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The process of health insurance coverage in Vietnam

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Abstract
Health is both a goal and a means of development; healthcare policies strongly influence equity and social welfare enjoyment. Health insurance, as part of the social security system, holds profound humanitarian and ethical significance, contributing significantly to social justice in healthcare and safeguarding people's health. Established formally in 2008, Vietnam's health insurance has undergone a developmental journey with noteworthy outcomes. This scientific article presents the development process of health insurance cards in Vietnam, achievements made, and future development directions. It aims to be a valuable reference for research, evaluation, and policy-making concerning health insurance in Vietnam.

Keywords: Health insurance, health insurance card, universal health insurance card rollout, healthcare services

Introduction

According to the World Health Organization (WHO), at least half of the world's population does not receive needed healthcare services, and approximately 100 million people are pushed into extreme poverty annually due to healthcare expenditures. This is a critical issue that must be addressed. The WHO emphasizes that achieving healthy lives for all requires individuals and communities to access high-quality healthcare services for self-care and family health. It also stresses the importance of skilled healthcare professionals providing quality care, centered around the people they serve, and policy-makers committing to investing in universal health coverage. WHO identifies universal health coverage as a strategic priority, where health insurance is a crucial tool to achieve this goal (WHO, 2019).

Recognizing this correct perspective, since December 1986, during the Sixth Party Congress, alongside the trend of openness and comprehensive national innovation, and amidst state budget constraints unable to meet the increasing healthcare needs of the population, Vietnam identified the establishment of a risk-sharing financial mechanism in healthcare, such as developing a health insurance system, as highly necessary. This was seen as an important initial step towards achieving universal health insurance coverage. It was also viewed as a significant financial solution in Vietnam's healthcare system development strategy. From here, the author divides Vietnam's health insurance card rollout process into two major stages. The first stage spans from 1986 (after the Sixth National Party Congress) to 1993. The second major stage extends from 1992 to the present.

Stages in the process of health insurance card rollout in Vietnam

1. Stage from 1986 - 1992

This stage laid the groundwork for the introduction of health insurance cards in Vietnam. Prior to this (before 1986), the state played a comprehensive role in providing healthcare to the population, meaning the state fully supported the costs of medical treatment when individuals needed healthcare services. However, during this period, Vietnam's healthcare system was poor, lacking in production funding, medications, medical equipment, and materials, and faced shortages of highly skilled doctors and medical professionals (Trinh Van Tung, Mai Linh, 2020). Consequently, healthcare quality was low. With the transition to openness in 1986, Vietnam's healthcare difficulties seemed even more severe, given the increased demand for effective healthcare (due to population growth and increased demand for healthcare services). While the healthcare system could not fully meet these needs, only about 50% of the financial demands were met by the state budget. Vietnam identified the establishment of a financial mobilization form to share risks in healthcare as necessary. This was a significant step towards the process of spreading health insurance cards in Vietnam. From this point onwards, the state-provided healthcare system in the centrally planned economy shifted to a multi-source financial healthcare system, with direct payments from individuals accounting for a large proportion. The country implemented the policy of innovating the healthcare sector under the motto "State and people together."

From the late 1980s to the early 1990s, a series of policy changes in the healthcare sector were implemented. The focus of these changes was on liberalization, privatization of the healthcare market, pharmaceuticals, and the official application of the fee-for-service regime in state healthcare facilities. For instance, Decision No. 45/HĐBT of the Council of Ministers (now the Government) issued on April 24, 1989, allowed healthcare facilities to collect part of the fees to improve patient service conditions. On June 15, 1989, the Ministry of Health and Finance issued Circular No. 14 guiding the implementation of Decision No. 45/HĐBT, which stated: "In places with conditions, it is possible to experiment with health insurance or contract medical examination and treatment with state-owned and non-state-owned healthcare organizations, establish local healthcare funds or base-level healthcare funds to assist patients who cannot afford to pay part of the fees." These healthcare policy changes meant that by the early 1990s, healthcare costs in Vietnam were more than 70% borne by individuals' out-of-pocket expenses (World Bank, 2016). However, alongside positive impacts, implementing these policies created financial barriers, preventing millions of people each year from seeking and receiving essential healthcare services, particularly in rural areas, among the

poor, and in economically and socially disadvantaged areas, leading to widespread poverty (World Bank, 2016).

In this context, a major challenge for the process of achieving universal health insurance coverage was to find ways to transfer healthcare costs from individuals' pockets to some form of prepaid payment. Vietnam began this process by piloting health insurance. On October 26, 1990, the Council of Ministers issued Directive No. 3504/KG directing the People's Committees of provinces, cities, and centrally-run municipalities, and the Ministry of Health to pilot health insurance. By June 1991, four provinces and cities had piloted health insurance on a large scale: Hai Phong, Quang Tri, Vinh Phu, and Ben Tre.

Thus, Vietnam moved from a comprehensive healthcare system with low service quality before 1986 to the post-1986 innovation era with the motto "State and people together" and the principle of "majority covering the minority." Vietnam's healthcare system remained poor, with low access to healthcare services and low healthcare quality, resulting in adverse impacts on equality and financial protection (World Bank, 2016).

2. From 1992 - present

This period marks the inception and development of Vietnam's health insurance system. Within this period, the author divides it into three smaller stages: Stage 1: from 1992 – 2008; Stage 2: from 2009 – 2014; Stage 3: from 2015 – present.

2.1. From 1992 – 2008

This stage is notable for the birth and initial development steps of the national health insurance coverage process. The concept of health insurance was first mentioned in Article 39 of the Constitution dated April 15, 1992, the Constitution of the Socialist Republic of Vietnam, which became an important constitutional foundation for the formation and development of the legal framework of health insurance and the implementation of health insurance policies in the country.

Subsequently, to specify Article 39 of the 1992 Constitution, on August 15, 1992, the Council of Ministers issued Decree 299-HĐBT promulgating the Regulations on Health Insurance, giving birth to the health insurance policy in Vietnam. The Health Insurance Regulations stipulate that health insurance is mandatory for officials, employees, retirees, disabled persons, employers, and workers, while other groups can voluntarily participate in health insurance. Among the voluntary participants, students accounted for a stable 20% of the population and were identified as one of the priority groups to be implemented to rapidly increase the health insurance coverage rate.

To encourage participation in health insurance, on August 27, 1994, the Government issued Decree No. 95/CP on partial premium reimbursement. It aimed to ensure that poor patients are exempted from payment and that those holding health insurance cards during examinations and treatments are treated as if paying out of their own pockets, thereby encouraging people to participate in health insurance.

In 2002, Decision 139/2002/QD-TTg led to the establishment of the Health Check-up and Treatment Fund for the poor (including ethnic minorities). This was a significant policy in the initial phase of the universal health insurance card rollout, recognizing and establishing the health insurance card coverage level for the poor and ethnic minorities. Accordingly, the poor and ethnic minorities could participate in health insurance or health facilities could be directly funded by the state budget to provide free medical examinations and treatments for the poor and ethnic minorities. In 2005, Decree 63/2005/NĐ-CP was issued, providing full financial support for the purchase of health insurance cards for the poor and ethnic minorities and making health insurance mandatory for this group.

The process of universal health insurance card rollout was particularly accelerated with the enactment of the Health Insurance Law in 2008, effective from July 1, 2009. The Health Insurance Law stipulated that all citizens have the right to participate in health insurance either mandatorily or voluntarily. Specifically, for formal employees, children under 6 years old, the elderly, the poor, and near-poor individuals, health insurance was mandatory. According to the law, the state is responsible for subsidizing all health insurance costs for children under 6 years old, the elderly, the poor, and ethnic minorities, as well as partially subsidizing health insurance costs for near-poor individuals and students. The law also outlined the roadmap for health insurance participation for other social groups. The 2008 Health Insurance Law created a National Health Insurance program, making health insurance the primary mechanism for achieving universal health care coverage.

2.2. From 2009 – 2015

This is a period of rapid development of health insurance, with the number of health insurance participants in Vietnam steadily increasing. The health insurance card coverage rate also significantly increased due to the enactment of the Health Insurance Law in 2008 and its implementation starting in July 2009. Since the enactment of the 2009 Health Insurance Law, the Party has issued important directives for the development of universal health insurance coverage, including Directive No. 38/CT-TW of the Central Party Committee dated September 7, 2009, on promoting health insurance work in new circumstances, and Resolution No. 21-NQ/TW dated November 22, 2012, on enhancing the Party's leadership in health insurance work during the 2012-2020 period. In 2012, the Ministry of Health developed the "Project to implement the roadmap towards universal health insurance for the period 2012-2015 and towards 2020." The project was approved by the Prime Minister in 2012, committing to achieving full health insurance coverage for all dimensions of the population. Specific targets were also set out in the project: by 2015, achieving 70% health insurance coverage of the population, and by 2020, reaching 80% health insurance coverage; by 2015, reducing the proportion of out-of-pocket health expenditures to below 40% of total health expenditures (Prime Minister, 2013).

Especially in 2014, the National Assembly passed amendments to the Health Insurance Law, effective from January 1, 2015. The amended Health Insurance Law closely adhered to the guiding principles of the 2013 Constitution and Resolution 21 of the Politburo, ensuring health insurance as a social security policy organized and implemented by the state with the participation of the people, aiming towards universal health insurance. The amended Health Insurance Law of 2014 made significant additions and amendments, including breakthrough measures to overcome limitations and shortcomings of the 2008 Health Insurance Law, laying the legal groundwork for advancing the goal of universal health insurance card rollout through annual expansion of health insurance coverage,

expanding the rights of health insurance participants, ensuring access to health services for all citizens, and ensuring financial protection for medical care when ill. It can be said that the amended Health Insurance Law of 2014 transitioned the process of universal health insurance card rollout into a new phase of development.

2.3. From 2015 - present

Decision 1584/QĐ-TTg dated September 14, 2015, of the Prime Minister assigned targets for implementing health insurance during the 2015 – 2020 period to the People's Committees of provinces and centrally-run cities. This decision was later replaced by Decision 1167/QĐ-TTg dated June 28, 2016, of the Prime Minister adjusting the targets for implementing health insurance during the 2016 – 2020 period. Accordingly, the targets for implementing health insurance were integrated into annual socio-economic development targets and five-year plans of localities with specific tasks and requirements set for ministries/agencies and localities. Ministries and levels were required to engage in propaganda, develop health insurance participants, and create favorable conditions for people to fully enjoy their rights, aiming towards universal health insurance card coverage for all citizens.

Also within this roadmap, Resolution No. 20 of the Central Executive Committee issued on October 25, 2017, outlined the goal of achieving a health insurance card coverage rate of 95% of the population by 2025 and over 95% by 2030. In 2018, Decree 146/2018/NĐ-CP provided guidance on the Health Insurance Law, which officially came into effect on December 1, 2018. From this time onwards, many more groups were added to the state-funded health insurance participant group, such as: civilian fire fighters participating in the resistance against the French and American wars, the war to protect the fatherland, and international missions; Youth volunteers in the South participating in the 1965 - 1975 resistance; Individuals awarded the titles of People's Artist, Outstanding Artist belonging to households with an average monthly income lower than the base salary. Similarly, the group of health insurance participants funded by employers was supplemented with additional categories such as relatives of workers, military officials serving in the army. At the same time, Decree 146/2018/NĐ-CP also stipulated that insured persons were entitled to additional benefits when seeking medical treatment, and it is now leading to the goal of universal health insurance card coverage for all citizens.

3. Achievements in the process of universal health insurance coverage in Vietnam

Through the implementation of programs and policies on health insurance, Vietnam has achieved noteworthy successes in the process of universal health insurance coverage. In 1992, when Vietnam first began implementing the universal health insurance program, there were just over 100,000 health insurance cards issued. By 2001, Vietnam had 16 million participants (12 million mandatory and approximately 4 million voluntary), achieving a coverage rate - measured by participation rate - of about 20% of the total population nationwide.

Moving into 2009, immediately after the health insurance law took effect, health insurance coverage in Vietnam increased significantly to 53.3 million participants, achieving a coverage rate of over 60% (Lưu Quang Tuấn, 2010). Although the rate of increase in universal health insurance coverage slowed thereafter, following the general development pattern of health insurance in countries worldwide, particularly in countries with a large informal labor sector like Vietnam, it is evident that the trend towards increasing health insurance coverage in Vietnam has been relatively stable and assured (Nguyễn Thị Minh Châu, 2019) (see Table 2.1).

By 2018, health insurance coverage reached 86.8% of the population, surpassing the target set by the Prime Minister's Decision No. 1167/QD-TTG dated June 28, 2016, by 3.3%. In 2020, the number of people covered by health insurance was 87.96 million, achieving a coverage rate of 90.85% of the population. In 2022, despite facing challenges in expanding health insurance coverage, coverage continued to expand and exceeded the set target with 91.1 million participants, reaching a coverage rate of 92.04% of the population, an increase of over 2.2 million people compared to 2021. By 2023, the country had more than 93.3 million people covered by health insurance, achieving a coverage rate of 93.35% of the population, approaching the goal of universal health insurance.

Table 1: Health insurance card coverage over the years

Year	Number of Health Insurance Participants (million people)	Health Insurance Card Coverage (%)
2004	18.39	21.1
2006	36.87	43.9
2008	37.70	43.76
2010	53.3	60.92
2012	58.98	66.44
2014	65.00	71.0
2016	75.915	81.8
2018	83.54	86.8
2020	87.96	90.85
2022	91.1	92.04
2023	93.3	93.35

Source: Compiled from reports by the Ministry of Health

Despite the relatively equitable access to health insurance in our country, the actual coverage of health insurance cards varies among different demographic groups and regions nationwide. Participation in health insurance differs depending on various socioeconomic strata within society. Typically, individuals in higher income brackets possess health insurance cards, whereas participation rates are more modest among lower-income groups.

The primary reason for the low coverage of health insurance cards is the difficulty people face in accessing them. Only eligible groups such as policy beneficiaries, the poor, or mandatory social insurance participants are able to obtain or be issued cards. For other groups (mainly farmers, simple laborers, artisans, traders, and service providers), the only option is self-payment of health insurance premiums, which is challenging for those living in economically disadvantaged areas where card costs are high due to inadequate premium regulations across different income brackets, especially for low-income groups (Đặng Nguyên Anh and colleagues, 2007).

Like many countries in the region, Vietnam faces a "coverage gap" issue where participation rates in health insurance are high among low-income and high-income groups but low among middle-income groups such as near-poor, non-poor, and informal labor areas (Viroj T., Đặng

Bội Hương and colleagues, 2011; Aparnaa Somanathan, A. Tandon and colleagues, 2014). The two groups with the lowest health insurance coverage rates are the near-poor and self-paying health insurance contributors, with corresponding rates of 21.4% and 26.1%, respectively (Institute of Strategy and Policy on Health, Health Insurance Department, 2013). Due to the low poverty threshold, near-poor individuals do not significantly differ from the poor in reality. For these individuals, affordability remains the greatest challenge when participating in health insurance, despite the high level of state subsidies (Aparnaa Somanathan, A. Tandon and colleagues, 2014).

Moreover, nationwide coverage of health insurance cards also differs in participation across regions and areas. Poor individuals in the Northwest, North Central, Central Highlands, and Mekong Delta regions have significantly lower participation rates compared to the Red River Delta and the other three regions (Đặng Nguyên Anh and colleagues, 2007). Evidence suggests that interventions can create differences. The results of a 2010 household living standards survey indicate that the Mekong Delta region has the lowest health insurance participation rate at only 47.5%, while the Northern Mountainous region has the highest participation rate at 79.2% (General Statistics Office, 2011). The implementation of the Northern Mountainous and North Central Highlands health support project since 2009, including support for health insurance participation fees for near-poor individuals, could explain this disparity (Institute of Strategy and Policy on Health, Health Insurance Department, 2013).

Conclusion

From these studies, it is evident that the process of expanding universal health insurance coverage in Vietnam has had significant impacts on people's access to healthcare services and treatment at various levels and dimensions. There have been notable achievements as well as persistent challenges. However, in its path towards universal health insurance coverage, Vietnam is considered successful in its efforts to expand health insurance cards to the entire population. Currently, the process of expanding universal health insurance coverage is ongoing in Vietnam, aiming towards comprehensive coverage for the entire population. Therefore, further research on this process is still necessary. From the perspective of viewing the process of expanding universal health insurance coverage as a general context to understand access to healthcare services, it is a necessary and innovative issue that has not yet been studied in Vietnam.

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