Vietnam

Social health insurance

Report of study visit
21 - 24 October 2014

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COOPAMI
# Programme Agenda

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<td><strong>Morning:</strong> Meeting with the Health Insurance Implementation Department at Vietnam Social Security Headquater in Hanoi</td>
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## Acronyms

<table>
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<th>Acronym</th>
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<tr>
<td>CHSs</td>
<td>Commune health stations</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOLISA</td>
<td>Ministry of Labor, Invalids and Social Affairs</td>
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<td>HIL</td>
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<td>SHI</td>
<td>Social Health Insurance</td>
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<td>VSS</td>
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**Introduction**

COOPAMI organized on 27 and 28 October 2014 an International Forum on the development of Social Health Protection in the Southeast Asian Region in Hanoi, Vietnam. This forum brought together 4 countries of the region (Thailand, Lao PDR, Cambodia and Vietnam) to share experiences on how to achieve universal social health protection. The presentations and results of the activities in groups can be find on our website: [www.coopami.org](http://www.coopami.org).

The forum was for me an opportunity for a study visit in Vietnam and to learn more about the Vietnam system of social health protection. During four days I have met people from Vietnam Social Security (VVS), Ministry of Health (MOH), a hospital, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), and Oxfam to receive more information about the health system and social health insurance in Vietnam.

This report is the results of these meetings and is an attempt to draw a brief picture of today’s social health insurance in Vietnam.
General country profile

Vietnam is located in South East Asia with a population of almost 90.0 million, ranking 14th among countries with the largest population in the world. Most of the population (68%) lives in rural areas (Website World bank, 21-11-2014).

Vietnam is a one-party Communist state and initiated political and economic reforms (Doi Moi) in 1986 with the goal of creating a "socialist-oriented market economy". The country has shifted from a centrally planned towards a market-oriented economy and evolved from one of the poorest countries in the world, with per capita income below $100, to a lower middle income country within a quarter of a century with per capita income of $1,960 by the end of 2013.

Over the last few decades, Vietnam has made remarkable progress in reducing poverty. The percentage of people living in poverty dropped from almost 60% in the 1990s to under 10% today. Over the same period, the mean income for the bottom 40% of the Vietnamese population increased by an annual average of 9% (Website World bank, 21-11-2014).

Regarding economic developments, Vietnam’s growth rate has averaged 6.4% per year for the last decade, but it has begun to slow recently. In 2013, GDP growth was 5.4 % and is projected to flatten in 2014 (Website World bank, 21-11-2014)

How did the social health protection policy evolved against this background? Before answering this question, let us first look at the health care delivery system of Vietnam.

Health care delivery system

Vietnam has a mixed delivery system, with the public sector dominant in the provision of hospital care services. Like a lot of countries, Vietnam has a public system that is based on a pyramid model with four levels:
1. At the commune level, healthcare is delivered by 11,000 Commune Health Stations (CHSs). CHS is the basic unit of the primary health care network, including preventive care, normal delivery, provision of drugs, family planning, and overall health promotion in the community. On average, a CHC serves just 7,000 people. Most Vietnamese communes have a health facility with a small number of village health workers.

2. At the district level, there are almost 600 district hospitals/polyclinics, all of which admit inpatients, and provide emergency care and basic treatment for common diseases.

3. At the provincial level, some 324 specialized and general hospitals treat diseases that are beyond the capability of the district hospitals or require “special treatment”. Province hospitals (including large city hospitals) are administered by the provincial health departments.

4. At the central level, specialized and general hospitals under MOH management provide highly specialized treatment with advanced techniques. These are the largest and most technically up-to-date facilities, with an average of over 500 beds. Almost all are located in Vietnam’s largest cities.

The Ministry of Health is the national authority with regards to the provision of health services. Provincial and District Health authorities and the Commune People’s Committee are responsible for the development and implementation of health strategies in Vietnam.

The private sector appears to have grown in recent years, with drug vendors and general practitioner clinics being the largest groups of registered private providers but the private hospital sector is highly undeveloped. There are around 170 private hospitals on a total of 2,150 hospitals and they represent 6% of the number of total hospital beds in Vietnam. These private hospitals are principally located in major cities (for example: 27 private hospitals are located in Hanoi). Vietnam has in total 21 hospital beds per 1,000 population.

There is an uneven distribution of human resources with shortages in some regions, facilities and specializations. The most qualified health workers are concentrated in urban areas.

Social health insurance

- A short history

The social insurance scheme has been in operation since the early 1960s. Prior to 1995, social insurance only covered employees in the state sector and it was managed by different public agencies under the supervision of the government.
The Doi Moi reform process led to a series of policy shifts in the health care system. Central among these reforms were the liberalization of the health care and pharmaceuticals markets, the introduction of official user fees at public health facilities and, more important, the inception of health insurance.

By the early 1990s, out-of-pocket payments accounted for over 70 percent of total health financing. To address the growth in out-of-pocket payments and associated problems of financial barriers to access, the government piloted a series of voluntary noncommercial health insurance schemes between 1989 and 1992. In 1992, Decree No. 299 was passed introducing a mandatory scheme for civil servants, formal sector workers, pensioners, and people receiving social assistance. This nationwide scheme covered all of the eligible population by 1993. (Aparnaa Somanathan, Huong Lan Dao, Tran Van Tien, 2014).

In 1995, the Government issued Decree 12 and Decree 45 forming the Vietnamese social security system in terms of general administration and fund-management. This time it extended social security coverage to civilian employees and the armed forces, with five types of benefits i.e. sickness, maternity, employment injury and occupational diseases, retirement pension and survivor’s benefit. In 2002, the health insurance, which had been administered by the Ministry of Health (MOH), was incorporated into the existing social security programme. In this year the government agency Vietnam Social Security was created.

A Health Care Fund for the Poor was created in 2003 to provide care for the poor, ethnic minorities, and the disadvantaged. Initially implemented as a separate social program, HCFP was rolled into the national compulsory health insurance scheme in July of 2009 as a result of a new National Health Insurance Law.

- **Who is covered by the social health insurance?**

Vietnam has made a policy choice to finance health care primarily through SHI. The Health Insurance Law (HIL) that was passed in 2009 created a national SHI program. It was an important law because it integrated the existing health insurance program with the program for the poor, thus bringing together all groups into one program.

In June 2014 the national assembly passed a new version of the insurance law that will be effective from 1 January 2015 and was designed to make participation compulsory. This amended health insurance law categorizes membership of health insurance into 5 groups based on contribution responsibility:

1. Salaried employees who have labor contract of 3 months onwards in all enterprises employing 1 worker or more;
2. People entitled to Social security benefits: people on pension or monthly working capacity loss benefit, work injury or occupational disease benefit, unemployment benefit
3. Commissioned and non-commissioned officers, the soldiers, people with meritorious services to the revolution, war veterans, Incumbent National Assembly and People’s Council deputies at all levels, ethnic minority people, the poor, children aged under 6 years
4. Members of households living just above the poverty line, pupils and student
5. Voluntary insured

In 2013, almost 61.8 million Vietnamese people or 68% of the total population were covered by the health insurance. 90% of them are covered by the compulsory insurance and 10% is covered by the voluntary insurance. The government wants to reach a coverage level of 80% by 2020 and 100% by 2030.

Source: VSS
• **How is the social health insurance financed?**

The revenues of HI funds come from different sources:

- Premiums paid by the employees and employers: 4.5% of salary (employer 3% - employee 1.5%)
- Premiums paid from the Social insurance funds (VVS fund)
- Premiums paid from the State Budget
- Premiums paid by the insured itself: 4.5% of minimum salary.

The premium rate is actually based on an individual contribution.

The government is responsible for fully subsidizing the health insurance premium for children under six, the elderly, and the poor, and for partially subsidizing premiums for the near-poor (70% of the premium) and students (30% of the premium). In some regions of Vietnam, local government subsidize 20% - 30% of the premium for the near-poor, meaning that 10 to 20% of the premium is left to be paid by the insurer.

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**Sources of Financing for SHI Revenues**

Source: Somanathan Aparna, Ajay Tandon, Huong Lan Dao, Kari L. Hurt, and Hernan L. Fuenzalida-Puelma. 2014
• **What is the SHI benefits package and how much of the costs is covered?**

Patients who have an identity card and HI card and seek health care services at their primary health care facilities stated in their HI cards are entitled to all benefits under the HI Law.

In principle, all SHI members are entitled to the same benefits package. The SHI benefits package includes a broad range of services from ambulatory care (examination and treatment) to rehabilitation and advanced diagnostic and curative services, regular pregnancy check-ups, birth-giving and travelling expenses from commune or district hospitals to higher-level hospitals in some cases.

Some services are not covered, like medical costs covered by other sources, routine health check-up, family planning services, infertility treatment, aesthetic services, occupational diseases, work related accidents; suicide, self-harm activities, substance abuse, consequences of law violation, etc.

The level of the costs covered by the SHI depends on the group with a variation of 100% - 95% - 80% of the total health expenditure. There is for example no co-payment charged for services provided at commune health stations (only outpatient), including child delivery services. For insured patients who bypass lower-level referral facilities, the co-payments will be higher.

In 2013, the co-payment paid by the insured is 14.76% of the total health insurance-covered medical care cost nationwide. If we look at the total health expenditure in Vietnam, the OOP payments accounts for almost 60%. The Government of Vietnam’s want to take progressively steps to reduce OOP payments made by patients to under 40 percent by 2015.

• **What is the institutional architecture of the social health insurance?**

The Ministry of Health is in charge of SHI policy formulation and monitoring and evaluation, while Vietnam Social Security (VSS) is responsible for managing the SHI fund and implementing the program by issuing health insurance cards and purchasing services for its members.

MOH established the benefit package and plays a prominent role in revising the package.

Institutionally, VSS is a ministerial-level government agency that reports to both the MOH and the prime minister. VSS is organized in three administrative levels:

- 1 VSS headquarter at central level: 24 departments
- 63 Provincial Social Security Offices: responsible for contracting and control
- 705 District Social Security Offices: responsible for contracting and control

The local Social Security Offices are responsible for the reviewing of the medical claims of the health care providers. Staff of VSS are reviewing the medical records and receipts directly at the health care facilities.

In addition, several other government agencies are involved in SHI. The Ministry of Labor, Invalids and Social Affairs (MOLISA) is responsible for the identification of the poor; local governments (and their Provincial Department of Labor, Invalids and Social Affairs) are responsible for the identification process and for producing the final list of the poor in the provinces. The Ministry of Finance (MOF) and provincial departments of finance are responsible for the allocation and transfer of money to VSS. (Aparnaa Somanathan, Huong Lan Dao, Tran Van Tien, 2014).

- **Does the patient has free choice of provider?**

Health care providers include public and non-public providers. All public providers were automatically approved to participate in social health insurance prior to November 2011, while private providers needed certification and permission.

In 2014, VSS contracted with 1,627 public establishments and 484 private ones.
The insured may register for HI-covered primary care services at medical establishments of Commune and District level. The insured may change the registered primary care provider at the beginning of every quarter. The CHSs are the first point of contact for much of the population, especially in rural areas.

Some special cases are entitled to register at provincial or central medical establishments under regulations of the Minister of Health.

Insured members can only use health services from the CHS or district hospital where they are registered, and must be referred to secondary or tertiary hospitals.

In case of emergency, an insured may seek medical care services at any medical establishment.

• **What are the provider payment methods?**

Costs of health care shall be paid by one of 3 following methods: fee-for-service, capitation, and case-based payment. At the present, the payment methods are mainly fee-for-service (1,261 medical establishments) and capitation (850 medical establishments). Capitation is mainly for the district hospitals (more than 60%).

Case-based payment, such as diagnosis-related groups DRG, is being piloted at 4 health care facilities.
Personal analysis of the social health protection in Vietnam

Vietnam has progressively introduced a social health insurance for its population with gradually expanding the target population and the benefit package, and reducing the financial contribution from the insured. Almost 68% of the population is covered by the HI. The Vietnamese government has the intention to reach 100% in 2030. But there is still a long way to go.

First of all, there is still an important group that is not covered by the HI. Like most countries who want to progress towards universal coverage in social health protection through the implementation of a health insurance, Vietnam has difficulties to reach the non-poor workers and their families in the informal sector, who belong to the voluntary enrollment group. Enrollment among the voluntary, contributory subcategory remains low because the cost is too high and/or the value of health insurance is not perceived as being commensurate with the cost of enrollment.

But there are also low enrollment rates, even among those in the formal sector, where enrollment is mandatory. Private companies fail to pay the social insurance contribution and the present administrative penalty policy is not strong enough. Only 60% of the workers in private companies is currently participating in the HI scheme.

Families of formal sector workers are not covered since SHI for formal sector workers is limited to individuals only. But with the new amended health insurance law, this will change and a family based enrolment will be effective from 1 January 2015. The HI contribution will be reduced for every extra family member.

Even though government is subsidizing a part of the premiums of the near-poor, there is still an important part of this group who are not enrolled. The reason is probably that the premiums are still too high, even with an important subsidy.

A special group are the migrant workers in Vietnam. Vietnam knows a lot of rural-urban migrants. Up to 90% of migrant workers in urban areas in Vietnam do not have access to social (health) protection due to their migration due to the absence of ho khau or the household registration system. Under this household registration system, each household is given a household registration booklet (so ho khau) which records the names, sex, date of birth, marital status, occupation of all household members and their relationship with the household head. In principle, no one can have his or her name listed in more than one household registration booklet. It became the basis for economic planning, the provision of social services and the distribution of food and goods. As the economy liberalized, however, it became easier for people to evade the system. Increasing numbers of people have moved away from the places where they are registered. In theory, migrants can get official permission to change their registration. In practice, large numbers of migrants cannot do so, unable to fulfill the conditions required. The expense and bureaucratic convolutions of accessing basic health services put them beyond the reach of many.
Another problem is that out-of-pocket payments is still very high, even for people who are covered by the HI. There are a couple of reasons for this. Firstly, VSS reimbursements do not completely cover the SHI benefits package and they pick up only a portion of the total cost of care, leaving providers to claim the remainder through user fees from patients. There is no cap on copayment expenditures. SHI includes caps on benefits, but no cap on copayment-related charges. Finally, deficiencies on the supply side lead patients to seek care outside the range of covered services. The quality of care is very different from level to level and from one region to another. There is little confidence in the CHS and as a result, patients are going directly to the higher levels of care, where they incur higher copayment rates, or seek care at private health facilities, which are not covered by SHI.

Another problem is related to the institutional architecture of the system. There seems to be a lack of management and controlling of the health insurance.

Firstly, the definition of the benefits package is not based on cost-effectiveness, affordability, or any technical criteria.

Secondly, everyone acknowledge that VSS is a passive purchaser with low implementing powers. This means that VSS does not have the ability to control the implementation process with implementing regulations, inspections for regulatory compliance, follow up of contract compliance, and resolving conflicts with providers and among providers and beneficiaries.

Fee-for-service is an important payment mechanism in Vietnam. Fee-for-service gives an incentive for the health care provider to provide more treatments because payment is dependent on the quantity of care, rather than quality of care and that is why a strong monitoring system and medical review system are needed and are important to follow what is happening on the field. But VSS is not monitoring the expenses or behavior of the providers to avoid overexpenditure. Instead, simple administrative and financial data are used for making budget adjustments from year to year. A real medical review system is not in place either. VSS is reviewing medical records and receipts but has not real power to punish overuse of acts or overprescription of drugs.

With the amended Health Insurance Law of 2014, the implementation capacity of VSS will be improve. VSS will receive effective mechanisms of enforcement such as administrative punishment and criminal prosecution. But it is clear that VSS needs to move away from being a passive purchaser to become an active and strategic purchaser. For this, the roles and responsibilities of VSS and MOH need to be well defined to avoid institutional fragmentation, dual mandates and competition between these two institutions.
References


