Chapter 2

BACKGROUND

Health insurance is linked with the health sector and the economy. So an overview of the socio-economic situation and the health sector in Vietnam as well as in Haiphong will be given below

2.1 Background of Vietnam

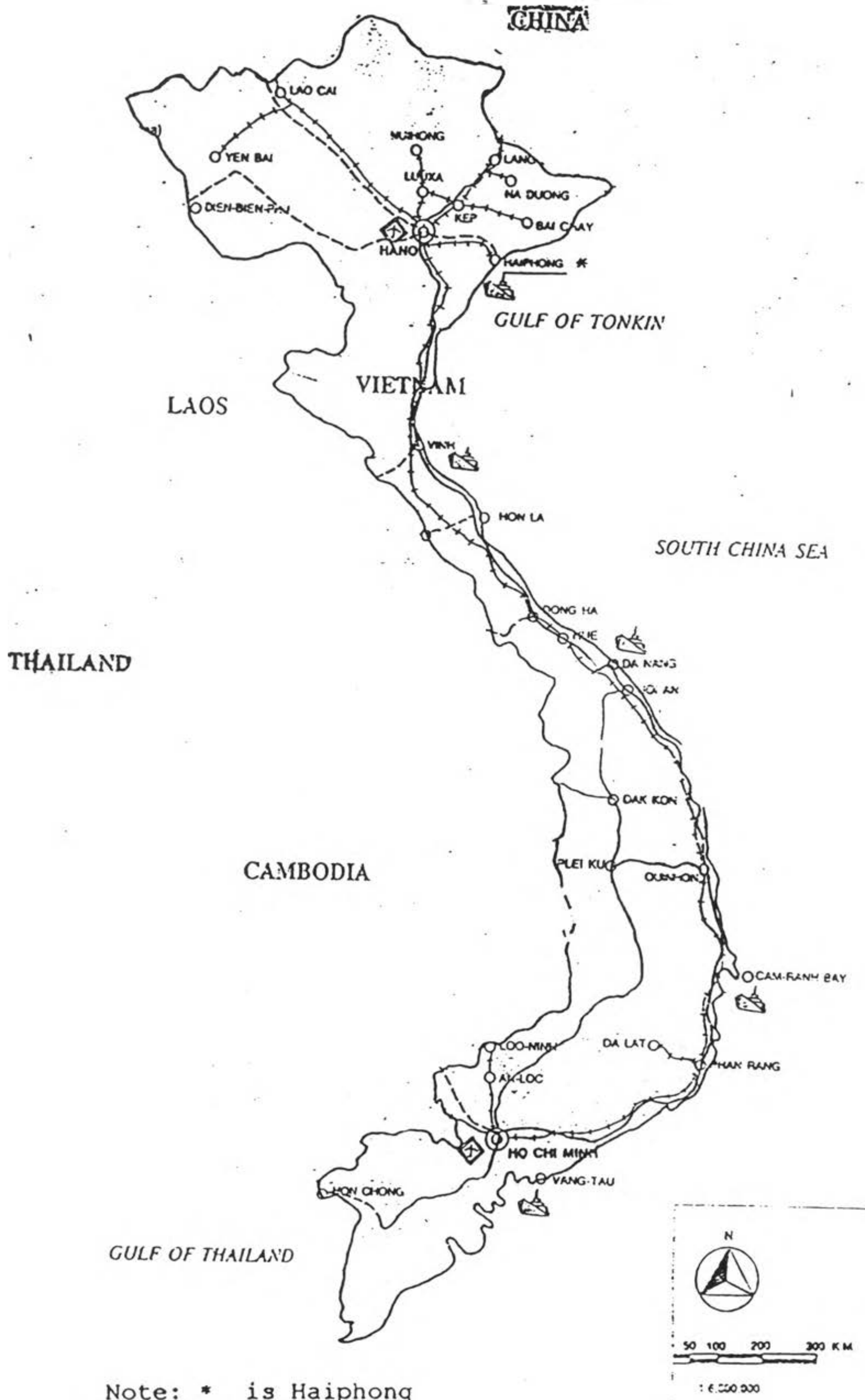
2.1.1 The socio-economic situation of Vietnam

Vietnam is a South-East Asian country, with an area of 330,991 square kilometers. It borders China in the North, Cambodia and Laos in the West and faces the Pacific Ocean on the East and South (see Figure 2.1).

The country is divided into 53 provinces, with 574 districts and more than 10,000 communes. The population is around 73 millions. About 78 percent of population reside in rural areas. In urban areas, the 4 biggest cities with population over 1 million are Ho Chi Minh city with 4.5 millions in the South, Danang with 1.5 million in the Center zone, Hanoi with 2.5 millions and Haiphong with 1.5 million in the North. Obviously, the health of the population depends not only on the health care services but also other health-related factors such as the economy, education, environment. Vietnam has one of the highest literacy rates in Asia. The adult illiteracy rate was 6% in 1995 (World Bank, 1996). The percentage of households with access to safe water was 31.8% in 1995. Agriculture accounts for 40% of the country's Gross National Product (GNP), industrial production makes up another 40-50%, while light industry and "non-productive" areas such as health care and education make up the remaining 15-20% of GNP (HC Publication,1993).

With diversified and abundant natural and human resources, long coastline and good geographical position, Vietnam has the natural capacity to achieve rapid and sustained economic growth. However, during the period of the 1970s and 1980s economic development was very low, with a crisis in the middle to late 1980s accompanied by high inflation, deficit of State budget, low GNP per capita. The country has been constrained by a lot of factors such as the consequences of many years of war, the embargo on trade and investment, the shortcomings of

Figure 2.1 The Map of Vietnam



Note: * is Haiphong

managemen etc.

The economic reform since 1986 was aimed to stimulate economic growth by shifting from a centrally planned economy to a market economy managed by Government. The reform emphasizes on policies to increase the food supply, household consumer goods production and exports, to tighten the currency supply and control inflation in order to reduce the budget deficit; and to rebuild stability on a sound economic foundation. As a result, agriculture has increased and restrictions on private commerce and industry have been eased. From a country had not been able to achieve food self-sufficiency, Vietnam has now become the world's third largest exporter of rice with 3 million tons per year, only after United States and Thailand. Hyperinflation was cut down from 67% in 1990 to 17% in 1992 and is about 10% now (World Bank,1996). The trade liberalization measures in the economic reform program has led to an opening of the Vietnam economy to the global economy. Rates of growth of exports and imports in 1994 were 20.6% and 27.4%, respectively (World Bank,1995). Economic growth has taken off, with an annual real growth rate from 1992 to 1995 reaching 8 or 9 % overall (see Table 2.1)

Although many achievements has been attained, because of coming from a very low starting point, now Vietnam still ranks among the low-income countries in Asia, with income per capita roughly being about US$300 per year.

The economic reform and its consequences has strongly affected on the health sector, especially in regard to health care financing. A series of measures has been adopted in the health sector in accordance with the reform policy such as: user charge, the legalization of private practice, market mechanism in the pharmaceutical field, and the health insurance scheme.

2.1.2 The health care issues in Vietnam

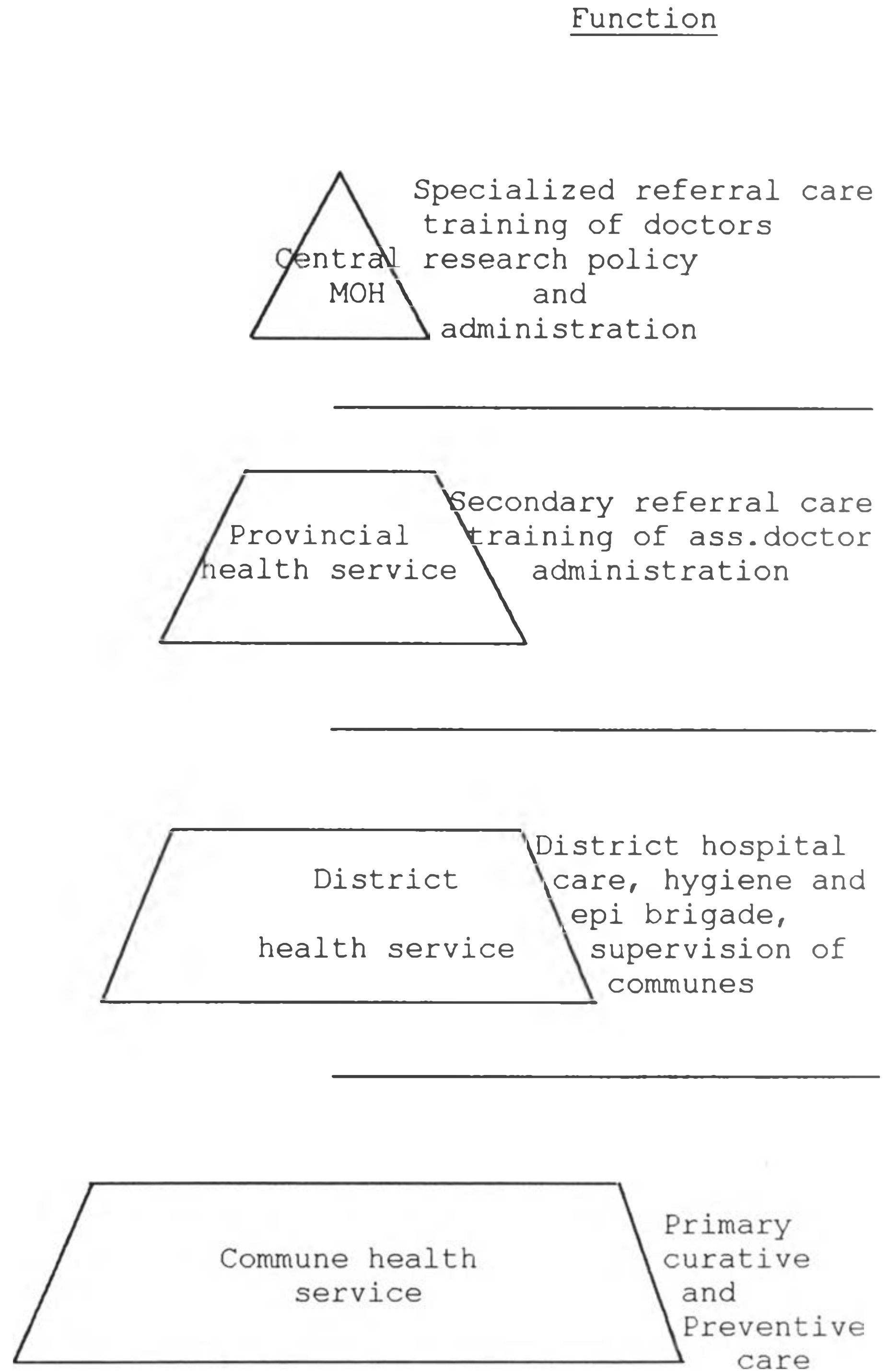
The health sector in Vietnam is comprised of the mainly public sector with 4 levels: central, province, district and commune (see Figure 2.2). It operates following the principle of referral system. The central health facilities are mostly responsible for tertiary care. At provincial and district levels, secondary services are provided. The primary health care is taken place at commune health stations. With 24 patient beds

Table 2.1 Gross Domestic Product growth rate

Year	GDP growth rate (%)
1981-1989 (avg.)	4.4
1990	4.5
1991	6.0
1992	8.6
1993	8.1
1994	8.6
1995	9.5

Source: World Bank 1996, World Development Report 1996: from plan to market, Oxford university press.

Figure 2.2 The structure of health system in Vietnam



per 10,000 population, Vietnam has one of the most favorable hospital bed ratios in Asia and in the entire developing world (Save the Children Fund, 1992). The total numbers of hospitals and health centers in 1995 were 877 and 10,305 respectively. In a wide network of health facilities, Vietnam has a large and experienced staff with more than 200,000 members. In 1995, the number of doctors per 10,000 population was 4.2, relatively high in the region. Thanks to the favorable conditions mentioned above, the health indicators of Vietnam are impressive even compared with countries having considerably higher per capita income (see Table 2.2). The percentage of fully vaccinated of children was 94.1, the life expectancy increased from 44.2 in 1960 to 65.0 in 1995, and under five mortality rate dropped from 232.0 per 1,000 in 1960 to 44.2 per 1,000 in 1990.

After 1986, the health sector was incorporated into Vietnam's extensive program of socio-economic reform. Economic reform helps the development of health and health services more favorable. Health services are expanded to the private sector and becoming more competitive. The door-opening policy facilitates supplies of medical equipment and drugs. Besides these positive effects, the economic reforms has also had negative effects on health and health services. The increasing costs of medical care and drugs are associated with decreasing affordability and accessibility to the health services of many people especially the poor.

a. Health care financing

In the early years of the transition period from a subsidized economy to a market economy under Government regulation, the health sector faced difficulties in financing because of a decrease of subsidy and external aid from the former Soviet Union and Eastern European countries. However, as a result of reform, the proportion of the National Government budget for current expenditures spent on health has increased from 2.76% in 1986 to 4% in 1990, and remained around this percentage up to now (see Table 2.3).

However, the insufficiency of the Government budget was recognized. The deterioration of hospitals is common problem all over country from central level to local level. Overall, Vietnam has a serious shortage and obsolescence of medical equipment. Maintenance expenditures are severely underfinanced by the national and provincial health budgets. The financial resources

Table 2.2 Selected Vietnamese Social Indicators comparing with other countries

Country	Social indicators						
	Pop. (million) (1994)	GNP per capita (USD) (1994)	Life exp. (year) (1994)	Adult liter -acy rate (%) (1995)	Infant morta -lity rate (per 10,000) (1994)	Pop. per physi -cian (1989-1994)	Pop.per hospit -al bed (1989-1994)
Cameroon	13.0	680	57	63	57	681	300
China	1,190.9	530	69	81	30	7,028	1,503
Indonesia	190.4	880	63	84	53	4,427	615
Lao	4.7	320	52	57	92	1063	612
Thailand	58.0	2,410	69	94	36	12,060	393
Vietnam	72.0	200	68	94	42	2,279	261

Source: World Bank 1996, World Development Report 1996: from plan to market, Oxford university press.

Table 2.3 Vietnam National Health Budget 1991-1995

Unit: Billion dong

Index	1991	1992	1993	1994	1995
National budget	12,081	22,815	38,080	48,270	60,200
Health budget	716	1,020	1,468	2,220	2,817
	(5.9)	(4.47)	(3.85)	(4.6)	(4.7)

Note: Figures in parentheses are health budget as the percentage of national budget.

Source: Ministry of Planning and Investment quoted in Nguyen Quang An, 1995

are usually not available for replacing medical equipment when it is required. Consequently, a reform in health care financing has been implemented by introducing user fees and health insurance in order to increase resources for financing the health sector. From 1989, a system of user fees for all levels of hospital through the country has been established. It is reported that the contribution coming from user fees only covers about 5-7% compared with Government expenditures on health (see Table 2.4). This ratio is comparable with the cost recovery ratio in other low and middle income Asian countries.

Obviously, there was a close link between health insurance and user fees policy. On the other hand, the payment to a hospital for the insured's medical cost is done in accordance with user fees. Therefore it is necessary to mention here issues relating to the user fees. The health care services had been provided free for all in Vietnam until the year 1989 when the decision of the Ministerial Council on collection of the user fees came into practice. This policy has been modified in 1995. According to this modification, patients have to pay a package of fees concluding: drugs, blood transfusions, laboratory tests, X-rays, consumable materials, operations, consultation fees, bed-day charges. The non-insured patients, without free health card, have to pay user fees by themselves. The health insurance pay contracted hospitals the user fees for insured patients registered there. The revenues from user fees are used as follows:

* 70% is allocated to health facilities to supplement the expenditure on health care.
* 25%-28% is used as rewards to health workers with high sense of responsibility, devotion and care.
* 2%-5% will be transferred to either the Ministry of Health (by central health institutions) or the provincial health service (by the local health units) to support health units incapable of charging for services.

In hospitals the revenues mainly come from 3 sources: user fees, health insurance and the state subsidies based on bed-days. The health care services provided by public hospitals are predominant in Vietnam, the doctors as well as other health workers being paid on a salary basis. However, there is now also a growing private sector.

Table 2.4 User fees comparing with Government expenditure in health care

Unit: Billion dong

Item	1990	1991	1992	1993	1994	1995
Govt's expenditure	427	716	1,020	1,468	2,220	2,817
User fees	20	45	72	102	110	150
	(4.68)	(6.28)	(7.06)	(6.95)	(4.95)	(5.32)

Note: Figures in parentheses are user fees as the percentage of government expenditure.

Source: Ministry of Finance, Vietnam quoted by Nguyen Quang An (1996)

b. Health insurance in Vietnam

Structure of health insurance in Vietnam

The health insurance scheme has been introduced officially since 1992, as a measure to create more resources for the Health sector. Health insurance mainly is compulsory, with voluntary and free health cards for the poor. The details of each scheme are as follows:

(1) Compulsory Health Insurance(CHI):

This scheme has been established officially since 1992. It is applied to government servants, private employers and employees with a premium occupying 3% of salary, government servants and employees pay 1%, the remain 2% being paid by Government or employers. For the retired persons and people subsidized by Social Affair Department the premium are paid by Social Security Fund. The target population which the CHI program intends to cover is 5 millions, including 1.5 million government servants, 2 million industrial workers and 1.5 million retired persons. Over the last four years, the coverage percentage has been increased to 96% of the total population (see Table 2.5).

(2) Voluntary Health Insurance (VHI)

The first pilot of the VHI program was initiated in 1990, particularly in Haiphong. The target population of the VHI program is people outside the scope of the CHI scheme and other groups who can use public health care services free of charge, including children under 6 years of old, minorities, and the poor with certificate cards allocated by the local social affair office. At present, the problem of the VHI program in Vietnam is the existing gap between the target number and the actual number of insured persons under this scheme for the whole country (see Table 2.6).

(3)Free health card

This program have been implemented since 1993 in several provinces. The program is subsidized by local government. The targets of this program are the disabled, the handicapped and old persons who are alone, and very poor persons with the standard used for assessment that his or her income is not enough to buy 20 kilograms of rice per month (equal to 50,000dong). The number of free health cards distributed was only around 20,000,

Table 2.5 Situation of Compulsory Health Insurance in Vietnam

Index	1992	1993	1994	1995
Target pop. covered	5,000,000	5,000,000	5,000,000	5,000,000
No of actual insured	2,228,000	3,722,237	3,946,220	4,800,000
	(45)	(64)	(79)	(96)

Note: Figures in parentheses are number of actual insured as the percentage of target population covered

Source: Department of Vietnamese Health Insurance, 1996

Table 2.6 Situation of Voluntary Health Insurance in Vietnam

Unit: 1,000 persons

Item	1990	1991	1992	1993	1994	1995
Target pop. covered	35,353	36,091	36,813	37,550	38,295	39,000
No of actual insured	108	216	310	534	610	650
	(0.3)	(0.6)	(0.8)	(1.4)	(1.6)	(1.7)

Note: Figures in parentheses are number of actual insured as the percentage of target population covered

Source: Department of Vietnamese Health Insurance, 1996

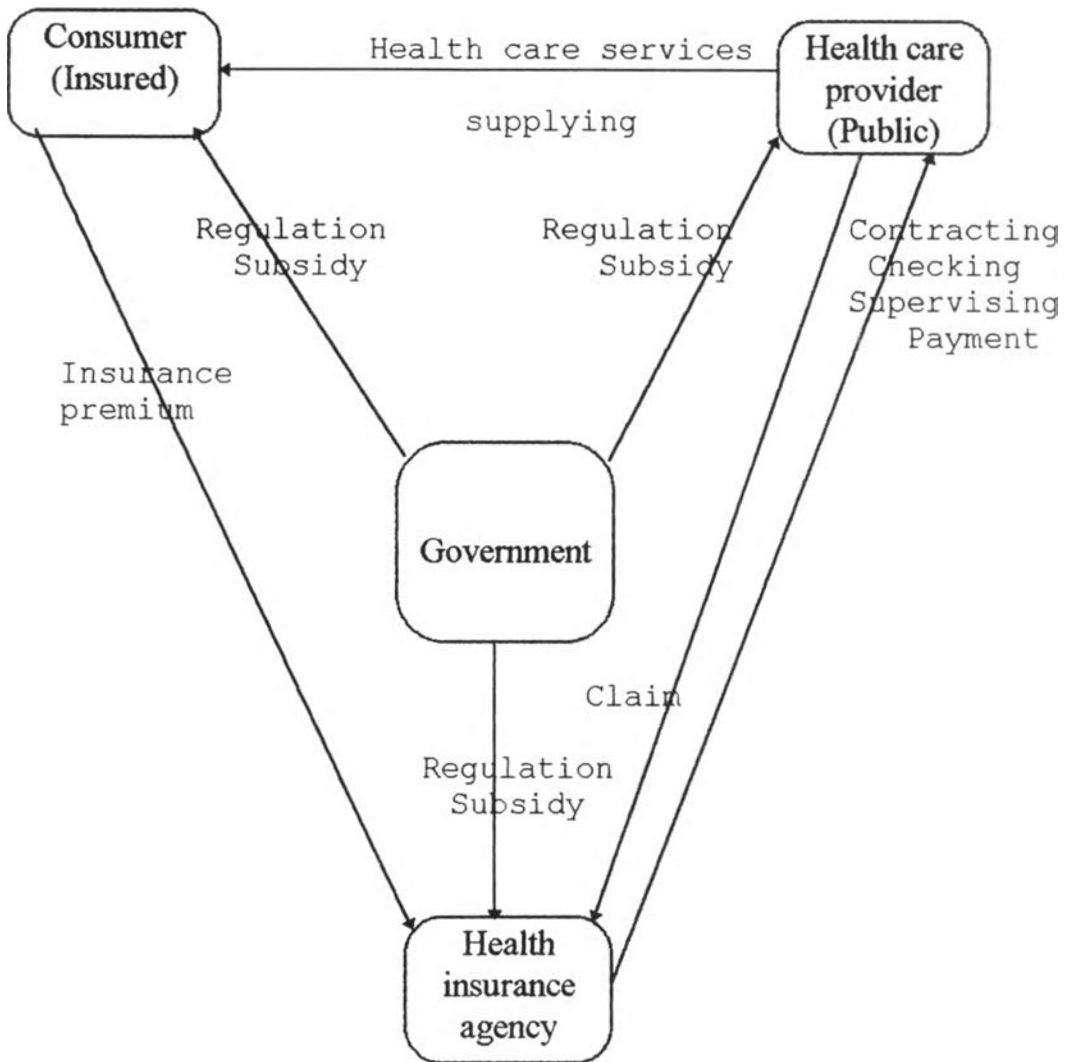
compared to 2 million population in this group. The main reason is the limited budgets of local governments.

Regardless of the type of health insurance scheme involved, any insured person has the right to receive free health care services within the scope of insurance. The insured person would be provided the health insurance card and free choice of the primary health care facility which has a contract with the insurer. In case of emergency, the insured person can be treated at any health care facilities in country. The insurer is responsible for payment of medical costs of insured patients which are within the scope of the insured amount, based on user fees. The scope is to insure for both inpatient and outpatient services in terms of recurrent expenditure and a part of the capital cost of health care services. Insured patients pay nothing when they receive health care services from a provider inside the insured scope, while non-insured patients have to pay fee for service at health facilities out of their pocket.

Financial mechanism of Health insurance in Vietnam

Figure 2.3 illustrates the financial mechanism of the health insurance system in Vietnam. Under the health insurance scheme, all costs incurred by insured patients at health facilities will be reimbursed by the health insurance company. A mixed payment system has been selected in Vietnam: Capitation and fee-for-service combined payment for outpatient (OP) care; fee-for-service and flat payment per bed per day for inpatient (IP) care. Revenues from the health insurance premiums are under obligation to be sent to the provincial city health insurance agency. Of total revenues, 8% can be spent on administration, 2% is contributed to the central reserve fund, the rest (90%) has to be used for paying health care service benefits of insured patients. The examination and treatment fund is divided equally for outpatient (OP) fund and inpatient (IP) fund. Payment for outpatient care is based on fee-for-service (according to the user fees) but the total fund does not exceed 45% of premium collection from the members registered in the health facilities (5% of outpatient fund is reserved for primary health care). Inpatient care is also paid, according to fee-for-service principle, for drugs, blood transfusions, laboratory tests, X-rays etc, and expenditure for consumable materials, and room is based on a flat payment for bed per day. The health facilities are entitled to reimbursement from health insurance agency for the number of outpatient consultations and

Figure 2.3 Diagram of financial mechanism of Health insurance in Vietnam



treatments or number of inpatient days depending on the category of hospital. The payment are made periodically for every 3 month.

The existing health insurance scheme in Vietnam is a public system, organized and managed by governmental organization, called Vietnam Health Insurance Department, with sub-departments for each province. The health insurance agency is the public, non-profit organization. The hospital costs are reimbursed by the insurer (third - party payment) directly to the hospital after checking and under supervision of health insurance officers. Some cost inflations has been reported and health insurance agencies are attempting to develop more sophisticated ways of ensuring that treatment given is appropriate. This monitoring is carried out by insurance representatives attached to each hospital. A national guide has been issued for this purpose that describes simple treatment outlines for 400 diseases.

c. Quality of care

The quality of care is strongly associated with the utilization of health services. The change in utilization can reflect, to some extent, the quality of services. The low utilization of health facilities is a major concern in Vietnam. The data in Table 1.1 provided by the Ministry of Health (MOH) of Vietnam (1990) shows a decrease of utilization of health services during the period 1986-1990 in terms of the annual number of consultations, the annual number of inpatient admissions as well as the annual number of hospital days/person. This reduction reflected, to some extent, the worsening provision of medical care. There is a wide variation across provinces and regions.

The statistics on numbers of health personnel as well as numbers of health facilities can be misleading when reflecting on the actual quantity and quality of health care delivery. It is difficult to know how many of the 10,035 commune health centers in the country are operative in the sense of being able to offer even the most basic health care (Save the Children Fund - 1992). Frequent absenteeism from jobs, low morale and low productivity are the consequences of low wages in the public sector. In an evaluation of the health sector cooperation program between Vietnam and Sweden conducted by SIDA (1992), the low utilization of health facilities in Vietnam was cited as major concern. Bed occupancy rates for hospitals average less than 50%. Annual per

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capita contact rates with the health services average between 0.3 to 0.5 for the overall population with wide variations among provinces and regions. The main factor behind the low utilization of health facilities is their poor quality and the long distance to access to facilities for people living in mountainous and remote areas.

In a survey of health providers conducted by MOH in 1991 in 3 provinces, the majority of providers cited low salaries(91.1%), inadequacy equipment (87.6%) and inadequate drugs and medical supplies (82.6%) affecting the quality of health services.

2.2 Background of Haiphong

2.2.1 The socio-economics of Haiphong

Haiphong is one of the 4 biggest cities of Vietnam. It is located in the north-east of the country with 3 urban districts and 9 rural districts. Total population is about 1,8 millions with 350,000 households and 31.5% of those live in urban and sub-urban areas. Haiphong is the second biggest port of Vietnam. This province is also famous for its seaside district, namely Doson. The structure of Haiphong's economy is based on 3 sectors: industry, agriculture and services the contributions to GDP of which are 35%, 30% and 25%, respectively. In addition, foreign investment in Haiphong has been increasing for recent years. There are 50 foreign projects with investment capital of 1 billion USD in this province by the year 1996. The average income per capita in Haiphong is estimated about US$ 500 in 1995 significantly better than neighbouring provinces. Normally, following the criteria of the Social Affairs Office of Haiphong, a family with income per head lower than 50,000 dong is classified as very poor, from 50,000 dong to 200,000 dong is poor, while higher levels are listed as average income families. At the time of this study, 1 US$ was equivalent to 11,000 Vietnam dong.

2.2.2 Health care issues in Haiphong

The health system in Haiphong is organized into 3 levels: province, district and commune working as a referral system. Haiphong has 21 hospitals of which 13 are district hospitals and 8 specialized hospitals. The biggest general hospital is Viet-Tiep hospital. 100% of 211 communes in Haiphong are covered by commune health

stations. There is a total of 3,000 hospital beds. The number of patients admitted per year in city and district hospitals is 62,500 and 41,000, respectively. The same as general situation in the whole country, most of hospitals and health stations are operating with a lack modern equipment, old buildings which need to be improved.

a. Health care financing in Haiphong

Similarly to other provinces, the provincial health budget in Haiphong is derived from 4 sources: local government budget, foreign aid, hospital fees and health insurance reimbursement. Besides that, it can receive an assistant budget from national programs. The Haiphong authority pays attention to the health sector by allocating around 11-12% of its annual budget for health (see Table 2.7). This budget can provide enough for low-standard operating costs of hospitals, but of course not enough for capital costs such as renewal of medical equipment or buildings. The proportion of Government subsidy, including the resources from national programs, compared to the total health budget of Haiphong is around 65-70%. The hospital fees proportion and revenues from health insurance increased in parallel, contributing about 10% of the total health budget in 1995. Even though the health insurance scheme just covered some 20% of the population, it made have the same contribution to the health budget as did user fees. In 1995, local government subsidized about 38,800 dong for one patient staying one day in the hospital, both for non-insured and insured patients, through user fees or health insurance premium.

b. Health insurance in Haiphong

Haiphong was among the first provinces to establish the Health insurance scheme for the whole province. The voluntary health insurance scheme has been open since 1990 and from 1992, at the same time with other provinces in Vietnam the compulsory health insurance has officially operated in this province. Some of the main issues and bottlenecks in health insurance development in Vietnam were studied via a preliminary evaluation of the HI scheme in Haiphong.

The health insurance office of Haiphong signed contracts with 21 hospitals in the province in order to provide health care services for Haiphong's insured patients. The same structure of health insurance now operates the whole country. Health insurance in Haiphong

Table 2.7 Local Health budget of Haiphong 1990-1995

Unit: Million dong

Item	1990	1991	1992	1993	1994	1995
Gov't budget	12,308	17,050	26,350	37,100	40,131	42,018
	(64.2)	(68.3)	(62.3)	(67.0)	(68.2)	(68.4)
National program	626	903	1,370	1,883	1,938	2,140
	(3.3)	(3.6)	(3.2)	(3.4)	(3.3)	(3.5)
Foreign aids	4,942	4,749	6,088	5,219	3,462	4,009
	(25.8)	(19.0)	(14.4)	(9.4)	(5.9)	(6.5)
Hospital fees	929	1,712	3,168	4,714	6,093	6,625
	(4.8)	(6.9)	(9.9)	(10.3)	(11.7)	(10.8)
Health Insurance	375	567	4,303	5,470	6,372	6,675
	(1.9)	(2.3)	(10.2)	(9.9)	(10.8)	(10.9)
Total health financing resource	19,180	24,981	42,279	55,386	58,806	61,467
No of population (1,000 person)	1,460	1,490	1,516	1,542	1,565	1,588
Health budget per capita (dong)	13,140	16,770	27,900	35,920	37,580	38,707

Note: Figures in parentheses are as percentage of total health financing resources

Source: MOH, MOF,Vietnam; Health Office of Haiphong

includes CHI program, VHI program, free health card, and insurance program for school children (see Table 2.8)

2.2.3 Introduction of Viet-Tiep hospital

Vietnam-Czechoslovak Friendship hospital, popularly known as Viet-tiep hospital is the biggest general hospital in Haiphong with 600 beds. This hospital was built by the Czechoslovak Government in 1958. Then it received continuous assistance from the Czechoslovak Government until the year of 1991 when that country was separated in to 2 countries, Czech and Slovak Republics.

The hospital combines 39 departments, of which there are 22 clinical departments, 7 laboratory departments. Total personnel are 800 persons, with 550 health professionals. It is responsible for final referral hospitalization in this province. Viet-Tiep hospital is also the biggest contractor of the Health Insurance Department of Haiphong. Data provided in Table 2.9 shows that the performance of Viet-Tiep hospital is very good. The utilization rate of health services provided by the hospital, including OP and IP increased over the period 1992 to 1996. The number of admissions decreased a little in 1995 due to the construction and repairing of this hospital. The hospital mortality rate dropped from 1.34 in 1992 into 0.76 in 1996. These figures revealed that the quality of services provided by this hospital are good. The occupancy rate is very impressive. However the average length of stay is considerably higher compared with other countries. The proportions of financial sources coming to this hospital in 1996 are shown in Table 2.10. The revenues from health insurance make an important contribution in expenditure of this hospital, not only for covering the medical costs incurred by insured patients but also the supplement for purchasing essential drugs (500 million dong) and medical equipment (300 million dong).

Table 2.8 Situation of Health Insurance Issues in Haiphong

Item	1990	1991	1992	1993	1994	1995
Total pop. (million)	1,460	1,1490	1,516	1,542	1,565	1,588
Target to cover by CHI	190000	190000	190000	200000	210000	210000
No of actual insured	na	na	110547	144942	157825	165000
% covered/ target	na	na	58	72.5	75.2	78.6
Total revenues (million dong)	na	na	3960	5220	6300	6600
Total expenditure (million dong)	na	na	3470	4250	5052	5345
Surplus	na	na	490	970	1248	1255
Target to cover by VHI	934700	953400	972500	992000	1040000	1060000
No of actual insured	47127	58547	70326	89302	108004	105000
% covered/ target	5.0	6.1	7.2	8.4	10.4	9.9
Total revenues (million dong)	377	585	844	1250	1512	1575
Total expenditure (million dong)	375	567	833	1220	1320	1330
Surplus	2	18	11	30	198	245
School children(*)	208000	212000	216000	220000	225000	230000

Note: (*):Almost School Children under 16 year old join Insurance Program for PHC, Dental care at school, Hospital care for accidence and risk

Source: Health Insurance Office of Haiphong

Table 2.9 The statistic data of Viet-Tiep hospital (1992-1996)

Item	1992	1993	1994	1995	1996
Total admission	13,895	17,959	19,977	17,058	20,033
No of Insured admission	1,830	3,706	6,372	6,174	8,591
Total discharge	12,417	17,430	19,375	16,506	19,373
Total patient days	137,716	167,944	195,128	193,285	240,707
Total OPD visits	98,760	104,378	109,413	127,512	129,272
No of Insured visits	na	na	na	na	35,369
Total deaths	166	173	195	167	147
Total beds	415	491	596	530	659
Hospital mortality rate (100*death/ discharge)	1.34	0.99	1.00	1.01	0.76
Average LOS (Patient days/admission)	9.90	9.35	9.77	11.33	12.02
Occupancy rate (100*Patient day/365*beds)	90.9	93.7	89.7	100	100

Source: Viet-Tiep hospital-Department of planning and administration, 1996

Table 2.10 The financial revenues of Viet-Tiep hospital in 1996

Source	Amount in billion dong	Proportion in %
Local Gov't budget	4.8	57.2
User fees	1.2	14.3
Health insurance	2.4	28.5
Total	8.4	100

Source: Viet-Tiep hospital - Department of finance, 1997