International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Viet Nam

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December 2021

Extending Social Health Protection in Viet Nam: Accelerating progress towards Universal Health Coverage

1. Introduction

One of the fastest growing economies in Asia, Viet Nam began its transition to a socialist-oriented market economy in 1986, following political and economic reforms known as Doi Moi. Since then, Viet Nam has been transformed from one of the poorest countries in the world to a thriving lower middle-income country. GDP per capita steadily increased from US$423 in 1986 to US$2,715 in 2019, and remarkable progress in poverty reduction has been achieved (World Bank n.d.). In tandem with sustained economic growth and substantial declines in poverty, vast progress has been made towards improving the health of the Vietnamese population over the past few decades, with health outcomes advancing alongside rising living standards and improved access to health services (Teo et al. 2019). However, the country faces an increasing burden of non-communicable diseases (NCDs) such as cancers, hypertension, and diabetes, as well as challenges related to a rapidly aging population (Teo et al. 2019).

To promote equitable health outcomes, Viet Nam enshrined the right to health protection for all citizens in its Constitution in 1980 (article 61), which the country is striving to achieve through the implementation of a national social health insurance (SHI) scheme. With the introduction of Viet Nam's Health Insurance Law in 2008, a roadmap towards universal health insurance was planned out [1] and amendments to this law have made health insurance compulsory for all. [2] The Government has since exceeded its 2020 target of 90.7 per cent population coverage (Kim Loan 2020) and the new Social Security 5-year plan 2021–2025 has set the ambitious target to achieve SHI coverage of 95 per cent by 2025. Although a high level of coverage has been reached, out-of-pocket (OOP) health spending continues to increase and inequities and coverage gaps persist, particularly among near-poor groups, self-paying households, internal migrants and workers in informal employment, who comprise a large share of the workforce in Viet Nam. These challenges are of particular concern in the context of the impacts of the COVID-19 crisis.

[1] Viet Nam Health Insurance Law 2008, No. 25/2008/QH12.
[2] Viet Nam Health Insurance Law Amendment 2014, No. 46/2014/QH13., article 1.

2. Context

Political and economic restructuring in the late 1980s precipitated the end of Viet Nam's previously universal state-funded health system, which operated with limited resources but was free for the entire population. This was accompanied by a sharp cut in government health spending and increased participation of private actors in health care delivery (Ramesh 2013). To compensate for diminished government funding, user fees were introduced during the late 1980s and early 1990s to supplement inadequate state budget supply-side subsidies to public health care facilities. Unfunded exemptions for vulnerable and meritorious groups were ineffective and these policies led to a dramatic increase in OOP payments; in the 1990s, OOP health expenditure accounted for more than 70 per cent of total health spending (Ramesh 2013; Somanathan et al. 2014). To address this, the Government introduced a set of broad national health system reforms throughout the 1990s to improve service coverage, access, use, leadership, health financing and community-level health outcomes, and to reduce hospital overcrowding and costs (London 2008).

In 1992 a contributory SHI scheme for workers in formal employment and pensioners was introduced (Le et al. 2020; ILO 2019; Palmer 2014). Two years later, a voluntary scheme was established for informal economy workers, students and dependents of those in the compulsory scheme (Le et al. 2020). In an effort to protect hard-to-reach populations, the tax-funded Health Care Fund for the Poor was later introduced in 2002 to provide social health protection for the poor, selected ethnic minority groups, and individuals living in the most disadvantaged regions, through payment of SHI contributions or cash reimbursement of health services. [3] In 2005, these efforts were further complemented by the Government mandated provision of tax-funded coverage for all children under 6 years of age. [4] Other entitlement programmes were also established to provide financial support for health care for other groups, such as military and public security health services and programmes implemented by the Ministry of Labour, Invalids and Social Affairs (MOLISA) for persons of merit and social assistance beneficiaries.

In 2008, the first Health Insurance Law was issued, through which all the funds and schemes were consolidated into one national SHI scheme, reliant on a mixed financing system combining tax revenues, contributions and OOP payments. This established a single pool, with the exception of separate funding pools for persons engaged in active military and public security forces. SHI is now the primary vehicle for delivering social health protection in Viet Nam, alongside state funded preventive medicine and public health, which constitutes an essential complementary source of resources. The social security funds for active duty military and police forces, which are pooled separately, have slightly more generous benefits. However, the design of these schemes is aligned with SHI, and claims review and payments are also implemented through the Viet Nam Social Security (VSS) agency.

As SHI has developed, the Government has gradually shifted away from subsidizing curative health care facilities to subsidizing SHI contributions for the poor and the vulnerable. The state budget is still responsible for preventive medicine and public health, but funding for personal services that were formally provided by vertical programmes are gradually being integrated into the SHI system. In 2017, the Central Committee of the Communist Party of Viet Nam set the objective to progress towards universal health coverage (UHC) through universal health insurance, and to guarantee equal rights and obligations in accessing health insurance benefits and services. [5]

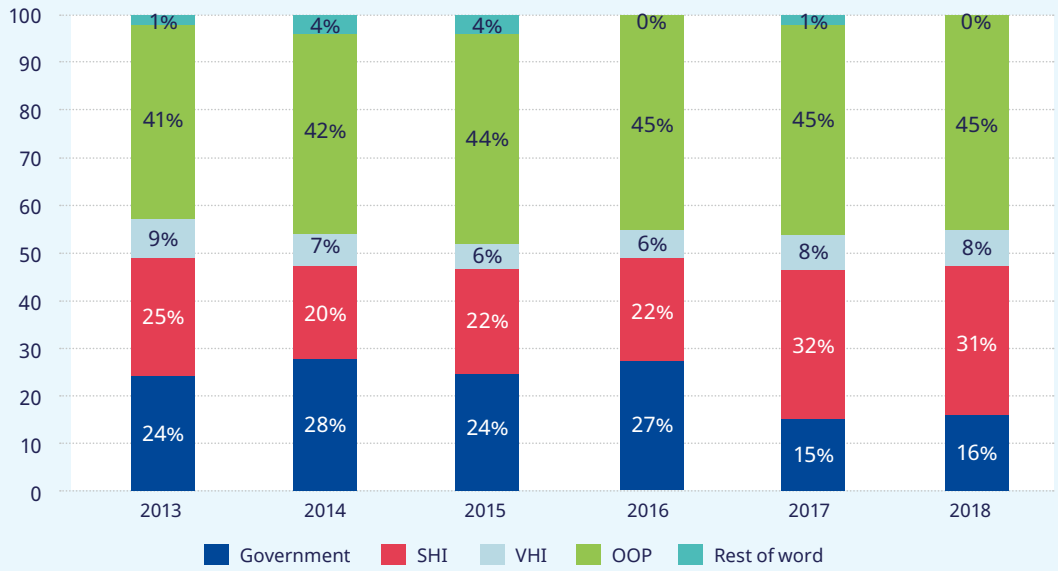
[3] Decision 139/2002/QD-TTg of 2002 on Health Care for the Poor.
[4] Decree 36/2005/ ND-CP of March 17, 2005 Detailing the Implementation of a Number of Articles of the Law on Protection, Care and Education of children.
[5] Resolution 20-NQ/TW of the 2017 Sixth Plenary Session of the 12th Party Central Committee on the Protection, Care and Improvement of People's Health in the New Situation.

3. Design of the social health protection system

- Financing

Due to substantial increases in both public and private spending, total spending on health in Viet Nam has increased significantly since 2000, with current health spending accounting for 5.9 per cent of GDP in 2018 (WHO n.d. a).

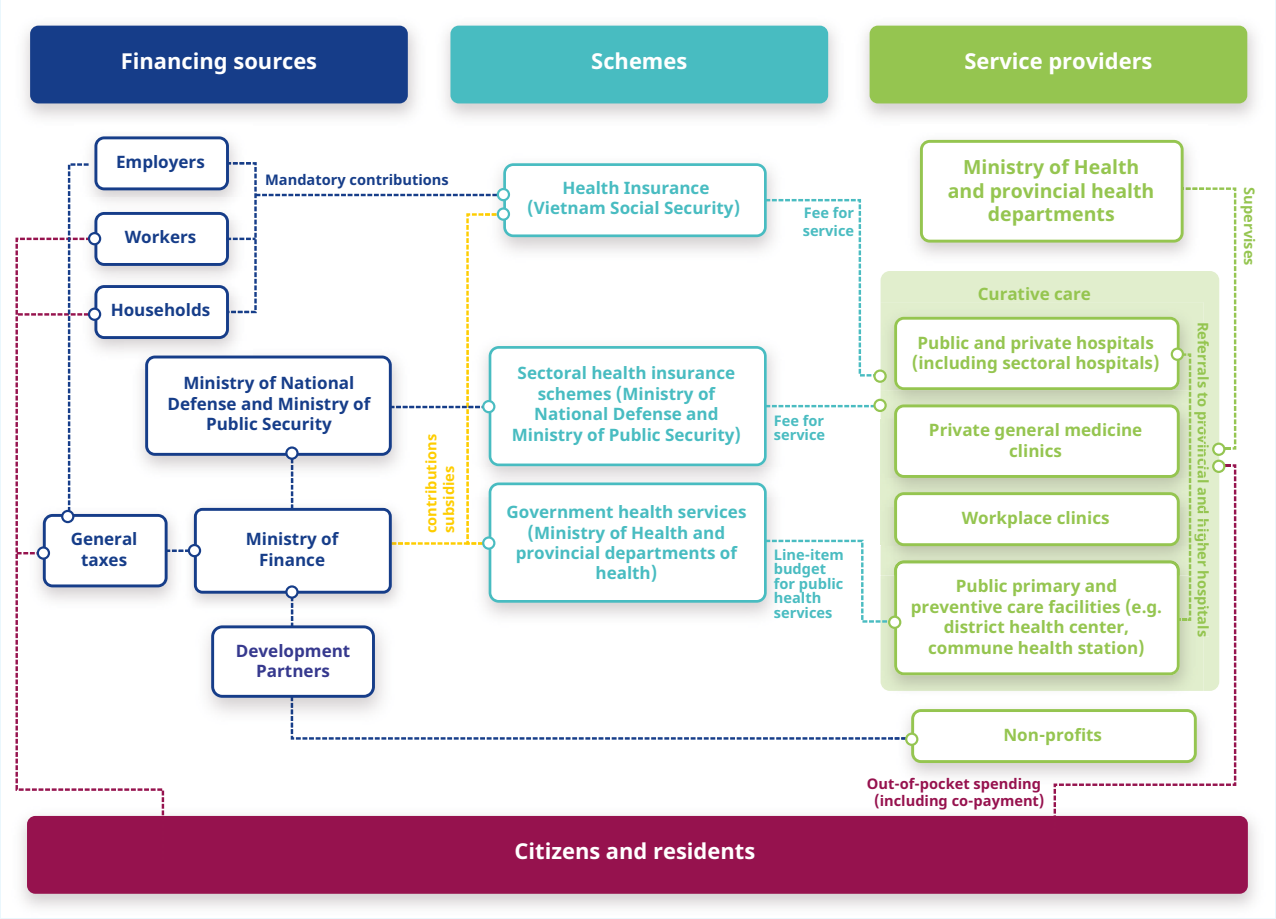
Figure 1. Health expenditure structure in Viet Nam (as a percentage of current health expenditure), 2013 2018



Source: Adapted by author based on presentation by the Viet Nam Ministry of Health at NHA workshop in Hanoi in December 2020 (Viet Nam Ministry of Health, Unpublished).

The structure of sources of current health expenditure have changed substantially over the years. Between 2000 and 2018, OOP spending increased from 37 per cent of current health expenditure to 45 per cent. This large increase in OOP spending began in 2012, alongside a considerable drop in the share of state budget spending from 44 to 29 per cent. This was only slightly compensated by an increase in the share of SHI from 17 to 20 per cent. External financing for health (including funds distributed by government and direct transfers through non-profits) as a share of current health expenditures also dropped, from 4 per cent in 2000 to 2 per cent in 2018 (WHO n.d. a).

▶ **Figure 2. Overview of main financial flows of the social health protection system in Viet Nam**



Source: Authors.

SHI relies on a mixed financing system encompassing both contributory and tax-financed membership, which is somewhat complicated due to the fact that the scheme consolidates many different entitlements funded from multiple sources. The contribution rate is currently set at 4.5 per cent of contracted or civil servant salary (insurable salary), pension, social benefit or base salary, [6] depending on the beneficiary group. However, the Health Insurance Law allows the government to increase the rate to a maximum of 6 per cent. A ceiling of 20 times the base salary is imposed for employed member contributions. Contribution rate, funding source and co-payment level are detailed in Table 1 for each population group and memberships categories, as defined in the law.

[6] Base salary is a fixed amount used as the base to calculate salaries of government employees and general living costs for a defined period (for example, the base salary is VND1,490,000/month for the period July 2019-December 2020). This base salary is adjusted regularly by the Government. At the time of publication, the base salary had not been revised for the year 2021.

▶ Table 1. Summary of key design features: coverage, benefit and service provision

Population groups and membership categories	Contribution rate	Funding source	Member co-payment level
Group 1: Individuals whose contributions are shared between employers and employees			
• Formal economy workers • Civil servants (excluding active armed forces	4.5% of insurable salary	Employers contribute 3%; employees contribute 1.5%	20% of eligible treatment charges
• Contract-based public officials at commune-level	4.5% of base salary	Employers contribute 3%; employees contribute 1.5%	20% of eligible treatment charges
Group 2: Individuals whose contributions are paid by VSS			
• Pensioners • Current recipients of social insurance benefits including unemployment benefits, disability benefits, paid sick leave, and so on.	4.5% of pension or base salary, or allowance depending on the specific group	VSS pays full amount	5% of eligible treatment charges for pensioners and those on disability benefit. 20% of eligible treatment charges for the rest
Group 3: Individuals whose contributions are fully tax-financed			
• Active duty military or police forces	4.5% of insurable salary	State budget pays full amount	0%; coverage includes items required by patients that are not in the service package covered by SHI, with payment from the sectoral social security fund.
• Students of military or police training institutions	4.5% of base salary		
• Persons of merit (revolutionaries, war invalids, Agent orange victims, caregivers of war martyred families, and so on) • Social assistance recipients (including elderly aged 80 and older and people with disabilities)	4.5% of base salary	State budget of MOLISA and DOLISA	0% of eligible treatment charges 5% of eligible treatment charges for dependents of revolutionaries
• Members of poor households • Ethnic minority groups living in selected underprivileged regions • Children under the age of six	4.5% of base salary	State budget	0% of eligible treatment charges
• National Assembly and People's Council elected representatives • Organ donors • Foreign students studying in Viet Nam with a Viet Nam Government scholarship • Commune-level officials receiving monthly pensions from state budget • People who exhausted their disability benefits but receive monthly payments from the state budget	4.5% of base salary	State budget For scholarship recipients, contributions are paid by scholarship providers out of the scholarship coverage.	20% of eligible treatment charges
Group 4: Individuals whose contributions are partly subsidized by tax			
• Individuals living in near-poor households in poor districts	4.5% of base salary	State budget	5% of eligible treatment charges

Population groups and membership categories	Contribution rate	Funding source	Member co-payment level
• Individuals living in near-poor households not in poor districts	4.5% of base salary	30% from individual; 70% from state budget	5% of eligible treatment charges
• School children and college students • Average income agricultural households	4.5% of base salary	70% from household; 30% from state budget	20% of eligible treatment charges
Group 5: Remaining individuals (except dependents of armed forces personnel)			
• Individuals not covered in any of the above categories, usually informal economy workers, whose contributions are paid on a family basis	1st household member: 4.5% of base salary. The 2nd, 3rd, 4th household members: respectively 70%, 60%, 50% of the 1st member's contribution rate The 5th member onwards: 40% of the 1st member's contribution rate	Household pays full amount	20% of eligible treatment charges
Group 6: Dependents of armed forces personnel			
• Dependents of military, police personnel (parents, spouse, biological and adopted children)	4.5% of base salary	Employer of military, police personnel pays (state budget, service delivery unit or enterprise)	20% of eligible treatment charges

Source: Author based on the Health Insurance Law 2008; Health Insurance Law Amendment 2014; Decree No. 146/2018/NĐ-CP; and Decree No. 70/2015/NĐ-CP.

Central and local budgets finance part of the contributions. For partly subsidized groups, local governments can voluntarily top-up the subsidized amount using their local budgets or other resources. According to government sources, 59 out of 63 provinces in Viet Nam provide health insurance subsidy top-ups for individuals from near-poor households, in addition to the 70 per cent subsidy regulated by law. Moreover, many provinces have expanded subsidies to other groups of the population. In particular, SHI insurance for 65—70-year-olds is often fully subsidized by local government budgets, even though the law only mandates free health insurance for people over 80 years of age. Households contribute their share as prescribed by law, and the local or central budget contributes the balance.

Frequency of contribution payment depends on the membership category an individual falls into. Employers are responsible for paying monthly contributions to the SHI Fund on behalf of their employees, along with other social security contributions. VSS is responsible for paying monthly contributions for pensioners and recipients of social insurance benefits from social insurance funds. Tax-financed contributions are paid quarterly, and informal economy workers who are enrolled on a household basis can choose to pay contributions quarterly, semi-annually or annually.

- Governance

The SHI fund is implemented and managed by VSS which also manages other contributory social protection benefits through an integrated approach, including maternity, old-age pension, employment injury, unemployment, sickness and survivorship. VSS reports to the Ministry of Health (MOH) on the administrative management of the SHI scheme, to MOLISA regarding social insurance, and to the Ministry of Finance (MOF) regarding financial management of social insurance funds, including the SHI fund. MOH has oversight, policy-making and regulatory functions with regard to SHI and reports to the

National Assembly and the Government Office of Viet Nam on the scheme's performance. It is also responsible for setting prices of medical services and regulations surrounding medicine procurement and quality.

Identification of subsidized beneficiaries is the responsibility of multiple government agencies, with MOLISA taking responsibility for identifying vulnerable households and establishing lists of social assistance beneficiaries and persons of merit eligible for subsidized health insurance. The Ministry of Education and Training compiles lists of students, and the Ministry of Public Security and Ministry of National Defence provide lists of their staff and dependents covered by SHI, though they manage insurance cards for active service members separately.

The management of SHI consists of tripartite representation: (i) the Government is represented by the Ministries of Labour, Health, Finance, and Home Affairs, as well as VSS; (ii) employers are represented by the Viet Nam Chamber of Commerce and Industry (VCCI), and; (iii) workers are represented by the Viet Nam General Confederation of Labour (VGCL), the Viet Nam Cooperative Alliance (VCA) and the Viet Nam Farmer's Union. [7]

- Legal coverage and Eligibility

SHI is mandatory and intended to cover all residents, regardless of employment status or citizenship, as stipulated in the Health Insurance Law (2008) and its subsequent amendment in 2014. Decree No. 146/ND-CP (2018) classifies the population into six SHI membership categories based on sources of contribution to the scheme, which includes 35 different sub-groups. Decree No. 70/2015/NĐ-CP supplements this with stipulations for active duty armed service members (See Table 1 for details).

Formal economy workers and civil servants working outside the military and police forces must enrol via their employer and must comply with payroll-based contributions, including those with time-limited contracts of three or more months, as well as those without time limits. For recipients of both long-term and short-term social insurance benefits, enrolment is automatic through the administrative system. Population groups who are fully subsidized by the state budget — including both vulnerable groups (such as members of poor households, children under 6 and persons aged 80 and older), meritorious groups (including revolutionaries, veterans and organ donors) and the armed forces — are enrolled automatically. For certain groups, including school pupils and university students, the near-poor and middle-income farmers, enrolment is also compulsory but only partially subsidized. Active members of the armed forces and dependents of employees in the military and police are covered by contributions solely from their employers. Those who do not fall under any of the above categories are legally obliged to enrol on a household basis using a discounted contribution structure for each additional household member.

- Benefits

All SHI members are entitled to a single and broad set of benefits (ILO 2019; Somanathan et al. 2014) including diagnosis and treatment, rehabilitation, antenatal care, delivery care and, in some situations and for certain groups, medical transport. Following the Heath Insurance Law Amendment in 2014, a series of subsequent sub-legal regulations have been introduced to define the SHI benefits package using a positive list approach. In particular, under several MOH policy documents, SHI covers medicines, radioactive substances, technical medical services, medical devices and consumables, which includes traditional and modern medicine methods. [8] The MOH has imposed some restrictions on the benefits, such as limiting provision of some services and medicines to tertiary facilities with advanced capacities, limiting some services or drugs to specific diagnoses, or limiting coverage to a small percentage of costs for high-cost items. However, these restrictions are not applied to active service members.

The Health Insurance Law of 2008 and its 2014 amendment also contains some blanket restrictions in the form of a negative list of services not covered by the SHI scheme, which consists of items that are covered by other funding sources (preventive services, contraception, forensic medicine, clinical trials, medical interventions in

[7] Decree No. 01/2016/NĐ-CP prescribes the functions, duties, power and organizational structure of Viet Nam Social Security.
[8] Circular No. 43/2013/TT-BYT; Circular No. 50/2014/TT-BYT and other technical medical services approved by the Minister of Health for implementation in medical facilities are not yet listed in these two circulars. This includes both traditional and modern medicine services. Circular No. 30/2018/TT-BYT and 27/2020/TT-BYT stipulates lists of modern and traditional medicines covered by health insurance

times of natural disasters, and prosthetic devices for war victims and people with disabilities), elective services (health check-ups, fertility treatments, foetal screening not related to treatment, abortion, elective aesthetic medicine services and nursing homes) and other services (optometry, hearing aids, mobility devices, medical care and rehabilitation for substance abuse).

In 2017, a basic primary care package was demarcated under Circular No. 39/2017/TT-BYT [9] covering curative and rehabilitation care services, medicines covered by SHI at commune level, and primary care, disease prevention and health promotion provided at district health centres or commune-level facilities and covered by state funding. [10] The MOH is working on integrating treatment costs for some infectious diseases into the SHI package. Costs of antiretroviral treatment for HIV have been covered since 2019 and COVID-19 treatment was covered in 2020, with work ongoing for tuberculosis. Costs associated with prevention and control of infectious disease are still paid through the state budget (ILO 2019).

- Provision of benefits and services

SHI members can access health care services at one of the many public or licenced private facilities contracted by VSS. The network of registered facilities providing health care services to SHI members includes primary care facilities (such as commune health centres, regional polyclinics, [11] district health centres, workplace clinics and some private clinics) and public hospitals (including provincial, central, general and specialized hospitals, traditional medicine hospitals, rehabilitation hospitals, sectoral hospitals and private hospitals). The hierarchical design of the health system and nationwide network of commune health stations has enabled the SHI system to set up a rational referral network and facilitated the integration of preventive medicine and curative care services for insured members. However, the continued underfunding and inadequate quality assurance surveillance of commune-level services, combined with improved transportation networks and rising incomes have led many people to bypass these facilities and seek care directly at higher level facilities without referrals. As a result, the Health Insurance Law amendment reversed the requirement of commune-level facilities to refer insured patients to the district level for care. This facilitates access to more specialized medical services, but undercuts the integration and coordination of care by a primary care provider at the commune level.

Viet Nam's primary care network, which consists of 11,100 commune-level health stations, 277 regional polyclinics, 710 workplace clinics and a large number of private clinics, reaches every commune in the country, including those in remote areas. All 713 districts have a district health centre providing preventive medicine and public health services, and 666 districts also have a district-level hospital. A total of 47 central and 470 provincial general and specialist hospitals, traditional medicine hospitals, and rehabilitation facilities are run by the Government, compared with a total of around 230 private hospitals (Viet Nam Ministry of Health 2019). VSS automatically covers services provided at commune health centres (with no contract required), and contracts all public sector hospitals and health centres, including a share of private hospitals, to provide insured services to patients. In total, VSS covers all commune level health stations, and contracts more than 2,500 higher level facilities, of which 31 per cent are private (5 per cent of total facilities covered are private) (VCCI and ILO, unpublished). However, few of the large number of private outpatient clinics used widely by the population are contracted by VSS.

To access SHI benefits, most members are required to make co-payments at facility level, the value of which varies depending on a patient's SHI membership category. According to Decree 146/2018/ND-CP certain vulnerable groups (such as children under 6 years of age, the poor, individuals from disadvantaged ethnic minority groups and social assistance recipients), and meritorious groups (revolutionaries, war veterans, active armed forces and family members of certain meritorious groups) do not have to pay any co-payments when seeking care in compliance with the health care facility referral regulations. Pensioners, individuals who are living in near-poor households and family members of certain persons of merit are only required pay a 5 per cent co-payment. For members who do not

[9] Viet Nam Ministry of Health Programme 527/CTr-BYT of 2013 to improve quality of medical services at health facilities with the objective of ensuring satisfaction of health insured patients.
[10] Viet Nam Ministry of Health Circular No.39/2017/TT-BYT of 2017 Regulating a Basic Health Care Package for Primary Care Facilities
[11] In Vietnamese, these are called "Phong kham da khoa khu vuc".

belong to these categories, a co-payment of 20 per cent applies.

Although SHI members are required to register their health insurance cards with a primary care provider, patients can access insured services at other facilities without referral and without additional co-payments in cases of inpatient care at provincial level facilities or below, or outpatient care at other district level facilities or below. However, if the patient seeks inpatient care at a central level facility without a referral, VSS will only pay 40 per cent of the normal coverage rate, with the patient paying the rest as a co-payment. If a patient seeks outpatient care at a provincial or central facility, SHI does not cover the costs of services, except in cases where individuals are permitted to register for care at such facilities. For most member groups, SHI benefits can be accessed right after registration without any waiting period. However, for the near-poor, school pupils, university students and household members, there is a 30-day waiting period. To access SHI benefits, the insured individual is required to show their VSS issued SHI card, or evidence that the card is being processed. Patients who follow the referral line need to present all referral documents together with their SHI card to avoid paying higher co-payments.

A purchaser-provider split is in place, although some purchaser functions, such as determining the benefit package and prices, are still implemented by the MOH, which is also still directly involved in service provision through central medical care facilities. Under the Health Insurance Law, three types of provider payment methods can apply: capitation, fee-for-service and case-based payment. Implementing Decree 146 stipulates that primary outpatient health care will be paid on a capitation basis and fee-for-service payments will apply to services not paid by other methods, but does not specify the scope of services to be paid by case-based payments. Currently, providers are almost exclusively paid on a fee-for-service basis. Widespread balance billing practices, which drive competition among providers to generate revenues rather than reduce costs, combined with policies promoting financial self-reliance among public facilities, complicate the introduction of payment mechanisms other than fee-for-service (Somanathan et al. 2014). The lack of a gate-keeping function at primary care facilities further complicates development of the capitation payment policy. Work is on-going to develop the capitation and diagnosis-related payment mechanisms.

4. Results

- Coverage

Legal coverage in Viet Nam is 100 per cent, as universal health insurance is compulsory by law (article 1, Health Insurance Law Amendment 2014). However a proportion of the population remains uncovered, including undocumented persons. Nonetheless, strong political commitment to achieve UHC in Viet Nam has led to a rapid increase in coverage over the years, from around 71.4 per cent in 2014 to 90.85 per cent by the end of 2020 (VCCI and ILO, unpublished). There is presently no in-depth analysis clearly identifying the remaining 10 per cent of the population who are uncovered. Internal government reports indicate that the majority of the uncovered population are made up of informal economy workers within second and third quintile income groups (Somanathan et al. 2014), as well as students. A recent study found no significant impact of information provision or subsidized contributions to further increase coverage among informal economy workers (Wagstaff et al. 2016).

According to official government sources, in 2018, the coverage rate reached 100 per cent among the poor, disadvantaged ethnic minority persons and social assistance recipients, whose contributions are financed by tax revenues. Furthermore, as a result of generous government subsidies, the coverage rate among the near-poor was also relatively high, at around 95.3 per cent in 2018. High level attention from the Prime Minister's office, including assigning annual coverage rate targets for each province and monitoring achievement, are likely to have contributed to this sustained coverage expansion. [12]

- Adequacy of benefits/ financial protection

Viet Nam has achieved great progress in reaching out to the poor and the vulnerable through generous SHI subsidies and varied co-payment rates for different membership categories, which

[12] Prime Ministerial Decision 1167 dated 28 June 2016 on Adjusting the Targets for Implementing Health Insurance for the Period 2016–2020.

has significantly enhanced financial protection for vulnerable groups. However, the aforementioned co-payment structure only applies to those who comply with the referral system, which many individuals do not adhere to due to concerns over poor quality at the primary level (Le et al. 2018). For outpatient care at central or provincial hospitals, [13] patients who have not been referred are required to pay 100 per cent of the total cost, which significantly increases OOP payments for self-referred patients. Due to recent policy reforms, penalties for by-passing the referral line for inpatient care up to the provincial level have been removed. However, the penalty for by-passing referrals at central facility level is very high, with a 68 per cent co-payment rate, from which the poor, ethnic minority persons living in disadvantaged areas and residents of islands are exempt (article 22, Health Insurance Law Amendment 2014).

Another factor which undermines financial protection for SHI members is underutilization, which has been attributed to a perceived quality gap between premium services care services for those who can afford and are willing to pay out-of-pocket and VSS-contracted services within the same public facilities (Le et al. 2018). This is perpetuated by increasing privatization of public hospitals under a policy of hospital autonomy, which risks limiting financial protection for SHI members in the future.

As a result of these obstacles, OOP payments in Viet Nam are increasing and remain very high, accounting for more than 45 per cent of the country's current health expenditure in 2017, which rose from 37 per cent in 2000. However, this increase in OOP expenditures has been concentrated among higher-income households who can afford premium services (Teo et al. 2019). As a result, despite high OOP spending, there have been substantial improvements in households' financial protection against large health expenditures, with catastrophic expenditure declining over time, from approximately 16 per cent in 2004 to 9.5 per cent in 2016 (Teo et al. 2019). Notably, Viet Nam is among the top five countries in terms of declining impoverishment due to OOP spending, with the rate of impoverishment due to health spending as low as 1.3 per cent (Teo et al. 2019).

- Responsiveness to population needs
    - o Availability and accessibility

The broad network of VSS-contracted facilities noted above ensures patient accessibility to providers and a choice for the patient. Among remote and geographically isolated population groups, village health workers and village birth attendants affiliated with a commune health station contribute greatly to the provision of public health services and first aid for people in rural areas (Le et al. 2018). Despite these favourable conditions, persons living in remote and disadvantaged regions continue to face various socio-economic barriers to access, including long distance to the nearest facility, poor service quality in primary care and lack of affordability (Tran et al. 2016). Furthermore, there is an uneven distribution of human and financial resources between urban and rural regions, which negatively affects equity in health care access (Lieberman and Wagstaff 2009; Somanathan et al. 2014). In particular, commune health stations are significantly under-resourced and underused, which has implications for equity in health care access, especially among those living in remote and disadvantaged areas. (Somanathan et al. 2014). In 2018, survey results indicate that individuals in the poorest quintile had greater access to inpatient care but lower access to outpatient care than those among richer quintiles. However, for both inpatient and outpatient care, the poorest quintile had minimal access to tertiary facilities, relying heavily on district and lower level facilities, while richer quintiles had substantially higher access to tertiary and private health services for both inpatient and outpatient care (General Statistics Office 2019).

    - o Acceptability and quality

Even though the SHI benefits package is broad and generous in theory, access to effective primary and secondary health services at facilities close to home is complicated by perceptions of low quality of care due to limited equipment and medicines (ILO, 2019f; Somanathan et al. 2014). Primary care facilities, especially those in rural areas, suffer from insufficient funding and limited capacity among medical staff (Lieberman and Wagstaff 2009; Somanathan et al. 2014; World Bank 2016). In 2017, the number of doctors and nurses/midwives per 10,000 inhabitants in Viet

[13] Due to the weak referral system, many tertiary facilities also provide outpatient care and medical services that can be conducted at lower levels of care.

Nam was estimated at 8.28 and 14.46 respectively (WHO n.d. b), which is slightly lower than WHO recommended ratios (WHO 2006). [14]

Overcrowding and long waiting times are common at provincial and central hospitals (Nguyen and Cheng 2014; Somanathan et al. 2013). As previously noted, self-referrals are commonplace, largely as a result of perceived poor quality of care at primary facilities (Le et al. 2018). To compound this, tertiary facilities have the financial incentive to directly compete with low-level facilities for profit, due to the user fee, hospital autonomy and social mobilization policies initiated in the health sector starting in the 1990s (Barroy et al. 2014; Ramesh 2013); this deepens existing quality disparities between facilities.

Moreover, there is an increasing quality gap between services offered within the same facilities, which has led to a perception of discrimination against SHI users (Dang 2013; Duong 2014; Kim and Vu 2013). At large hospitals, the queue for VSS-contracted services is often longer than that for premium services which are not covered by SHI. Those who use these services can also benefit from better infrastructure, facilities and equipment. Commercial health insurance payments for these premium services exacerbates incentives for public hospitals to prioritize resource allocations to these departments, undermining the solidarity of the SHI system. This divide between two lines of services within public facilities is the result of a decentralization policies that have allowed public service providers to generate and retain revenues to deal with a lack of funding, and low wages for medical staff (Lieberman and Wagstaff 2009; Ramesh 2013). Given the competitive advantage of tertiary facilities over lower-level hospitals in this regard (Barroy et al. 2014), this disparity may be reinforced as public hospitals in Viet Nam become increasingly "private".

Since 2015, patient satisfaction surveys have been used to measure patients' opinions on the quality of health care services delivered. A 2014 UNICEF-funded study in Dien Bien, one of the poorest provinces in Viet Nam, rated patient satisfaction for all services at more than 78 per cent. [15] Given the poor quality of care at primary level, the high level of satisfaction indicated in these two studies may point to low expectations among those living in disadvantaged areas, or a potential reluctance to voice complaints.

As a result of these challenges, quality of care has recently become central to government efforts to strengthen the health system. Through the implementation of a 2009 programme [16] and a 2020 Directive on quality of health services for insured patients, [17] the 2008 Law on Health Insurance has focused attention on the need for a range of measures to improve quality of care and ensure satisfaction of insured patients. The 2009 Law on Examination and Treatment began the institutionalization of certification of health care professionals and licensing of health care facilities to improve quality of care. After results of a pilot in 2013, a set of 83 quality standards were issued in 2016 in an effort to monitor and evaluate hospital structural quality. [18]

▶ 5. Way forward

Viet Nam has demonstrated a high level of political commitment to achieving UHC and made substantive progress in expanding SHI coverage. However, challenges remain in terms of ensuring affordable, equitable and quality health care for all. Maintaining and further expanding effective population coverage to the missing 10 per cent of the population will require determining new strategies, which may include extension of state budget-funded subsidies to further support the participation of workers in the informal economy. The implementation of regulations such as Decree 146, allowing provinces to use local budgets to increase subsidies for partially subsidized groups, as well as activities to tackle non-compliance with compulsory contributions among the employed as part of VSS's 2021–2025

[14] The WHO recommended doctor-to-population ratio is 10 per 10,000 people. If combining the total number of medical doctors and nurses/midwives, Viet Nam marginally reached the minimum threshold of 23 doctors, nurses and midwives per 10,000 population that was established by WHO as necessary to deliver essential maternal and child health services.
[15] Surveyed services included ante-natal care, medical check-up, vaccination, maternal and child care and health promotion via health communication activities.
[16] Viet Nam Ministry of Health 2009 Programme 527/CTr-BYT to Improve quality of medical services at health facilities with the objective of ensuring satisfaction of health insured patients.
[17] Viet Nam Ministry of health Directive 25/CT-BYT of 2020 on Continuing to Strengthen Insured Medical Services Quality Management.
[18] Viet Nam Ministry of Health Decision 6858/QD-BYT of 2016 Issuing the Vietnam Hospital Quality Standards.

five-year plan, are expected to contribute to further coverage expansion. [19]

Recent years have seen increases in user fees to cost-recovery levels, combined with phasing out supply-side subsidies and pressure on hospitals to increase revenues to cover full operating costs and supplement low civil servant salaries of staff in public hospitals, as part of the policy of hospital autonomy. This has driven rising OOP payments, which is starting to erode the financial protection of SHI coverage. Increasing SHI enrolment is therefore not sufficient to guarantee effective and equitable access.

Another challenge lies in addressing the rising cost of care in the context of a rapidly ageing population, the associated double burden of disease, and rapid diffusion of expensive technologies and medicines without adequate regulations or incentives to avoid overuse. The Health Insurance fund has experienced consecutive years of expenditure exceeding revenues, which needs to be addressed before the depletion of the reserve fund in order to maintain the existing coverage rate and level of benefits, without increasing contribution rates. Cost control, particularly though more strategic purchasing and provider payment reforms, is already part of the SHI scheme reform plans. [20] These reforms are expected to enhance efficiency and affordability of what the SHI fund purchases, while ensuring it maintains effectiveness in meeting people's needs. Enhancing effectiveness of the primary health care network, and increasing satisfaction with and trust in primary health care is also needed to ensure greater focus on disease prevention, management and health promotion, which are more appropriately provided at primary care facilities rather than hospitals. This shift will require increased compliance with a rational referral system.

▶ 6. Main lessons learned

- The enshrinement of the right to health in the Viet Nam Constitution has successfully facilitated the extension of social health protection coverage. Including universal SHI coverage in the Constitution helped to increase its priority level and enhance government accountability, requiring the Government to implement the required reforms to ensure this constitutional right. It fostered the necessary level of political commitment, which has been crucial to developing and enforcing legislation and guaranteeing adequate funding for UHC. In addition to improvements to the SHI legal framework, Viet Nam's ambition to achieve UHC has been reflected in many political documents and targets. Increased budgetary allocation for health has also been observed.
- The consolidation of various health protection schemes initiated in 2008 was instrumental to creating a single risk-pooling mechanism for financing health care. It has contributed to improving the efficiency of the SHI Fund, and constitutes the necessary foundation for strategic purchasing.
- The Government's pro-poor policies and significant budget allocations have enabled the equitable extension of population coverage. However, middle income households lack coverage and do not benefit from the effective benefits received by poorer groups, which are still substantially lower than middle-and high-income groups. The complex classification of the population into multiple groups and sub-groups to set contribution amounts, and allocating subsidies on the principle of "fairness" may be limited. Achieving UHC will require new strategies, including potentially fully subsidizing the remaining uncovered population, to maintain and further expand coverage.
- Increasing SHI enrolment is not sufficient to guarantee effective and equitable access. Focus should also be placed on strengthening effectiveness and trust in primary health care, enhancing the potential for care coordination through primary care providers, and better integrating disease prevention, health promotion and curative care services through a patient-centred approach, while ensuring appropriate evidence-based care at all levels.

[19] Decision 1320/QĐ-BHXH dated 23 October 2020.
[20] As per the Five-Year Socio-Economic Development Plan No. 3353/KH-BHXH of Viet Nam Social Security for the Period 2021–2025.

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Supported by LUXEMBOURG AID & DEVELOPMENT

This profile was prepared by Sarah Bales and Marielle Phe Goursat, with the support of Henrik Axelson, Dung Doan Thuy, Nga Leopold and Christina Morrison (ILO). It benefited from the review, inputs and quality assurance of Nguyen Khanh Phuong (Health Strategy and Policy Institute, Viet Nam).

The Editor of the series is Valérie Schmitt, Deputy Director, Social Protection Department.

This country brief is extracted from and one of 21 country profiles published in the ILO's report: "Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific".

Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

ISBN 9789220359280 (print)
ISBN 9789220359297 (PDF)