REACHING A UNIVERSAL HEALTH INSURANCE IN VIET NAM: CHALLENGES AND THE ROLE OF GOVERNMENT

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Given the level of economic development in Viet Nam, the country's health sector is quite impressive. The country has now set its sights establishing universal health insurance coverage by 2015. This article aims to, first, describe the current health-care system in Viet Nam accompanied by a number of challenges the country faces in delivering and financing health-related services, and then provides some policy discussions on how to achieve this ambitious plan. The article also stresses the important role in attaining universal health insurance coverage by providing quality services and guaranteeing financial protection for both health-care suppliers and consumers.

JEL classification code: I14, I18.

Key words: Health-care system, universal health insurance, Viet Nam.

I. INTRODUCTION

The implementation of the *Doi Moi* (renovation) programmes about 20 year ago has transformed Viet Nam from being one of the poorest countries in the world in the late 1980s to a low middle-income country since 2008. The average gross domestic product (GDP) growth rate was about 7.4 per cent during 1991 to 2010, and this, in turn, has helped boost GDP per capita from $98 in 1990 to $1,170 in 2010. Also, thanks to this remarkable economic growth, the national poverty rate decreased significantly from 58.1 per cent in 1993 to about 9.5 per cent in 2010. Along with

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these remarkable social and economic achievements, great strides have been made in the country's health sector, in which the health outcomes are similar to those of high-middle income and advanced countries in many aspects. The Vietnamese now enjoy a healthier and longer life, which, in turn, has lifted the country into the ranks of medium human development countries, placing 113 out of 169 countries in the world in 2010 (UNDP, 2010). The Government recently announced its plan to achieve universal health insurance coverage by 2015. This plan entails: strengthening the health-care system, extending delivery of health-care services to all people and improving the quality and contents of health-care packages offered by both public and private health providers to insured beneficiaries. By 2010, health insurance coverage had reached 62 per cent of the total population or about 53 million persons. Under current regulations, the compulsory health insurance scheme covers people working in the formal sector, as well as specific groups of the population (including the poor, children under six years of age and veterans). As indicated in the Health Insurance Law enacted on 1 January 2007, coverage will be gradually expanded to the rest of the population until universal coverage is reached: first to all students, then to the "near-poor" (who are not poor, but his/her household per capita expenditure is less than 125% poverty line), and finally to all workers in the informal sector. This is expected to be completed by 2015.

Several challenging issues must be dealt with in the transition towards a universal health insurance system, including the delivery and financing of health-care services.

With regard to delivery, achieving such an ambitious policy goal will largely depend on the ability to extend the existing voluntary health insurance scheme to people working in the informal sector. In other words, making health insurance compulsory for all Vietnamese. Notably, in the past years, few of the people working in the informal sector have voluntarily joined the health insurance system, and based on this alone, reaching the goal of universal health insurance coverage by 2015 will require a change in mindset among informal workers and non-working family members towards health insurance.

In addition, achieving universal health insurance coverage will also require dealing with financing issue. By 2008, health insurance revenue represented less than 1 per cent of GDP, and health insurance covered only 13 per cent of total health expenditure (Viet Nam, 2007). Other financing sources for health expenditure, particularly from public ones, remain stable and low. As such, out-of-pocket (OOP) spending consequently remains high. Increasing public spending on health to encourage participation of informal workers and their dependents will expand the coverage of health insurance as well as help relieve financial constrains in the longer term.

The main objective of this paper is to describe the current state and challenges of the health-care system in Viet Nam with a special focus on financing and delivery of services through health insurance, and to provide some policy suggestions to deal with issues related to the goal of achieving universal health insurance by 2015. The paper is organized as follows. In the next section, we will provide an overview on the development of the Vietnamese health-care system, with a discussion on its current state and the challenges in financing and the delivery of services. The third section will provide an analysis of the delivery patterns of health-care services through health insurance. The paper will also discuss financial requirements for reaching a universal health insurance with simulation results from Lieberman and Wagstaff (2008). The final part will provide concluding remarks.

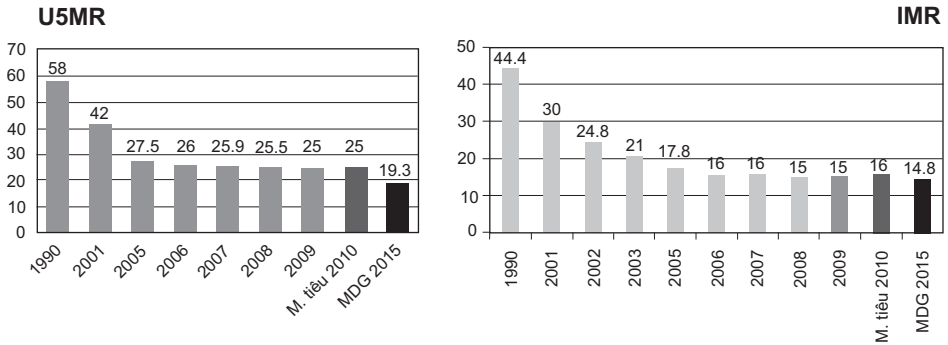
II. HEALTH-CARE PERFORMANCE, SERVICES DELIVERY AND FINANCING IN VIET NAM

The health sector has received special attention from the Government, in particular the Ministry of Health (MOH), which has instituted a number of policies, guidelines, and regulations to strengthen the health system and improve the health of the Vietnamese people. This section briefly presents several main health policies which aim to deliver efficient and financially viable health care services.

Performance of health sector and challenges

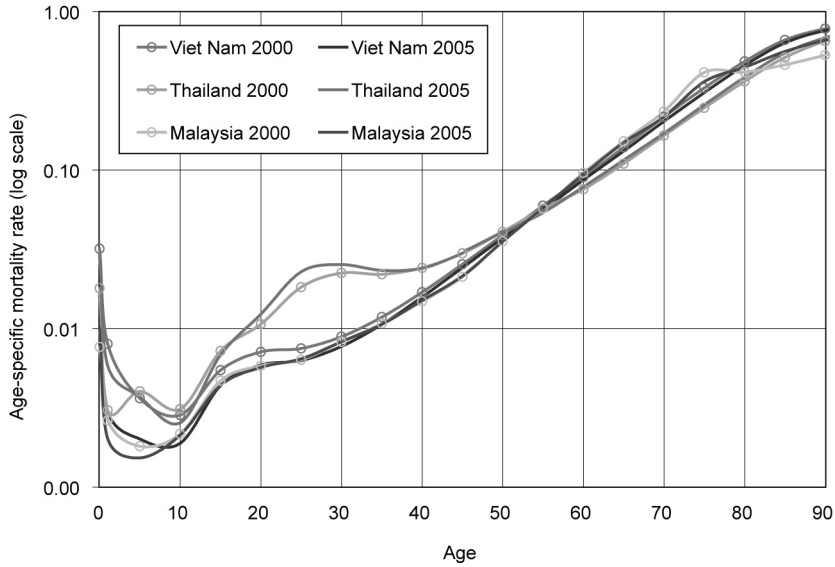
Among the eight Millennium Development Goals, three are related to basic health indicators, including reduction of child mortality; improvement of maternal health, and tackling of HIV/AIDS, malaria, and other diseases. As assessed by a number of studies, such as Adams (2005) and WHO (2009), Viet Nam has achieved certain successes along the pathway towards the Goals. Viet Nam has achieved most of the Goals during the period 2006 to 2010. For instance, in 2009, the maternal mortality rate (MMR) reached 75 per 100,000 live births in comparison with 233 per 100,000 live births in 1990; under-five child malnutrition rate was 20.6 per cent, which is close to the target of 20 per cent by 2010; and under-five mortality (U5MR) and infant mortality rate (IMR) per 1,000 live births reached 25 and 15, respectively, attaining the targets of 25 and 16, respectively, by 2010 (figure 1).

Figure 1. U5MR and IMF in Viet Nam, 1990-2009



Source: Ministry of Health (various years)

Figure 2. Trends in age-adjusted mortality: Viet Nam, Malaysia and Thailand



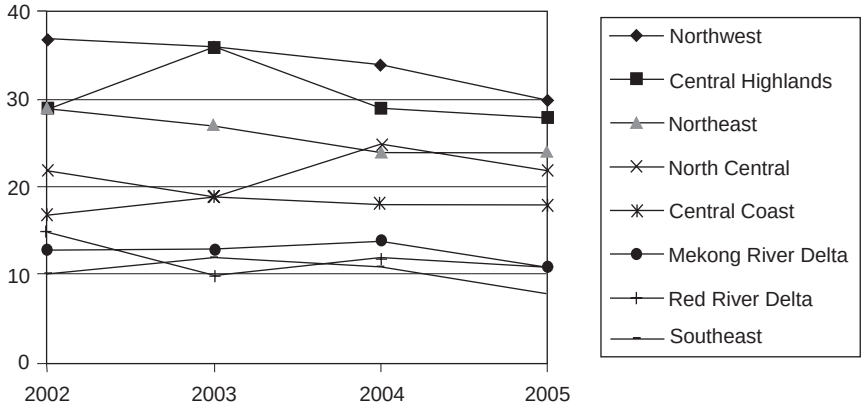
Source: WHO Life Tables for Member States, as quoted by Lieberman and Wagstaff (2008).

Viet Nam has also done well in terms of child mortality, in which there has been a rapid reduction in comparison with Malaysia and Thailand – two Asian countries with significantly higher per capita incomes than Viet Nam. Unlike Thailand, which saw rising age-specific mortality rates at some ages between 2000 and 2005, and Malaysia, where the decline in age-specific mortality appeared to have stagnated,

Viet Nam saw reductions in age-specific mortality at all ages between 2000 and 2005. Also, Viet Nam's age-specific death rates compared favourably with those of Malaysia across the full range of ages (figure 2). In accordance with a number of other studies, Lieberman and Wagstaff (2008) show that such impressive achievements in the health sector are results of a widely-covered grass-roots health system in Viet Nam focusing on various preventive health-care services.

However, a number of critical challenges need to be responded to if Viet Nam is to continue its above-mentioned achievements. First, there are wide gaps and notable variations in IMR by region. For instance, in the three regions with the highest IMRs, an infant has a probability of dying before reaching his or her first birthday about two and a half times higher than an infant in the three regions with the lowest IMRs (figure 3). Particularly high IMR has been observed in certain provinces. In the period 2005 to 2008, the highest IMR incidence was in Kontum (62.6 per cent in 2005; 48 per cent in 2008); Ha Giang (55.8 per cent and 40.0 per cent, respectively); Lai Chau (44.0 per cent and 33.0 per cent, respectively). These provinces experienced an IMR of about 5 to 6 times as much as developed provinces, such as Hanoi (7.9 per cent and 7.0 per cent, respectively) and about 2 to 3 times as much as the national average (17.8 per cent and 15.0 per cent, respectively). Such a disparity could be explained in large part by differences in the level of development among the regions in such factors as income, education, infrastructure and availability of services.

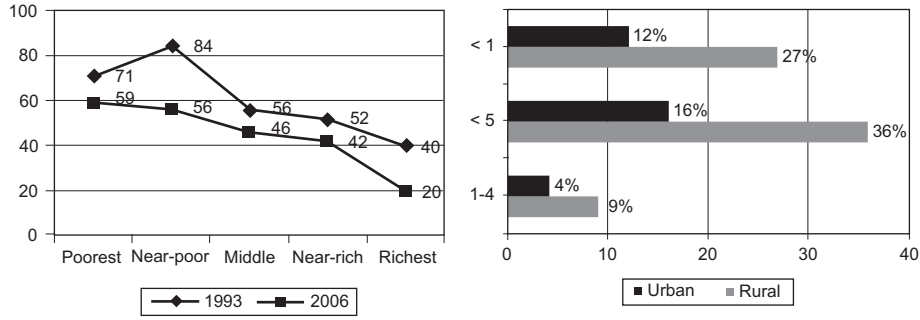
Figure 3. Regional differences in IMR



Source: Hayes and others (2009).

Significant differences in IMR have also been observed between income groups and rural and urban areas. The gaps in IMR between the poorest and richest groups, and between rural and urban areas have widened (figure 4). This situation indicates that persons from rural areas and with low incomes will have difficulty in overcoming the high incidence of IMR, which in turn, will have a negative impact on their human development.

Figure 4. Differences in IMR between income groups and rural and urban areas



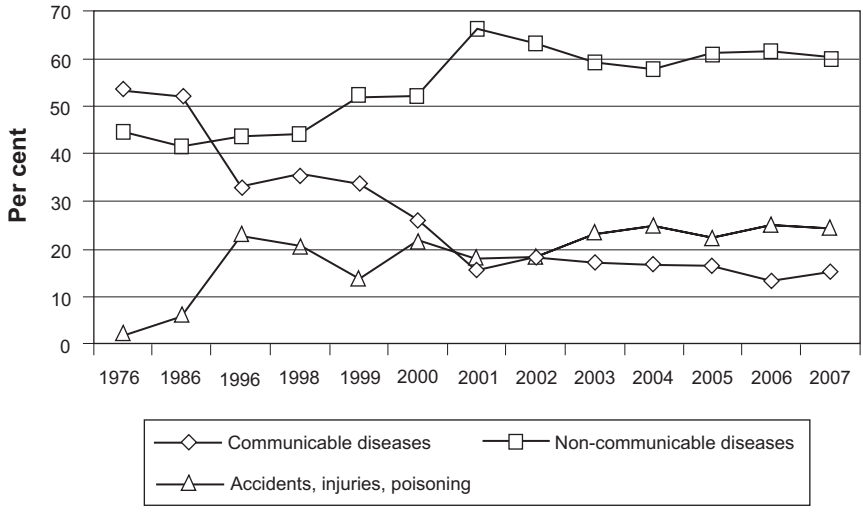
Source: UNICEF (2008).

Second, another great challenge is that the structure of causes of death has also changed (figure 5). The population is going through a so-called "epidemiological transition", with communicable infectious diseases being replaced by non-communicable chronic degenerative illnesses as the major causes of death. In 1976 and 1986, the communicable diseases still accounted for more than 50 per cent of such deaths, but by 2000 they accounted for less than 30 per cent of such deaths, and today the figure is less than 20 per cent. At the same time, the non-communicable diseases rose from less than 50 per cent to about 60 per cent of these deaths. A striking increase in accidents, injuries and poisoning are some of the increasing important issues concerning illness and death in Viet Nam today. As Hayes and others (2009) argued, such changes are due to swift socio-economic changes, which result in lifestyle-related causes of death.

Services delivery and challenges

The health-care network has wide coverage, in which most communes have health care stations. In terms of human resources providing health care, health workers are available in all communes and wards. In 2008, 65 per cent of communes

Figure 5. Causes of death reported in public health facilities, 1976-2007

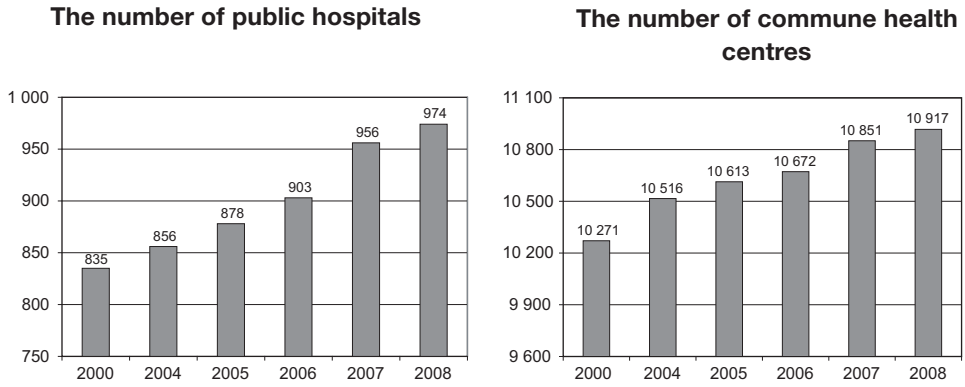


Source: The Ministry of Health, Health Yearbooks 2001-2007, as quoted by Hayes and others (2009)

had doctors, and 87 per cent of villages had health workers or staff. The number of public health establishments has increased over time. During the period 2000 to 2008, the number of public hospitals increased from 835 to 974, and the number of commune health centres increased from 10,271 to 10,917 (figure 6). The number of doctors and nurses in public medical hospitals and stations also increased significantly. Figure 7 shows that the number of doctors and nurses increased by about 46 per cent and 41 per cent, respectively, during the period 2000 to 2008. The growth rate of medical staff was much higher than the growth rate of the population. As a result, the average number of doctors and nurses per 100,000 people increased remarkably between 2000 and 2008 (figure 7).

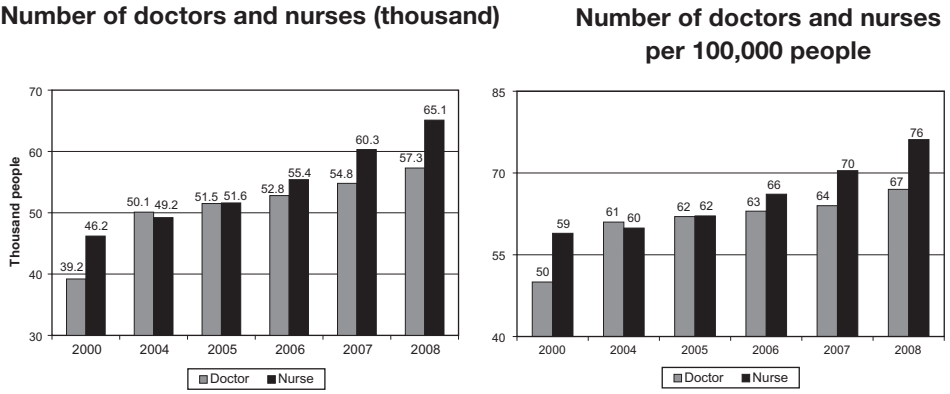
However, there are a number of challenges that the Vietnamese health-care system has been facing in terms of delivery. First, there is a variation in the number of public health establishments and medical staff across regions (table 1).

Figure 6. Public health establishments



Source: Viet Nam, General Statistical Office (various years).

Figure 7. Doctors and nurses in public establishments



Source: Viet Nam, General Statistical Office (various years).

Table 1. Public health establishments and medical staff

Regions	Number of public health establishments and medical staff				Number of public health establishments and medical staff per 100,000 people			
	Commune centres	Hospital	Doctors	Nurses	Commune centres	Hospital	Doctors	Nurses
Red River Delta	2 546	170	9 764	23 621	13.7	0.92	52.6	127.4
North-East	2 434	155	6 160	17 495	25.2	1.61	63.8	181.3
North-West	736	46	1 329	6 263	27.6	1.73	49.9	235.0
North Central Coast	2 043	108	4 912	15 871	18.9	1.00	45.5	147.0
South Central Coast	1 023	88	3 930	10 741	14.1	1.21	54.2	148.1
Central Highlands	823	67	2 402	7 330	16.4	1.34	48.0	146.5
South-East	1 259	127	8 288	20 349	8.6	0.87	56.8	139.4
Mekong River Delta	1 806	154	7 886	23 241	10.2	0.87	44.6	131.3
All Viet Nam	12 670	915	44 671	124 911	14.7	1.06	51.8	144.9

Source: Viet Nam, General Statistical Office (various years).

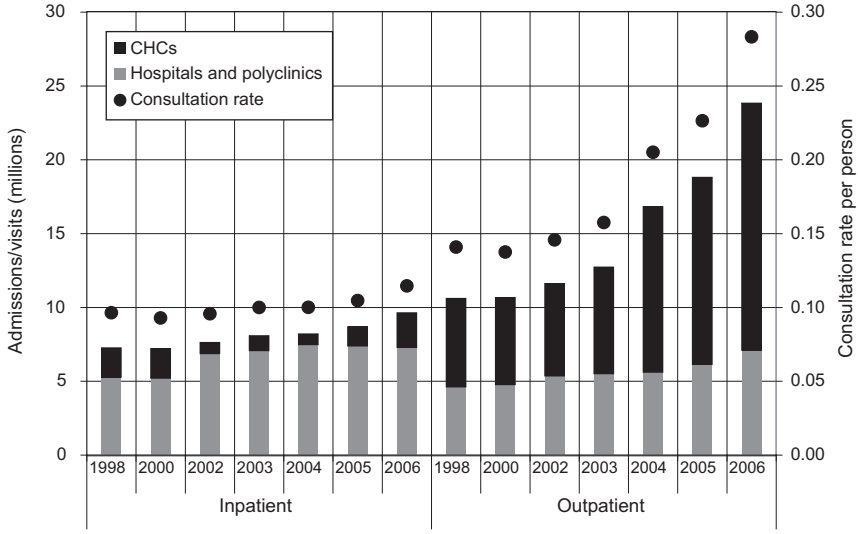
Although the number of public health establishments and medical staff is higher in regions with large populations, such as the Red River Delta and the Mekong River Delta, the number of public health establishments and medical staff per 100,000 people is higher in poor regions with small populations, such as the North-East and the North-West. Similar trends are also found at the provincial level (Nguyen, 2010). This reflects various pressures on delivery of health-care services in regions and provinces with high population density in terms of providing adequate and quality care to people.

Another issue related to the availability of health-care services is the concentration of health centres where people can go for treatment. As shown in the report by the Ministry of Health and Health Partnership Group (Viet Nam, 2007), due to the low quality of health care at communal health centres, people usually choose to go to district and provincial hospitals for better treatment. This, in turn, creates overcrowding in these types of hospitals. In addition, as few communes are located near district and provincial hospitals, people have to travel long distances to the nearest hospital. Using data from the Viet Nam Household Living Standard Survey (VHLSS) 2008, Nguyen (2010) estimates that the average distance from commune centres to the closest district hospital in the rural areas is 13.3 km, 22.5 km and 15.6 km for North-East, North-West and Central Highlands, respectively. The distance to the provincial hospital is much longer, about 39.3 km. Travelling such a long way might be a factor preventing people living in disadvantaged areas to get

good treatments. As such, improving the quality of care at communal health-care centres is critical to increase people's utilization and access to good health-care services.

Second, biases in inpatient admissions and outpatient visits remain persistent over time. Hospitals increased the number of outpatient visits and inpatient admissions by an average of 5 per cent annually (figure 8), but communal health centres tended to reduce the inpatient admissions. Nevertheless, in the same period, communal health centres experienced a dramatic increase in outpatient visits, at an average of 13 per cent growth per year. In comparison with developed countries, inpatient admission rate in Viet Nam is not much different, but its outpatient visit rate is much lower. This implies that the current health-care system in Viet Nam is heavily biased towards inpatient care, and this is due to the poorly developed primary care system.

Figure 8. Inpatient admissions and outpatient visits, 1998-2006



Source: Viet Nam, Ministry of Health (various years), as quoted in Lieberman and Wagstaff (2008).

Analysing both inpatient admissions and outpatient visits by various population groups also helps to provide more understanding of the accessibility of people to health-care services. The access to health care services is reflected by health care visits (table 2). Table 2 presents the percentage of people using inpatient and outpatient services in different types of health care centres in 2008. It shows that

older persons visit medical establishments for both inpatient and outpatient care more frequently than do younger persons. Females tend to have more visits to health centres for outpatient care than do males, but this is converse for the case of inpatient care. Also, people in disadvantaged groups maintain lower utilization rates for both inpatient and outpatient care than do other groups. In particular, the poor, ethnic minorities and people living in mountainous regions use inpatient and outpatient care services less frequently than other groups of people.

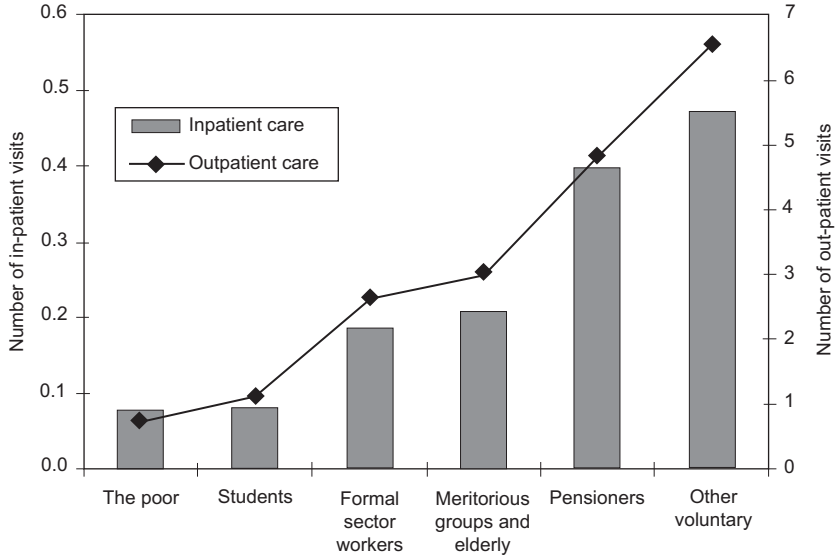
Table 2. Percentage of people using inpatient and outpatient care, 2008

	Inpatient				Outpatient			
	All health centres	Commune centres	Hospitals	Private	All health centres	Commune centres	Hospitals	Private
All Viet Nam	6.61	0.90	5.65	0.22	31.76	10.06	13.18	13.44
Age group								
Below 15	5.02	1.05	3.98	0.08	33.09	13.82	10.66	13.08
16-60	5.95	0.78	5.06	0.25	27.87	7.68	12.12	12.24
Above 60	14.70	1.35	13.38	0.36	54.65	17.33	25.96	22.24
Gender								
Male	5.97	0.71	5.18	0.24	28.36	8.53	11.99	11.78
Female	7.23	1.09	6.10	0.20	35.02	11.52	14.32	15.04
Ethnicity								
Kinh and Hoa	6.54	0.74	5.68	0.24	32.68	8.97	14.32	14.61
Ethnic minorities	7.13	1.98	5.45	0.10	25.76	17.15	5.74	5.78
Poverty								
Non-poor	6.72	0.74	5.86	0.26	32.50	9.10	14.24	14.37
Poor	5.98	1.85	4.37	0.00	27.38	15.72	6.90	7.94
Urbanity								
Urban	5.97	0.25	5.59	0.22	31.83	4.10	17.87	14.13
Rural	6.86	1.15	5.67	0.22	31.73	12.33	11.38	13.18
Region								
Red River Delta	6.52	0.74	5.65	0.17	27.27	7.90	13.55	10.06
North-East	7.73	1.55	6.33	0.11	24.77	12.90	9.64	5.32
North-West	8.42	1.80	6.76	0.20	21.87	12.78	6.92	4.24
North Central Coast	6.94	1.11	5.77	0.24	24.63	10.89	9.99	6.79
South Central Coast	7.93	0.86	7.07	0.24	31.49	8.80	13.73	14.08
Central Highlands	6.47	0.72	5.28	0.78	35.65	12.57	11.85	17.14
South-East	5.27	0.19	4.94	0.28	33.13	5.43	17.98	14.05
Mekong River Delta	6.20	1.10	5.11	0.10	44.31	13.45	13.92	25.30

Source: Nguyen (2010).

Health insurance is a good channel for people to improve their access to health-care services (Lieberman and Wagstaff, 2008; Nguyen, 2010). However, figure 9 shows low accessibility for more vulnerable groups even if they are health insurance holders. Caution should also be applied in interpreting the outpatient hospital visits of the voluntary insured, because majority of them (which are students and pupils) never received reimbursements for the treatments (Giang, 2007). As shown, however, the hospital visits and admissions are disproportionate among health insurance participant groups. Although the number of hospital visits (outpatient) of the poor has increased over time, the poor made 60 per cent fewer hospital visits than other mandatory participants. In terms of inpatient hospital use, the poor used 65 per cent less than other mandatory participants. In addition, rural-urban migrants are also unlikely to be covered and able to access health services, as World Bank (2007) shows that 87 per cent of migrants, who were sick and treated at health facilities, had to pay for the cost of services and medications out of their pockets; only 12 per cent had the cost covered by their families; and none of them had health insurance. Such a significantly lower hospital utilization rate for these groups is due to the financial cost and other difficulties in reaching hospitals in terms of distance and transportation, as well as distrust and other attitudes of the

Figure 9. Inpatient admissions and outpatient visits by health insurance holders



Source: World Bank (2007).

service providers (World Bank, 2007). A report by the United Nations (2003) indicates that hospital service providers seem to discriminate against people whose fees are waived and those with free insurance cards, and even sometimes also against those who hold insurance cards.

Financing and challenges

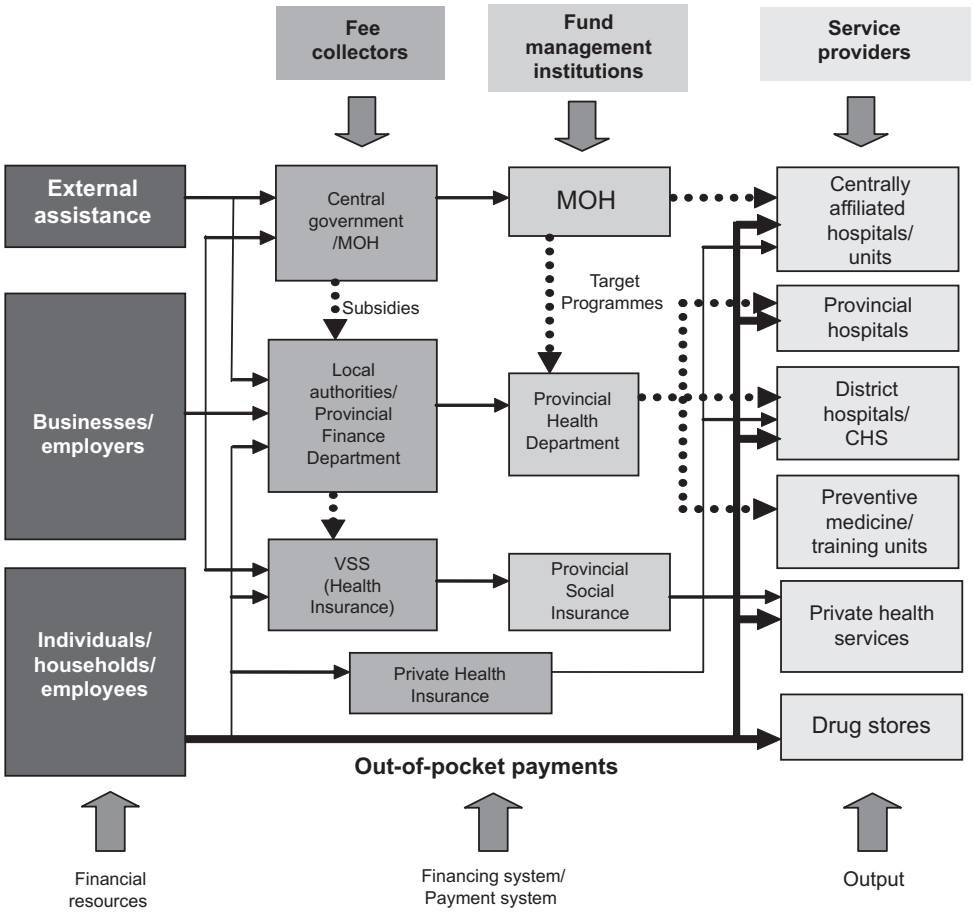
According to the Ministry of Health and the Health Partnership Group (Viet Nam, 2007), public expenditures on health care include two basic financing schemes, i.e. (a) direct subsidies from the government budget to service providers; and (b) payments through health insurance. In detail, payments from the government budget are deducted from the government revenues, while health insurance revenue is mostly from contributions by employees and employers. The budget funds are usually planned on an annual basis through various review processes and then given directly to service providers through the Ministry of Health. Furthermore, the central health-care budget goes to the central level of the health system, while the subnational budget goes to provincial and lower-level health system. Most capital investment costs and a part of recurrent costs, particularly for the salaries of health workers in the public health care centres, are covered by the government budget. Health insurance revenues, meanwhile, are managed by the Viet Nam Social Security (VSS). Figure 10 describes the health-care financial flows in Viet Nam.

Since 2005, in accordance with Decree 63, a part of the annual government budget has been allocated to VSS as a health insurance premium for the poor and under-six children. Similarly, the Government also subsidizes health insurance premiums for other population groups, including national merits. As such, social insurance revenues include contributions from employers and employees as well as subsidies from the government budget. The Government also provides subsidies for near-poor groups. In addition to the government budget and health insurance, private payments, especially out-of-pocket payments (OOP), are also a key component of health financing.

In 2008, Viet Nam's total health expenditures accounted for 6.5 per cent of GDP with an average expenditure per capita of $46. These figures were fairly high in comparison with the average total and per capita expenditure of the countries in the region, pegged at 3.4 per cent and $31, respectively. For the whole country, per capita expenditure on health increases from VND 504,000 in 2004 to VND 604,000 in 2008, and health expenditure accounted for 6.5 per cent and 6.8 per cent of the total household expenditure in 2004 and 2008, respectively (Nguyen, 2010).

The proportion of public financing (government budget and health insurance) out of total expenditure for health is lower than other countries in the region

Figure 10. Health care financial flows in Viet Nam

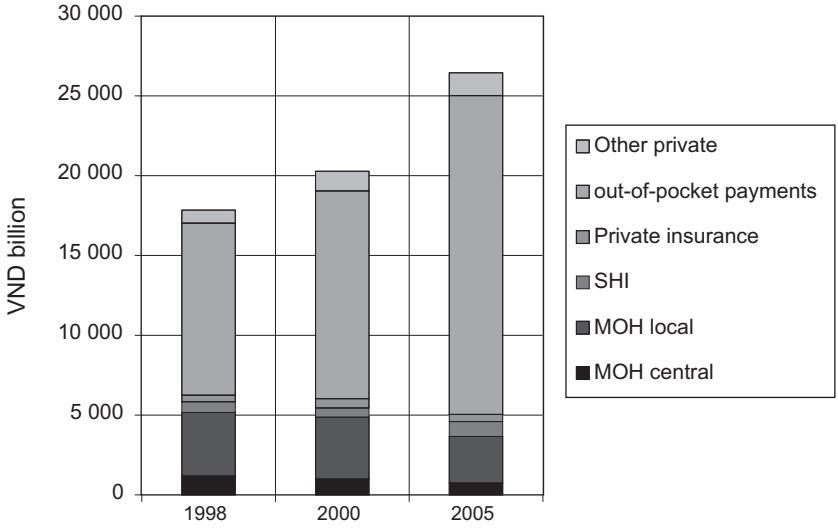


Source: Viet Nam (2007).

(29 per cent compared to 34 per cent in 2008), and as a result, more than 70 per cent of health expenditures were from out-of-pocket payments. This number was reduced slowly from more than 80 per cent in 1998 and 75 per cent in 2005 (figure 11).

Exploring further OOP, data from VHLSS 2008 show that OOP (including expenditures for treatment fees, drugs, cost for travel, meal and accommodation) is unfavourable to the poor, rural people, ethnic minorities and people living in mountainous regions as regards inpatient services, while it is more "favourable" to these same groups for outpatient services (table 3). As explained by Nguyen (2010),

Figure 11. Components of health revenues in Viet Nam



Source: Viet Nam National Health Account, as quoted in Lieberman and Wagstaff (2008).

this difference might be due to three facts: (a) poor people and ethnic minorities are more likely to have health insurance, which can help them reduce OOP spending; (b) health-care services in rural and remote areas, where the poor and ethnic minorities are mainly located, usually have lower quality and thus lower costs than those in urban and richer regions; and (c) the poor tend to spend less on health-care services due to limited budgets.

Although the government has increased its spending for health care in recent years, it has been noted that Viet Nam is below regional standards in terms of the degree to which government health spending reaches the poor (figure 12). This is due to the fact that most general government spending on health has still been on supply-side subsidies, with health insurance accounting for a mere 13 per cent of total health spending as of 2008. The supply-side subsidies are absorbed mostly by urban hospitals, while health insurance enrolments and outlays are highest among the better-off (Lieberman and Wagstaff, 2008).

In order to fully attain universal health insurance by 2015, a number of policies and programmes on health insurance have been implemented. The issuance of the Health Insurance Law in 2007, particularly, has created an important legal corridor for realizing the policy on health insurance.

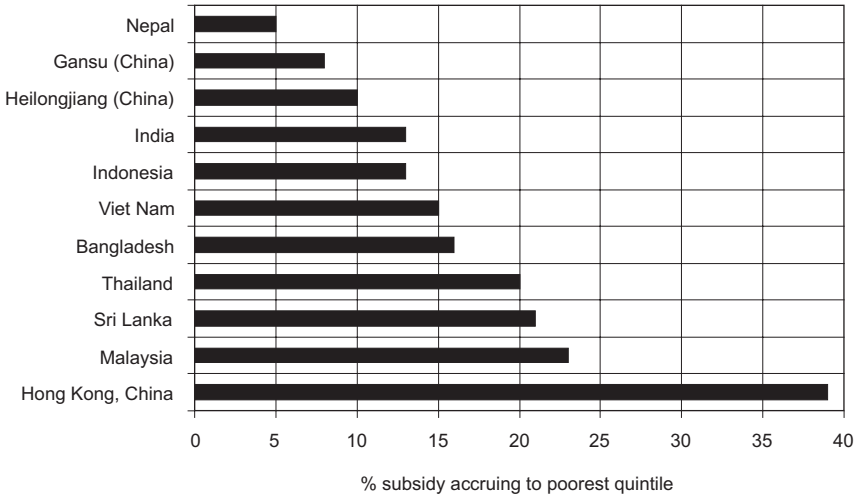
Table 3. OOP for inpatient and outpatient services by population groups, 2008
(Thousands of Vietnamese dong)

	Inpatient				Outpatient			
	All health centres	Commune centres	Hospitals	Private	All health centres	Commune centres	Hospitals	Private
All Viet Nam	2 218.0	339.5	2 390.7	5 182.0	227.0	70.1	394.5	201.9
Age group								
Below 15	1 140.8	187.0	1 343.1	2 753.1	107.8	39.9	198.8	104.8
16-60	2 427.1	411.1	2 570.3	5 591.8	260.3	67.0	409.5	238.3
Above 60	2 494.8	333.7	2 650.0	4 608.4	278.6	134.0	531.2	198.9
Gender								
Male	2 503.7	386.2	2 619.0	6 464.6	241.3	58.5	405.4	209.2
Female	1 991.8	310.2	2 204.9	3 751.7	215.9	78.3	385.6	196.5
Ethnicity								
Kinh and Hoa	2 415.4	376.7	2 556.6	5 386.3	239.8	78.0	401.4	201.9
Ethnic minorities	1 037.4	249.2	1 262.4	2 149.3	120.9	42.9	281.4	202.4
Poverty								
Non-poor	2 470.7	399.3	2 608.4	5 182.0	246.6	77.8	412.6	210.5
Poor	539.4	197.6	666.3		89.6	43.7	172.9	110.0
Urbanity								
Urban	2 813.4	304.4	2 854.1	6 055.8	294.5	67.0	378.7	264.0
Rural	2 020.3	342.5	2 216.2	4 854.9	201.1	70.4	403.9	176.5
Region								
Red River Delta	2 380.1	338.5	2 613.0	3 074.7	266.2	79.2	383.0	263.5
North-East	1 613.1	298.7	1 878.1	2 854.7	196.6	53.5	340.9	309.7
North-West	1 119.9	356.0	1 185.8	4 399.0	180.3	51.6	344.5	435.7
North Central Coast	2 259.4	367.0	2 303.8	9 440.9	247.4	69.6	447.8	289.2
South Central Coast	1 599.1	260.3	1 692.1	2 853.7	232.2	50.7	332.1	232.5
Central Highlands	2 320.6	317.4	2 328.6	5 358.2	223.9	38.5	378.6	254.1
South-East	3 521.7	841.8	3 405.8	7 300.5	321.4	200.9	481.5	264.4
Mekong River Delta	2 050.0	311.4	2 409.4	1 153.6	147.9	46.7	344.9	95.5

Source: Nguyen (2010).

There are two subschemes in the social health insurance system of Viet Nam: the mandatory scheme and the voluntary scheme. Health insurance regulations, issued on 15 August 1992, provide mandatory health insurance for employees in enterprises, socio-economic organizations, civil servants, pensioners, early retirees due to loss of workability, and national devotees. The Government of Viet Nam has continuously included specific target groups in response to their needs. In 2005, for example, all children under six years old became eligible for free health care in public

Figure 12. Who benefits from government health spending in Viet Nam?



Source: O'Donnell and others (2007), as quoted by Lieberman and Wagstaff (2008).

health facilities. As such, the mandatory social health insurance scheme in Viet Nam currently includes three different programmes: (a) employment-based programme; (b) health-care funds for the poor; and (c) free health insurance programme for under-six children. Table 4 summarizes the Vietnamese social health insurance system by subschemes, programmes, ratios, target groups and contribution levels.

Table 5 shows the numbers and ratios of the insured people in both mandatory and voluntary health insurance schemes. The covered groups include formal sector employees, the poor, the elderly, students and children under six years of age. The number of individuals insured through the voluntary scheme remains low. Most of the current insured participants in the voluntary scheme are schoolchildren who are strongly encouraged to purchase insurance by school authorities (Giang, 2007). There have been a number of reasons for such a low coverage, including low income, poor quality of public health services, poor marketing of the scheme, contribution levels and payment inflexibility, and aversion to collective State approaches (Cha, 2009). In terms of financing, the mandatory health insurance system is financed by 2 per cent of employers' and 1 per cent of employees' contributions. In addition to the employed, other population groups (retirees, the disabled and meritorious people) also have a contribution rate of 3 per cent either out of their pensions or the minimum government subsidies in the case of those receiving social benefits. As can be seen in table 5, the majority of the social health insurance

Table 4. Summary of Viet Nam social health insurance scheme, 2009

Schemes	Programme	Target groups	Financing
Mandatory	Social health insurance (SHI)	Formally employed	3% payroll tax (2% employers and 1% employees)
	Health care for deserving people	Retirees, disabled (unable to work), meritorious people and others	3% of pension or State assistance, General government revenues and provincial resources
	Health-care funds for the poor	The elderly, the poor, the ethnic minorities in mountainous areas and inhabitants in disadvantaged communities	VND 148 000 (per year)
	Free health care	All children under 6 years of age	Government revenue
Voluntary	Students	Students and school children	VND 100 000-120 000 (per year)
	Other	Self-employed, informal sector workers, dependents of SHI members	VND 300 000 (per year)

Source: Cha (2009).

Table 5. Coverage of the social health insurance, 1993-2008

Year	Total participants (millions of persons)	Coverage rate (as a percentage of total population)	Categorical participants (millions of persons)	
			Mandatory	Voluntary
1993	3.8	5.4	3.5	0.3
1998	9.7	12.5	6.1	3.6
2003	16.0	20.0	11.1	4.9
2004	19.0	23.1	13.6	6.4
2005	23.5	28.4	14.0	9.5
2006	34.5	41.0	25.0	9.5
2007	36.6	43.0	25.6	11.0
2008	41.0	47.2	30.0	11.0

Source: Viet Nam (2009).

participants are those who cannot afford to make contributions or those who can barely make ends meet. The limited number of employed persons participating in the scheme results in limited revenue, which in turn requires an increasing government responsibility to maintain the balance in health-care financing.

Table 6 presents the general collection and spending of social health insurance during the period 2003 to 2008. The debt accumulated since the health insurance system started is due to the lack of people contributing to the system, a fixed contribution rate of 3 per cent since 1992, and difficulties in collecting contributions. The major deficits occur in the free health care for the children under six and the voluntary health insurance fund. There are four main reasons for the deficit: (a) relatively low health insurance fees; (b) frequent hospital use; (c) abuse of the system by both providers and patients; and (d) inclusive health-care packages. Cha (2009) provides careful analysis of these reasons. First, the current health-care system is proven to be already burdensome to the poor. Therefore, increasing the contribution level and/or the co-payment is an unlikely solution for this problem and is against the purpose of implementing pro-poor health policies. Second, the majority of the population group, young children, in the voluntary health insurance scheme are usually the most frequent hospital users, except for the elderly. This means that the voluntary health insurance is under a great deficit because it mainly covers a target group that is prone to illness and hospital use. However, children are obviously an important population from a policy and economic perspective and cannot be disregarded by the health insurance system. Third, some health experts expressed concern about the possible abuse of the health insurance card. However, relatively low rates of hospital use suggest that the abuse of health insurance card by patients rarely happens; the average number of hospital visits per health insurance card was only about two times a year in 2008. Lastly, providing an inclusive health-care package is an ongoing effort by the Government of Viet Nam to protect the poor and the near poor from the financial shocks associated with severe illness. Health insurance experts note the hefty challenge of maintaining equilibrium between improving services to satisfactory levels while managing a sustainable health insurance fund. Furthermore, there are great regional inequalities, horizontal and vertical, in the allocation of the State budget for health insurance.

As regards universal health insurance coverage, the issue of most concern is the financial viability of such a scheme, and how to finance it. As suggested by Lieberman and Wagstaff (2008), it would be radical to implement such a scheme by mixing contributions (paid by formal-sector workers) and the government budget (for the others). As the coverage is expanded to the entire population, both revenues and outlays for the health insurance scheme will increase. Table 7 shows the results from a simulation model by Lieberman and Wagstaff (2008) using data from VHLSS

Table 6. Social health insurance fund balance, 2003-2008

Year	Participants (millions of persons)	Average cost (Vietnamese dong/person/ year)	Health-care fund (billions of Vietnamese dong)	Payments (billions of Vietnamese dong)	Balance (billions of Vietnamese dong)
2003	16.0	126.688	2 027	1 179	848
2004	19.0	136.842	2 600	2 133	467
2005	23.5	137.400	3 229	3 251	- 22
2006	34.5	125.507	4 330	5 805	-1 475
2007	36.6	162.630	6 224	8 124	-1 900
2008	41.0	230.000	9 000	10 400	-1 400

Source: Viet Nam (2009).

2006, in which they assume that those who are currently uninsured have the same inpatient admission and outpatient visit rates as those who are currently insured, and that VSS will spend the same amount per contact for the newly insured as it spends on those currently insured. The results show that expanding coverage to the entire population would raise health insurance outlays from VND 5,804 billion to VND 12,102 billion (or from VND 70,000 per capita to VND 147,000 per capita, an increase of VND 77,000 per capita). On the assumption that general revenues would be used to finance coverage of all those not currently enrolled with VSS and all those voluntarily enrolled with VSS, but with contributions remaining at their existing level for formal-sector workers, general government spending on health (including VSS contributions) would rise by a total of VND 76,000 per capita, or VND 6.3 trillion in aggregate. These changes would raise general government expenditure on health as a share of GDP from 1.5 per cent to 2.2 per cent. If this extra spending were financed entirely through additional borrowing, Viet Nam's fiscal deficit as a percentage of GDP would increase from 3.8 per cent to 4.4 per cent in 2006. One good prospect from this simulation is that the total OOP spending on health care would fall from VND 29,901 billion (67 per cent of total health expenditure) to VND 26,664 billion (56 per cent of total expenditure) – a reduction of VND 3.2 trillion, equivalent to a fall of 11 percentage points.

Table 7. Simulating the costs of universal health insurance coverage

Population: 82.48 million

GDP per capita: VND 11,806,000

	Current (2006)	100% coverage, additional coverage financed by government spending, current depth of coverage	100% coverage, additional coverage financed by government spending, double VSS revenues
			Billions of Vietnamese dong
Government expenditure on budget support (supply-side)	9 000	9 000	9 000
Government expenditure on subsidy to HI (demand-side)	3 155	9 973	19 946
Voluntary contributions	520	0	0
Earnings-related contributions	2 129	2 129	4 259
Out-of-pocket payments	29 901	26 664	14 561
Total	*44 706*	*47 766*	*47 766*
OOP share (Percentage)	67	56	30
VSS outlays	5 804	12 102	24 205
Government expenditure on health care	12 155	18 973	28 946
General government expenditure on health care	14 804	21 102	33 205
Overall government expenditure including VSS contributions	267 600	273 898	286 000
Extra general government expenditure compared to current		6 298	18 400
			Thousands of Vietnamese dong per capita
Government expenditure on budget support (supply-side)	109	109	109
Government expenditure on subs to HI (demand-side)	38	121	242
Voluntary contributions	6	0	0
Earnings-related contributions	26	26	52
Out-of-pocket payments	363	323	177
Total	*542*	*579*	*579*

Table 7. ***(continued)***

Population: 82.48 million

GDP per capita: VND 11,806,000

	Current (2006)	100% coverage, additional coverage financed by government spending, current depth of coverage	100% coverage, additional coverage financed by government spending, double VSS revenues
VSS outlays	70	147	293
Government expenditure on health care	147	230	351
General government expenditure on health care	179	256	403
Overall government expenditure including VSS contributions	3 244	3 321	3 468
			As a percentage of GDP
General government expenditure on health care	1.5	2.2	3.4
Private expenditure on health care	3.1	2.7	1.5
Overall government expenditure including VSS contributions	27.5	28.1	29.4
Fiscal deficit (current, and for scenario if extra spending financed through borrowing)	-3.9	-4.4	-5.7
Government revenues (current, and for scenario if extra spending financed through higher revenues)	27.1	27.8	29.0

Source: Lieberman and Wagstaff (2008).

III. POLICY DISCUSSION

In order to attain universal health insurance coverage and provide the people with increased accessibility to health-care services, apart from dealing with various issues related to the health status of the people, Viet Nam needs to transform the current health insurance scheme. In that regard, there are three key issues for policy consideration: efficiency (financial sustainability); effectiveness (access to and quality of care); and equity (health-care status, fair financing, and risk protection).

First, financial sustainability refers mainly to the long-term ability and potential to generate sufficient resources to support health while containing costs. The current scheme has faced significant financial challenges. There will be a range of possible responses, including further government subsidies, a reduction in reimbursable services, and changes to the provider payment mechanism. However, considering the financial burden already imposed on patients coupled with the recent increase in the contribution rate from 3 per cent to 4.5 per cent (effective from 1 January 2010 in accordance with Decree 62), any possibility of a reduction in reimbursable services should be ruled out.

Second, with a view to reaching financial sustainability, policymakers should reduce supplier-induced costs by encouraging providers to use a payment mechanism, which can share risks and rewards, and a monitoring mechanism to control under-utilization of services. Equally important, policymakers also need to reduce consumer-induced costs by allowing consumer cost-sharing through deductibles and co-payments but having unlimited access to services with adequate financial protection. A recent study by Sepehri and others (2010) shows that access to insurance benefits is constrained by the recent health-care reform initiatives, allowing public hospitals to establish wards for private fee-paying patients and provide them with better quality care – including on-demand services, such as choice of doctor, choice of room, and choice of scanning technology – than is normally available in regular hospital areas. In other words, financial sustainability should be emphasized from both the supply of and the demand for health-care services.

Third, improvement of service delivery. An effective health system provides timely access to the full array of needed services, together with efficacious and safe care leading to improvement in health, continuity of care, and respect. To enhance accessibility to care and quality of care, Viet Nam needs, firstly, to ensure the availability of health care by (a) increasing the number of physicians, nurses and hospitals in all regions/provinces, and (b) requiring all private health-care providers to join the social health insurance system. As such, patients can choose any health-care service provider, whether they are private or public. In addition, it is urgently needed to monitor the quality of care through appropriate prescription guidelines, treatment completion rates, readmission rates, the rate of avoidable hospitalizations, and the rate of follow-up visits, among other things.

Fourth, equity should be promoted by improving resource mobilization and allocation to the extent that favours the poor and other vulnerable groups. To reach equity, private health insurance should not be widely encouraged; rather, private health insurance can be supplementary to the mandatory health insurance scheme in order to reach the entire population. In addition to this initial policy direction,

policymakers should also pay attention to: (a) minimizing adverse selection and encouraging broader risk pooling by mandating insurance to all, encouraging collective enrolments, and creating incentives for low-risk individuals to join the insurance pool; (b) minimizing risk selection along with broader risk pooling; (c) ensuring financial stability with sufficient minimum capital and reserve requirements; and (d) ensuring that insurance packages provide adequate financial protection by defining a universal package for all people along with specific packages that meet demand.

Lastly, delivery and financing of health-care services will not be efficiently implemented without good institutional arrangements for the health-care system as a whole. To have a universal health-care system, in which every citizen can access the needed health-care services, the key policy action is to boost the quality of services coverage at the commune and district levels. This action will also be highly appropriate from equitable perspectives. Investment in grass-roots provincial health centres will be pro-poor, since the poor use communal health centres (CHCs) and district hospital services more heavily than their share in the population suggests, in large part because those who are better-off typically gravitate towards higher quality providers in district, provincial, and central level hospitals. The poor, who stand to gain most from reductions in mortality rates from preventable causes, also benefit disproportionately from the improved operation of CHCs as the primary bases from which preventive health services are delivered. As argued by Fritzen (2007), there should be two types of policy interventions that need to be given heightened priority by health planners – delivery and financing health-care services, with special attention to equity. The first one is focused on improvements to the institutional environment underpinning CHC performance, in which the most important actions are to understand the set of pressures and incentives felt by CHC personnel (such as a low compensation rate along with high responsibility in providing services) and to identify appropriate mechanisms for increasing the pressure for responsive CHC performance while ensuring an adequate flow of resources to them for meeting minimum standards. The second one pays greater attention to the demand side of interventions underpinning health quality and access, i.e., interventions aiming to increase basic health knowledge and to influence the demand of individuals for basic services.

In addition, the issue of how to protect and further develop the quality of preventive service activities should also be urgently considered. These services will remain essential functions for all CHCs to perform. Seeking to build and maintain all CHCs to more or less the same specifications arguably starves resources that can be targeted to preventive health functions that are probably under-funded relative to their social value. In fact, under the current CHC financing mechanisms, the quality of

preventive services is partly dependent in many CHCs on their success in increasing utilization rates.

IV. CONCLUDING REMARKS

In this paper, we showed that, in order to reach universal health insurance coverage by 2015, Viet Nam needs to deal with a number of policy issues in its health-care system. Particular focus should be on accessibility and quality of health-care services for more vulnerable groups, i.e., rural, low-income, and ethnic minority people since they usually have lower capacity to access quality health-care services than their better-off counterparts. In addition, as Viet Nam has a high incidence of catastrophic household health spending, which in turn further limits people's access to health-care services, the role of government in addressing the financial challenges in health care, particularly for the more vulnerable groups of people, is important. Increasing public spending on health care and improving the quality and delivery of services are among the key policies that need to be implemented to reach efficiency, effectiveness, and equity.

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