



Social Health Insurance in Vietnam: Financial Protection of the poor and OOP protection

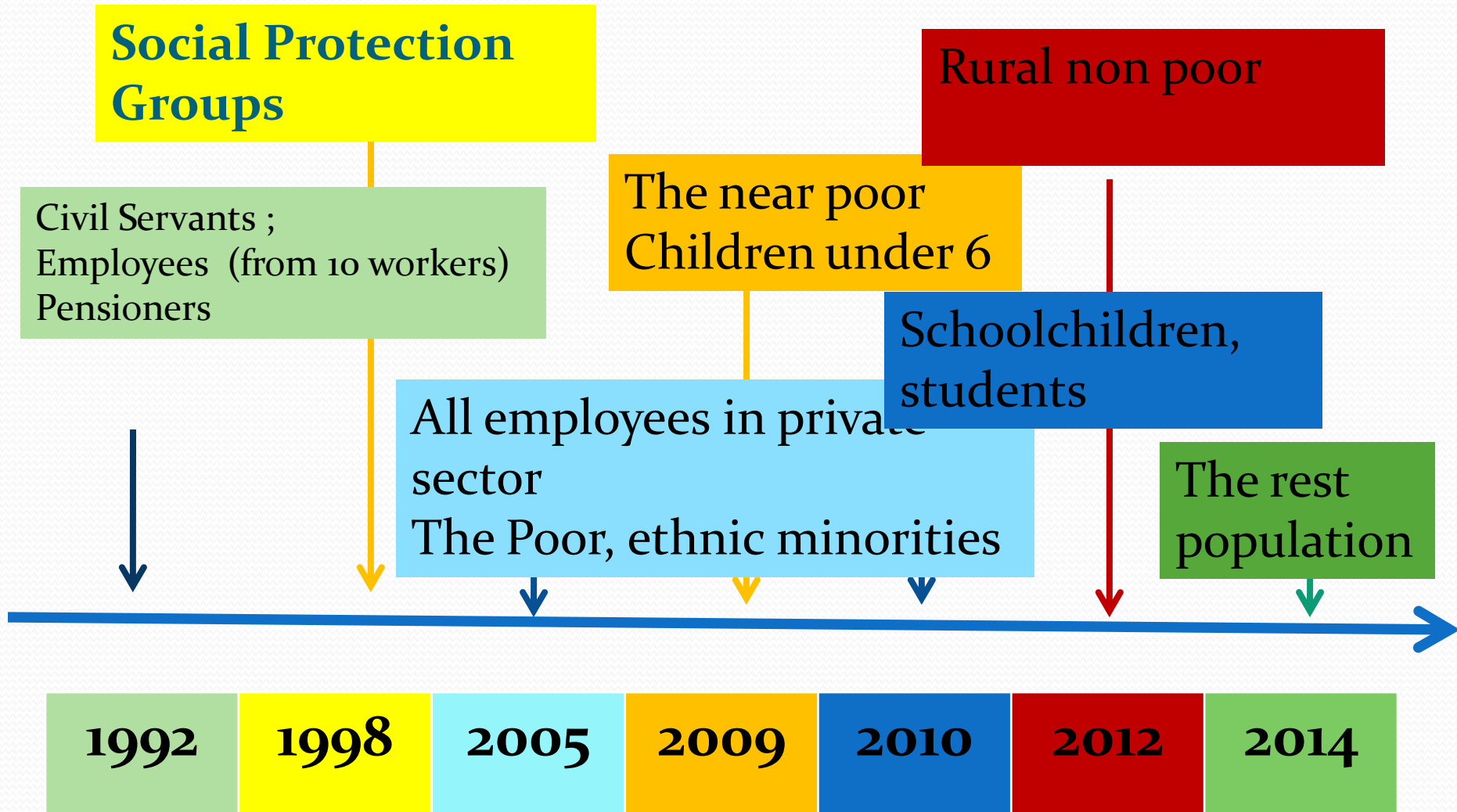
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2. Main Achievements
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SHI development

- **First SHI scheme: 1992** (compulsory: formal sector & voluntary: informal sector)
- **Health Insurance Law (2008): “Compulsory enrolment with government subsidy to achieve UC by 2014”**
 - UC means last groups of population to be under compulsory coverage by 2014*
- **Government subsidy by the Law:**
 - **100%** subsidy for the poor, elderly over 80 years, under 6 years children, ethnic minorities; and some social protection groups;
 - **70%** subsidy for the near poor
 - **30%** for medium income informal sector households.

Time Schedule of Compulsory HI Coverage



HI Contribution

Payroll deduction for formal sector, Fixed rate for informal sector.

- **Formal sector workers:** 4.5% of salary/wages (employees 1.5%, employers 3%);
- **Dependents of formal sector workers:** 15\$US/person/year (3% minimum salary) paid by employees;
- **Pupils and students:** 15/person/year (3% of minimum salary), government subsidizes at least 30%;
- **Other informal sector groups:** 22 USD person/year (4.5% minimum salary). Government subsidies 100% for the poor, children under 6 and some other vulnerable groups; 70% for near poor, and at least 30% for medium income

Benefit package

Benefit

- Comprehensive package: **outpatient, inpatient at all levels;**
- Diagnostic screening of some diseases;
- Positive drug list (804 medicines, 57 radioactive medicines and 95 herbal traditional drugs);
- Positive list of medical services (thousands medical services, most advanced high tech services).

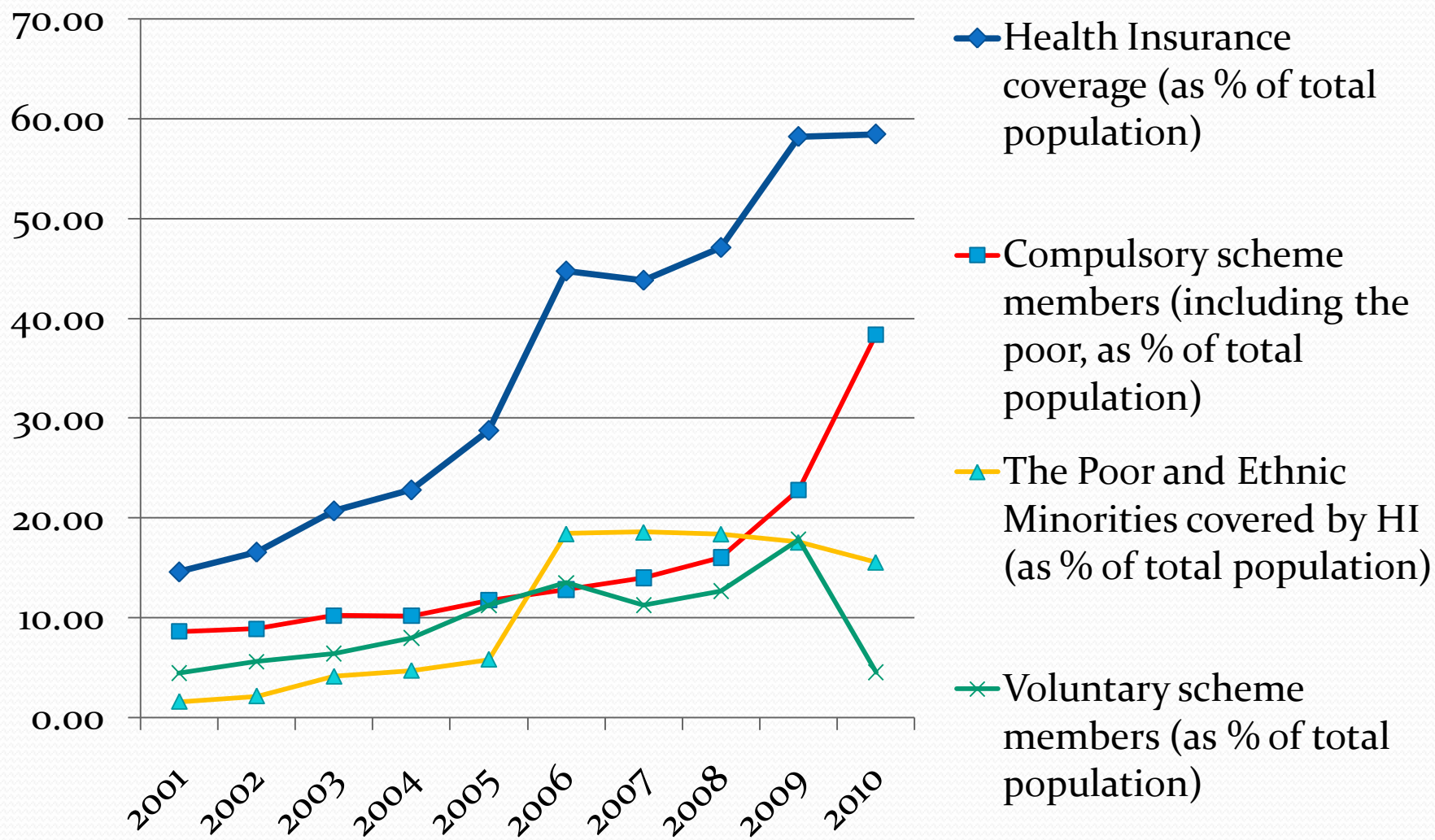
Services/cases not included in benefit package:

- Meal;
- **Preventive health services** (covered by government budget), Health checks;
- Family planning services;
- **Suicides, drug addiction, violation of law;**
- Cosmetic surgery; prosthesis

Financial Coverage

- Copayment 0%, 5% and 20% applied to different membership groups **without ceiling of copayment amount;**
- By-pass: copayment 30% 50% and 70% at district, provincial and tertiary hospitals respectively
- **Ceiling of reimbursement** of expensive high tech services equal to 40 times of monthly minimum salary (2000USD)
- **No copayment** if service cost less than 15% of minimum salary (7.5 USD), or service provided at **commune health stations;**
- **Exemption of copayment for children under 6 years** and some other special social protection group members.

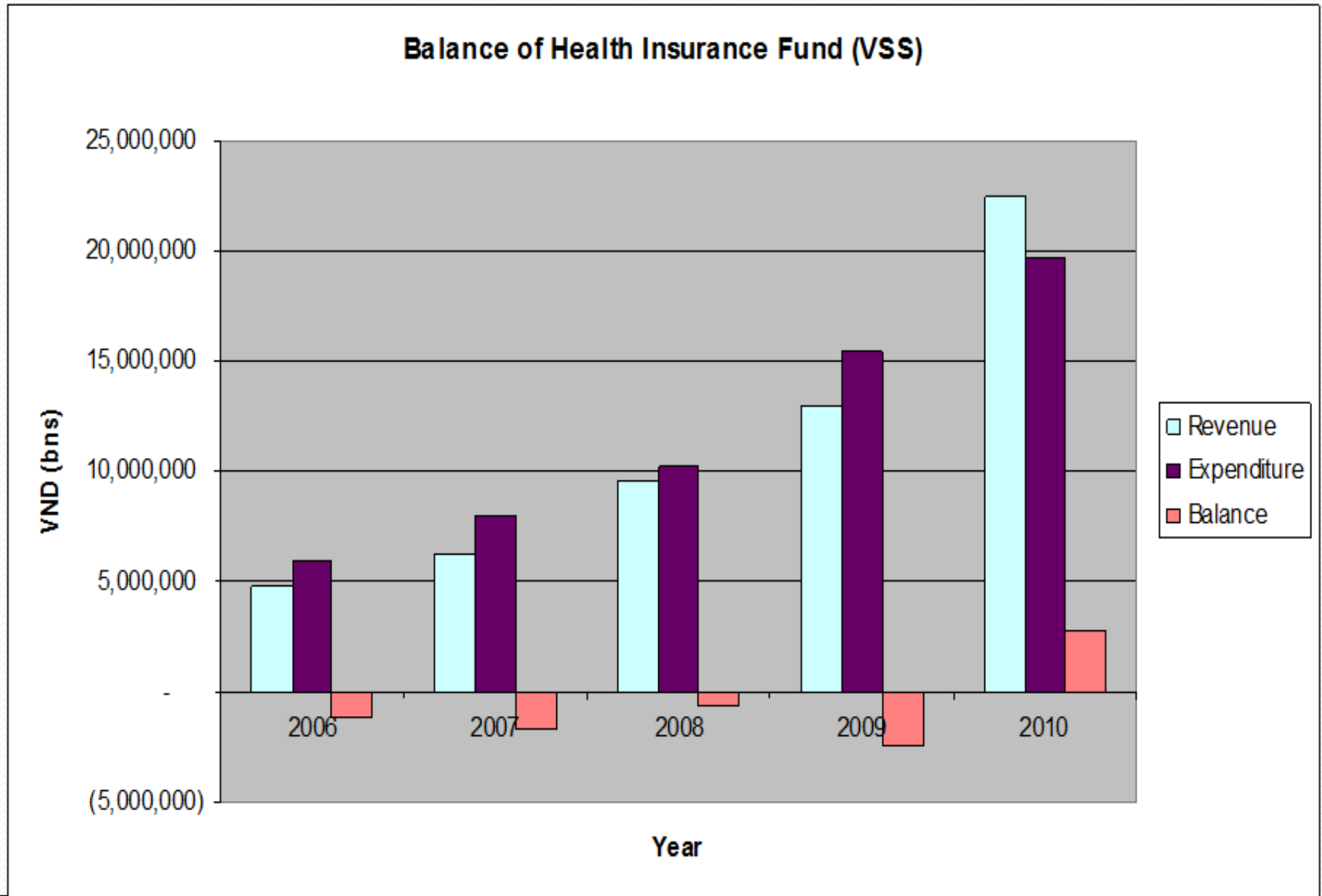
HI Coverage by compulsory and voluntary groups in 2001 - 2010



Health service utilization rate by insured 2001 - 2010

	2003	2004	2005	2006	2007	2008	2009	2010
Average number of hospital admissions per capita per year	0.10	0.10	0.14	0.11	n.a.	0.12	0.13	0.16
Average number of outpatient visits per capita per year	1.33	1.47	1.55	1.54	n.a.	1.67	1.71	1.86

Balance of HI fund

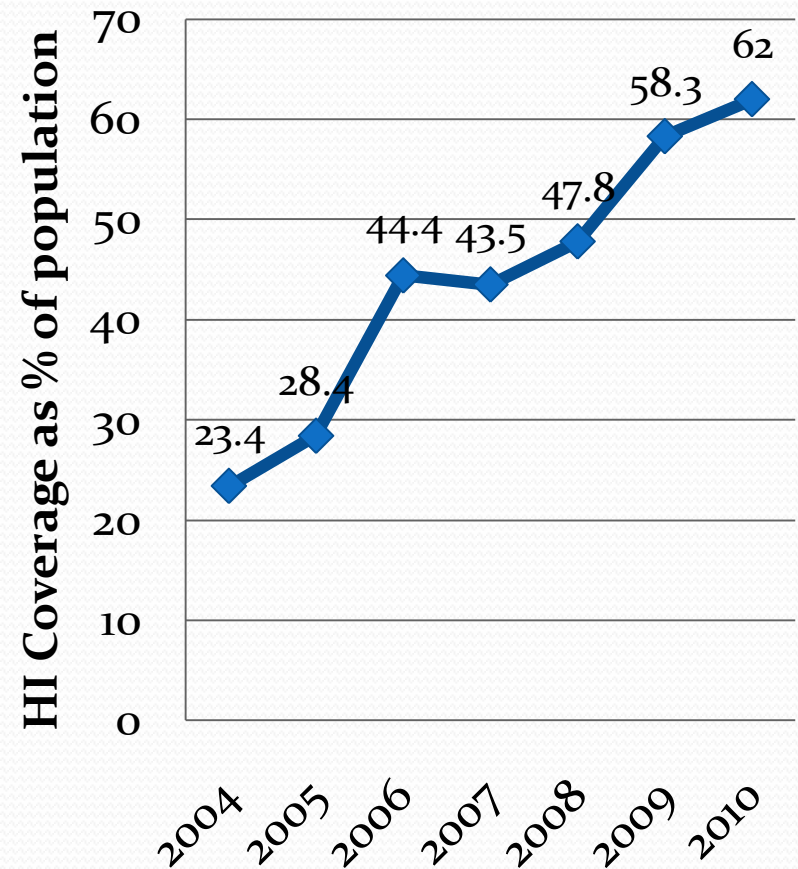


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SHI coverage trends in recent years

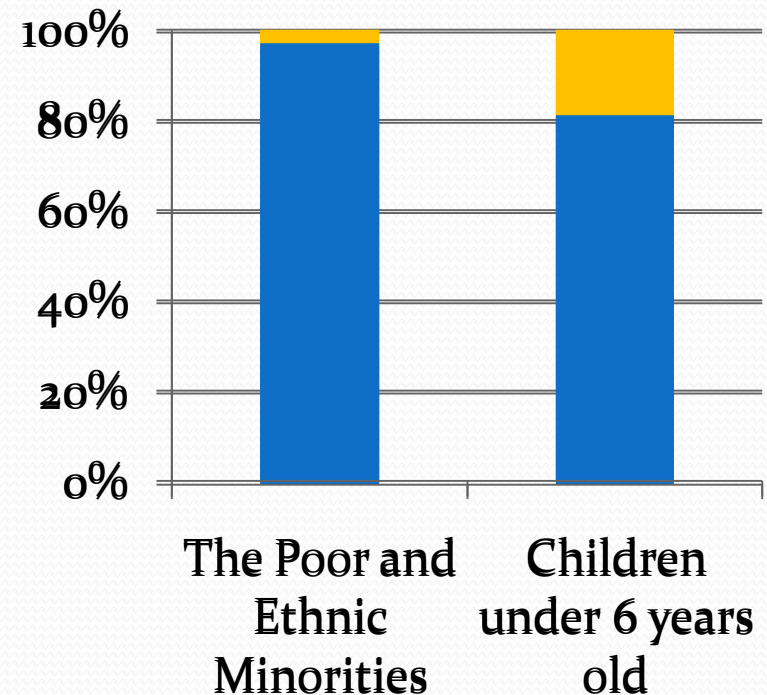
- 62% of population covered by 2010;
- **Rapid expansion:** the poor, children under 6 and others...



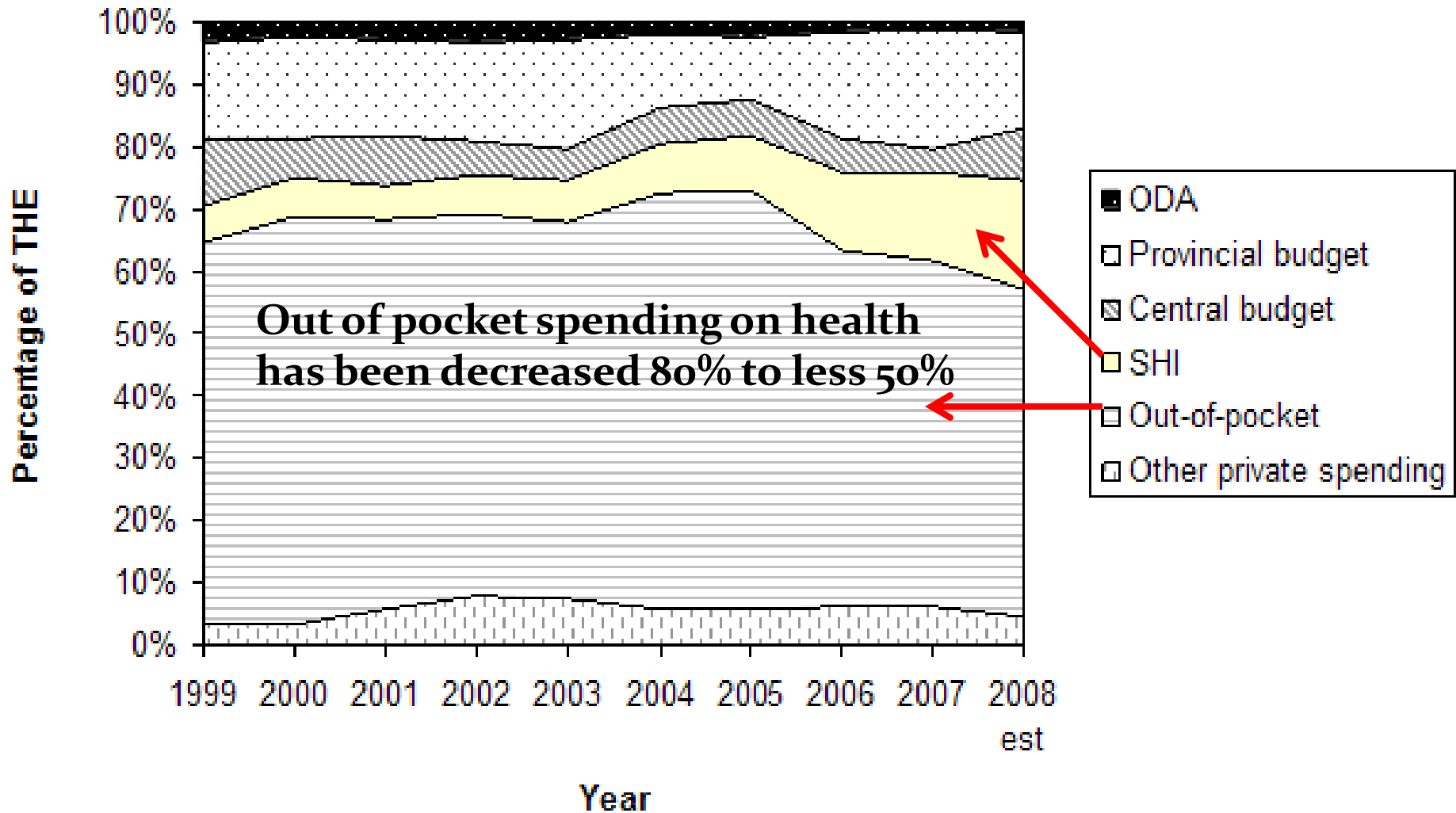
Main achievements

- All the most vulnerable groups are covered
- Quality of health care ?
- Beneficiary satisfaction ?
- Impact on health status ?
- Impact on equity in health financing and access ?

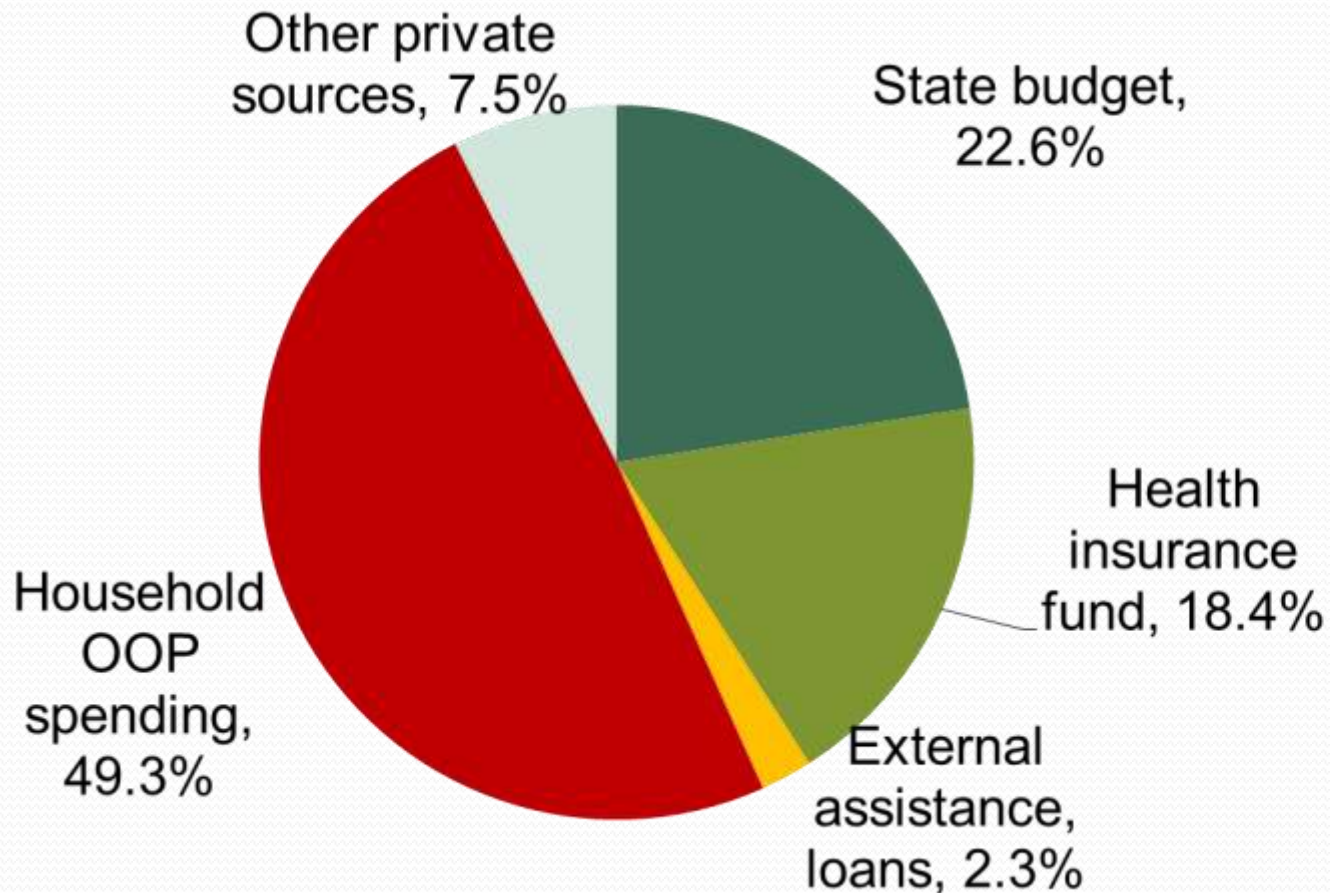
Coverage of the poor and children under 6



Health financing 1999-2008



Share of sources of total health expenditure in 2009



Source: MOH, 2011

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Some Challenges

Population Coverage

- a) Fragmentation of membership and individual enrollment (24 groups)
- b) Low coverage of informal sector;

Health Service Coverage

- c) Cost effectiveness of benefit package

Financial Risk Protection

- d) Low financial risk protection;
- e) Passive role of VSS in purchasing and provider payment arrangement

a) Fragmentation in Enrolment

Individual enrollment, fragmented membership leading to negative implications:

- **Children under six years and elderly (100% Gov. Subsidy) could easily have been covered by a family-based scheme.**
- **Members of the same family enrol in different HI groups, making complex enrolment and contribution collection, requires the assistance of different government agencies.**
- **Children above six years fall outside the SHI scheme if not entered school.**

b) Coverage of Informal Sector

- **Compliance of informal sector** under contributory mechanism has been **very low** despite many efforts;
- The **near poor** group: **11% compliance in 2010**;
- Current contributory mechanism seems to be inadequate for informal sector

c) Health service coverage

SHI benefit package is comprehensive, but

- **Exclusion of Occupational diseases and accidents** at the workplace is a particular **concern for large informal sector** (no employer to take responsibility for these charges).
- **The reimbursement drug list:** has not been based on evidence of cost-effectiveness; **The process for adding or removing drugs** from it does **not have well defined steps**
- **Quality limitation:** Insured can not receive eligible benefits (due to non availability of services, low payment ceiling etc).

d) Low finance protection for HI card holder

The current copayment policy considerably limits the risk-protection function of SHI.

- Copayment for referred patients: 0% - 5% - 20%
- Copayment for “By pass” patients: 30% at district hospitals, 50% at provincial hospitals, and 70% at central and tertiary hospitals.
- Very high copayment for costly high tech services (ceiling of 2000 USD for HT services)

As there is no ceiling for copayment, accumulation of copayments can become catastrophic expenditure for households.

High expenditure and impoverishment by socioeconomic status, data for 2008 (source: HMU/WHO 2011)

Expenditure quintile	Share of households facing:	
	High expenditure (%)	Impoverishment (%)
1st quintile	7.8	7.5
2nd quintile	6.0	8.6
3rd quintile	5.5	1.5
4th quintile	4.5	0.1
5th quintile	3.6	0.0

e) Shortcomings in Purchasing and Provider Payment Mechanisms

- Fee for service: dominant for secondary care
- Capitation introduced for both primary care and **hospital care** at general district hospitals
- Capitation rate is calculated separately for 6 membership groups, **grouping not necessary related to age, gender and health risks;**
- Capitation rate is calculated based on historical expenditure of the previous year specifically for each province and **not based on actual health care need;**
- Hospital expenditure ceilings linked to SHI revenues of members to that same hospital

Options for Achieving 3 Dimensions of Universal Coverage at Affordable Health Cost

- To replace individual enrolment by **family/household enrolment**
- **To increase compliance in private formal sector:**
Enforcement measures
- To cover informal sector:
Contributory or tax-based mechanism?
- Redefine benefit package, to be cost-effectiveness based;
- Reform in provider payment mechanism (capitation, case based)
- Revise copayment policy
- Improve capacity of VSS and quality of Health care service

**Thank you for
your attention !**