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Public Health Insurance in Vietnam towards Universal Coverage: Identifying the challenges, issues, and problems in its design and organizational practices

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Midori Matsushima*

Assistant Professor, Osaka University of Commerce

Hiroyuki Yamada

Assistant Professor, Osaka School of International Public Policy (OSIPP)

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【Abstract】Vietnam is attempting to achieve universal health insurance coverage by 2014. Despite great progress, the country faces some challenges, issues and problems. This paper reviewed official documents, existing reports, and related literature to address: (1) grand design for achieving universal health coverage, (2) current insurance coverage, (3) health insurance premium and subsidies by the government, (4) benefit package and payment rule, and (5) organizational practices. From the review, it became apparent that the insurance system is broadly speaking complex and there are huge ambiguities, which seems hindering universal coverage of health insurance. Also, hidden distorted incentives and lack of financial stability are the main challenges in the current public health insurance system in the country.

* Address: 4-1-10 Mikuriyasakae-machi,Higashiosaka-shi, Osaka 577-8505, JAPAN

Tel/Fax: +81-(0)6-6785-6246 E-mail: midori@daishodai.ac.jp

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1. Introduction

Many emerging and developing countries are in the process of improving their public healthcare system while having made efforts in implementing health financing reforms. Some countries have been attempting to advance even further toward the ultimate goal of universal health insurance coverage[1]. Vietnam is no exception. Ekman et al. (2008) reported the progress of the government's attempt to expand the coverage of public health insurance in Vietnam. Since then, the Vietnamese government has placed further emphasis on this issue and it now has a grand design and time line to achieve universal health insurance coverage by 2014. Hence, various dynamic changes have occurred in the public health insurance system of Vietnam in recent years, especially, since the report by Ekman et al. (2008). From the experiences of advanced countries, designing a public health insurance system that is robust in the initial stage is crucial because an institution such as a health insurance system could become permanent and many advanced countries are now suffering from difficult public healthcare reforms in terms of how to contain increasing health-related expenses that jeopardize financial sustainability[2]. A study of the Vietnam case will therefore be educational for other developing and emerging countries as well.

This paper aims to review official documents, existing reports, and related literature to address the following issues: (1) grand design for achieving universal health coverage, (2) current insurance coverage, (3) health insurance premium and subsidies by the government, (4) benefit package and payment rule, and (5) organizational practices (insurance administration and health service delivery).

After the review, we identified at least six serious problems and challenges. First, "universal" coverage does not imply "fully compulsory" coverage of the targeted groups because many people are still uninsured even if they are defined as being in the "compulsory" groups. This is because they are supposed to pay the health insurance premium, but they do not. Second, as a result of the first point, there are many typical incentive problems, such as adverse selection and moral hazard, which are discussed in the literature of health and development

[1] According to the WHO (2012), Universal coverage (UC), or universal health coverage (UHC), is defined as ensuring that all people have access to necessary promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

[2] See Clements et al. (2012) for instance. WHO (2010) broadly discusses difficulties in health system financing.

economics. These problems appeared among people in the voluntary groups as well. Third, the current system is very complicated largely because the enrolment criteria are mainly based not on the individual but on the family. For instance, in order to determine the eligibility of an individual for the public health insurance scheme, the commune must be involved as well as several government bodies. Fourth, there are various ambiguities in the system. For instance, how to judge whether an individual is near poor in an agrarian economy in rural areas where harvested crops are for self-consumption. Fifth, the greater degree of autonomy of hospital directors with insufficient regulations and a fee-for-service (FFS) payment system could raise concerns over supplier-induced demand and financial sustainability of the health insurance system as a whole. Finally, given the current system outlined above and greater expansion of the compulsory group with subsidies, financial stability may be faced with major challenges in coming years.

Although our paper focuses on the health insurance system of Vietnam, we believe the findings obtained here are very helpful for other emerging and developing countries in designing financially sustainable and clear-cut health insurance systems. At the same time, our findings will provide some guidance to empirical researches on the utilization of formal public health insurance, behaviours of health facilities (and their workers), and financial sustainability.

The remainder of the paper is organized as follows. The next section overviews the economy and health situation of Vietnam. Section 3 reviews its health insurance policies between 1992 and 2014. Section 4 provides details of the health insurance system such as premiums, subsidies, and benefits. Section 5 discusses the organizational structure: from top to bottom. Concerns on financial stability are explored in Section 6 and conclusions are drawn in Section 7.

2. Background

Since the introduction of the economic policy "*doi moi"* in 1986, Vietnam has experienced rapid and continuous economic growth. Although the economic crisis, which started in 2008, had a negative impact on Vietnam by decreasing the GDP growth rate from 8.5% in 2007 to 5.3% in 2009, the Gross National Income per capita (PPP International dollars) has grown continuously (World Bank, Database). Moreover, the poverty rate is lower than economically more advanced neighbouring countries such as the Philippines, Indonesia and China.

Vietnam has made huge progress in its health profile as well as its economic growth. In 2011, life expectancy at birth was 75.2 years, which is longer than those in economically more developed nations in the region such as Malaysia, China, and Thailand. In the case of Malaysia, its Gross National Income per capita (PPP International dollars) is 4.5 times higher than that of Vietnam. Also, the under-five mortality rate (per 1,000 live births) was 24 in 2011, which is significantly lower than that of Indonesia and the Philippines (World Health Organization 2011).

Despite the great progress made in health profile, there has been growing concern regarding the people's burden on health spending. In Vietnam, the private health expenditure is significantly higher than that of the government. In 2009, the private health expenditure accounted for more than 60% of the total health expenditure (World Health Organization 2011). The problem is that a large portion of the private expenditure comes from households' out-of-pocket payment (OOP). According to Lieberman and Wagstaff (2009), more than 15% of Vietnamese people spent over 25% of their discretionary income on their health. Spending such a proportion of income creates vulnerability among sick people, and is claimed to be a major risk factor of income poverty[3]. In order to improve this situation, in 2009, the Vietnamese government declared the implementation of universal health insurance by 2014, and since 2010, the government has been working towards universal coverage with the Vietnam Social Security which is a government-affiliated agency responsible for implementing health insurance policy. Although the coverage rate has increased steadily, the government is currently facing challenges to reach the entire population due to issues surrounding the design of the scheme, organizational practice and health service delivery. Also, the government has to consider the sustainability of financing health insurance as the OOP has been the main income source of the health administration for years.

3. Overview of health insurance policies and insurance coverage (1992-2014)

3.1. Health insurance policies: 1992-2007

The foundations of Vietnam's health insurance system were established between 1992 and 1998 in order to achieve improved health of the people. Figure 1 presents the timeline and the roadmap of health insurance universal coverage.

[3] See Gertler and Gruber (2001) for instance.

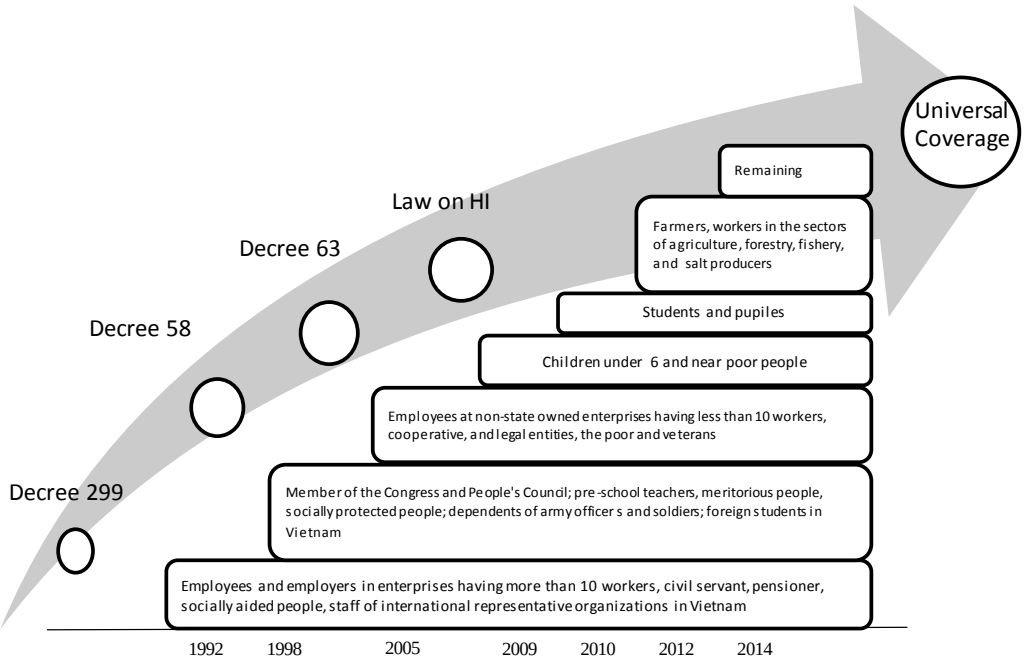

Figure1: Timeline and roadmap of universal health insurance coverage (Created by the author using information from Libermann and Wagstaff 2009, Tran et. al 2011, VSS 2010)

As the figure shows, Decree No.299/HDBT was issued by the Council of Ministers in 1992 aiming to cover workers at state owned and non-state owned enterprises with more than 10 workers, pensioners, socially disadvantaged people, and staff of international representative organizations in the country. In 1994, Decree No 95/1994/ND-CP was issued stating that the poor should benefit from user fee exemption, and are entitled to free medical treatment. The major success of this period was nearly 100% coverage of the target population. However, the failure was that user fee exemption for the poor caused huge difficulties for health facilities' finance because the government could not provide extra funding to health facilities to exempt patients from paying fees.

In 1998, the issue of Decree No 58/1998/ND-CP attempted to cover more people as a compulsory group including members of the Congress and People's Council, pre-school teachers, dependents of army officers and soldiers, foreign students, meritorious people, and socially protected people. As the policy for the poor, Circular No.05/1999 was issued in 1999, which legalized provinces to use their budget to enrol at least 30% of the poor in the compulsory health insurance scheme. In 2002, Decision No. 139/2003/QD-TTg introduced the

Health Care Fund for the Poor (HCFP) in every province in order to allow the poor and ethnic minorities to enrol in the health insurance scheme or to provide the poor with free medical treatment. However, this has created administrative problems. At the administrative level, it was difficult to identify the poor. Hence some of the poor were unable to enjoy the benefit (Tran et al. 2011).

To improve the health insurance system, in 2005, Decree No. 63/2005/ND-CP was introduced for the expansion of compulsory enrolment to workers of non-state owned companies with less than 10 employees. This also included the ethnic minorities and the poor who were entitled to benefits provided in Decision No. 39/2002/QD-CP. Hence, the user fee exemption for the poor including ethnic minorities was no longer implemented; instead, every poor person and ethnic minority was enrolled in the health insurance scheme. In 2007, Joint Circular No. 06/2007/TTLB-BYT-BTC was introduced, which was to guide the voluntary participation in the health insurance scheme. By this period, several impact evaluations had been conducted. As positive findings, researchers reported that the health insurance has reduced out-of-pocket payments and improved catastrophic payments (Sepehri et al. 2006, Wagstaff 2005, Wagstaff 2010). Despite these positive findings, challenges were also addressed. Sepehri et al. (2006) and Chang and Trevidi (2003) found that the utilization of healthcare centers and hospital length of stay have increased due to supplier-induced demand. Also, financial sustainability was indicated as one of the key challenges. The health insurance fund began to run at a deficit. That is why, in addition to economic development, the government was advised to create other means of collecting more revenues (Ekman et al. 2008, Liberman and Wagstaff 2009). Additionally, difficulties of expanding the coverage were addressed because of the registration systems being mainly individual based (Tran et al. 2011), and rural and informal workers are unwilling to join the insurance scheme (Ekman et al. 2008).

3.2. Health insurance policies (2008-2014) and the coverage rates

Despite the concern over financial sustainability, the government enacted the Law on Health Insurance in 2008, and it became effective in 2009, aiming to achieve universal health insurance coverage by 2014. Under the provision of the Law, children under 6 years old and the near poor became a compulsory group. Also, students and pupils, who used to be in the voluntary group, were included by January 2010. Additionally, farmers, workers in the sectors of agriculture, forestry, fishery, and salt producers are targeted to be included by January 2012. These

inclusions however, are expected to further increase the burden on finances. Also, as will be discussed later in more detail, the benefit packages remain broad and undefined.

Since 1992, the insurance coverage rate has increased significantly. In 1993, only 5.4% was covered, and by 2010, the figure had grown to 59.64%. Furthermore, the coverage rate is expected to grow even further after 2011.

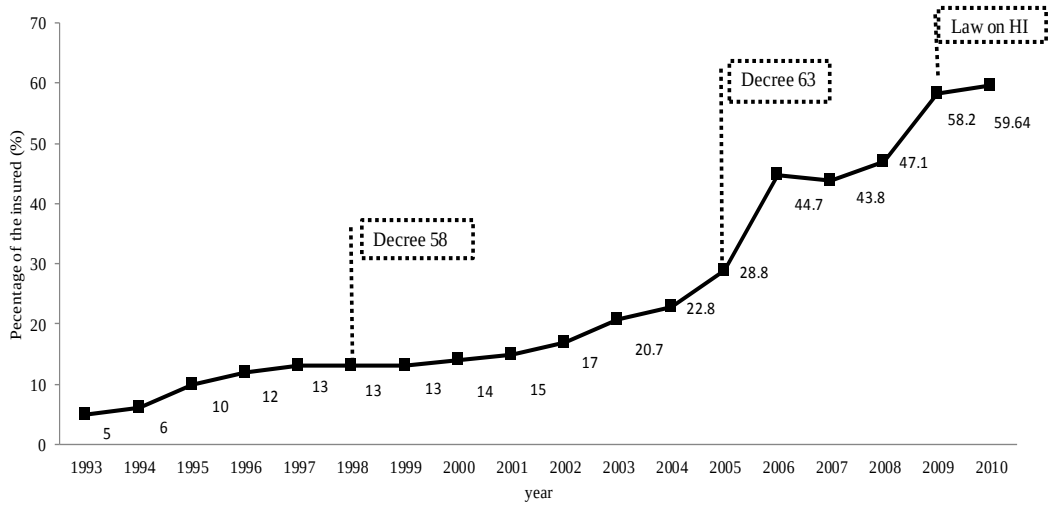

Figure2: Trend in health insurance coverage (1993-2010)
Created by the author using information from VSS (2010) and Tran et al. (2011)

When looking at the breakdown of the insured population, it becomes apparent that even compulsory groups are not fully covered. Employees of private enterprises have a low enrolment rate despite the existence of the Law on Enterprise. According to the law, the companies are responsible for registering employees contracted for more than 3 months in social security. Nonetheless, nearly 50% of enterprises fail to provide the health insurance to their workers. This is due to weak enforcement measures, collusion between employees and employers in reporting monthly salary and buying health insurance, and lack of knowledge on health insurance and its benefits (Liberman and Wagstaff 2009, Ha 2011).

Additionally, while the most vulnerable people are mostly covered such as the poor and recipients of social allowance, about 20% (1,920,000) of children under 6 years old remain uninsured even though their enrolment costs are fully paid by the state budget. Also, the

coverage rate for the near poor is only 11.38% even though the insured are eligible for at least 50% of subsidies.[4] Additionally, the coverage for the unemployed remains zero. Hence, there are still many vulnerable people left without health insurance.

Table1. Breakdown of the insured population in 2010

target groups	target populations (thousand)	covered people (thousand)	percent covered(%)
Total	***85,666***	***51,093***	***59.64***
Compulsory groups	***67,114***	***47,176***	***70.29***
employees of enterprises and other companies	11,911	6,361	53.40
civil servants	**3,142**	**3,142**	**100.00**
foreign students	**3**	**3**	**100.00**
part-time officers at communal level	182	0	0.00
pensioners	**920**	**920**	**100.00**
recipients of social allowances	**1,305**	**1,254**	**96.09**
unemployed people	80	0	0.00
local authorities	**41**	**40**	**97.56**
meritorious people	**2,113**	**2,113**	**100.00**
veterans	**374**	**350**	**93.58**
members of national assembly and people's council	**123**	**119**	**96.75**
privileged social groups	843	384	45.55
the poor	**13,945**	**13,511**	**96.89**
dependents of meritorious people	869	0	0.00
dependents of army and police officers	1,281	297	23.19
children under 6	10,103	8,183	81.00
near poor people	6,081	692	11.38
students and pupils	13,798	9,807	71.08
Voluntary groups	***18,552***	***3,917***	***21.11***
relatives of employees	6,820	0	0.00
farmers, self-employees, and members of cooperatives	11,732	3,917	33.39

Source VSS (2011) cited in Tran et al. (2011). Calculation was adjusted.

[4] In Vietnam, the poverty line is set by the government for a specific period of time depending on the socioeconomic situation at that time. During the past decade, the government adjusted the poverty line three times: in 2005, in 2009, and in 2011. The latest decision of the government in 2011 has set the poverty line as shown in the Table below.

Table. National poverty line for 2011-2015

	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

Note: VND400,000 VND is about 20 US$ (on 2/9/2012)

Source: Decision No 09/2011/QD-TTg

4. Design of health insurance scheme

This section examines the grand design of the health insurance scheme; mainly premiums, subsidies and benefit.

4.1 Health insurance premiums and subsidies

A different contribution rate applies depending on the enrolee's status. One of the fundamental issues is that the enrolment of the most compulsory schemes is not family but individual based. This increases the complexity for the enrolment criteria and process, which hinders the increase of the coverage.[5] Also, the complexity of the categorizations for premiums creates administrative difficulties. Currently, there are 7 different categories for the premium rate. By 2014, the number of categories will increase to 11. The rates of the premiums and subsidies are also shown in Table 2 below. These rates became effective on 1st January 2010 unless otherwise stated.

Table2. Health insurance premium rate (as of January 2010)

Category	**Rate**	**Subsidies**
Compulsory groups		
Formal sector workers, Officers	4.5% of monthly salary	No subsidies
Pensioners	4.5% of monthly pension	100% paid by the social security agency
People on working capacity loss allowance	4.5% of working capacity loss allowance	100% paid by the social security agency
Poor, Children under 6, Meritorious people, Near poor etc.	4.5% of the monthly minimum salary	100% subsidy by the government (Near poor receive at least50% subsidies from the government)
The unemployed	4.5% of unemployment benefit	100% paid by the social security agency
Pupils and students	3% of the monthly minimum salary	30% subsidy by the government

[5] According to Tran et al. (2011), during drafting of the Health Insurance Law, shifting from individual based enrolment to family based enrolment was suggested but the suggestion was not taken into consideration.

Voluntary groups		
Every voluntary participant	4.5% of the monthly minimum salary	No subsidies
**From 2014 all voluntary groups are included in the compulsory group*		
Household works in agricultural forestry, fishery industry (average living standard)	4.5% of the monthly minimum salary	30% subsidy by the government
Household works in agricultural forestry, fishery industry (near poor)	The prescribed rate for the first person; 90%, 80%, 70% of the premium rate applicable to the first person, for the second, the third and the fourth persons, respectively; 60% of the premium rate for the fifth person onwards.	No information
Relatives of employees whom employees have to look after and who live together with them in the same families	4.5% of the monthly minimum salary	No information
Relatives of employees whom employees have to rear and who live together with them in the same families (near poor)	The prescribed rate for the first person: 90%, 80%, 70% of the premium rate applicable to the first person, for the second, the third and the fourth persons, respectively; 60% of the premium rate for the fifth person onwards.	No information

Source: VSS (2010)

As observed in Table 2, the premium rate varies depending on which category each individual belongs to, and the subsidies for some people are not clear and complicated. In particular, the category of "Poor, Children under 6, Meritorious people, Near poor etc." includes 17 detailed specifications as shown in Table3.

Table3. Subdivision of poor, children under 6, Meritorious people, near poor etc.

1. People on monthly social insurance allowance for labour accident or occupational disease
2. People on monthly allowance from state budget
3. Commune, ward or township cadres who have stopped working and are on monthly insurance allowances/monthly allowance from state budget
4. People with meritorious service to the revolution

5. War veterans as defined by the war veteran law
6. People who personally participated in the anti-US resistance war for national salvation under the Government's regulations
7. Incumbent National Assembly deputies and People's Council deputies at all levels
8. People on monthly social allowance as prescribed by law
9. Poor household members; ethnic minorities living in areas with difficult or exceptionally difficult socio-economic conditions
10. Relatives of people with meritorious services to the revolution as prescribed by the law on preferential treatment toward people with meritorious services to the revolution
11. Relatives of in-service officers, career army men of the People's Army, non-commissioned officers and soldiers who are serving in the People's Army
12. Relatives of professional officers and non-commissioned officers and both officers and non-commissioned officers specialized in technical areas who are serving in the people's security force, non-commissioned officers and soldiers who are serving in the people's security force for a given period
13. Relatives of career officers and army men conducting cipher work in the Government Cipher Committee and those conducting cipher work and salaried according to the state payroll of People's Army officers or the state payroll of People's Army career men who are neither army men nor policemen
14. Children aged under 6 years
15. People who have donated parts of their bodies under the law on donation, taking and transplantation of tissues and human organs and donation and taking of cadavers
16. Foreigners studying in Vietnam who are granted scholarships from the Vietnamese State's budget
17. Members of households living just above the poverty line (near poor).

Source: VSS (2010)

Tran et al. (2011) also pointed out that these subdivisions mean that a multitude of ministries and agencies at different administrative levels are involved in the registration process. For instance, formal sector employers are responsible for ensuring their workers have health insurance, the Ministry of Labour Invalids and Social Affairs (MOLISA) is responsible for enrolling the poor, and other groups on benefits provided by the Ministry of Labour. The Ministry of Defence and the Ministry of Public Security are responsible for their workers. Moreover, the commune people’s committee is responsible for identifying children under 6, and so forth. Because enrolment is not family but individual based, various ministries need to be involved even just to enrol one family. For instance, formal sector workers are enrolled in the health insurance scheme by employers. However, housewives need to be identified as eligible

persons by the responsible ministry for enrolment in the voluntary insurance scheme. Moreover, if a couple has children under 6, the children need to be identified by the commune people's committees for their health insurance application.

These detailed subdivisions do not make the categorization easy. Rather, it makes it more difficult to categorize one person into the group when there is no clear guideline on which category should be treated as the priority. For instance, the unemployed are likely to be poor, but the unemployed and the poor receive subsidies from different agencies. Hence, clear guidelines and knowledgeable workers are essential.

Compulsory groups are required to pay the premiums every month. The voluntary enrolees can choose to pay every 6 months or annually. For the first time, the enrolees have to wait 30 days for the insurance to be valid for the basic treatment and 180 days for technologically advanced medical treatment. Once the insurance becomes valid, the continuous payment allows people to receive the benefit whenever they have medical treatment. However, when the insured fails to pay on the due date, he/she can only use the health insurance card 30 days after the date of payment, and has to wait 180 days to be able to use the insurance for technologically advanced medical treatment (VSS 2010).

4.2 Benefit

The current benefit package is regulated based on the Social Health Insurance Law 2008. Before the introduction of the law, there was already a claim that the benefit was too broad, undefined and unappealing (Ekman et al. 2008). And, the problems have seemed to be inherited to the Social Health Insurance law 2008.

4.2.1 Benefit for the basic treatment

The insurance is effective when the insured are provided with medical care at the community health center or district hospital where they are registered, or higher level health facilities to which they are have been referred. Patients can choose to register at which community health center or district hospital they wish to be treated within the given options by the government (Ministry of Health 2009). If the insured preferred to be treated in other commune health centers or district level hospitals, the insured have to pay the hospital directly, and the OOP will be reimbursed later at their place of residence except in emergency cases. In the case of an emergency, the treatment will be given for free. People can also use private clinics with limited benefit from the health insurance scheme.

When the insured receives medical care at the registered health facilities, different benefits apply depending on the category of the insured. Because the co-payment system has been in place since January 2010, not all insured people can receive free medical consultation and treatment, yet the insurance covers at least 80% of the medical cost (see Table 4). For the people who are not covered for 100%, they have to pay the rest directly to the hospital (VSS 2010).

Table4. Benefit for basic medical services

For basic medical care services		
100% medical consultation and treatment costs	95% of medical consultation and treatment costs	80% of the costs
●Specialized technical officers ●Specialized technical non-commissioned officers ●Professional officers ●Professional non-commissioned officers of the People's Public security ●Meritorious persons ●Children under 6	●Persons on pension or monthly working capacity loss allowance ●People on monthly social welfare allowance as prescribed by law ●Poor household members; ethnic minorities living in areas with difficult or exceptionally difficult socio-economic conditions	●Other categories of the insured

*Ministry of Health coordinates with Ministry of Finance to adjust the level when there is a change in minimum wage

Source: VSS (2010) Source: VSS (2010)

The transportation cost is also covered by the health insurance in accordance with Circular 09/2009/TTLT-BYT-BTC when the patients need to be transferred to another hospital with a higher technical level in the same administration area due to emergency or technical reasons. Nonetheless, these merits are limited to eligible persons, children under 6, people on monthly social welfare allowance, the poor, ethnic minorities living in difficult socio-economic conditions and the near poor (VSS 2010).

When the insured receive the medical treatment at a non-primary care provider or non-affiliated hospitals of primary care providers determined by the Ministry of Health (except for emergency cases), the cost will only be covered within the scope of their entitlement defined in Article 21 of the Law on Health Insurance depending on the grade of health facilities. The grade is determined based on the level of services and facilities, which are announced by each provincial health department. Grade-I is the hospital with the best quality services followed by grade-II, and grade-III. For grade-III, 70% of the medical costs will be covered. For grade-II, 50% of the medical costs will be covered, and for grade-I, 30% of the medical costs will be covered. At any medical treatment facilities, for each use of technologically advanced medical treatment, the ceiling is defined as 40 months of the minimum monthly salary (VSS 2010).

4.2.2 Benefit for technologically advanced medical services

According to government Decision No. 36/2005/QD-BYT, there are 177 technologically advanced medical services including dialysis, transplants, certain types of cancer treatment and cardiovascular operations etc. In practice, many technologically advanced medical services are related to severe illnesses. Without treatment, such illnesses could be fatal.

For technologically advanced medical services, the regulation is even more specific, and the ceiling applies to all insured people. Children under 6, revolutionary activists prior to 1st January 1945, revolutionary activists between 1st January 1945 and 19th August 1945, Vietnamese hero mothers, war invalids and beneficiaries of policies for war invalids, class-B war invalids, disabled soldiers who have lost 81% or more of their working capacity, ill /injured soldiers are treated for free when these patients are treated for recurring illnesses and diseases (VSS 2010).

Pensioners and people on monthly working capacity loss allowance, people on monthly social welfare allowance as prescribed by law, poor household members, ethnic minorities living in difficult socio-economic conditions are covered for 95% of the costs. Other insured people are covered for 80% of the costs.

For any costly technologically advanced medical treatment, there is a ceiling on the maximum benefit for the treatment of each episode, and the ceiling is defined as 40 months' minimum salary. (VSS 2010, Tran et al. 2011). In 2012, the minimum salary is between VND1.4 million to 2 million depending on residential area (Decree No. 70/2011/ND-CP). Hence, the ceiling is equivalent to US$ 2,682.8 to US$ 3,838.8 (US$1=VND 20,865.50). Because of this ceiling, technologically advanced treatment could cause extremely high OOP expenditure.

4.2.3 Drugs

Many drugs are covered based on Decision No.5/2008/QD-BYT issued in 2008. Patients can obtain these drugs at the health facilities at which they are registered by reimbursement. The list includes 750 medicines and 237 traditional herbal medicines. Although the long list of reimbursed drugs is in generally beneficial to the insured, there are a few concerns. Firstly, the list is not created from a cost effectiveness perspective, and some drugs that are rarely used even in highly developed countries are very expensive. Secondly, there is no monitoring or regulation of drug price. Hence, price setting of drugs is left to the discretion of the hospital, which often leads to high drug prices. Thirdly, hospitals often lack drug stocks. Since reimbursement of drugs only applies to the purchase of drugs in the hospital where the insured are registered, there are many cases in which patients cannot obtain the drugs that they need. When patients purchase drugs from a private pharmacy, the cost must be covered by the OOP.

4.2.4 Non-eligible cases

There are 17 cases that are not eligible for health insurance coverage as indicated in Table 5. The cost for medical check-ups or medical examinations is not covered apart from screening tests for the early diagnosis of some cancers because the government provides preventive care for free to everyone regardless of whether they are insured or non-insured.

Table5. Non-eligible cases

1. Cases in which costs are paid by the state budget
2. Convalescence at sanatoria or convalescence establishments
3. Medical check-up
4. Prenatal tests and diagnosis for non-treatment purposes
5. Use of obstetric supportive techniques, family planning services or abortion services, except for cases of discontinuation of pregnancy due to fatal or maternal diseases
6. Use of aesthetic services
7. Treatment of squint, short-sightedness and refractive defects
8. Use of prostheses including artificial limbs, eyes, teeth, glasses, hearing aids or movement aids in medical examination, treatment and function rehabilitation
9. Medical examination, treatment and function rehabilitation in the case of occupational diseases, labor accidents or disasters
10. Medical examination and treatment in the case of suicide or self-inflicted injuries
11. Medical examination and treatment for addiction to drugs, alcohol or other habit-forming substances
12. Medical examination and treatment of physical or mental injuries caused by the law-breaking costs
13. Medical assessment, forensic examination, forensic examination, forensic mental examination
14. Participation in clinical trials or scientific research
15. Work injuries within the payment scope of employers according to legal regulation on work accidents
16. Traffic accidents due to breaching of the law and others traffic accidents that are covered by work injury scheme
17. Extra medical service costs (include medicines, medical materials, medical service) upon request of the patient

Source VSS (2010)

Tran et al. (2011) shows some concern over these non-eligible cases, especially in the treatment for traffic accidents. This is because the patients have to prove that the accident was not a law violating act, which is rather difficult. When one is injured due to a traffic accident, firstly the patients have to pay at the hospital, and the OOP will then be reimbursed later if the patients can obtain an official statement issued by the police to prove that they did not violate the law, which is required by the regulation, Inter-ministerial Circular No. 09/2009/TTLT-BYT-BTC. It is reported that many patients fail to obtain reimbursement because

the official statement lacks information to prove their right to be covered by the health insurance (Tran et al. 2011). In Vietnam, traffic accident is one of the leading causes of death, recording about 15% per 1,000 deaths from traffic accidents in 2007 (World Health Organization, Database). [6] Taking this situation into consideration, difficulty in using health insurance for traffic accident injuries is an issue to be reviewed.

As was seen, the benefit package is broad when it comes to basic treatment; however, technologically advanced services and non-eligible cases are subject to detailed regulations. If the patients cannot fully understand these regulations, they will not receive the maximum benefit. Instead, this could work in the hospital's favour by increasing their revenues through the provision of technologically advanced medical services unnecessarily or prescribing expensive drugs. When a hospital abuses the system, the patients would perceive the health insurance as not providing attractive benefit, which hinders universal coverage.

5. Organizational practices

5.1. Administration

In order to achieve universal coverage, administrations need to be effective. The VSS is a governmental policy implementing agency. For the health insurance, the Ministry of Finance and the Ministry of Health take the initiative with the government. Under the VSS, there are provincial social security offices followed by district social security offices. Under the provision of district social security offices, pay-agents and collection agents are employed. In order to give advice on management, provincial health departments of MOH work together with provincial social security offices. District-level health facilities are also expected to cooperate with provincial and district social security offices.

[6] Death from traffic accident is defined as death within 24 hours of the crash.

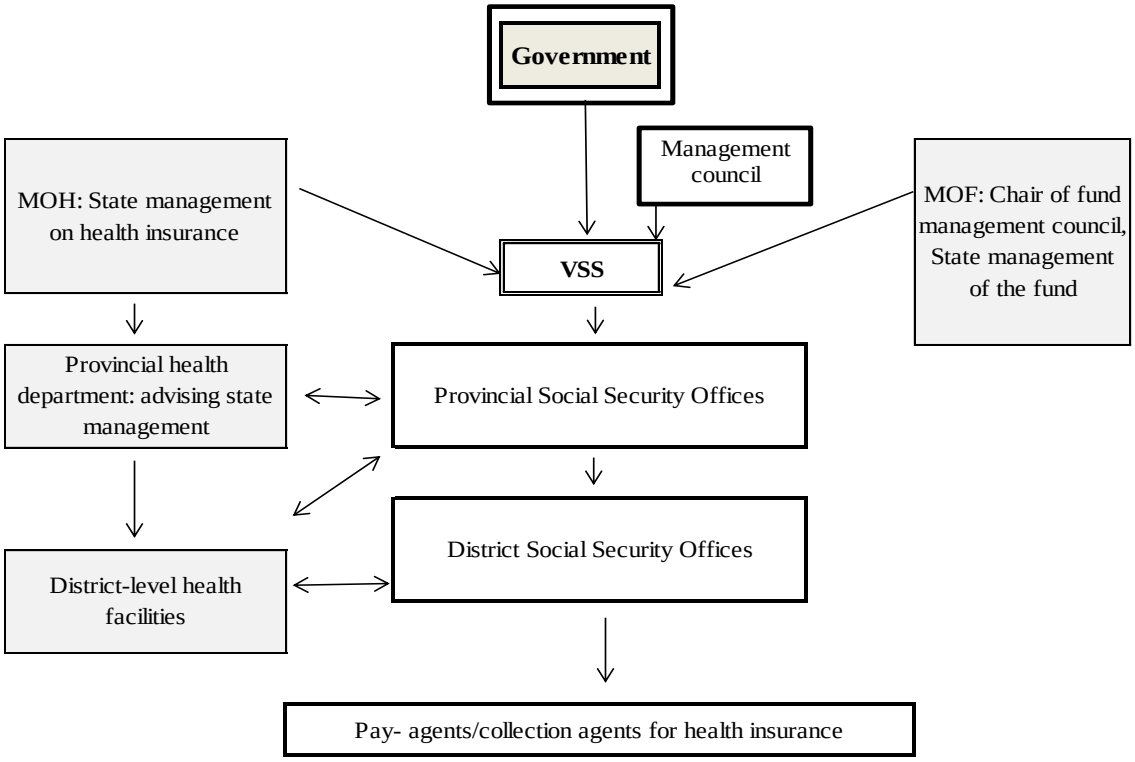

Figure3. Organizational structure of Vietnam social security
Source: Created by the author using information from VSS (2010) and Ha (2011)

However, there is no clear explanation on the more detailed role of each office. In particular, the problem of information dissemination has been reported. It is reported by the Ministry of Health (2011), cited in Ha (2011), that more than 30% of heads of households answered that they do not know about the Health Insurance Law, and more than 90% of heads of households are unaware or have little knowledge about premium rates. Nguyen (2008) also reported the under-utilization in health insurance due to lack of knowledge on the usage of health insurance.

5.2. Health service delivery

In Vietnam, hospitals enjoy great autonomy, which appears to have created some unfavourable situations for the insured. In 2006, Decree No. 43/2006/ND-CP was issued, which gives a hospital director even greater autonomy including financial management, human resource management, service delivery and even treatment fees within a band. The director can decide additional salary, bonuses and allowances for the workers within the 71% of net revenue as well as hiring and promoting workers. Consequently, a hospital (and potentially hospital workers) has a higher incentive to sell their services at a higher price. Because many hospitals now have more technologically advanced medical equipment due to joint ventures with the

private sector, they can provide more technologically advanced medical treatment that brings about greater profit to the hospitals and recovers the installation cost of such equipment. In practice, unnecessary highly technological treatments are frequently reported as in Ha (2011), and Liberman and Wagstaff (2009). This is a typical problem of supplier-induced demand, which has already been discussed in the context of the evaluation of the Vietnamese health insurance.

Additionally, hospitals prefer fee-for-service (FFS) payment to capitation or Diagnostic-Related Group (DRG) payment for the health insurance because they are allowed to set the prices for their services.[7] Even if it is regulated as "within a band", it leads to higher prices especially in areas where the public can afford the payment or where there is no competition. Consequently, the poor suffers more. Liberman and Wagstaff (2009) point out that the VSS only plays a passive role as payers of bills, and does not represent the insured. Moreover, neither the VSS nor the state plays a supervisory role in the quality assurance of the hospital even though there are reports such as Long (2008) that patients have to pay indirect costs such as underhanded payments in order to obtain quicker treatment. Hence, the patients are left alone in a vulnerable position and normally ignorant regarding medical treatment.

Therefore, as an organizational practice, both the insurance administration and service deliveries have serious problems. In particular, both supplier-induced demand and FFS pose a further challenge to the financial sustainability of Vietnam's health insurance system in coming years.

6. Financial Sustainability

In many countries with universal health insurance coverage, financial sustainability is an issue. Although the economic development of Vietnam continues to create higher tax revenue, deficit of the health insurance fund has continued (Ha 2011). In 2009, according to Ha (2011), the balance between contribution income and benefit payment was VND 2,415 billion, which is a significantly larger deficit than that of 2008. To our knowledge, the government has not yet proposed how it will sustain the health insurance system financially. Nevertheless, as the country heads towards achievement of universal coverage, the financial situation is expected to become worse. People who are now enrolled in the voluntary health scheme do not receive any subsidies. However, when they become included in a compulsory group within 2 years, part of

[7] The FFS is applicable to both outpatients and inpatients, and the regulation is relatively weak. Fee is determined for each service by relevant state agencies taking into account the capacity of the hospital in terms of their techniques and ability of residents to pay for the treatment. Capitation is paid by the health insurance fund every month per enrolled patient regardless of the number of treatments and treatment types. The calculation for the capitation is based on the expenditure of the previous year. The DRG is applied to patients with acute pneumonia for adults or children, appendix operation, and normal delivery. There are only two hospitals piloting this system, and Tran et al. (2011) reports that there are no plans for further expansion of this payment system.

their premiums will be covered by the government or social security agency. Indeed, the public health-related expenditure has already started increasing, especially, in recent years. Figure 4 shows the time series of public health expenditure in terms of percentage of GDP and the total government expenditure, respectively. Clearly, the public health expenditure is already on an increasing trend. In particular, the public health expenditure increased about 1 percentage point in terms of GDP during the past decade. The government's health related expenditure relative to the total government expenditure increased greatly in the past few years, implying other expenditures are being squeezed out. Containing public health expenditure while keeping OOP low is apparently a major challenge for Vietnam.

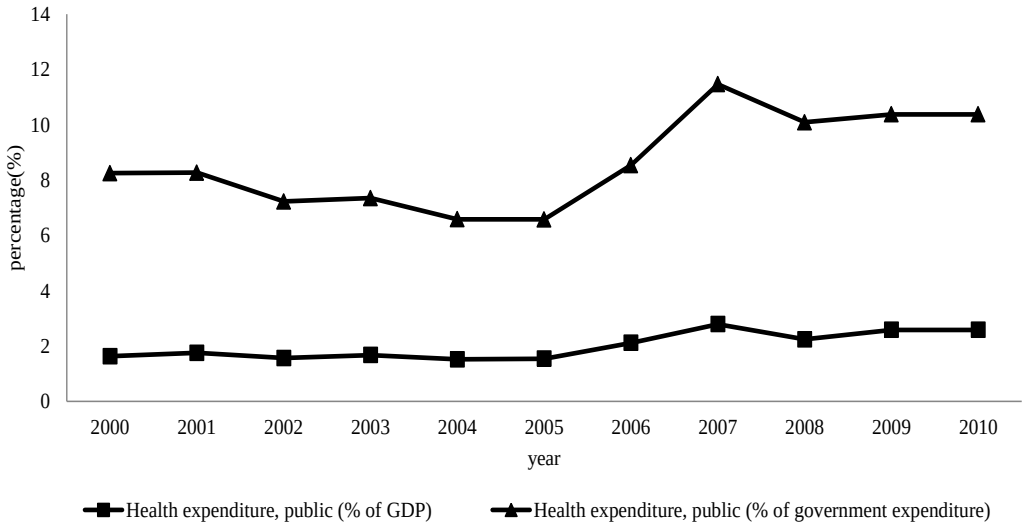

Figure4. Public health expenditure in Vietnam
Source: World Development Indicators (World Bank, Database)

7. Conclusion and suggestions for further research

The purpose of this paper is to review official documents, existing reports, and related literature to study Vietnam's attempt at universal coverage of public health insurance by 2014. To this end, we reviewed the current system and its plan toward 2014 and identified the issues to be addressed in order to provide a better public health insurance system. We found, broadly speaking, complexity and ambiguity, hidden distorted incentives, and financial stability are the main challenges in the current public health insurance system. If these problems are not addressed at the early stage of designing the insurance system, the challenges will continue in coming years because an institution, such as a health insurance system, could be permanent and the hysteresis effect could come into play.

Although our work is figurative, it does provide some guidance to empirical researches on the utilization of formal public health insurance, behaviour of health facilities (and their workers), and financial sustainability.

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