internal medicine, obstetrics and gynaecology, surgery, paediatrics, infectious diseases, traditional medicine and an emergency ward. In 2009, there were 383 provincial level facilities[36].

There are 1366 district level facilities that occupy the third level[36]. They are comprised of district general hospitals, district preventive medicine centres, inter-communal policlinics and district community health centres. A district hospital often contains four basic departments, including internal medicine, obstetrics and gynaecology, surgery and an emergency ward. Each of them serves the population of their respective area.

The lowest level, the commune level, contains 11,636 Community Health Centres (CHCs) and commune level facilities covering 98.6% of all communes/wards throughout the country[36]. They are responsible for providing primary health care, outpatient services and normal delivery services. Moreover, they are responsible for implementing national health programmes such as family planning, the expanded programme for immunization, nutrition, and acute respiratory infection. Health workers are operating in 99, 409 villages throughout the country accounting for 84.4% of all villages[36].

Moreover, there are health facilities belonging to different sectors (post and communication, transportation, agriculture, etc.). Among these facilities, 47 medical facilities receive state subsidies and 717 sectoral facilities operate with funding from their own sector.The number of patient beds per 10,000 inhabitants in 2010 is about 20.5 beds(excluding CHC beds), which is on a par with other countries in the South East Asian region. By the end of 2010, 63% of total health facilities,both public and private,were contracted by VSS to provide health care for insured people. Three-fourths of contracted facilities were community health centres.

To facilitate the access to health service among insurers, the Law on HealthInsurance regulatesthe organization of examination and treatment for people who participate in health insurance and the reimbursements for medical examination and treatment costs by health insurance. Moreover, in 2009 the MOH issued Circular No. 10/2009/TT-BYT guiding the registration of the first point of care for insured patients and referral mechanisms[37]. Under the Circular, private health providers were permitted to provide both outpatient and inpatient care for insured people. The regulations on the first point of registered care and referral systems for the insured were expected to achieve several objectives: i) to ensure all insured people have convenient access to health care services at all levels; ii) to improve efficiency in using human resources and reduce crowdedness; iii) to improve quality of care by promoting competence between public and private providers; and iv) to widen the choice of service providers for insured people which would in turn help to expand the coverage of health insurance.

Table 13presents the first point of care among the insured between 2008 and 2010. District-level health facilities were chosen to be the first registered point of care by 40-60% of insured people. Second most popular to district-level health facilities were community health centres

which absorb around one-fifth of insured people. The percentage of people using district-level facilities increased in 2010, which is probably due to the Circular Ten that narrowed choices for higher level services, especially central health facilities, in order to reduce overcrowding.

Table 13: The first point registered care among insured people by level, 2008-2010

Central level	2008	2009	2010
Provincial level	12.0	20.2	19.0
District level	18.2	17.2	
Community level	46.0	43.4	61.0
Tuyến cộng đồng	23.7	19.3	20.0

Source: Author's calculations based on the secondary data[28]

In order to strengthen the effectiveness of the referral system, the MOH developed and issued a list of services and the level of medical facility that should be capable of performing those services at different health care levels[38, 39]. In 2010, the Medical Service Administration revised the referral guide and has been seeking feedback. This referral guide is the basis for the development of the referral system. Investment projects to purchase medical equipment, train medical workers and rotate health workers from higher level to lower level facilities are all measures to strengthen the capacity for medical examination and treatment of lower level facilities in line with the lists of services provided by different levels of the system and reducing the need for referring patients.

However, weaknesses of the health service provision system have been and will potentially be challenges for the universal coverage of health insurance. Notable issues include the system's failure to meet the increasing needs for convenient and quality health service for local people. Nor does it ensure the entitlements of insured people such as clinical level of care, quality of care and efficient administrative procedures. For example, lack of paediatricians and paediatric medical equipment at the primary health care level prevents parents from choosing a CHC or district hospital to be the first point of registered care for their children.

Moreover, human resources are unable to meet the needs for health care services in the context of epidemiologic transition and the needs for effective primary health care services. Evidence shows that poor people and ethnic minorities are still facing difficulties in accessing inpatient and outpatient medical examinations and treatment services compared with other groups and although the curative care network has been developed broadly throughout the country, form central to local levels, the quality of services varies substantially between localities and regions[40].

> *They provided my family members with free health insurance cards because we are all poor. However, we were not well informed about the benefit packages and how to use the card... I came here (a CHC) when I was ill, asking for some drugs. But I found that the given drugs were not good quality and did not meet my needs. The drugs could not help me get well quickly. ...I think that Ihave a stomach diseasebecause it hurts right here in the upper central region of the abdomen. As I thought health workers here at Phu Lac Community Health Centre are not good, I did not consult here butI bought medicines from a pharmacy store to treat the*

disease. I also did not go to the district hospital because I had no idea whether or not services are free at the district hospital.

IDI with a Nung man in Phu Lac, Thai Nguyen

3.5. Health insurance and its impacts

A key aim of health insurance is to protect people from financial loss when accessing health services. However, it is expected that health insurance would lead to better health outcomes as it increases health service utilization among the insured. Unfortunately, there is little data in Viet Nam about health outcomes. However, an analysis conducted by Wagstaff and Pradhan in 2005 found a positive impact on the nutritional status of both children and adults who had compulsory health insurance[41].

Despite its problems, results of quantitative analyses report strong evidence that social health insurance in Viet Nam is contributing to the provision of affordable health care for its members[42], thereby increasing utilization of health services and reducing out-of-pocket spending for the care obtainedirrespective of schemes[31,43-46]. More specifically, using non-experimental analytical techniques (differencingwith propensity score matching), studies have shownthat the HCFP programme has led to a substantial increase inthe use of public hospitals for inpatient care; the differencebetween those covered by the programme and those in thematched control group was over 82% in favour of thebeneficiaries. While the exact level seems to differ betweenstudies, there was a significant difference in the averagelevel of out-of-pocket spending of around 20%, and, as a consequence, the beneficiaries of the programme had asignificantly lower share of catastrophic health spending ofslightly less than 20%[47].

3.6. Key target populations

According to VSSstatistics, by the end of 2010, there were around 36 million people without health insurance, accounting for 42% of the total population.Table 14 below introduces key target groups (having more thanone million members);together they make up 87.2% of uninsured people.

In the current situation, moving towards universal coverage of health insurance will be challenging for several reasons. Firstly, although employees of enterprises and companies are required by Decree[63] and the Health Insurance Law to have compulsory health insurance, only half of this group had health insurance in 2010. The Law on Enterprise also requires mandatory health insurance.Private enterprises are responsible for registering all their employees with labour contracts of three months or more for social security 8. However, the compliance of this group is low because of i) weak labour registration and enforcement measures; ii) collusion between employees and employers in reporting the monthly salary and buying health insurance; and iii) lack of knowledge about insurance and its benefits[33, 48].

Table 14: Key target populations for universal coverage in 2010

	Uncovered people	Percent
Total key targeted population	31,485,000	100
Compulsory scheme	16,850,000	53.5
Employees of enterprises and other companies	5,550,000	17.6
Children under six	1,920,000	6.1
Near poor people	5,389,000	17.1
Students and pupils	3,991,000	12.7
Voluntary scheme	14,635,000	46.5
Dependents of workers	6,820,000	21.7
Farmers, self-employed and members of cooperatives	7,815,000	24.8

Source: VSS, 2010 and 2011[22, 23]

> *The Social Security Agency can do nothing if an enterprise does not buy health insurance for its staff.The enforcement is not strict enough. I would say, at present, none of state organizations know exactly the number of enterprises and their workers who have labour contracts of more than three months. There are many ways for enterprises to elude buying health insurance for their staff, such as collusion between employees and employers and unlawfully reporting of their total number of employees...*
>
> IDI with a head of provincial health insurance department

In 2008, the Government promulgated Decision No. 117/2008/QD-TTgadjusted the subsidized health insurance enrolment fees for the near-poor group.Near poor was defined as "income per household memberthat is no more than 130% of the poverty line"[49]. According to the Decision, the state budget pays50% of enrolment fees for near poor people. In the Mekong River Delta region, 80% of enrolment fees were subsidized, of which 50% was paid by the government and 30% was supported by a World Bank Funded Project, the Health Care Support for the Mekong Region Project. Near poor people had to pay only 20%, equivalent to VND78 thousand ($US3.5) per year. Unfortunately, the coverage of health insurance among near poor people is still limited. In 2010, there were nearly 700 thousand near poor people getting health insurance, making up around 11% of total near-poor people nationwide. Approximately two-thirds of insured near poor people reside in the Mekong River Delta.Reasons for near poor people not having health insurance include:i)local authorities did not give specific guidelineson how to define near poor householdsor how to disseminate information on the health insurance policy;ii) poor awareness about the policy and low education level among near poor people; iii) lack of coordination between local agencies resulting inprovinces not developinga list of near poor people; and iv) low ability of near poor householdsto pay for health insurance[50].

With respect to voluntary groups, people are willing to buy health insurance if they find that it is worth paying for the benefits expected from health insurance and their probability of health shock is high. It was reported that healthy people with low risk of health shocks, as well as those who do not perceive the risk, are less willing to buy health insurance. Moreover, recent studies have found thatthe most common response for not having health insurance is

that people consider themselves healthy enough not to have health insurance and they want to choose health facilities for themselves [33, 48]

3.7. Accessing health insurance

Organizationally, VSS is arranged vertically into three tiers - central, provincial and district. But there is not a separate health insurance agency. The VSS has to reach out to people at community level via its contracted private agencies. Where there are few contracted agencies, people have to contact district level agencies to buy health insurance. As a result, accessing health insurance at community level is limited19[19].

3.8. Knowledge/understanding of the health insurance schemes and their benefits

Table 15: Knowledge/understanding about health insurance

(Unit %)

Contents	Head of household	Students
Do not know about the Health Insurance Law	30	16
Know about Health Insurance Law through commune staff/schools	33	53
Know about Health Insurance Law through radio	22	27
Know about Health Insurance Law through Health Insurance staff	5	1,3
Do not know how to buy Health Insurance or no answer	23	35
Do not know or give a wrong answer about premium rate	92	35
Do not know or givea wrong answers about government subsidies	-	22.5
N	120	80

Source: MOH, 2011 [19]
Note: total exceeds 100% as multiple-choice question.

Evidence shows that VSS's strategy in disseminating information, especially on voluntary health insurance is not effective and its marketing is poorly developed. As presented in Table 15one-third heads of household interviewed did not know about the Health Insurance Law[19]. One-third of surveyed students did not know where to buy health insurance or about government subsidies for enrolment fees. This rate was even higher among heads of household, where the majority of interviewed households (92%) did not know or gave a wrong answer about premium rates.

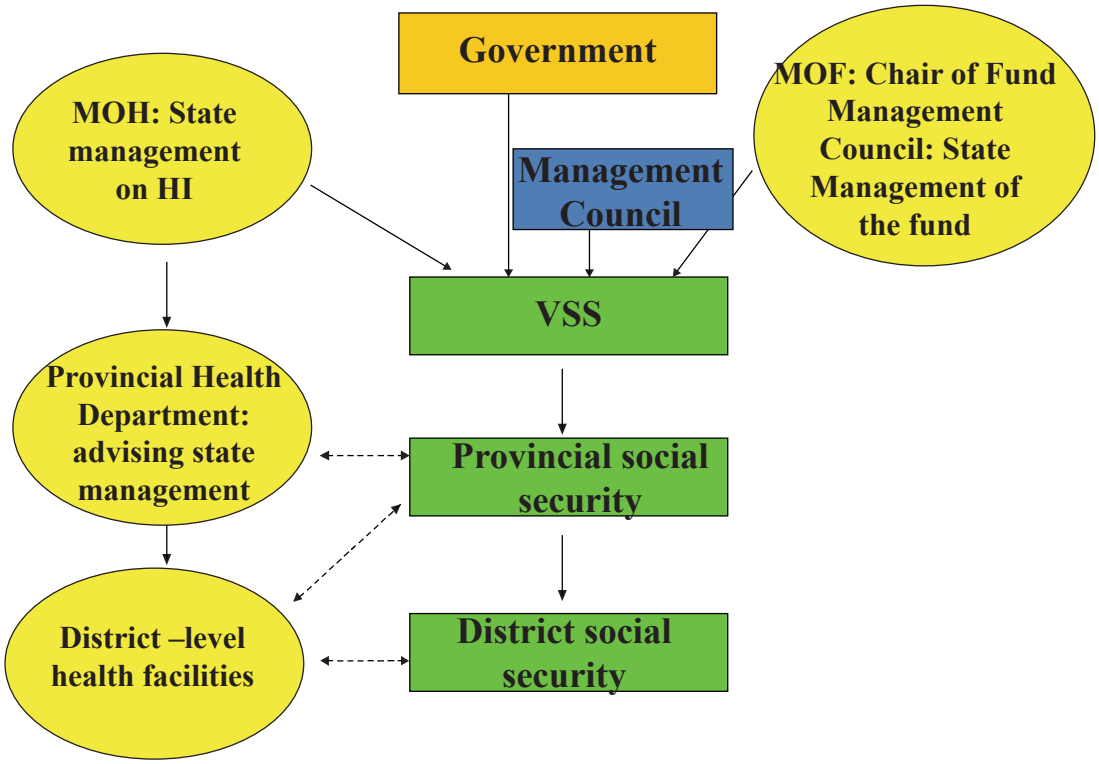
An MOH assessment conducted in NinhBinh, Nghe An and Tay Ninh provinces among near poor people also found that the propaganda regarding policy, guidelines and government subsidies for health insurance has not been well implemented. Moreover, the proportion of near poor people who correctly understood the definition of a near poor household was only 42%[50].

> *... Could you tell me if the district hospital has an endoscope machine to check my stomach and how much I have to pay if I visit it?... I did not know that health services at district hospitalsare free of charge for a poor person like me.*
>
> IDI with a Nung man in Phu Lac, commune, Thai Nguyen

3.9. Organization of the health insurance system

Viet Nam Social Security (VSS) is the government agency responsible for implementing policies related to social insurance and health insurance[51].The organizational structure of VSS is laid out in Figure 9.

Figure 9: Organizational structure of Viet Nam Social Security



Source: MOH, 2011[19]

It is evident from this that in order to successfully implement health insurance, collaboration and coordination between government organizations such as MOH, Ministry of Finance, MOLISA and mass organizations, such as the Women's Union and Famer's Union, and harmonization between policies issued by these organizations are of strategic importance.

Moreover, at the primary level where the policies for the insured are in need of being closely monitored, the number of staff and their capacity to perform these tasks are limited. In many districts, VSS workers lack knowledge in medicine and enrolment assessment[51]. As a result, the implementation at the primary level are contracted out to agents, on the basis consistent with the associations, unions of communes, wards and social agencies contracting with the agent in this case.

3.10. Payment systems

The Health Insurance Law defines three key payment methods:Fee-for-service (FFS), capitation and case base, of which FFSremains the most common method used. The fee schedule is determined by relevant state agencies, based on which, the local authorities (in charge of hospital management in their locality) specify the precise fee level for each service, taking into

account the technical capacity of the hospital and the ability to pay of the local community. FFS is applied for both inpatient and outpatient care in a context of relatively weak regulation, thereby encouraging overuse of service, especially para-clinic services, such as tests, X-rays, CT-scans, among health providers[48].

Recent government policy to enhance the financial autonomy of public revenue and to permit public hospitals to retain some share of their revenue to invest in their production capacity (referred to as "Decree 10" and then "Decree 63"), providesgreater incentive to hospitals to increase their provision of care.The overuse and overprovision of services may satisfy thoseusers who believe that more services and more expensive services means better quality (andbetter customer service by providers), however, it causes inefficiencyin the health system. Moreover, FFS payments can also result in a situation where hospitals try toattract more patients, even those with mild illnesses (that could be treated at lower levels) in order to increase revenue.

The second most popular method of payment is capitation(a flat fee for each patient), whichis mainly used in district hospitals and community health centres. Unfortunately, an assessment in HoaBinh found that capitation payment is not applied equally to all health care services at commune and district level and out-patient wards in district hospitals, with which health insurance members can directly register for primary care. Interestinglypayment for an outpatient service at the district hospital is three times higher than that at a CHC (VND 90,000 compared with 30,000)[52]. As a result, there is concern that capitation-payment has an inherent risk of under-servicing and quality skimping.

Nevertheless, in the current situation in Viet Namwhere administrative capacity at commune level remains very limited, those interviewed agreed for the most part that the advantages of capitation and in particular the predictability of the available resources outweigh the expressed risks. Particularly at CHC level, health care provision is largely challenged by a lack of human resources, often equipped with low professional skills including management, weak flow of communication with health services and administrations at hierarchically higher levels, significant under-funding and a subsequent low expectation by the population of receiving sufficient care of good enough quality at that level.[3] Considering that regular shortages in drug supplies additionally worsen the situation, capitation payment, despite its well-known limitations, is perceived as enormously helpful for bringing this vicious cycle to an end.

In this regard, additional measures to constantly improve the quality of service provision can hardly be overestimated.Recently, a newmechanism called Diagnosis-Related Group has been proposed and piloted in some district hospitalswith the hope ofincreasing the performance of the service delivery system and mitigating the health-related financial burdens for the service users.

3 KICH, Indicator report 2010, p. 36.

3.11. Affordable premiums

Table 16: Contributions for health insurance in 2010

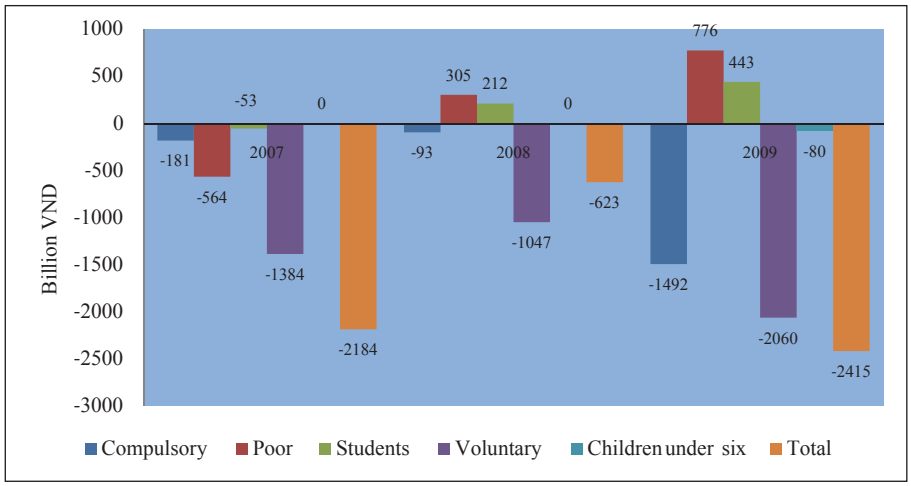
Programme	Contributions
Compulsory groups	
Formal sector workers and civil servants	4.5% of the minimum wage, 3% is paid by government or employer and 1.5% is paid by employee
Pensioners	4.5% of minimum pension wage paid by VSS with subsidies from state budget
Meritorious people, children under six years, the poor, etc.	4.5% of the minimum wage paid by the state
Near poor people	4.5% of the minimum wage. 2.25% is paid by the state for the first person. The second, third, and fourth persons in the same household pay 90%, 80%, and 70%, respectively, of the fee incurred by the first person. From the fifth person onwards, the premium is 50% of the first person's.
Students and pupils	3% of the minimum wage, 1% paid by the state for non-poor households and 1.5% for near-poor households
Voluntary groups	
Relatives of employees	4.5% of the minimum wage
Farmers, workers in the sectors of agricultural, forestry, fishery and salt production	4.5% of the minimum wage. Minimum 1.5% paid by the state

Source:Government of Viet Nam, 2009[53]

Premiums of health insurance have varied between 3-10% of the minimum wage since the introduction of health insurance in 1992. Specifically, in the first two years, the premium rates were 10% for civil servants and pensioners but only 3% for company employeesdue to the difference in salary scales[54]. Since 1994 the premium rate of 3% minimum wage was applied to all groups [16, 55]. Decree No. 62/2009/ND-CP provides in detail the enrolment fees applied from January 1, 2010 to December 31, 2011, from January 1, 2012 to December 31, 2013, and from January 1, 2014 onwards[53]. Currently, a premium of 4.5% of the minimum wage, allowance and pension salary is applied for employees, of which two-thirds are paid by employers. The enrolment fee of students is 3% of the minimum wage. Details of the percentage of enrolment fees by different groups as defined in the Decree are presented in Table 16. It is important to note that the annual fee for labour groups is nearly VND450 thousand or $US 22.4, which accounted for about 45% of average health expenditure per capita in 2009[7].

3.12. Financial sustainability

Figure 10: Balance between contribution income and benefit payment, 2007-2009



Source: Author's calculations based on secondary data[28]

The financial sustainability of health insurance depends on the ability to mobilize sufficient revenues and to control costs. Financial sustainability is,therefore, a further challenge for the development of health insurance in Viet Nam. Figure 10 summaries the balance between incomecontributions and benefit payments for the 2007-2009 period. These figuresclearly show that over the period, outlays exceeded revenues in the compulsory and voluntary schemes, though the Health Insurance fund did show a surplus in 2010[56], which is encouraging. It is worth noting that administrative costs were excluded from benefit payments. These deficits reflect two things: 1) a shift in the mix of enrolees toward groups whose revenues are particularly low relative to the revenues they bring to the fund; and 2) a tendency for outlays per enrolee to outpace revenues per enrolee.

Table 17: Enrolees, contributions and benefit payments in 2009

(Unit %)

	As % of total enrolees	As % of total contribution	As % of total
Formal sector workers and civil servants	16.1	38.7	22.2
Pensioners and unemployed	3.9	9.4	18.5
Meritorious people, children under six and the poor	49.4	34.4	34.0
Students and pupils	21.4	8.7	4.4
Voluntarily insured	9.3	8.8	20.8

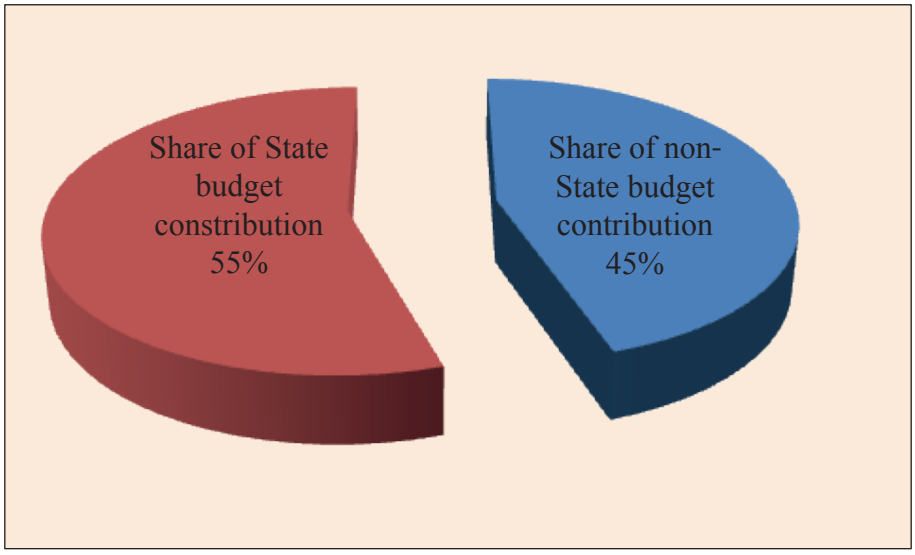
Source: Author's calculations based on the secondary data[28]

In 2009, formal sector workers accounted for nearly 16% of total enrolees, brought in 38.7% of total revenues, but consumed only 22.2 percent of costs (Table17). Pensioners, in contrast, accounted for only 3.9% of enrolees and 9.4% of revenues, but made up18.5%of benefit

payments. The voluntary insured (mostly farmers) made up 9.3% of total enrolees and 8.8% of revenue, but accounted for one-fifth of total benefit payments. When adding all enrolment fees paid or supported by the state such as contributions for children under six, poor and ethnic minorities and people living in difficult socio-economic conditions, it is surprisingly tonote that the state remains the biggest payer of health insurance contributions (see Figure 11).

With respect to the second aspect of financial sustainability of health insurance, controlling costs, it is important to discuss issues of moral hazard, adverse selection and supplier-induced-demand. Moral hazard in this context refers to a situation where too much health care is demanded as a result of introducing insurance, which in turn increases costs[57]. In Viet Nam, there seems to be little compelling evidence thatmoral hazard would be a sufficiently large problem to cause thegovernment to reconsider its approach to health financing, although a study conducted by Jowett et al. in 2004 raised this concern[46]. Secondly, the question of adverse selection refers to a process in which individuals with a higher average risk are selected to be enrolees of health insurance. If this happens, reimbursement claims would be higher than expected. There is evidence suggesting that the voluntary health insurance scheme is experiencing a process of adverse selection. Table 4 shows that spending per voluntary member was higher than that of other groups. This problem was also reported in a 2008 review of health insurance by Ekman[47]. To avoid adverse selection, the Government has revised the policy for the implementation of voluntary schemes, introducing special provisions such as waiting periods to receive full benefits.

Figure 11: Percentage shares of total health insurance contributions in 2009



Source: Author's calculations based on secondary data[28]

Finally, the most concerning factor with regard to maintaining financial sustainability of the health insurance system is the issue of supplier-induced-demand – a process in which providers treat patients for longer spells with more expensive types of care than clinically necessary57. In the context of Viet Namweak quality assurance, increased financial autonomy in public hospitals, weak regulation capacity and loweffective oversight of the sector means that supplier-induced-demand may result in substantial cost escalations as pointed out by recent World Bank studies[58, 59].

IV. Conclusion

Evidently, Viet Nam has made impressive progress in introducing and expanding health insurance over the last two decades. The Government has developed several important programmes to subsidize such vulnerable groups as the poor, ethnic minorities and near poor, in order to reach the goal of universal coverage by 2014 as set in the Law on Health Insurance. Achieving universal coverage of health insurance is not merely an issue of getting the whole population covered by health insurance (breadth), but rather protecting people from financial losses (height) and ensuring quality and adequacy of services covered (depth) as discussed in the World Health Annual Report 2010[60]. However, achieving this goal will be extremely challenging.To expand the coverage and to ultimately achieve universal coverage, the following policy implications are highly recommended:

1. Mobilization of resources

Results show that the Health Insurance Fund ran at a deficitin 2009. In 2010, however, the HI fund had a surplus sufficient to erase the accumulateddeficit, mainly because of the increase of individual premiums from 3% to 4.5% of the minimum wage[56]. Nonetheless, the risk of running deficits will be elevated as fees for health services are expected to increase in the near future. With this in mind, the contributionby the insurer needs to be revaluated to insure long-term financial sustainability.As time goes on, alternative measures to raise more revenues should be identified.Increasing the efficiency of the collection of social health insurance contributions from enrolled companies, and ensuring all workers are appropriately declared, remains a priority.

This could considerably help maintain long-term financial sustainability since, as seen in Table 17,formal sector workers and their employerscontribute the majority ofthe HI fund revenue, but account for a proportionately smaller share of benefit payments. Moreover, the Castel report shows that 64.4% of personsin the informal sector (i.e. who are notdeclaredformal employees in private and public enterprises, or civil servants, and excluding the poor and near-poor) earn a relatively high income from their primary income-generating activity.In fact, 15.5% are actually wage-earning employees33. Increasing the proportion of informal sector workers who enrol and pay premiums into the HI Fund, and ensuring all wage earners are declared, would substantially enhance long-term financial sustainability of the fund.

2. Expanding the coverage

With respect to the coverage of population, the VSS figures in 2010 (see Table 3) show that by the end of 2010 only 58.4% of the total population had health insurance while 36.1 million of people remained uncovered.Castel estimates that expansion of the subsidized programmes and the use of institutional networks to launch information and enforcement campaigns should help to expand coverage in the coming years, but still about 24% of the population could remain uncovered by 2014 33. The potential uncovered group is made up of working age persons and the elderly in the informal sector who do not benefit from any financial aid to buy health insurance, as they do not fall into the recognised categories of poor or near poor. For the most part, they cannot get health insurance as a dependent of persons employed in the public sector or in private formal enterprises. Results from the study reveal a very low rate of participation in health insurance (11%) and a low willingness to participate,among populations

of the informal sector. International evidence points to the difficulties in covering the rural and informal populations with voluntary insurance.

In order toexpand the coverage (breadth) to this group, a concerted effort and harmonized collaboration between ministries, local governments, VSS and MOH must be achieved. Additionally, the depth of coverage should be taken into account by improving quality of care and removing unnecessary administrative procedures. Evidence has shown that expanding enrolment though business and employees registration, and using a family coverage approach could be easier and more efficient than expanding at individual levels[33].

It is noteworthy that the government of Viet Nam has acted to close several identified gaps. For instance, the 2008 Law on Health Insurance mandates a progressive phasing in of compulsory HI coverage: HCFP beneficiaries and pupils and students have already been included, while the informal sector is planned to be covered by January 2012);relatives of civil servants, state employees, cooperative members and individual businesses by early 2014, andall others by the end of 2014.[61]

3. Controlling cost escalation

In addition to expanding and deepening insurance coverage,containing health costsalso plays an important role in achieving universal coverage. As discussed above, both consumers and providers' behaviour may be affected by health insurance in ways that result in cost escalation. Cost escalation is affected by the scope of the benefit package and the way in which providers are reimbursed. With regard to the former, the question of what should be included in the benefit package should be considered carefully.

Regarding reimbursement, Viet Nam is in the process of piloting alternative reimbursement methods. However, it is important for the reimbursement methods to be effectively implemented in line with other dimensions of the health care system including the health information system and the regulation capacity of authorities. Moreover, as Viet Nam is keeping its policy on financial autonomy of public hospitals, the issue of supplier-induced-demand must be addressed through effective governance mechanisms to ensure compliance with HI rules and regulations, as well as implement effective QA mechanisms based on updated treatment protocols.

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