

Expanding Social Health Protection: Towards Equitable Coverage in Viet Nam



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With the recognition of the right to social security, including health protection and care, in the 2013 Constitution of the Socialist Republic of Viet Nam, the country has reaffirmed the priority of Universal Health Coverage (UHC). Currently, the Government of Viet Nam (GoV) is targeting 90.7 percent participation in social health insurance by 2020, with 100 percent coverage of the poor, elderly and other vulnerable groups¹.

In 25 years of implementing Social Health Insurance (SHI), Viet Nam has made laudable progress towards UHC. Significant challenges remain, however, in terms of improving quality of care and financial sustainability of the scheme. Ensuring an adequate level of financial protection to all remains arduous.

This brief documents the evolution of the social health protection mechanisms in Viet Nam over the past decades and draws key learnings from this experience, while highlighting remaining gaps towards UHC.



Main lessons learned

- In Viet Nam, asserting the right to health care and protection in the Constitution and establishing a sound legal basis for UHC facilitated the extension of social health protection coverage.
- Political commitment was - and still is - extremely important to develop and enforce related laws and regulations and guarantee adequate funding.
- Legally asserting SHI as *mandatory* for all was key in achieving nearly 87.7 percent of population coverage in 2018.
- The Government's pro-poor policies (e.g. subsidisation of the poor's contribution) facilitated the equitable extension of population coverage.
- Improving enrolment alone is not sufficient to guarantee effective access to all. Efforts should also focus on the adequacy of the benefits provided, looking in particular at strengthening Primary Health Care (PHC) and improving quality of care at all levels.

SDG 1.3 aims to implement nationally appropriate social protection systems and measures for all, including floors, and by 2030, achieve substantial coverage of the poor and the vulnerable.

Social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons. 185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), to achieve universal social protection.

This note presents a successful country experience of expanding social protection.

¹ Decision 1167/QĐ-Ttđ of Prime Minister on amendment of target on HI coverage in the period 2016-2020

1. Process

Viet Nam enshrined the right to health care and protection for all citizens in its Constitution for the first time in 1992. The same year, and based on a three years pilot, the national Viet Nam Health Insurance program was introduced. With out-of-pocket spending reaching 70% of total health spending in the early 90s, the scheme's mandate was to facilitate financial access to health care. The scheme provided mandatory coverage for certain population groups, namely civil servants, employees of state-owned enterprises, employees of private companies (with more than 10 employees), and pensioners. The rest of the population could enrol in a separate voluntary scheme.

In 2003, the Health Care Fund for the Poor (HCFP) was set up, using Government revenues to provide social health protection to the poor, ethnic minorities in selected mountainous areas, and all households living in municipalities officially designated as highly disadvantaged.

A first Health Insurance Law (HIL) was adopted in 2008. The Law made coverage compulsory for children under 6, the elderly, the poor and near-poor. It provided for full subsidies for these groups and ethnic minorities, as well as partial subsidies to near-poor and students. It also integrated the HCFP to the existing health insurance scheme, hence giving birth to the social health insurance single pool.

The HIL incorporated a roadmap planning the enrolment of all remaining categories, starting with farmers, workers in agriculture, forestry, fishery sectors and salt producers (included in 2012), and finally the self-employed, family dependents and others (in 2014). In the roadmap ratified by the Prime Minister's Decision 538/QĐ-TTg in 2013, the coverage target was set to over 80 percent by 2020. In 2016, in light of the successful achievements in term of population coverage, the target was revised upwards - 90 percent by 2020 - through the *Prime*

Minister Decision 1167/QĐ-Ttg on amendment of Health Insurance coverage target 2016-2020.

While the HIL 2008 introduced in principle a single pool for SHI and HCFP, in practice high fragmentation remained at the provincial level (see below). Confronted with an inefficient health financing system (Barroy, Jarawan, and Bales 2014), the GoV revised the Health Insurance Law in 2014, reinforcing measures to ensure compliance with compulsory enrolment for all.

Since then, the GoV issued a series of legal documents progressively expanding mandatory enrolment to the entire population, now categorized into 6 groups and 35 different sub-groups (Decree 146/2018/ND-CP). The six groups are named after the source of payment of their contributions, as follows: Employer/employee; Social Insurance; State Budget; State Budget (partial subsidies); Households; Employees (dependents of military and public security services).

2. Legacy and design

Governance

The SHI is implemented and managed by the Vietnam Social Security (VSS), a public service agency. The VSS is also responsible for collecting contributions for all social security benefits² - including social health insurance - and for processing benefit payments.

The MOH has an oversight and regulatory function. The MOH is in charge of monitoring and evaluation of SHI and reports on the scheme's performance to the National Assembly of Vietnam. It is also responsible for setting prices of medical services (Oanh and Phuong 2016). In parallel, the Ministry of Labour, Invalids and Social Affairs (MOLISA) is responsible for identifying vulnerable households and establishing lists of poor and near-poor households.

Financing

² VSS also covers benefits related to maternity, old-age, employment injury, unemployment

The GoV support to Social Health Protection was demonstrated through high budgetary allocations to the health sector. In 2016 Domestic Government Health Expenditure represented 47 percent of Current Health Expenditure, and between 8 and 10 percent of General Government Expenditure in the years following the adoption of the HIL 2008.³ This support was essential to the subsidisation of contributions for the most vulnerable populations.

Benefit package

Currently, the Social Health Insurance (SHI) scheme provides a unique, broad benefit package to all members. This has been, from the start, a major feature of the scheme. In addition to curative and rehabilitative services, the benefit package covers preventive services including immunization and control and prevention of infectious diseases (AIDS included⁴). In practice however, access to this broad package is hindered by limited health facilities equipment and low quality of services at primary level. The set of benefits covered also lacks prioritisation, as its composition does not rely on systematic Health Technology Assessment processes. 51 percent of the expenditure on selected medicines reimbursed through the SHI is considered to be inappropriate for the specified indications.⁵

Provider Payment methods

Under the health insurance law, three types of provider payment methods can apply: capitation for primary health care; fee-for-service for all secondary and tertiary hospitals and for referral health services, including high-cost services that are not paid by capitation; and diagnosis-related groups (DRGs), piloted in a few hospitals. In reality all providers are paid fee-for-service.

In 2016 the MOH developed new specific guidance on payment, which led to a general decrease in health services' tariffs for VSS providers. Since then, abuses in provider's tariffs setting were noted in

many places. The VSS now uses an electronic health insurance assessment system, which partly address this issue. Indeed, the MOH promoted the application of Information Technology (IT) in health services management, assessment and payment, with the aim of improving administrative procedures. The early deployment of IT applications also contributed to avoid fraud from patients and service providers.

Primary Health Care

Early on, efforts have focused on strengthening primary care (PHC) in Viet Nam, which led to relatively equitable access to PHC and a pro-poor distribution of benefits at primary level (World Health Organization 2018b). Specifically, the MOH issued a Circular regulating basic health service packages for grassroots health facilities. Accordingly, the basic health service package paid by the VSS includes almost 80 technical services for medical examination and treatment and 241 drugs that health stations should provide (include commune and ward health stations, town and equivalent, independent family doctor clinic, civilian army medical station and civilian military clinics).

Providers' network

As per regulation, the VSS facilities network includes all public facilities and licensed private facilities registered with VSS. In 2018, out of total of 2,316 contracted providers, 23 percent were private. This broad network aims to ensure maximal geographical access to providers and to give a choice to the patient. This requires a necessary trade-off between minimum quality standards and ensuring geographic access to everyone. As a consequence, a number of facilities are included on the list of approved facilities, while not yet meeting the government licensing requirements.

³ However, public resource mobilization is constrained by low tax revenue collection.

⁴ In addition to prevention, the scheme covers ART, lab tests required during ART such as virus load and CD4 counting

⁵ Kieu T., [Health Technology Assessment and Its Application in Vietnam](#), Value in Health, June 2017

3. Results

Effective Population Coverage

As of 31 December 2018, 87.7 percent of the total population was covered by the SHI, meaning that the target for 2018 was reached.⁶ These results were achieved thanks to the great commitment of the Government, VSS and MOH in the past few years, as described earlier.

However, population coverage remains inequitable. The enrolment rates are highest among low- and high-income groups, but persistently low among groups in the middle due to low enrolment of the near poor: the “missing middle” (Somanathan et al. 2014). Even when they are enrolled, irregular collection of contributions from independent and informal workers creates gaps in coverage. Similarly about 40 percent of the elderly population, many of whom are poor and live in rural areas, are not covered by SHI (Asian Development Bank 2016). Despite recent progress linked to the Law on Enterprise,⁷ nearly 20% of formal workers are not affiliated to the SHI (General Statistics Office of Vietnam and International Labour Organization 2016). This is believed to be due to various factors, including weak enforcement measures, collusion between employees and employers in under-reporting monthly salary and paying contributions, and overall lack of knowledge on SHI and its benefits (Matsushima 2014).



⁶ GoV targets coverage rates in the year of 88.1% in 2019 and 90.7% in 2020.

Utilisation of services

The extension of SHI coverage had a positive impact on health services utilization, as demonstrated for children under 14 for example: in 2010-2012, the student health insurance and free health insurance programs increased the number of health care visits of children by approximately 13.6 and 66.1 %, respectively (Nguyen 2016). Utilization rates show very few differences between rural and urban areas, revealing high geographic equity.

Yet the better-offs use mostly Central and Provincial Hospitals while the poor and near poor seek care at Community Health Centers and District hospitals first. This can partly be attributed to the perception of low quality of care at grassroots level. The rich (5th socioeconomic quintile) are also more likely to use certain health services than the poor: in 2013 there were still 23 points difference between the skilled birth attendance rates of the two quintiles (World Health Organization 2018a).

Risk pooling

As utilisation by the poor and near-poor is lower, these groups accounted for a larger share of revenue than expenditure, in practice subsidizing other groups (Joint Learning Network for Universal Health Coverage 2015).

Viet Nam's SHI is still highly fragmented, with 63 provincial funds, and only marginal equalization is made across these funds through central reserves. Redistribution effects are therefore in practice often regressive, from poorer to richer regions or groups (Barroy, Jarawan, and Bales 2014). The consequence is limited risk sharing and reverse cross-subsidisation.

Financial protection

OOP spending dropped from 49 percent in 2012 to about 44.6 percent in 2016. However considering that 87 percent of the population is covered by the SHI, out-of-spending remains surprisingly high.

⁷ According to this Law, the companies are responsible for registering employees that contracted for more than 3 months to social insurance.

Interestingly, recent evidence⁸ shows that OOP payments are mainly paid by the richest quintiles (48.2 percent of In-Patient care, 43.8 percent of Out-Patient care) and mainly at provincial and central hospitals. The poorest households (lowest quintile) accounted for only 6.2 percent and 5.8 percent of total OOP expenditures for in-patient and out-patient care, and mainly at lower levels (commune and districts). This is believed to be the result of effective financial protection (the poorest do benefit from the zero co-payment policy) but could also be a consequence of low access to health services.

Financial sustainability

Revenues of the SHI scheme increased steadily over the years, especially from the contributions from employers and workers and the state budget for subsidized groups. For instance, contributions from employers and workers in 2016 were almost double of their level in 2015. Due to the mix financing relying on contributions and subsidies, the participation of each group to the total membership is not proportional to the revenues they “generate”. For instance, the group of employers and workers accounted for 40 percent of 2018 total revenues but for only 15.5 percent of the total population enrolled in the SHI scheme. On the contrary, contributions from households and other groups (including people at working age in informal employment) generated 8.8 percent of total revenues but 18 percent of total membership.

The benefit packages remain generous which increases the burden on SHI spending (Oanh and Phuong 2016). In addition, some hospitals tend to oversupply expensive services, and there are no incentives for cost control or efficiency improvements at facility level. Yet, some measures have already led to efficiency gains at central level. The MOH and VSS for example organized a national drug tender, saving hundreds of billions of VND.⁹

⁸ General Statistics Office of Vietnam, Viet Nam Household Living Standards Survey, 2016

⁹ <https://vietnamnews.vn/society/419259/first-centralised-drugs-bid-saves-21-million.html#PHQDgzH8w8Kcm9w3.97>

4. Way forward

While much progress has been achieved on the way to UHC in Viet Nam recently, some important reforms are being considered to further strengthen efficiency and equity, while reducing OOP spending.

Financial sustainability

The most pressing issue regards the financial sustainability of the scheme. VSS runs on a deficit since 2016. In 2018, 60 out of 63 provinces are on a deficit, which reached, at national level the equivalent of 17 percent of the scheme’s revenues. Revenues from contributions remain low and the financial viability of the scheme is dependent upon the state allocation. In 2017, the state budget contributed to 43.3% of total SHI revenues¹⁰.



Management

Responsibilities of both the MoH and VSS are clearly stipulated in regulations, but mechanisms for collaboration are missing and the coordination between the two institutions remains to be strengthened. Differences in management structures and levels of authority between MOH and VSS make communication and collaboration difficult. Measures towards the improvement of SHI governance should include clearer cooperation lines between MOH and VSS, and the strengthening of the

¹⁰ VSS, Health insurance policy implementation Department. 2019. Current situation of health insurance policy enforcement in Vietnam (2008 – 2018) (presentation).

rights and responsibilities of VSS in policy decisions affecting the financial sustainability of the scheme.

Purchasing mechanisms

The MOH and the VSS will soon develop a strategy to (i) cover long-term health services (and therefore adapt to an ageing society), (ii) continue to expand the list of bidding drugs, (iii) negotiate with firms, pharmaceutical companies, medical equipment and supplies with potential in order to ensure a reasonable and sustainable supply.

More provider payment mechanisms are actively explored. Capitation, case-based payments and diagnosis-related groups have been piloted in some provinces. Building on these experience, VSS should also attempt to move away from fee for service and towards more strategic purchasing mechanisms.

IT system

VSS has adopted a modernisation Plan 2016-2020, including important business process re-engineering, HR reforms and the national integration of a Management Information System (MIS) (The World Bank 2017).

The MOH is looking at building a unified Information system at the primary care level, which will synchronously manage activities such as prevention, family planning, personal health management, and medical treatment. Promoting the application of information technology in medical examination and treatment will also be a priority, as well as correct social health insurance inspection and use of electronic social health insurance cards.

These cards, named integrated social security card (ISSC) should be issued together with the MOLISA by 2020 (Decree 146/2018/ND-CP). The ISSC will contain a unique ID for use within the VSS and MOLISA systems, and later linked to the National ID. A central database will provide the basic demographic information for issuing the ISSC. This will reinforce the integration of SHI with other social protection benefits.

While improving the issuance of social health insurance cards, it will be necessary to strengthen

monitoring and inspection – including reporting on equity - to strictly implement the provisions of the Law.

All together these measures are expected to provide the necessary foundation for Viet Nam to achieve its target of covering the entire population by 2025 and provide effective financial health protection to all Vietnamese and residents.

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