GOOD PRACTICE PRESENTATION

UNIVERSAL HEALTH INSURANCE COVERAGE - AN VSS' EXPERIENCE

Brunei, 12 October 2011

Vietnam Social Security

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Vietnam overview

Demographics (2009)

- Area: 331,698 km2
- Population: 86.0 million
- Pop. Density (pers./km2): 260
- Adult Literacy Rate (%): 93.5%
- GDP per capita: 1064 US$

Health indicators (2009)

- Life expectancy: 72
- IMR: 16/1000
- CMR : 25/1000
- MMR (per 100,000 live births): 69

Health financing reform

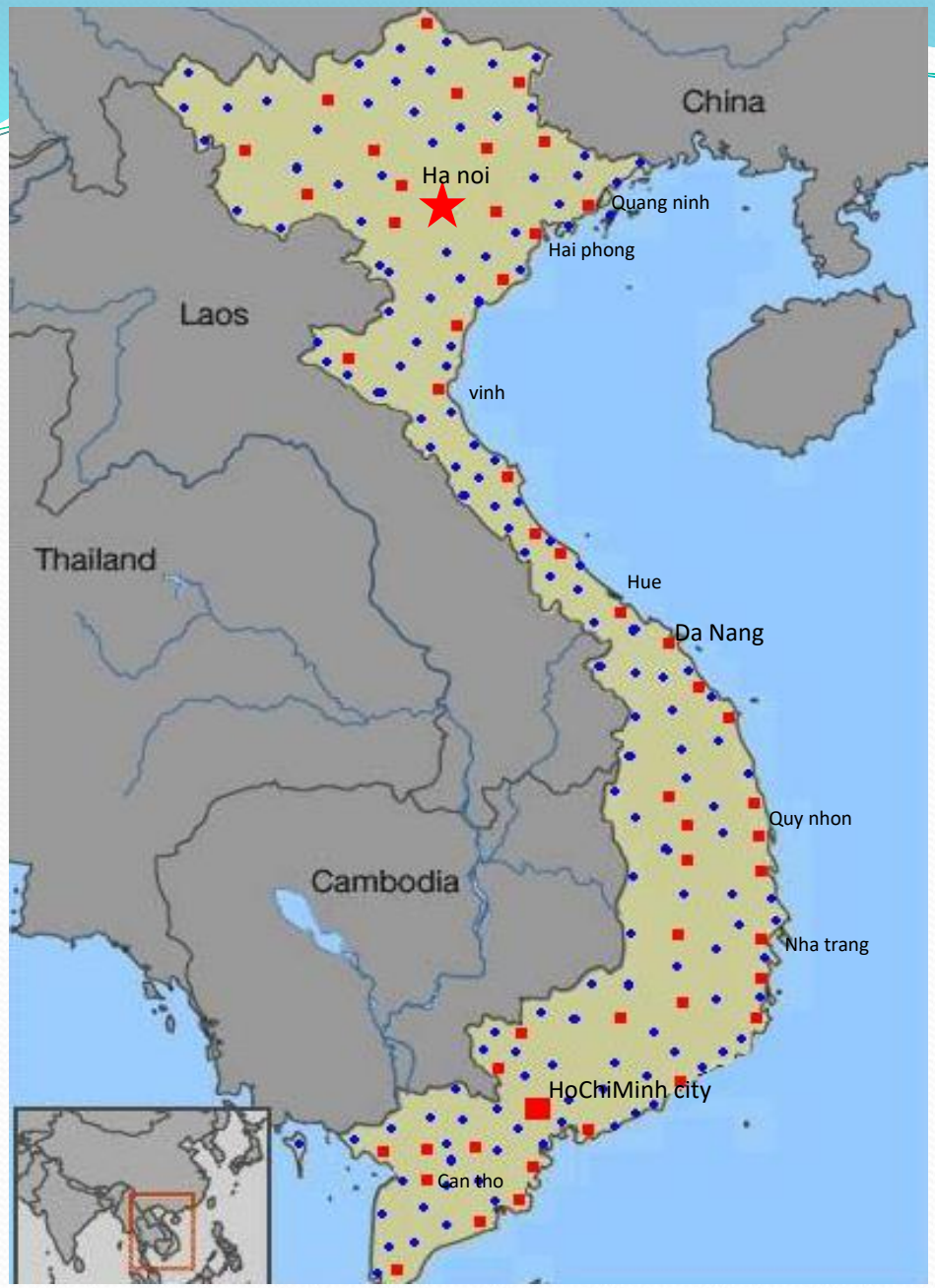
- Transition from tax-based financing to HI in the 90s

Health financing indicators (NHA, 2009)

- THE/capita at : 80 US$
- THE as % of GDP: 7.2%
- GGHE as % of THE: 38.7%
- PvtHE as % of THE: 61.3%
- Out of pocket expenditure as % of THE: 56.6%

Universal health insurance coverage

Map of VSS system



- **Vietnam Social Security's Headquarters**
- **Provincial Social Security Offices**
- **District Social Security Offices**

Health Insurance Policy in Vietnam

1992

- The Government issued Decree 299 on Health Insurance. VHI was formed under the Ministry of Health

1998

- The Government issued Decree 58 on Health Insurance. VHI was under a centralized management system from the Central to provincial levels and under the MoH

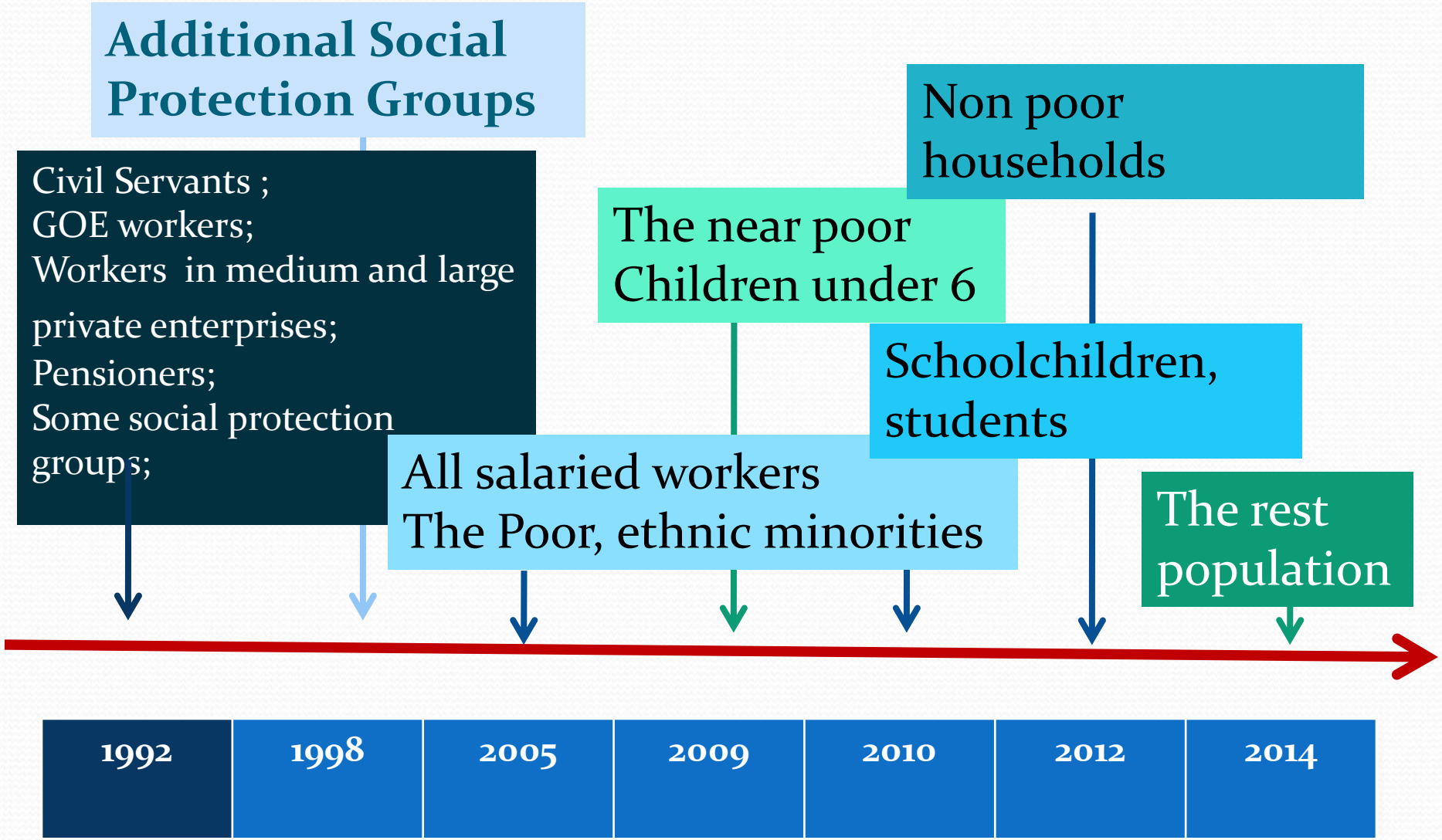
2002

- VHI system was merged into Vietnam Social Security – an Governmental Agency

2008

- Health Insurance Law was issued and came into effect from 1 July 2009

Compulsory Coverage Timeline



Policy decisions

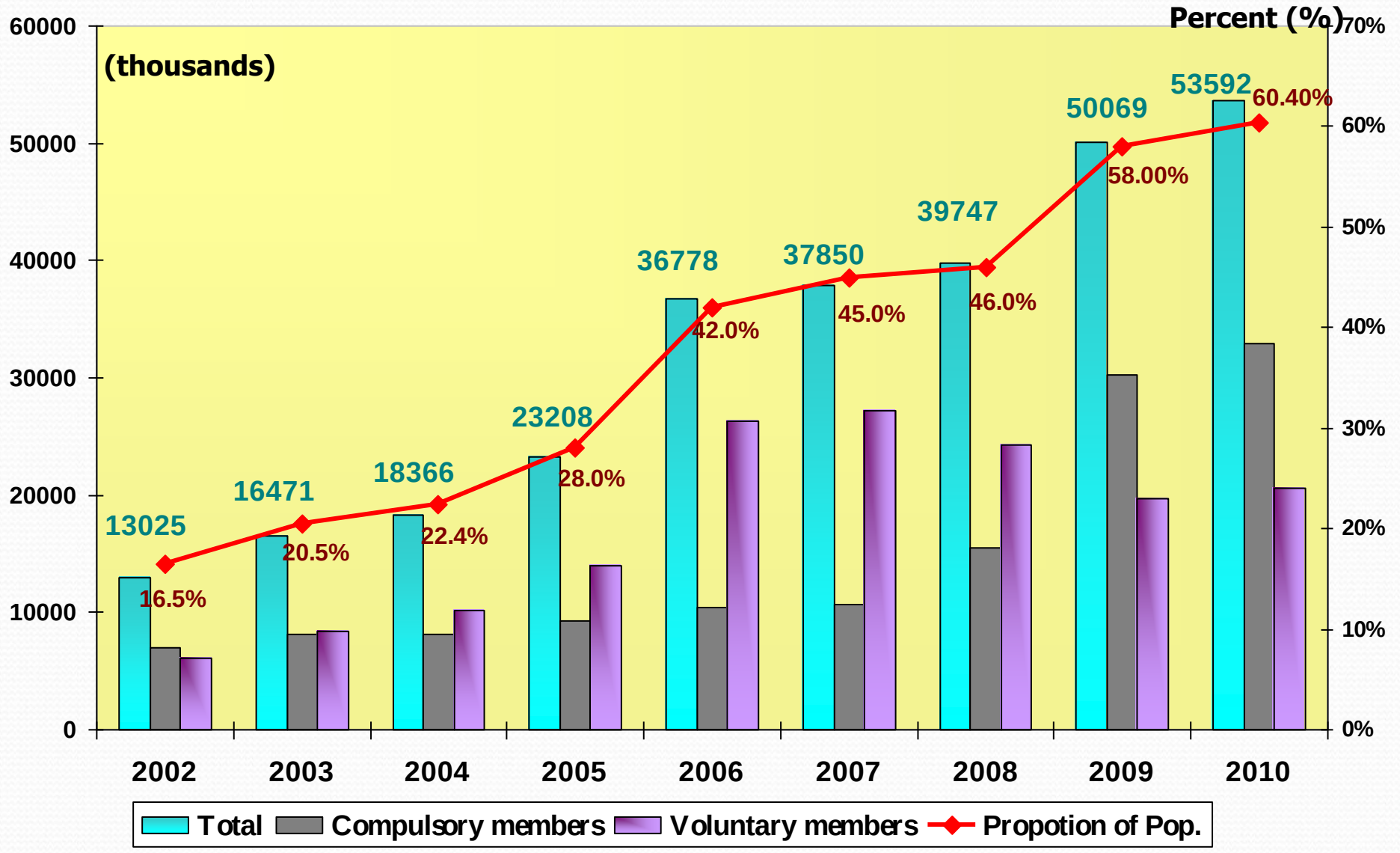
Membership grouping	Contribution
Civil servants	Employers & employees
Wage Workers	Employers & employees
Pensioners	Social Security Fund
Social Protection groups	Stage Budget
The poor and ethnic minority	Stage Budget
The near poor	Subsidy (50%)
Children under 6 years	Stage Budget
Schoolchildren and Students	Subsidy (30%)
Non poor households Voluntary scheme (to be compulsory after 2011)	non-subsidized

Policy decisions

Benefits package and service delivery system

- Benefit package (including outpatient and inpatient care) and service delivery is the same for the informal sector as for other sectors;
- Difference copayment for different groups, but not related to formal of informal membership. Ordinary copayment is 20% of health care cost, while pensioners, the poor and ethnic minority copay 5%.
- Children under 6 and special merit people have no copay.

Health Insurance Membership



Coverage in 2010

Major Population groups	Coverage in million	Coverage as % of total
Civil Servants	3.14	100%
Wage Workers	6.36	53%
Pensioners	0.92	100%
Social Protection Groups	3.94	97%
The poor and Ethnic Minority	13.51	100%
The Near Poor	0.69	11%
Children under 6 years	8.18	81%
Schoolchildren and Students	9.80	71%
Non Poor Households	3.92	33%

Policy decisions for informal sector coverage (1)

- *Pro poor policy:* covering the poor and vulnerable informal groups highest priority.
- *Revenue generation:* full government subsidy for the poor, ethnic minority, under 6 years olds + merit people; *at least* 50% subsidy for the near poor, 1/3 subsidy for others;
- Compulsory scheme currently being applied to all informal sector groups, with plan to cover last groups in 2014.

Policy decisions for informal sector coverage (2)

Institutional arrangements

- Informal sector being included to the national single health insurance programme;
- Contribution of all formal and informal subgroup members from all provinces are pooled into single national health insurance fund

Operationalizing coverage to the informal sector (1)

Awareness, targeting, enrollment and collections

- Commune organizations, labor and social agency are key players in identification of the poor, the near poor, ethnic minority group, children under 6, non-poor households;
- National economic household survey conducted annually to provide data for initial list of the poor and near poor;
- Voting for the poor/near poor by commune members; revision of the list;
- Schoolchildren and students: important role of schools.
- Health Insurance agencies are responsible for contribution collection (2x or once a year collection).

Operationalizing coverage to the informal sector (2)

Service delivery system

- Focus on improvement of district and commune health facilities (improvement of infrastructure, capacity building of health care staff) to provide better health service at commune level;
- 11, 000 communes with commune health stations, 60% occupied by doctor, 5-6 staffs;
- Provision of health care under contracts with health insurance at commune health stations;
- Capitation payment.

Success and challenges

Success:

- Single scheme, single fund for all population groups to maximize cross-subsidy;
- Equity in benefits and service delivery;
- Protection for the most vulnerable population
- 100% coverage of the poor and ethnic minority groups (14 millions)
- High coverage of children under 6 years (8 millions) ;

Challenge:

- Coverage of the near poor and non poor household: low compliance with adverse selection;
- High administration cost of contributory scheme

Experience on Universal HI Coverage

- Developing policy:
  - Good legal framework (HI Law)
  - Potential HI groups should be covered by compulsory HI (pupils and students).
  - HI premium should be suitable for each group and each economic development period.
  - Reasonable roadmap for Universal HI Coverage.

Experience (cont)

- Commitment of the Government:
  - Direct closely the implementations of Ministries/agencies.
  - Financial commitment from State Budget for:
    - Purchasing HI cards for people who are unable to pay the premium (the poor, children under 6, protection group).
    - Partly subsidizing HI premium for some special groups (pupil and student, near poor household).

Next steps

- Strategy: more involvement of local authorities in advocating people for enrollment;
- Study alternatives in covering the informal sector.
- For the whole health insurance system: revising benefit package based on cost-effectiveness evidence; revising provider payment methods.
- Improving the quality of HR;
- Applying IT in managing HI system.

Thank you !