Data Collection Survey on Social Security Sector in Viet Nam

Final Report

May 2014

Japan International Cooperation Agency
(JICA)

KRI International Corp.

NTT Data Institute of Management Consulting, Inc.

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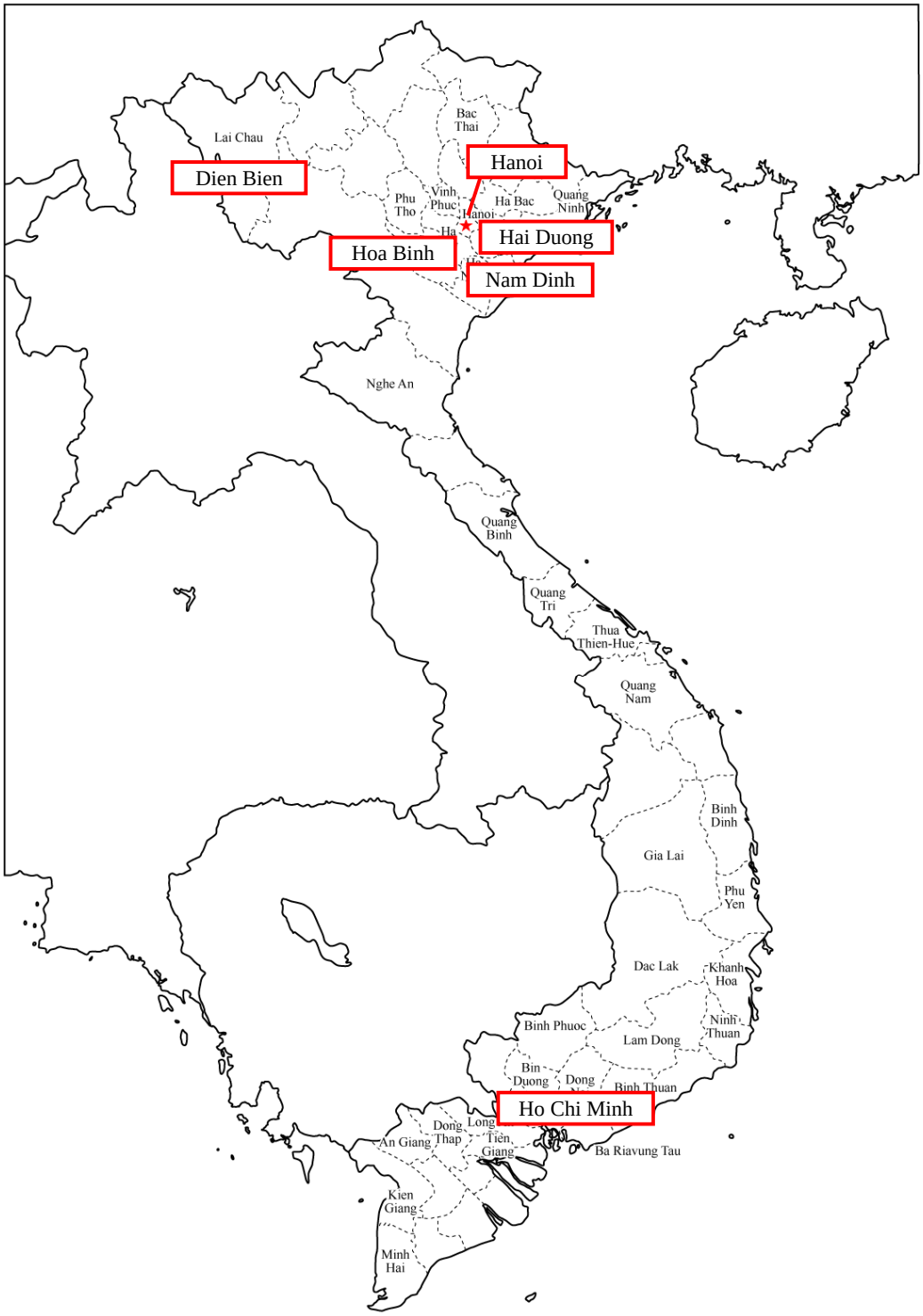
(JICA Rate in April 2014)

This report was prepared based on the information collected in Viet Nam and Japan from January to February 2014 and from January to April 2014, respectively. The recommendations are suggested by the Survey Team and do not represent JICA's official cooperation strategy for the particular sector or country.



Source: http://www.freemap.jp/download.php?a=asia&c=asia_viet_all

Survey Areas

Abbreviations and Acronyms

ADB	Asian Development Bank
ADL	activities of daily living
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of Southeast Asian Nations
ATM	automated teller machine
CHC	Commune Health Center
DF/R	Draft Final Report
DOF	Department of Finance
DOH	Department of Health
DOHA	Direction Office for Healthcare Activities
DOLISA	Department of Labour, Invalid and Social Affairs
F/R	Final Report
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GNI	Gross National Income
GSO	General Statistics Office of Viet Nam
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
Ho Ly	It is like a caregiver for patients and/or the elderly to help their daily activities in hospitals and elderly facilities.
IC/R	Inception Report
IFA	International Federation on Aging
ILO	International Labour Organization
ISHC	Intergenerational Self Help Club
IT	Information Technology
JAHR	Joint Annual Health Review
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOLISA	Ministry of Labour, Invalid and Social Affairs
MOT	Ministry of Transport
MPI	Ministry of Planning and Investment
MRI	magnetic resonance imaging
MSA	Medical Service Administration
NCD(s)	Non-Communicable Disease(s)
NGO	Non Governmental Organization
NHA	National Health Account
NPO	Nonprofit Organization
ODA	Official Development Assistance
OOP	Out-of-pocket
PHC	Primary Health Care
PPP	Purchasing Power Parity
SEDP	Socio-Economic Development Plan
SEDS	Socio-Economic Development Strategy
SHI	Social Health Insurance
SMS	Secondary Medical School
SS	Social Security
TFR	Total Fertility Rate
THE	Total Health Expenditure

The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
The Survey	Data Collection Survey on Social Security Sector in Viet Nam
The Survey Team	The consultant team for the Survey
UHC	Universal Health Coverage
UN	(the) United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
VAE	Viet Nam Association of the Elderly
VASS	Vietnam Academy of Social Science
VGCL	Vietnam General Confederation of Labor
VHLSS	Vietnam Household and Living Standard Survey
VHW	Village Health Worker
VNAS	Viet Nam Aging Survey
VNCA	Vietnam National Committee on Aging
VND	Vietnamese Dong
VSS	Viet Nam Social Security
VWU	Vietnam Women's Union
WHO	World Health Organization

Executive Summary

In Viet Nam, with economic growth and change of socio-cultural circumstances, the lifestyle of the people has been changed and life expectancy has been extended. Health and medical services have been improved therefore, indicators of health related Millennium Development Goals (MDGs) likewise followed. However, there are still gaps in the quality of health services and health status between urban and rural areas, and social vulnerables such as ethnic minorities and the poor are still in difficult situation to seek quality and affordable health care. Although the Government of Viet Nam has been dealing with such issues and aiming to achieve universal health coverage (UHC), new issues in health and population emerged such as aging and non-communicable diseases (NCDs). Regarding aging, Viet Nam might be aged society (aging rate >14%) in the next two decades. As Japan had experienced, aging could affect health and social welfare finances. Therefore, the Government of Viet Nam aims to achieve a universal health insurance coverage of 80% by 2020.

Under the above context, the Japan International Cooperation Agency (JICA) conducted the Data Collection Survey on Social Security Sector in Viet Nam (hereinafter referred to as “the Survey”) to collect a wide range of relevant information on social security sector with special focus on aging and health insurance to consider the strategy of future JICA’s assistance. The Survey was conducted from January to May 2014 including field survey conducted in January and February, and information sharing seminar in April.

Major concerned agencies who are involved in aging and health insurance are the Ministry of Labour, Invalid and Social Affairs (MOLISA), the Ministry of Health (MOH), and the Vietnam Social Security (VSS). MOLISA is responsible for policy formulation and preparation of relevant legislations, and monitoring of policy implementation in the field of aging and elderly care. MOH is responsible for health and medical services for the elderly, and health insurance. VSS manages social and health insurance fund and is responsible for premium collection as well as benefit and allowance payment. In addition, the Viet Nam Association of the Elderly (VAE) covers more than 90% of the elderly in Viet Nam and works to improve social participation and welfare of the elderly.

In general, policies and legislations have been developed. However, the number of legislations is so many that the concern might be on consistency among each other. Regarding aging, it seemed not a priority at the operational level, especially at the local level, as they have other priorities such as child health and poverty alleviation. Insufficient implementation of the manuals/guidelines/standards might also be one of the factors. Although home-based care by family members is still very common and has favorable public perception in Viet Nam, private elderly care facilities have been gradually increasing in response to changing family function and increasing needs for facility care. Each facility seemed to be struggling to establish a service and business model, and develop human resources to care for the elderly through its

own efforts. Whereas, family members taking care of the handicapped elderly seem to need technical, financial, and mental support to obtain necessary skills and lighten their burden.

As for health insurance, compulsory scheme has covered most of all the targets expect employees in private setor. For the voluntary scheme, near-poor group and farmers hesitate to be insured because of self-pay premium and uncovered costs such as transportation especially in the remote areas. The rich self-employed tends to prefer private insurance and private hospitals. When the revision of the Law on Health Insurance becomes effective, compulsory scheme will cover more people as it requires household coverage. Reliability of public health facilities, especially at the district level, might be another important factor to increase the coverage. People tend to seek care directly to top referral hospitals despite of more out-of-pocket expenses. For health facilities, procedures such as invoicing, examination, and payment are generally undertaken manualy, remuneration payment is sometimes delayed or not fully covered. This might affect the hospital operation and management. Under the current hospital financial autonomous system, when a hospital receives more patients and provides more services, it could redound to more income. Therefore, top referral hospitals receive more patients than its capacity, whereas lower level hospitals have less patients and less incentives. This might cause gap on the quality of human resources and services between urban and rural areas.

Based on the above situation analysis, the Survey Team developed logic models and road maps on aging and health insurance as shown in Chapter 7. Firstly, it is recommended to collect and analyze large-scale data on aging and health insurance to have a subjective policy evidence, to be able to establish a routine data collection system or regular national survey for monitoring. Such reliable data could contribute to grasp the actual situation at the operational level and develop practical manuals/guidelines.

Regarding aging, because non-communicable diseases (NCD) tends to increase among the elderly, geriatric departments should be introduced both in hospitals and educational institutions with concrete technical guidelines. In addition to curative services, prevention of NCD and physical/functional disabilities will be important to avoid explosion of medical costs. Also, the pension system should be reformed to unify management of beneficiaries in order to make the system efficient and ensure premium collection and benefit payments. Regarding home-based care, external support system for family members should be established, such as nursing facility and skilled human resources.

As for health insurance, most of the compulsory and subsidized groups have already been covered, therefore, it is important to understand how the government makes this voluntary group be interested in public health insurance. It could be one solution to expand the coverage of public health insurance to private hospitals, where the rich prefers to seek medical care. To expand the coverage of private health facilities, benefits of public health insurance should be strengthened and reliability of VSS should be improved. This might encourage people to enroll in public health insurance. To improve the remuneration payment to health facilities, operation of invoicing, examination, and payment procedures should be more efficient and transparent. This might lead the health facilities to contract with VSS. In this regard, the beneficiaries can receive quality health services at reasonable cost in the convenient facilities.

In addition, service improvement of lower level facilities is essential to increase the reliability of public health services to the people. This depends on various factors such as the facility, equipment, human resources, and physical access. The government has been dealing with it for a long time, even under the Socio-Economic Development Strategy (SEDS). Upgrading of such lower level hospitals might aid to mitigate the overload of top referral hospitals and increase health insurance coverage.

Based on the above analysis, the following cooperation strategies were recommended for future JICA's cooperation on aging and universal health coverage in Viet Nam.

Japan had experienced a rapidly aging population, population influx to urban areas, and respect to home-based care by family members in the 1970s. These experiences are similar to the current situation in Viet Nam. In Japan, gross domestic products (GDP) per capita in 1977, when the aging rate was over 8%, was USD 6,000, and universal health insurance had been achieved. Also, health service network had been expanded even in the rural areas. While in Viet Nam, GDP in 2020 will be less when the aging rate will be at the same level. With these good practices and lessons learned from Japanese experiences, the Japanese government could provide technical assistance in order to prepare for the coming age and achieve universal health insurance and UHC.

Data Collection Survey on Social Security Sector in Viet Nam

Draft Final Report

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Chapter 1 Outline of the Survey

1.1 Background of the Survey

Toward the Universal Health Coverage (UHC) [1], Viet Nam has been making various efforts in the areas of policy, legislation, governance, and service delivery. However, the recent demographic transition and change of health needs may affect these achievements. Aging in Viet Nam has been rapidly progressing and the population aging rate (65 and over) was 7% in 2013. It is estimated that Viet Nam will become an aged society (population aging rate: 14%) in the next two decade.

In order to respond to such circumstances, diversification and stabilization of financial sources of health care is one of the most pressing issues in Viet Nam.

As the Japan International Cooperation Agency (JICA) also recognizes the above challenges in the social security sector in Viet Nam, the Data Collection Survey on Social Security Sector in Viet Nam (hereinafter referred to as "the Survey") was conducted to collect relevant data and information on the latest situation and current status of the implementation of relevant policies and programs, and major stakeholders' activities of the social security sector with main focus on aging and UHC.

The objectives of the Survey are:

- To collect information on social security sector in Viet Nam, especially the latest situation of aging and UHC; and
- To analyze the collected information to be able to make suggestions for JICA future assistance in the social security sector in Viet Nam considering the experiences and resources relevant in the sector of Japan.

1.2 Scope of the Survey

To achieve the above objectives, the Survey was conducted on three subsectors; 1) aging, 2) UHC, and 3) health finance. All necessary information were collected from all levels including central ministries/agencies, provincial and municipal administrations, and service providers, as well as users of relevant services such as health care and social welfare for the elderlies.

1.3 Structure of the Report

This final report (F/R) consists of seven chapters. Chapter 1 outlines the survey and Chapter 2 summarizes the overview of the social security sector in Viet Nam. Situation analysis on aging (Chapter 3), UHC and health insurance (Chapter 4) and health finance (Chapter 5) are described in the following chapters. Chapter 6 overlooks at the relevant activities and strategies of development partners. These information were integrated and analyzed in Chapter 7 to draw suggestion on the roadmap towards aging and achievement of UHC in Viet Nam.

[1] UHC is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. (WHO [63])

1.4 Methodology

1.4.1 Work Flow and Schedule

Figure 1-1 presents the work flow of the Survey. Available data and information in Japan have been collected and analyzed. Then, the field survey plan was prepared. Those were included in the inception report (IC/R). Subsequently, the field survey-1 was conducted in January 2014 according to the plan to collect necessary data and information through interviews with concerned agencies and organizations, and obtaining relevant materials such as published reports, statistics, reports, and legislations. After the comprehensive analysis of the collected data, the field survey-2 was conducted in February 2014 to collect additional information and discuss the draft development options with the stakeholders.

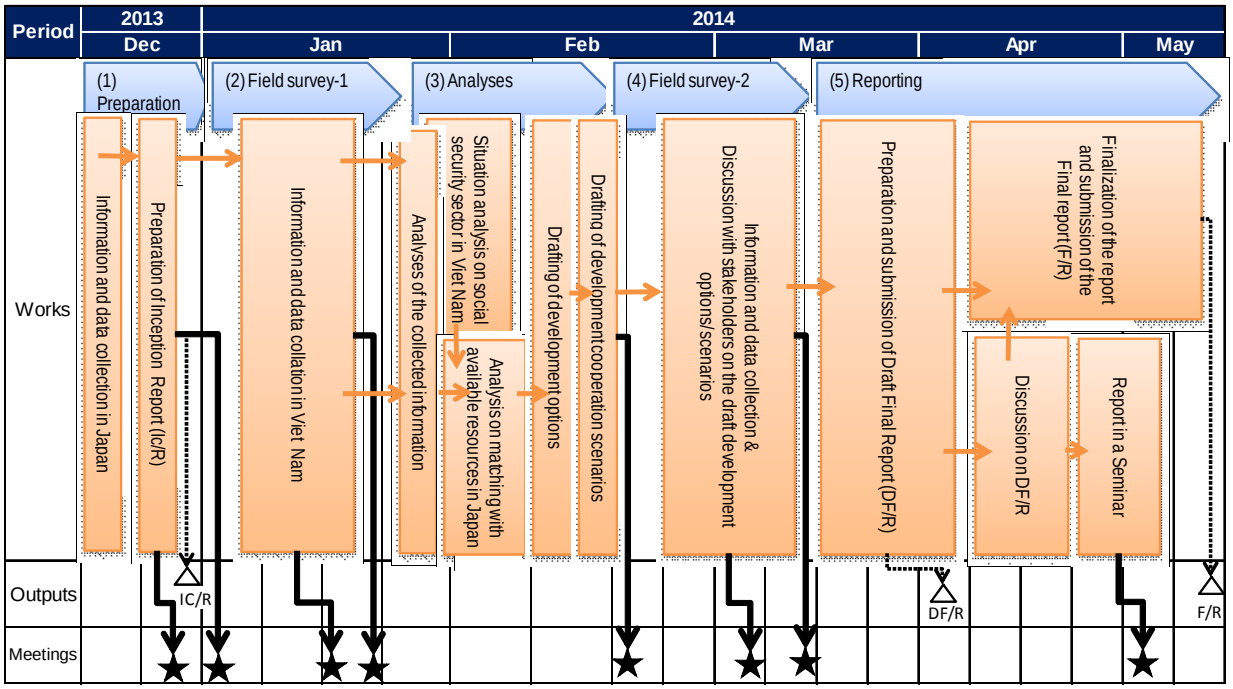


Figure 1-1 Work Flow of the Survey

The above survey outputs were compiled into a draft final report (DF/R) and finalized through discussions with stakeholders. The survey results was presented in a seminar to be held in Viet Nam on 21st of April 2014 (see Attachment 2). Then, the final report (F/R) was submitted in May 2014.

The work schedule is presented in Figure 1-2 on page 1-4. The itinerary of the field surveys and list of major interviewees are presented in Attachment 1.

1.4.2 Survey Team

JICA commissioned the joint venture of KRI International Corp. and NTT Data Institute of Management Consulting, Inc. (hereinafter referred to as “the Survey Team”) to carry out the Survey.

1.4.3 Reports

During the Survey, the Survey Team submited reports and outputs as shown in Table 1-1.

Table 1-1 Outputs of the Survey

Reports/Outputs	Language	Quantity		Timeline
Inception Report (IC/R)	English Japanese Vietnamese	10 8 10	1 CD-R	December 2013
Draft Final Report (DF/R)	English Japanese Vietnamese	10 8 10	1 CD-R	April 2014
Final Report	English Japanese Vietnamese	15 8 15	2 CD-R	May 2014
Collected materials	-	1 set	-	May 2014
Records of meetings	-	1	-	After the meeting
Monthly reports	-	1	-	Every month

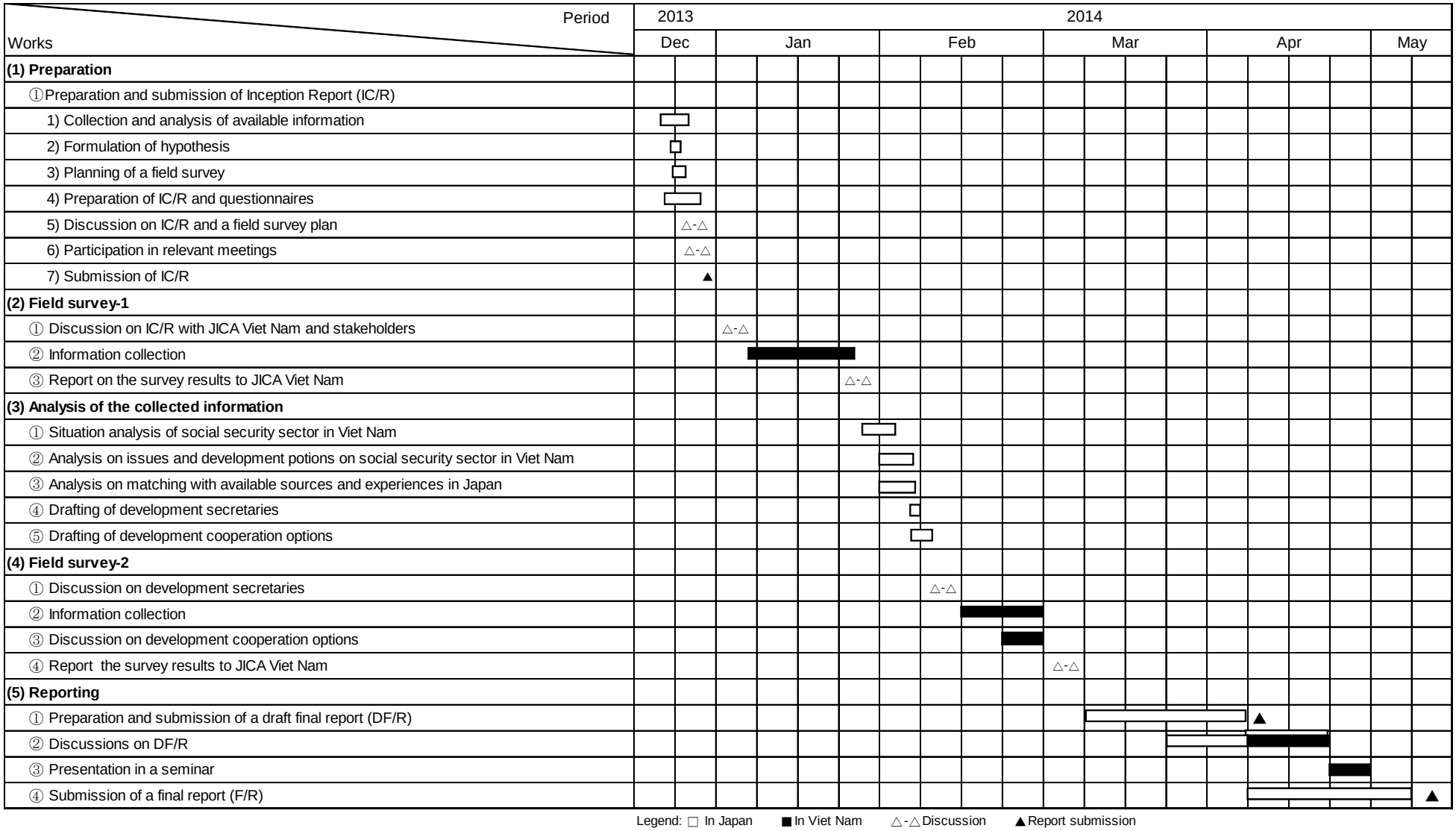


Figure 1-2 Work Schedule of the Survey

Chapter 2 Overview of the Social Security Sector in Viet Nam

2.1 General Information

Table 2-1 presents the major indicators of the socio-economic status of Viet Nam. A remarkable economic success has been achieved in Viet Nam after the introduction of the "Doi Moi[2]" Policy in 1986. Viet Nam had an average economic growth of more than 7% per year from 2000 to 2010, although it showed a sign of slowdown due to the Asian currency and economic crisis in 1997.

Table 2-1 Major Socio-economic Indicators

Indicators		Year
Population	88,775,500	2012
Population growth rate	1.06%	2012
Life expectancy at birth	75.46 years	2011
Crude birth rate (per 1,000 people)	16.16	2011
Crude death rate (per 1,000 people)	5.64	2011
Gross national income (GNI) per capita	USD 1,400	2012
Economic growth rate (%)	5.77%	2012
Primary school net allowance (%)	99.34%	2011
Human development index/rank	0.617/127	2012
Poverty gap at USD 1.25 a day (PPP) (%)*	40.10%	2007-2011

Source： World Development Indicators[1]
*Human Development Report 2013[2]

2.2 Health and Demography

(1) Demography

Total populatoin had exceeded 80 million in 2003 and as shown in Table 2-2, it was 88.8 million in 2012. Population growth rate has been declining and it was less than 2% in 1990.

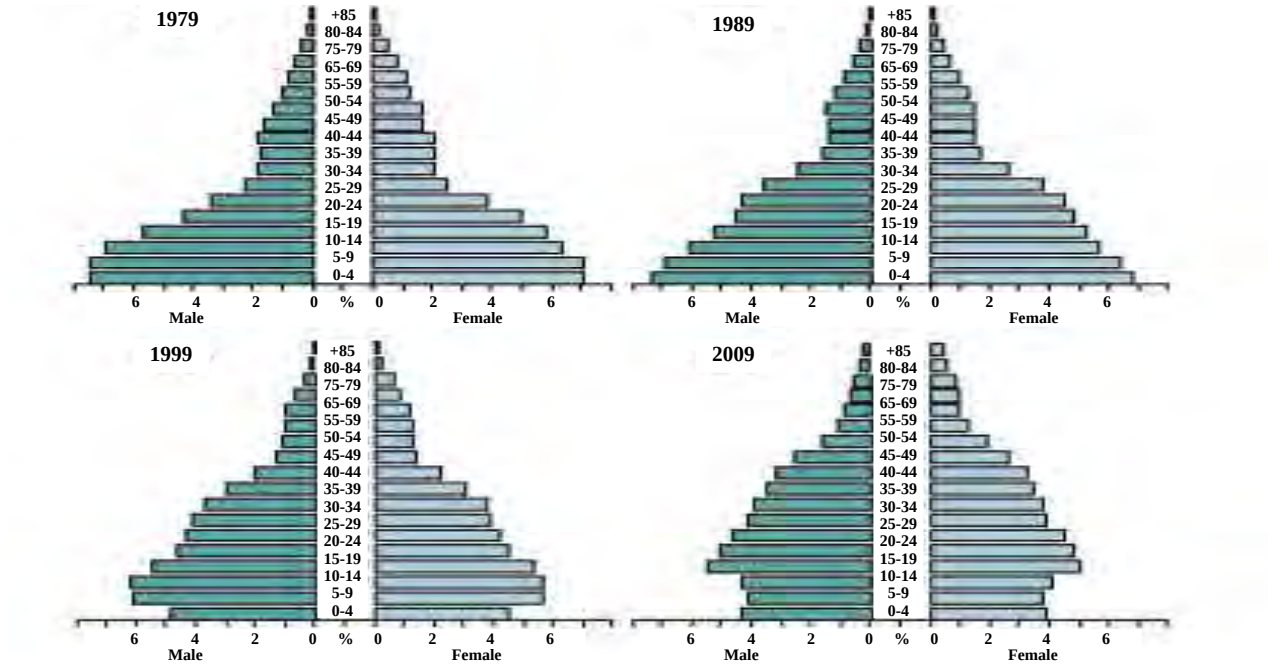
Table 2-2 Population Transition: 1990 - 2012

	1990	2000	2010	2012
Total population	66,016,700	77,630,900	86,932,500	88,775,500
Age 0 to 14 (% of total population)	37.41	31.58	23.49	22.87
Age 15 to 64 (% of total population)	56.88	62.00	69.97	70.58
Age 65 and over (% of total population)	5.71	6.42	6.54	6.55
Population growth rate (%)	1.90	1.34	1.05	1.06

Source: World Development Indicators [3]

As shown in Figure 2-1, demographic transition has been progressing and people aged 65 and over was 6.5% of the total population in 2012.

[2] The *6th National Congress of the Communist Party* promulgated Doi Moi reform introducing a market mechanism and open door policy.



Source： Population and Housing Census 2009, GSO, 2011[4]

Figure 2-1 Population Pyramid (1979, 1989, 1999, and 2009)

(2) Health Related Millennium Development Goals (MDGs)

As shown in Table 2-3, health related Millennium Development Goals (MDGs) (Goal 4: Reduce child mortality, Goal 5: Improve maternal health, Goal 6: Combat HIV/AIDS, malaria, and other diseases) have been improved.

Table 2-3 Status of Health-related MDGs

Goals	Major Indicators	1999	2000	Latest
Goal 4 Reduce Child Mortality	Under-5 Mortality Rate (per 1,000 live births)	50.5	31.5	23 (2012)
	Infant Mortality Rate (per 1,000 live births)	36.4	24.6	18.4 (2012)
Goal 5 Improve Maternal Health	Maternal Mortality Ratio (per 100,000 live births)	240	100	59 (2010)
Goal 6 Combat HIV/AIDS, Malaria and Other Diseases	HIV Prevalence among Population Aged 15-49 years	0.10	0.20	0.40 (2011)
	Malaria Prevalence (per 100,000)	—	—	104 (2010)
	Tuberculosis Prevalence (per 100,000)	403	344	323 (2011)

Source: The Official United Nations Site for the MDG Indicators [5]

(3) Disease Structure

As shown in Table 2-4, the major causes of morbidity are respiratory and digestive diseases, as well as hypertension. Traumas seemed to be the major causes of mortality. Health problems during perinatal and new born period seem to affect on health status of people.

Table 2-4 Major Causes of Morbidity and Mortality

Morbidity

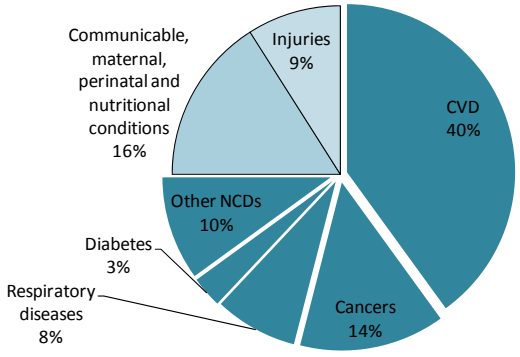
Diseases	Number (100,000)
Pneumonia	419.05
Acute pharyngitis and acute tonsillitis	349.89
Essential (primary) hypertension	317.65
Acute bronchitis and acute bronchiolitis	272.98
Diarrhea and gastroenteritis of presumed infectious origin	210.57
Gastritis and duodenitis	183.52
Other acute respiratory infections	145.73
Fracture of other lim bones	144.72
Disease of appendix	144.26
Other arthropod-bone viral fevers and viral hemorrhagic fevers	135.57

Mortality

Diseases	Number (100,000)
Intracranial injury	1.69
Pneumonia	1.65
Other respiratory disorders originating in the perinartal period	1.04
HIV/AIDS	1.04
Slow fatal growth, fetal malnutrition and disorders related to short gestation and low birth weight	0.92
Intracerebral hemorrhage	0.74
Acute myocardial infraction	0.69
Abdominal and pelvic pain	0.64
Other injuries of specified, unspecified and multiple body regions	0.56
Septicemia	0.53

Source: Health Statistics Yearbook 2011[6]

Figure 2-2 presents the proportion of non-communicable diseases (NCD). It shows that 75% of the total deaths are NCD-related especially that cardiovascular diseases and cancer are 40% and 14%, respectively. These are diseases requiring advanced diagnostic care, as well as life-long medication.



Source: NCD Country Profile 2011, WHO 2011[7]

Figure 2-2 Proportion of NCD-related Deaths

2.3 Development Strategies and Policies Relevant to the Social Security Sector

(1) Socio-Economic Development Strategy (SEDS) 2011-2020

The Socio-Economic Development Strategy (SEDS) 2011-2020 is a ten-year development strategy on the socio-economic sector. Among the three subsectors, i.e., economy, social and culture, and environment, aimed to achieve universal health insurance and secure social welfare and public health services.

Table 2-5 summarizes the SEDS 2011-2020 focusing on the social security sector.

Table 2-5 Summary of SEDS 2011-2020

View	Rapid and sustainable development, parallel restructure of policy and economy, human resource development, improvement of science and technology, and establishment of independent and autonomous economy	
Target (2020)	Economy	Gross domestic product (GDP) – average annual growth rate: 7%-8% GDP per capita – from USD 3,000 to USD 3,200
	Socio-culture	Human development indicator (HDI) – middle-high group Population growth rate – 1.1%; Life expectancy rate at birth – 75 years; Number of medical doctors per 10,000 – 9; Number of hospital beds per 10,000 – 26. Universal health insurance, security of social welfare and public medical services Poverty rate – decline 2% to 3% per year; National income – 3.5 times of 2010; Reduce income gaps
	Environment	Proportion of medical waste treated per regulation - 100%
Strategy	1. Completion of socialist market economy and sustainable macro economy. 2. Modernization of industry. 3. Development of modern and sustainable agriculture. 4. Development of service industry. 5. Infrastructure development. 6. Development of new cities and villages by sustainable regional development (Diversification and development of social insurance system, encouraging labors to join such insurances by giving preferable conditions). 7. Improvement of income level and increasing growth of the middle classes. 8. Development of medical services and improvement of health care (Strengthening of health service network at each level; standardization of services; improvement of policy and legislations of health insurance and medical care towards universal health insurance; safety net for the poor, children, and the elderly; quality improvement of human resource for health, allocation of medical doctors to all villages, enhancement of preventive medicines). 9. Improvement and development of the education and training system. 10. Rapid development of science and technology to contribute to economic development. 11. Environmental conservation and respond to climate change. 12. Ensuring political and social order and raising the international position.	

Reference: SEDS 2011-2020, Viet Nam Government Portal [8]

(2) Socio-Economic Development Plan (SEDP) 2011-2015

The Socio-Economic Development Plan (SEDP) 2011-2015 is a five-year development plan along with SEDS with 20 target indicators. Social safety net will be enhanced under this plan. Table 2-6 summarizes SEDP 2011-2015 focusing on the social security sector.

Table 2-6 Summary of SEDP 2011-2015

Indicator (Target: 2015)	Indicators set for the economic sector are ten, eight for social sector, and two for environmental sector. The following are relevant to the social security sector: - GDP average growth rate for five years: 6.5% to 7.0%; - National income: twice to 2.5 times of 2010; Decline of poverty household - 2% per year; - Population growth rate: 1%; Number of medical doctors per 10,000 – 8; Number of hospital beds per 10,000 - 23
Implementation	1. Improve the national operation, direction, and management. 2. Restructure the investment, financial market, and business operations. 3. Control inflation. 4. Develop legislations for completed socialist market economy, and review the transportation infrastructure development. 5. Strengthen the social security net to secure occupation, develop social and health insurance and social long-term care policy, increase the coverage of social and health insurance. 6. Restructure the education and training system, and investment to science and technology. 7. Develop the legislation on environmental conservation. 8. Strengthen the judicial system and relevant human resources. 9. Strengthen the national defense and participation to international society.

Reference: SEDP 2011-2015, Viet Nam Government Portal [9]

(3) Five-Year Health Sector Development Plan 2011-2015

Five-year health sector development plan 2011-2015 was established along with SEDS 2011-2020 and SEDP 2011-2015. The main objectives are health system development which prioritize socio-economic difficult areas, enhancement of preventive medicine and national health program, improvement of curative and diagnosis tic services, strengthening of population, family planning and reproductive health services, human resource for health, health information system, health finance including health insurance, domestic development of medicine and medical equipments, as well as management capacity of health sector management (Table 2-7).

Table 2-7 Objectives of Five-Year Health Sector Development Plan 2011-2015

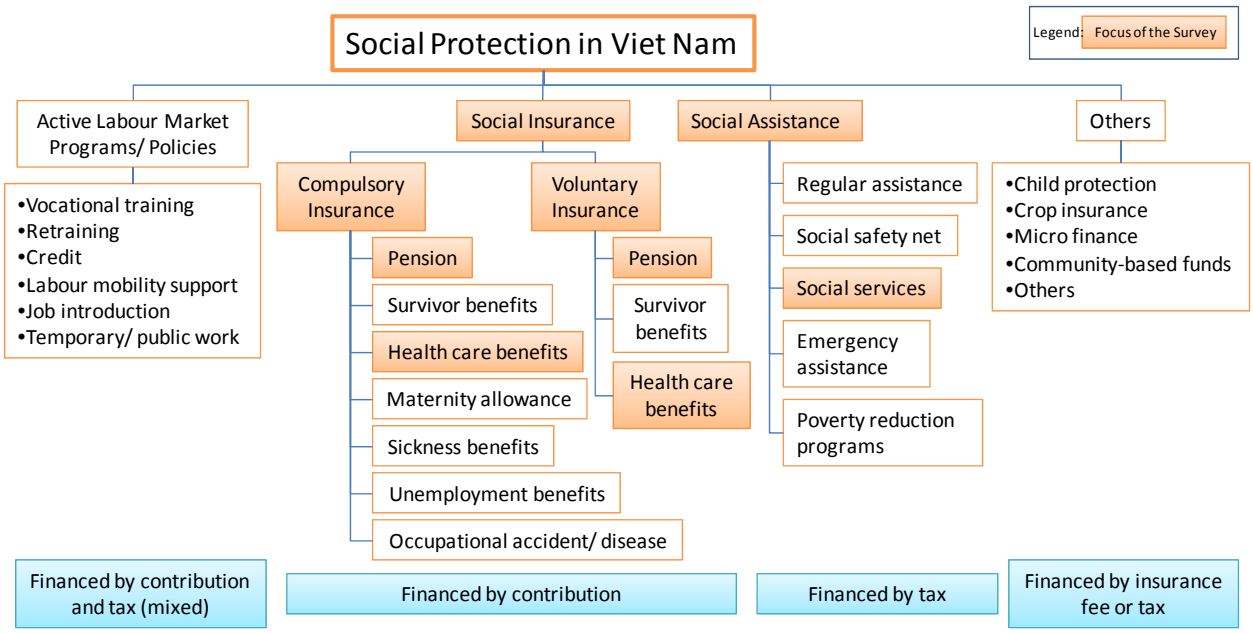
Indicators	2010[*1]	Target by 2015
Number of doctors per 1,000 population	7	8
Number of pharmacist per 1,000 population	1.2	1.8
Village with village health workers (VHW) (%)	85	90
Commune with a doctor (%)	70	80
Commune with a midwife/ an assistant doctor to take care perinatal and pediatric care (%)	>95	>95
Hospital beds per 10,000 population (excluding Commune Health Center)	20.5	23.0
Infants having all vaccination (%)	>90	>90
Commune achieving new commune health standard (%)	-	60
Health Insurance Coverage (%)	60	80
Life expectancy at birth (years)	73	74
Maternal mortality ratio (per 100,000 live birth)	68	58.3
Infant mortality rate (per 1,000 live birth)	<16	14.8
Under five mortality rate (per 1,000 live birth)	25	19.3
Population (thousands)	86,920	<92,000
Population decline rate (‰)	0.20	0.20
Population growth rate (%)	1.04	0.94
Sex ratio at birth[*2]	111	113
Malnutrition rate under five (weight against age) (%)	18.0	15.0
HIV/AIDS prevalence (%)	<0.3	<0.3

Note: *1 –Estimated, *2 – boys against 100 girls

Source: Five Year Health Sector Development Plan 2011-2015[10]

2.4 Overview of the Social Security Sector in Viet Nam

The social insurance is regulated by the Law on Social Insurance (71/2006/QH11). The Institute of Labour Science and Social Affairs (ILSSA) and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) organized the social insurance as shown in Figure 2-3. Pension is relevant to the elderly and health care benefits includes health insurance. The details are described in Chapters 3 and 4.



Reference: Viet Nam Social Protection Glossary [11]

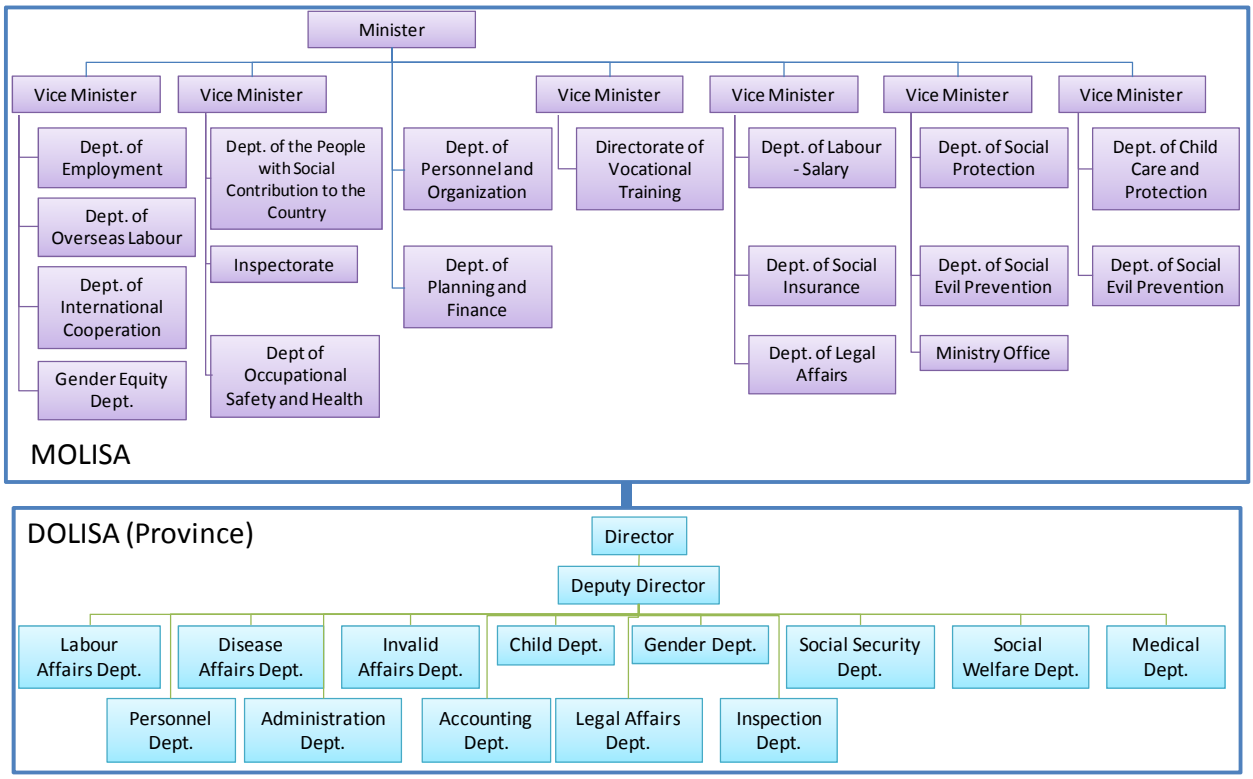
Figure 2-3 Structure of Social Insurance in Viet Nam

2.4.1 Concerned Agencies

At the central government level, the Ministry of Labour, Invalids and Social Affairs (MOLISA, Figure 2-4) and the Ministry of Health (MOH, Figure 2-5) are the major concerned agencies. The Viet Nam Social Security (VSS) is an executing agency of social and health insurance.

MOLISA is responsible for policy formulation and preparation of relevant legislations, and monitoring of policy implementation in the field of aging and elderly care. Among the state management agencies, the Department of Social Insurance takes responsibility of the pension while the Department of Social Protection is working for the elderly care.

The Department of Labour, Invalids and Social Affairs (DOLISA) is another important organization at the provincial level. DOLISA manages provincial social assistance programs. Also, DOLISA plays an important role in health insurance by identifying the poor and the near-poor whose insurance premiums are subsidized by the government.

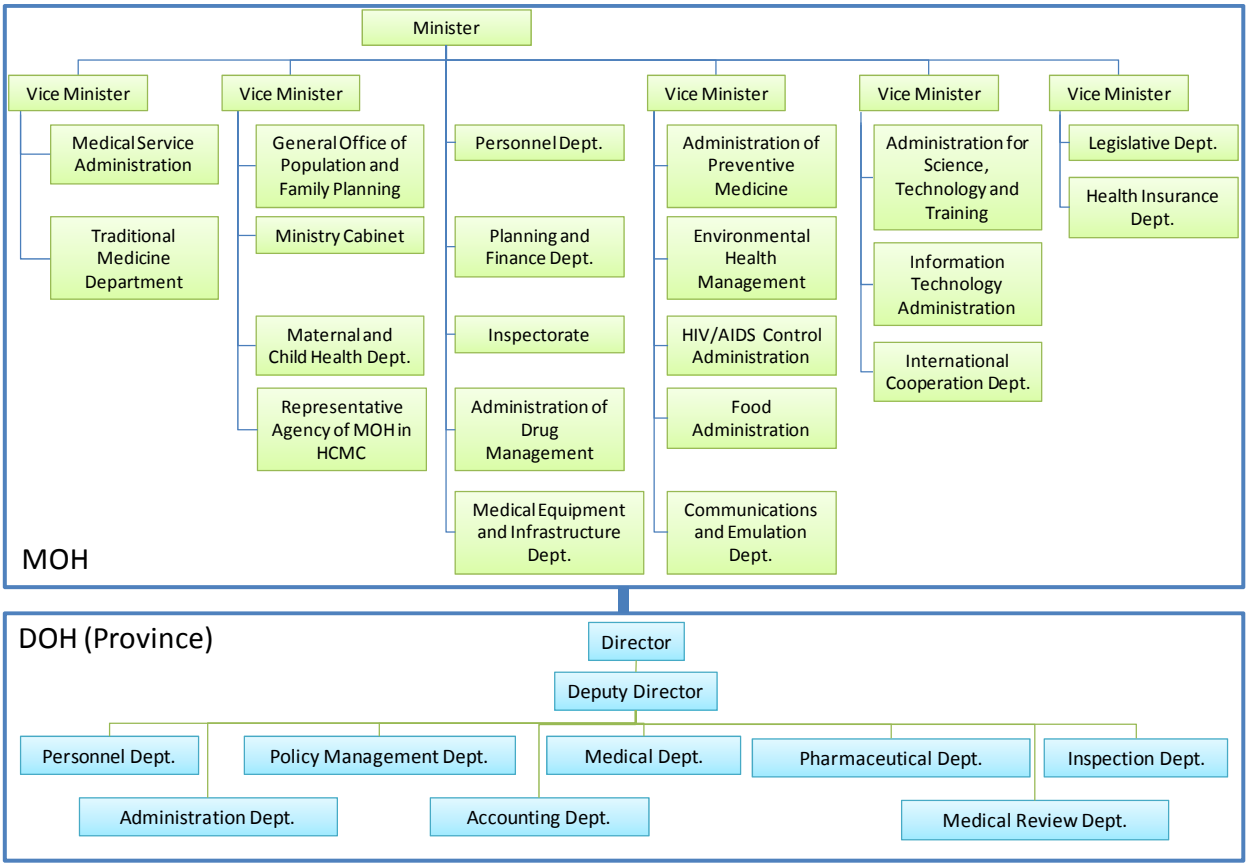


Reference: MOLISA Website [12], JICA Viet Nam Office

Figure 2-4 Organizational Structure of MOLISA and DOLISA

MOH is responsible for the health and medical services of the elderly, and health insurance. Among the state management agencies, the Medical Service Administration (MSA) is competent in curative service for the elderly including necessary human resource development and technical guidelines, while the Health Insurance Department is responsible for the preparation of relevant legislations and monitoring of policy implementation on health insurance. The General Office of Population and Family Planning is responsible for health promotion and statistics on the elderly.

The Department of Health (DOH) manages provincial health facilities and staff. Except from some centrally funded national programs, DOH has no financial relations with MOH. Its budget is allocated through the Provincial People's Committee. Also, DOH takes charge of medical care for the elderly, promotion of establishment of geriatrics in regional general hospitals, health enhancement for the elderly, and disease prevention. The commune health center (CHC) at the commune level is administered by DOH at the district level.



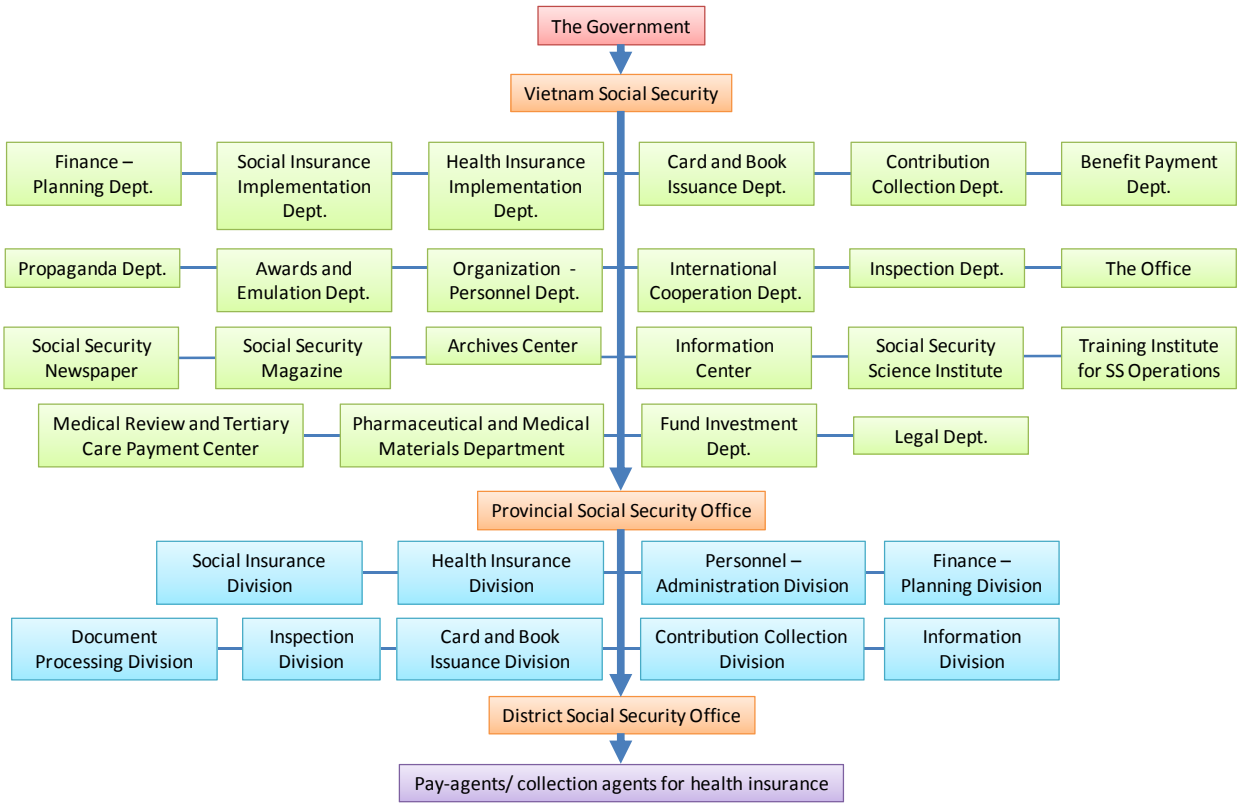
Reference: Joint Annual Health Review 2013[13], Decree No. 188/2007/ND-CP [14], JICA Viet Nam Office

Figure 2-5 Organizational Structure of MOH and DOH

(1) Vietnam Social Security (VSS)

The VSS manages the social and health insurance fund and is responsible for premium collection as well as benefit and allowance payment. The organizational structure of VSS is presented in Figure 2-6. In 1995, long-term insurances (pension, etc.) dealt by MOLISA and short-term insurances (workmen's compensation insurance, maternity allowance, etc.) which was the responsibility of the Vietnam General Confederation of Labour (VGCL) were integrated and transferred to VSS. Then, the Health Insurance under the Vietnam Health Insurance was merged to VSS in 2002 and unemployment insurance was added in 2009[15].

The collected premium is delivered to VSS to be managed at the central level. Social security (SS) in each province applies for the budget in case of any shortage and return to the balanced budget[16].



Source: Introduction of Viet Nam Social Security [17]

Figure 2-6 Organizational Structure of VSS and SS

SS in the provincial/city level manages the insurance publicity, premiums collection, card issuance, and fund management. It operates a whole regime of social security including health insurance, pension, and unemployment insurance. It also makes contracts with provincial and district healthcare institutions regarding health insurance. The organization of provincial SS offices are identical with each other. VSS has provincial offices and district branches. Table 2-8 shows the number of staff at three provincial SS offices, which were visited by the Survey Team.

Table 2-8 Provincial VSS Organizations

Province	Population (1,000)	Number of VSS Staff
Dine Bien	Approx. 530	238
Hoe Bin	Approx. 806	Approx. 300
Nam Dinh	Approx. 1800	267

Source: Survey Team

Chapter 3 Situation Analysis of Aging

3.1 Law and Policy on the Elderly

3.1.1 Law and Policy on the Elderly

(1) Framework

The 1992 Constitution of the Socialist Republic of Viet Nam stipulates that the elderly people shall receive state assistance. Pursuant to the Constitution, the Ordinance on Elderly People (23/2000/PL-UBTVQH10) was issued in 2000. Following this, the Ministry of Labor, Invalids and Social Affairs (MOLISA), the Vietnam Association of the Elderly (VAE), and other relevant organizations jointly drafted the Law on the Elderly[15]. Based on the draft, the Law on the Elderly (39/2009/QH12) had been enacted in 2009, and has taken effect in July 2010. It can be said that this law, which comprehensively prescribes the care for the elderly, has guided the care for the elderly in Viet Nam to a new stage.

Based on the Law on the Elderly, the Prime Minister's Decision on Approving the National Action Program on the Elderly in the Period 2012–2020 (1781/QD-TTg) was promulgated in 2012, and a number of other decrees and guidelines, such as the Decree of the Government Detailing and Guiding a Number of Articles of the Law on the Elderly (06/2011/ND-CP), have been issued.

Provisions requiring long-term care to the elderly are contained in the Law on Persons with Disabilities (51/2010/QH12), while those relating to pensions are contained in the Law on Social Insurance (71/2006/QH11). The medical system for the elderly people relies on Articles 12 and 13 of the Law on the Elderly and the Circular for Guidance of Implementing Health Care for the Elderly (35/2011/TT-BYT). In this regard, it can be said the Viet Nam is ahead of other countries in development of a legal system related to the care for the elderly. The dissemination and implementation of those schemes, however, have been insufficient due to lack of human and financial resources. In the Survey, there were some cases that the contents of such ordinances, decrees, and circulars were not comprehended at the provincial level and commune level[18].

The amendment to the Constitution of the Socialist Republic of Viet Nam, adopted by the National Assembly in 2013, stipulates that "The elderly shall be respected and cared for by the State, family, and society to promote their role in the cause of national construction and defense" (Clause 3, Article 37), and that "The State shall create equal opportunities for citizens to enjoy social welfare, develop the social security system, and adopt policies to support the elderly, people with disabilities, poor people, and other disadvantaged people" (Clause 2, Article 59). Such provisions on the dignity of the elderly were newly included in the Constitution.

(2) Law on the Elderly

The Law on the Elderly, which consist of 31 articles and six chapters, contains provisions on the rights and obligations of the elderly, the responsibilities of families, the state and the society in taking care of the elderly, the social participation of the elderly, and VAE (Table 3-1).

The Law on the Elderly defines the elderly as Vietnamese citizens who are 60 years of age or older. It provides for the elderly's rights to lead basic lives and requests the elderly to set bright examples of moral quality and lifestyles for the youth and to be exemplary in observing the party's policies and the state's laws. The provisions also stipulate that the elderly's families are obligated to take care of the elderly and that individuals shall respect and help the elderly. The Law on the Elderly establishes June 6 of each year as the Vietnam Elderly Day and declares the promotion of international cooperation.

Table 3-1 Composition of the Law on the Elderly (2009)

Chapter 1	General Provisions (Articles 1 to 9)
Chapter 2	Taking Care and Looking after the Elderly
Section 1	Taking Care of the Elderly (Articles 10 and 11)
Section 2	Caring for the Elderly Health (Articles 12 and 13)
Section 3	Care for the Elderly in Cultural, Educational, Physical Training, Sports, Recreation and Tourist Activities, Use of Public Facilities and Participation in Mass Transport (Articles 13 to 16)
Section 4	Social Patronage for the Elderly (Articles 17 to 20)
Section 5	Longevity Congratulation and Celebration, Funeral Organization (Articles 21 and 22)
Chapter 3	Promoting the Elderly Role (Articles 23 and 24)
Chapter 4	The Vietnam Elderly Association (Articles 25 to 27)
Chapter 5	State Agencies' Responsibilities for Elderly-Related Work (Articles 28 and 29)
Chapter 6	Implementation Provisions (Articles 30 and 31)

(3) National Action Program on the Vietnam Elderly 2012-2020

The National Action Program on the Vietnam Elderly in 2012–2020 was established in 2012 with the aim of promoting the roles of the elderly, which in particular include their participation in cultural, social, educational, economic, political activities, and the implementation of the rights and obligations of the elderly, enhancing physical and spiritual health of the elderly, and improving their material life quality of the eldelry. The program has set up targets for 2015 and 2020 with regard to the social participation of the elderly, the establishment of geriatrics, the dissemination and enlightenment activities through radio, television agencies, and the participation in intergenerational clubs in communes,wards and towns.

Despite the severe national financial situation, the priority to secure the budget for policies on the elderly has been high, and the budget has been allocated preferentially for the National Action Program on the Vietnam Elderly in 2012–2020[3]. Table 3-2 presents the outline.

[3] According to an interview with the Ministry of Finance.

Table 3-2 Outline of the National Action Program on the Vietnam Elderly 2012-2020

Indicators	Targets	
	2015	2020
Proportion of the elderly involved in economic and productive activities with necessary support	15%	50%
Proportion of communes, towns and wards which established a fund to promote care and role of the elderly	>25%	>80%
Proportion of the elderly who receive medical treatment and care by family or community	100%	100%
Proportion of special hospitals (excluding pediatrics and rehabilitation hospitals) and traditional medicine hospitals	25%	90%
Proportion of provincial hospitals having a geriatric department	25%	100%
Proportion of central and local radio and television agencies having forum on the elderly	80%	100%
Number of the elderly been entitled of monthly pension and use of a care facility	>1.5 million	>2 million
Proportion of the elderly receiving community care among the one without the entitlement as care facility users	>20%	>80%
Proportion of the elderly living in permanent houses	100%	100%
Proportion of commune, town and wards established Intergenerational self-help club (ISHC, see Section 3.5.4)	15%	50%
Proportion of the elderly participating Intergenerational Self-help Club (ISHC) in the commune, town and wards	70%	70%

Reference: 1781/QD/TTg[19]

3.1.2 Competent Authorities and Departments in Charge

(1) Vietnam National Committee on Ageing (VNCA)

The Vietnam National Committee on Ageing (VNCA) was established in 2004 as an organization assisting the prime minister on the formulation of guidelines, policies, and plans for the care of the elderly, and the promotion of the role of the elderly. The deputy prime minister serves as the chairperson of the committee, the chairperson of VAE and the minister of MOLISA serve as the vice chairpersons, the deputy minister of MOLISA serves as the permanent commissioner, and the deputy ministers and deputy chairpersons of relevant ministries and organizations serve as the 18 commissioners[4].All employees are civil servants; the secretary general is seconded from MOLISA, and the other nine staffs are employed by the office.

There is a similar organization at the provincial level. The vice chairperson of the People's Committee serves as the leader of the organization, the deputy director of the Department of Labor, Invalids and Social Affairs (DOLISA) and the vice chairperson of VAE serve as the subleaders. Though there are no similar organizations below the provincial level, the people's committees of districts and communes assume the role of the organization.

[4] Ministry of Home Affairs, Ministry of Planning and Investment, Ministry of Finance, Ministry of Health, Ministry of Education and Training, Ministry of Culture-Sport and Tourism, Ministry of Information and Communication, Ministry of Justice, Ministry of Agriculture and Rural Development ,Vietnam Social Insurance, the Committee for Ethnic Minorities, Vietnam Fatherland Front, Vietnam Women's Union, Vietnam Confederation of Labor, Vietnam Veterans, Vietnam Farmers' Association, Youth Union of Ho Chi Minh, Vietnam Study Encouragement Society.

In order to grasp the implementation status of the policies such as the Law on the Elderly, VNCA visits the organizations at the provincial level and people's committees at the district level or lower, and investigates the problems in those regions[5].

(2) Central Level

As mentioned in Section 2.4, MOLISA has jurisdiction over social protection and social insurance policies, and the Ministry of Health (MOH) has jurisdiction over healthcare. Other relevant organizations and their tasks as designated by the National Action Program on the Vietnam Elderly are shown in Table 3-3.

Table 3-3 Relevant Organizations on Policies on the Elderly

Relevant Organizations	Tasks
MOLISA	Preparation of relevant policy and legislations and formulation of programs and action plans in collaboration with the relevant ministries, VAE, and the People's Committees of provinces and cities, monitoring of those implementation, supervising of relevant facilities, conduct of survey and data collection
Ministry of Health	Preparation of technical standard of the elderly care, supervising of hospitals providing geriatrics, necessary human resource development, as well as disease prevention and health promotion for the elderly
Ministry of Planning and Investment	Coordination of the official development assistance (ODA) for the implementation of the National Action Program on the Vietnam Elderly, and integration with the socio-economic development plan
Ministry of Finance	Guidance inspections and supervision of the use of funds for the implementation of the National Action Program on the Vietnam Elderly
Ministry of Home Affairs	Guidance to local authorities to support the establishment and operation of the funds for the care and promotion of the roles of the elderly
Ministry of Construction	Construction of social housing for the elderly who are single, lonely, and/or helpless, and provision of support to the elderly by construction of housing or repair of dilapidated housing
Ministry of Agriculture and Rural Development	Direction and creation of conditions for the elderly who are healthy enough to participate in activities of the agricultural and rural development fields
Ministry of Culture, Sports and Travel	Guidance to activities on culture, art, and fitness, instruction and establishment of training classes, education for sports staff in health clubs for the elderly, guidance and organization of workshops for the elderly, inspection, supervision and strict management of cultural relics, histories, museums, famous temples, and fitness with ticketing
Ministry of Information and Communications	Direct the press agencies about the contents of activities related to the elderly, and organize forums for the elderly
Ministry of Transport	Inspection and supervision of units engaged in public transport and free services for the elderly.

Reference: 1781/QD/TTg[19]

(3) Vietnam Association of the Elderly (VAE)

VAE is a socioeconomic organization established in 1995, and has over seven million members, accounting nearly 90% of the elderly[6]. VAE consists of the central committee, 63 representatives at the provincial and city levels, 698 representatives at the district level, and 12,000 units of local VAE and

[5] VNCA interview
[6] The reason of no participation is living in remote area, bedridden, etc.

98,000 branches at the commune and ward levels[7]. VAE has built a close relation with MOLISA, and the chair of VAE assumes the position of vice chairperson of VNCA. VAE plays an important role in the policies for the elderly in Viet Nam

Major activities of VAE include improvement of the elderly care, enhancement of roles of the elderly, protection of their legal rights and benefits, surveys of status of the elderly, preparation of proposals to the government on issues related to the elderly, and implementation of projects for the well-being of the elderly[8]. VAE also supports longevity celebration (see Section 3.3.4(1)) in cooperation with DOLISA.

VAE manages about 60,000 elderly clubs throughout the country and organizes fitness and cultural activities, and workshops on health enhancement. The operating fund of VAE is taken from membership fees (VND 2,000 per month) that are paid on a voluntary basis[9].

VAE has made lists of the elderly by region. In cooperation with DOLISA, VAE has collected data on the age, sex, social protection, reception of pension, merits, and medical subsidies of the elderly in each region. The lists are under control of DOLISA[10].

3.2 Status of Aging in Viet Nam

3.2.1 Status of the Elderly

(1) Elderly Population in an Aging Society

Vietnamese society is facing a transformation of its population and is undergoing rapid aging of society. According to the General Statistics Office (GSO), the average life expectancy (2012) of Vietnamese people is 73 years old (70.4 years old for male and 75.8 years old for female)[20] (Table 3-4), and as of 2012, the elderly population aged 60 years or more amounts to 9.02 million, which constitutes more than 10% of the whole population of Viet Nam[21]. The elderly is defined as people aged 60 years or more according to the Law on the Elderly (see Section 3.1.1(2)).

Table 3-4 Life Expectancy at Birth

	2004	2006	2008	2010	2012
Total	72.1	72.8	73.2	72.9	73.0
Male	69.4	70.2	70.6	70.3	70.4
Female	74.9	75.6	76.0	75.7	75.8

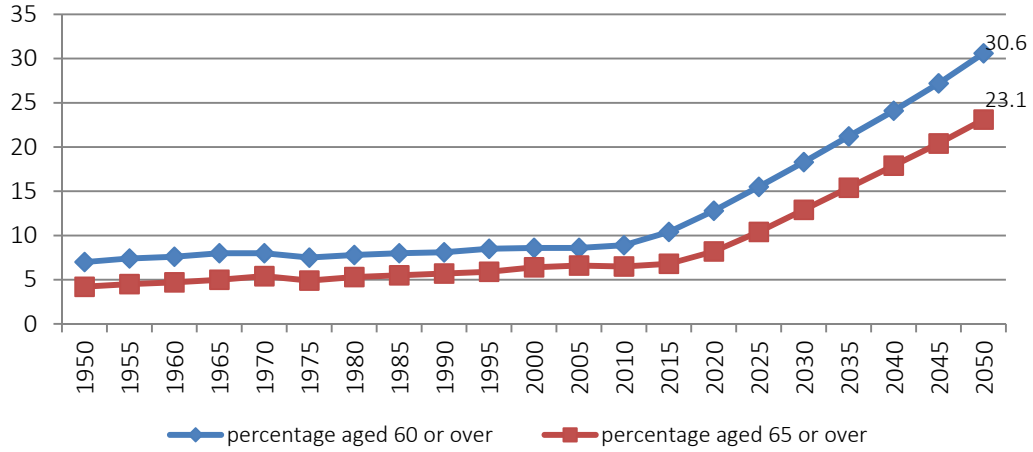
Source：2012 Statistical Handbook[20]

The population aging rate (aged 65 year or more) has reached 7% in 2011, and Viet Nam became an “aging society” six years earlier than originally expected.

It is estimated that Viet Nam will be an aged society (population aging rate of 14%) in 2037. It will take 20 years to become an aged society from Viet Nam’s current aging society, whereas in Japan it took 26 years. Aging in Viet Nam is expected to progress more rapidly than in Japan.

[7] According to the presentation by VAE.
[8] For example, the project of free cataract surgery for the elderly has been supported with VND 250 billion by hospitals, NGOs and embassies since 2012.
[9] According to the interview with VAE. They are apart from labor costs, administration costs.
[10] Nam Dinh Province DOLISA interview.

The speed of aging in Viet Nam is higher than the growth rate of Viet Nam's gross domestic product (GDP). The total fertility rate (TFR) is 1.8 (2011), which is falling below 2.0. This accelerates the rate of aging society with a low birth rate[22] (Figure 3-1).

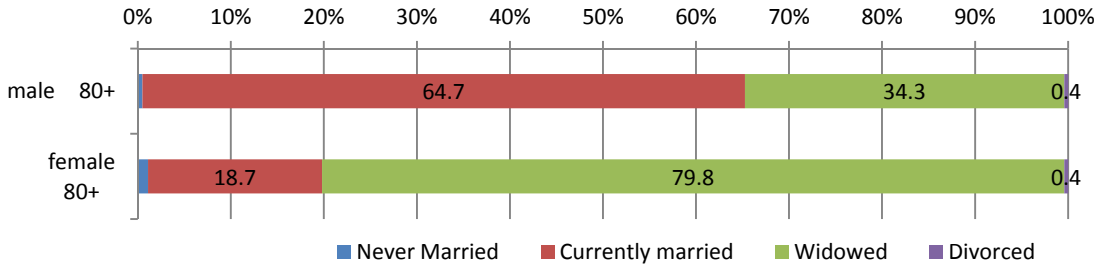


Source：World Population Prospects: The 2012 Revision[23]

Figure 3-1 Population Aging Rate (1950－2050)

(2) Household Composition of the Elderly

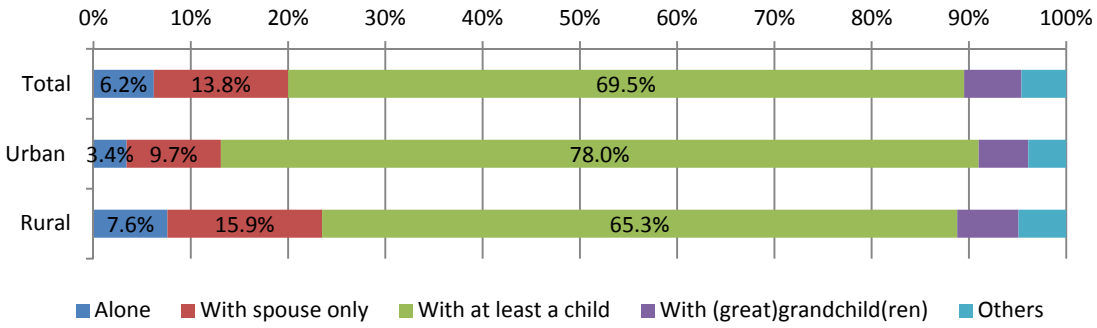
Since the life expectancy of females is longer than that of males, the proportion of single females among the elderly increases as they age. The ratio of males to females in the population who are aged 60 years or more is 41.4:58.6[24]. While the percentage of married males among males aged 80 years or more is 64.7%, and that of married females among females who are aged 80 years or more is only 18.7%. Moreover, the percentage of widowed females reaches 79.8% (Figure 3-2) .



Source：The 1/4/2012 time point population change and family planning survey-Major finding [21]

Figure 3-2 Marital Status of the Elderly Aged 80 Years or More

As shown in Figure 3-3, the percentage of the elderly living with their children is 70% in the whole country, but the percentage in rural areas is lower than that in urban areas. The percentage of the elderly who are alone or living with a spouse or grandchildren is high. The eldery households living with only great/grandchildren are called "skip-generation" households. It is caused by migration of working generation from rural to urban to seek better paid job. And when they offer their parents to move and live with them in the urban area, the parents would not accept ant prefer to stay in their hometown.



Source： Vietnam National Aging Survey (VNAS) 2011 [25]

Figure 3-3 Household Structure

The Vietnam National Aging Survey (VNAS)[11] found some abuse cases among the elderly living with his/her family. In particular, 11.0% of the elderly are spoken to harshly, 3.4% are neglected, and 1.6% suffered violence[25]. The dignity of the elderly is an issue that need to be solved.

(3) Residences of the Elderly

According to Vietnam Household and Living Standard Survey (VHLSS) 2012, the percentage of the elderly living in urban areas is 30.2%, and in rural areas is 69.9%. The elderly in urban areas has been gradually increasing, which shows the same trend as the percentage of the whole population (Table 3-5) .

Table 3-5 Proportion of Population by Urban/Rural (%)

		2004	2006	2008	2010	2012
60+	Urban	25.5	27.5	28.3	30.2	30.2
	Rural	74.5	72.5	71.7	69.8	69.9
All	Urban	24.3	26.8	27.6	29.9	29.8
	Rural	75.7	73.2	72.4	70.1	70.2

Source： Viet Nam Household Living Standards Survey (VHLSS) 2012[24]

The percentage of the elderly living in rural areas, especially in agricultural areas, is quite high. The Red River Delta, North Central Region, Central Coastal Region, and Mekong River Delta, where agriculture is the main industry, have a high percentage of elderly residents (Table 3-6).

Table 3-6 Proportion of the Elderly Population by Area

	0-14	15-59	60+
Red River Delta	21.8	64.4	13.9
Northern Midland and Mountain Areas	26.1	64.7	9.2
North Central Area and Central Coastal Area	23.5	64.5	12.0
Central Highlands	28.5	65.1	6.4
South East	21.8	68.7	9.6
Mekong River Delta	23.4	65.4	11.2

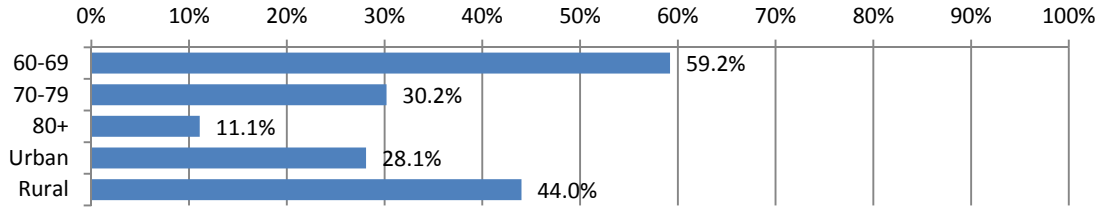
Source： VHLSS 2012 [24]

[11] Supported by fund of Atlantic Philanthropies (USA charities) and technical support of Helpage International, VWU and VAE first conducted the nationwide survey for elderly in 2011. The survey used the method of probability proportional to size (PPS). The target of the survey was the residents in 200 communes of the 12 provinces. The number of the total surveyed people is 4,007; 1,218 people aged 50-59, 2,789 people aged 60 or over. The ratio of male and female is 60.3：39.7.

For example, 14% of the population of Nam Dinh Province in the Red River Delta are elderly people, especially in rural areas, the percentage of the elderly population in some provinces, in particular, goes up to 82.6%[12].

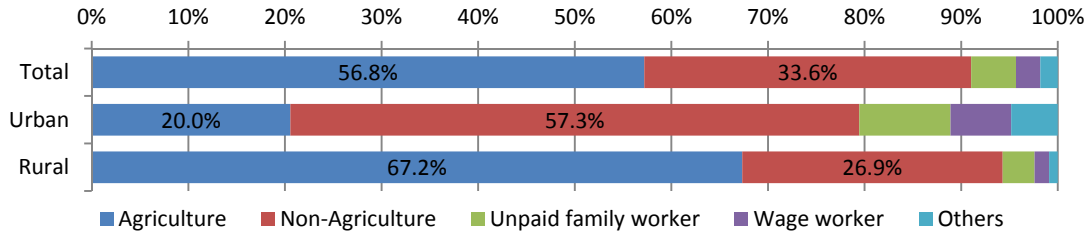
(4) Status of Working

Nearly 60% of the elderly aged 60-69 years are working and the labor force participation ratio is higher in rural areas than in urban areas (Figure 3-4). This might be explained by the fact that rural areas have a high proportion of agricultural population (Figure 3-5). However, the percentage of the elderly with insufficient income reaches 30.0% in rural areas, in contrast to 17.9% in urban areas, which indicates the income of the elderly is kept low in rural areas[25].



Source： VNAS 2011[25]

Figure 3-4 Proportion of the Elderly Currently Working

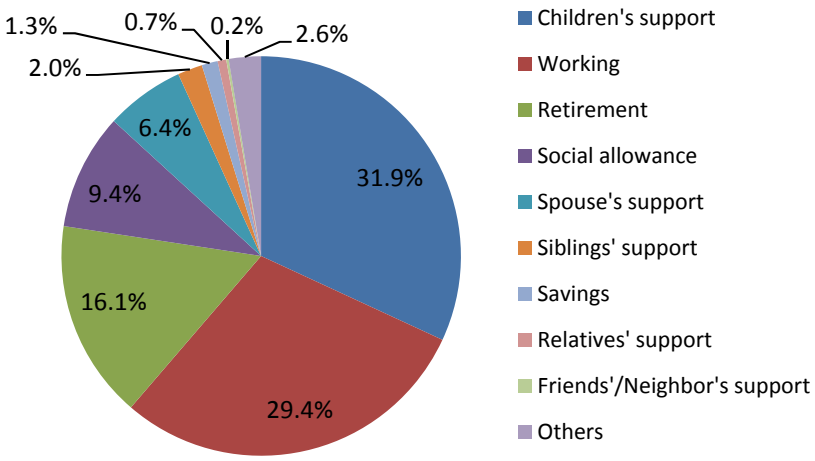


Source： VNAS 2011[25]

Figure 3-5 Types of Jobs of Currently Working

A large proportion of the elderly depends on their children as their source of income; 32% get support from their children, 29% from wages, and 16% from retirement benefits (Figure 3-6). Those who have savings make up only 10.4% and nearly 90% of the elderly have no savings. The reasons for going into debt are as follows; 34.2% due to investment in business, 16.9% due to construction or repair of their house, 13.8% due to health problems, and 8.6% for daily expenses, which shows that a health problem could result in debt[25].

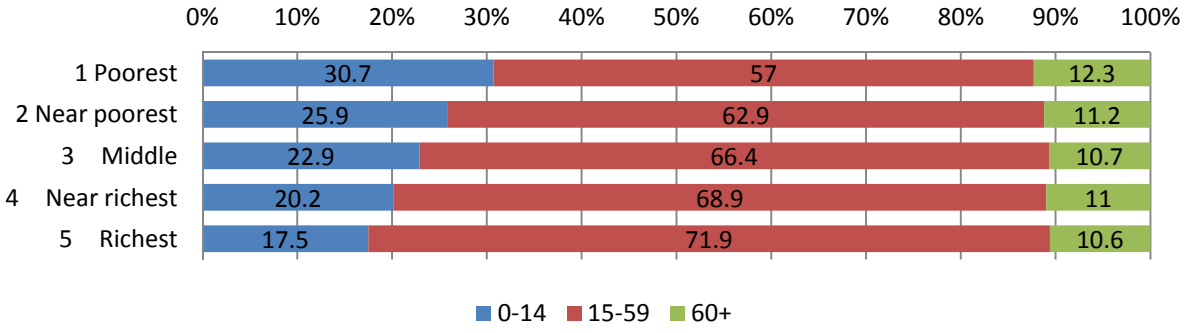
[12] According to an interview in Nam Dinh Province.



Source： VNAS 2011[25]

Figure 3-6 Main Sources of Income

The percentage of the elderly among the poorest groups represents 12.3%, which is higher than that among the more affluent groups (Figure 3-7). The average annual expenditure of the poor elderly who are aged 60-69 years is VND 7,896,000, which is only one third of VND 26,229,000, the expenditure of the non-poor[26].



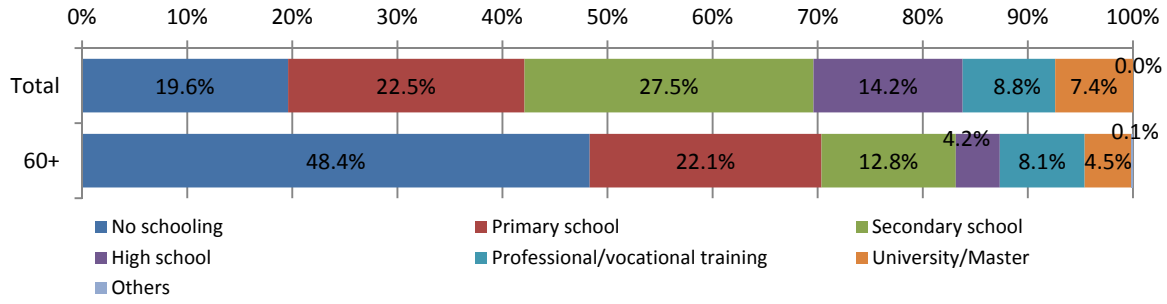
Source： VHLSS 2012[24]

Figure 3-7 Proportion of Population by Age Group and Income Quintile

It is inferred that although a large percentage of the elderly living in the rural areas is high and most of them are engaged in agriculture, their income would be kept low, and single or female elderly without support from their children or spouse live under difficult circumstances.

(5) Education Standards/Living Conditions/Social Participation

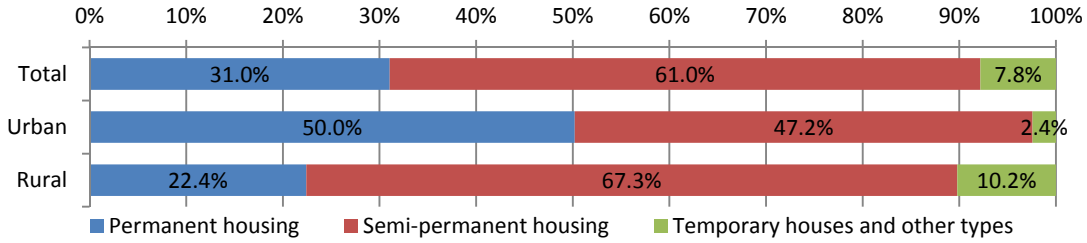
As shown in Figure 3-8, 48.4% of the elderly have never attended school or not completed primary school. The higher the age is, the lower their education level is. The percentage of the elderly who are literate is 51%, while that of the elderly aged 80 years or more is only 27.3%[25].



Source： VHLSS2012[24]

Figure 3-8 Education Levels

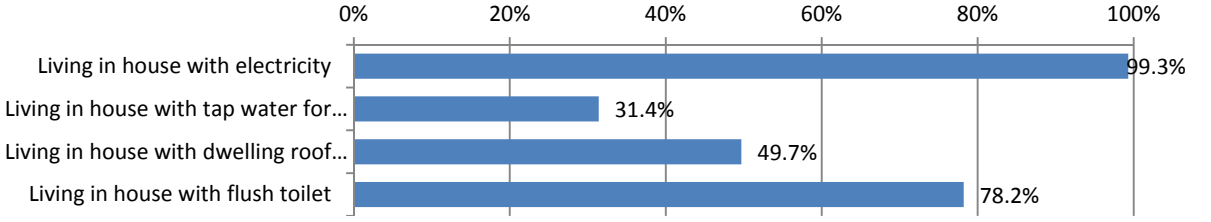
Ninety percent (90%) of the elderly are living in either permanent or semi-permanent housing, and only 7.8% of them are living in temporary unstable housing. The percentage of those living in temporal housing is larger in rural areas than in urban areas (Figure 3-9) .



Source： VNAS 2011[25]

Figure 3-9 Housing Conditions

As shown in Figure 3-10, the proportion of the elderly living in houses with electricity reaches nearly 100%, and in houses with flush toilets nearly 80%.



Source： VNAS 2011[25]

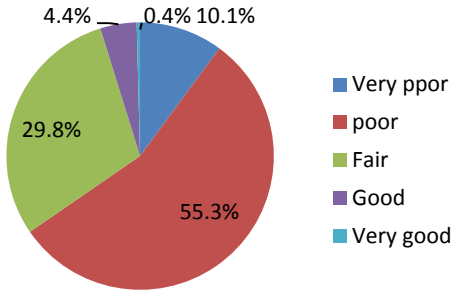
Figure 3-10 Living Situation

As for the situation of social participation of the elderly, 36.4% of the elderly are participating in some form of social activity or club that are held in communes or wards. Also, 71.0% of them have membership in VAE, and 82.5% have participated in an activity of VAE over the last 12 months[25]. These numbers suggest that VAE is deeply rooted to the social activities of the elderly.

3.2.2 Health Status

(1) Health Status

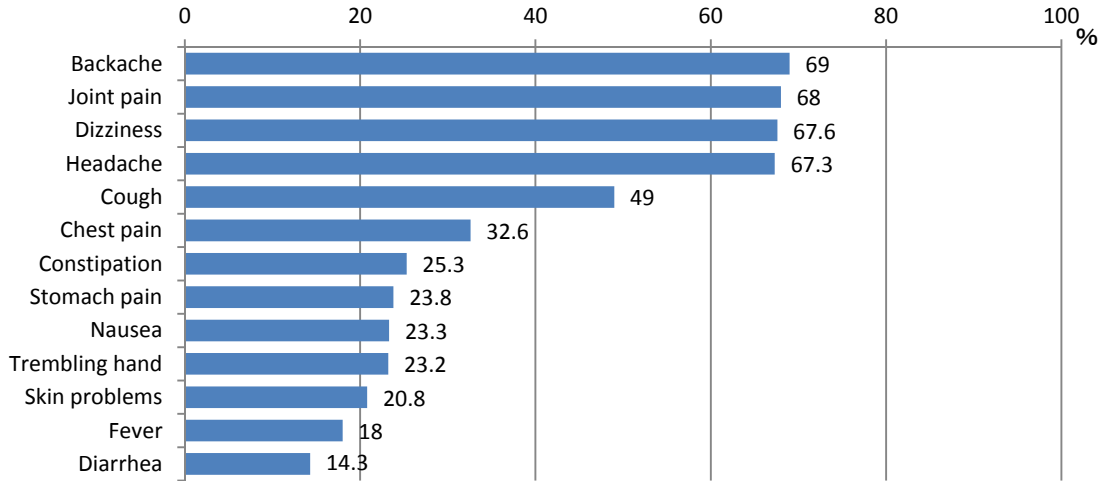
According to VNCA's survey, 90.8% of the elderly suffer one or more diseases, and among the elderly aged 80 years or more, 96.6% self assesed that they have some kinds of heatlh problems[27]. In addition, 65% of the elderly responded that their health status is poor (Figure 3-11) .



Source： VNAS 2011[25]

Figure 3-11 Health Status

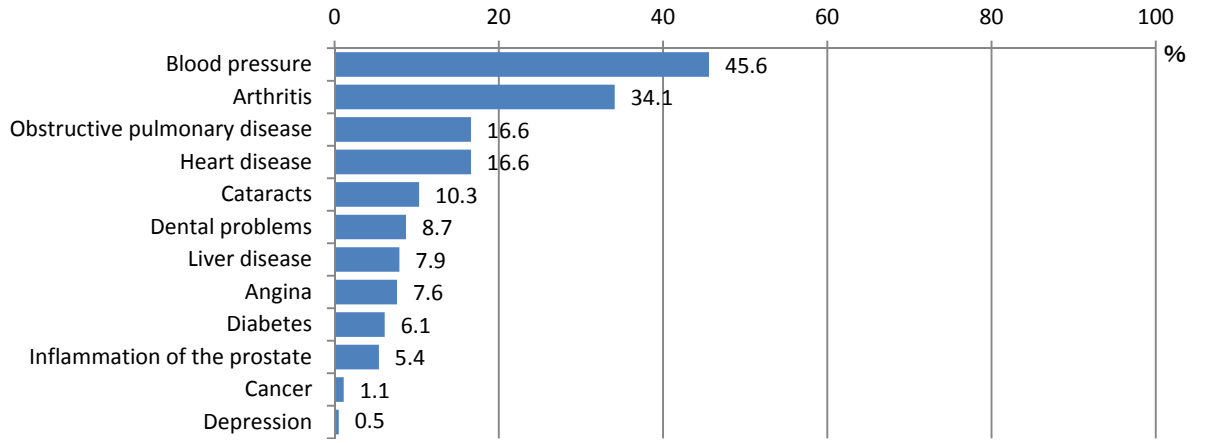
As Figure 3-12 shows, nearly 70% of the elderly complained about experiencing sickness, such as backache, joint pain, headache, and dizziness.



Source： VNAS 2011[25]

Figure 3-12 Sickness Experienced by the Elderly in the Last 30 Days

The most common health ploblems of the elderly are chronic diseases such as high blood pressure, arthritis, heart disease, obstructive pulmonary disease, and cataract (Figure 3-13).



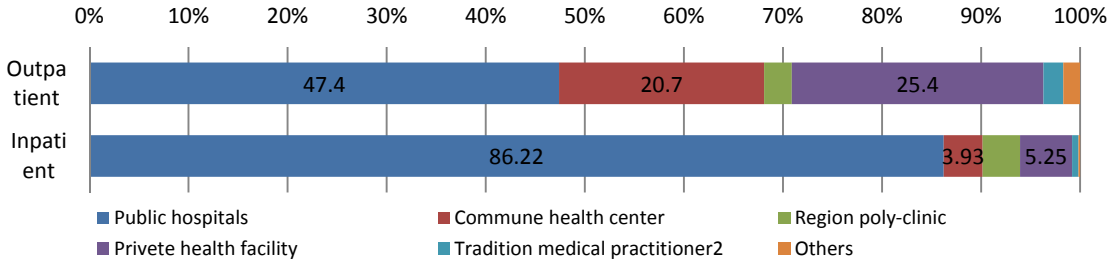
Source： VNAS 2011[25]

Figure 3-13 Major Health Problems among the Elderly

According to interviews at the hospitals, chronic diseases such as diabetes, cancer, and brittle bone disease are rising as well with the increase of the elderly[13]. However, since there are no statistics on causes of morbidity and mortality by age group, it is difficult to grasp a specific tendency. Chronic diseases could decline quality of life and cause long-term medical treatemnt and nursing care. Then, the burden to the household economy could continue for long time and heavy and some family members might have to leave his/her job to take care of the patient.

(2) Status of Medical Treatment/Health Insurance

According to VHLSS 2012, 64.8% of the elderly had health treatment at medical institutions within the last 12 months. Out of which, the percentage of the elderly who used health insurance or was eligible to free treatment was 11.9% for inpatients, and 38.3% for outpatients[24]. Among the elderly visitet out patient department, 47.4% went to public hospitals, 25.4% went to private health facilities, and 20.7% went to commune health center (CHC).The percentage of inpatients by public hospitals is accounted for 86.2%. Among incharged to inpatient department, 86.2% was in public hospitals (Figure 3-14) .



Source： VHLSS 2012[24]

Figure 3-14 Percentage of Treatment by Type of Health Facility

Since the health risk will higher when the age is older and medical treatment requires a certain amount of money, when the elderly are not insured, health problem might threaten his/her household economy. Among the elderly, 26% is not insured in average and it is higher in younger generations as shown in

[13] According to interviews with hospitals, the percentage of the elderly is unclear due to lack of statistics by age group.

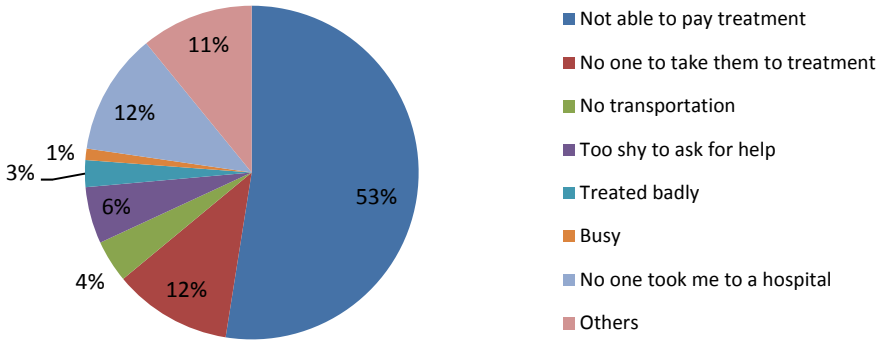
Table 3-7. Although 80 years and over can be insured without premium payment, 10.7% is not insured (Table 3-7).

Table 3-7 Proportion of Uninsured Elderly

	Total	60-69	70-79	80-
Uninsured	26.1%	33.8%	25.9%	10.7%

Source： VNAS 2011[25]

The heavy burden of medical treatment costs can also become a factor to cause delay in seeking care. The percentage of the elderly not receiving medical care despite being in a condition that apparently requires medical care is 54.9%[25], because they are not affordable to pay for the treatment, have no transportatoin or surrpot to take them to a health facility (Figure 3-15). Then, after the condition is quite serious, the elderly tend to seek care finally.



Source： VNAS 2011[25]

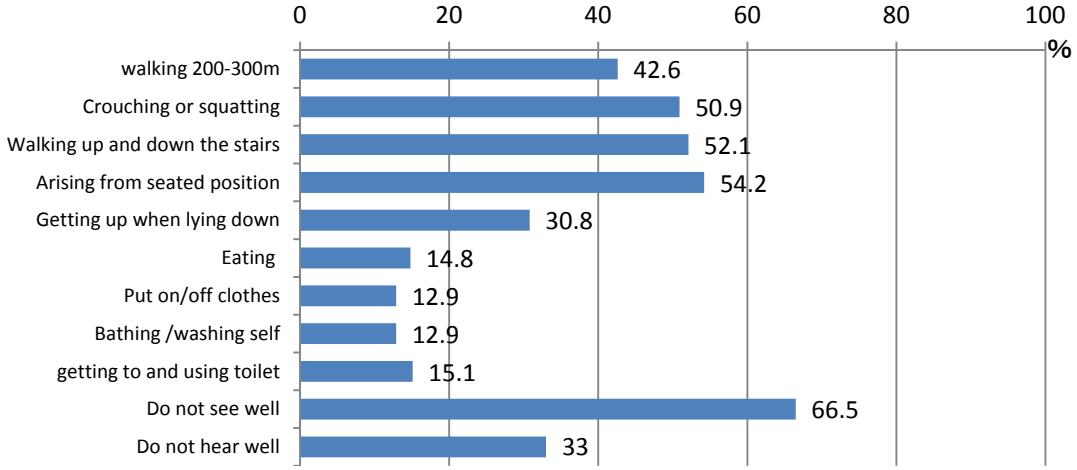
Figure 3-15 Reasons for No Treatment

(3) Activities of Daily Living (ADL)

According to VNAS, more than half of the elderly have problems in daily activities such as standing up or going up and down the stairs, and the percentage of the elderly who have problems in performing activities of daily living (ADL), such as eating and bathing, is approximately 13% (Figure 3-16). In addition, 66.5% of the elderly have vision impairments, 33% have hearing impairments, and 48% have memory issues (Figure 3-17).

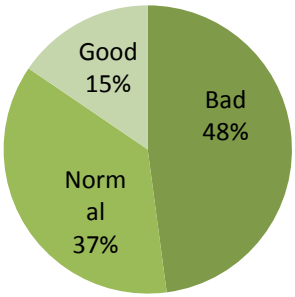
A nationwide survey regarding the elderly with disabilities has not been carried out[14], but the percentage of the elderly who have been certified as disabled in a particular region under the Law on Persons with Disabilities was approximately 2.5% of total elderly population[15].

[14] According to an interview with MOH.
[15] In Dien Bien Province, there are 800 (approximately 2.5%) elderly persons with disabilities among the elderly population (32,000).



Source： VNAS 2011[25]

Figure 3-16 Status of Activities of Daily Living (ADL)

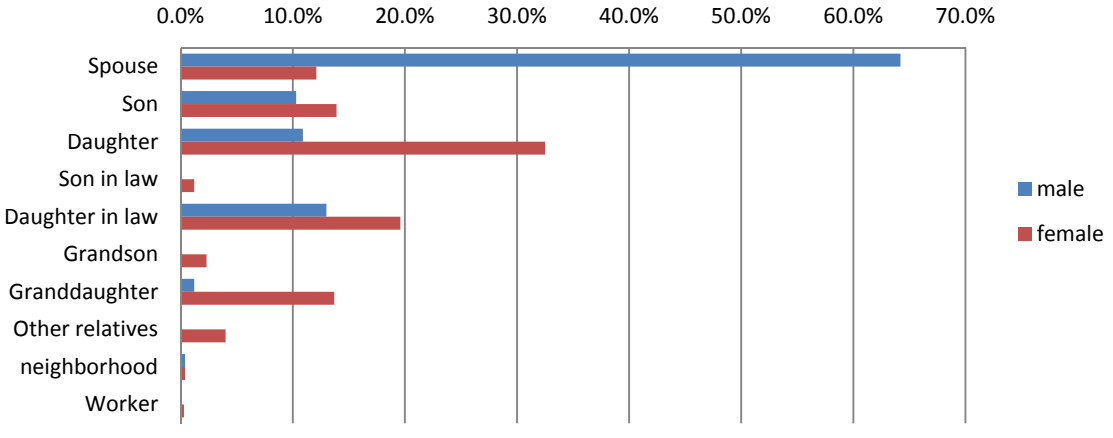


Source： VNAS 2011[25]

Figure 3-17 Status of Memory

(4) Feelings Regarding Caring for the Elderly

In Viet Nam, home-based acre by family memver is still very common and has favourable perception. Despite the fact that technical skills held by the family regarding nursing is scant, the family continues to nurse the elderly, even if the nursing period spans five or ten years. As shown in Figure 3-18, women (a wife, a daughter, a daughter in law, and grand dauther) mainly support daily activities of the elderly.



Source： VNAS 2011[25]

Figure 3-18 People Supporting the Elderly with Daily Activities

On the other hand, the demand for admitting the elderly in the care facilities even if he/she has a family is slowly increasing, mainly in urban areas. Despite the fact that public facilities require user fee if one has a family, the demand for admissions is rising (see Section 3.4.1).

3.3 Welfare Policy for Elderly People (Social Assistance and Social Insurance including Pension)

The social security systems (Figure 2-3) for the elderly consist of old-age pension supported by social insurance, medical insurance covered by social assistance, and welfare benefits for the elderly.

3.3.1 Old-Age Pension

There are long-term and short-term social insurances. Old-age pension is a long-term one.

(1) Pensioners

All workers with a direct contract for more than three months, public servants, Vietnamese military officers, noncommissioned officers and soldiers, military and public security officials, and those working overseas based on an employment contract have to join the social pension scheme. It is planned to also cover workers with contracts of more than one month. Men aged 15 to 60 years and women aged 15 to 55 years are obliged to participate in the pension system.

On the other hand, voluntary social insurance covers self-employed workers. A challenge for the system is how to cover farmers, who account for about 70% of the population.

(2) Insurance Rate and Collection System

The rate of the social insurance premium has been on the rise year after year and the total rate of the old-age and bereaved family pensions has risen to 22% in 2014 (Table 3-8). Of them, 14% is paid by employers and 8% is by employees.

Table 3-8 Compulsory Social Insurance Contribution Rate

Contribution	Retirement and Survivorship Fund	Work Injury and Occupational Disease Fund	Sickness and Maternity Fund	Unemployment Insurance Fund	Total
2012-2013					
Employer	13%	1%	3%	1%	18%
Employee	7%	-	-	1%	8%
State budget	-	-	-	1%	1%
Total	20%	1%	3%	3%	27%
From January 2014					
Employer	14%	1%	3%	1%	19%
Employee	8%	-	-	1%	9%
State budget	-	-	-	1%	1%
Total	22%	1%	3%	3%	29%

Source： Introduction of VSS[17]

The employers pay premiums for their employees accrding to a contract with the Vietnam Social Security(VSS) or provincial Social Security (SS). Since small- and medium-sized companies tends to fail or delay the premium payment, the government imposes interests and fines on overdue payments[16].

[16] According to an interview with VSS.

(3) Eligibility

As a rule, men aged 60 years or older and women aged 55 years or older are eligible as pensioners if they have paid premiums for more than 20 years. Those who have been engaged in dangerous jobs or heavy labor jobs designated by MOLISA and MOH can receive their pension after a 15-year premium payment. The revised Law on Social Insurance, which is uner preparation to be submitted in August 2014, would extend the eligible timing by four months every year starting in 2016 until the eligible ages are reached which is 62 years for men and 60 years for women[17]. But in Vietnam, workers usually do not work longer and the average retirement age is 53 years. There is a gap between the eligibility ages and retirement ages.

(4) Standard Payment

It is a defined-benefit pension based on the average monthly income of pensioners. The replacement ratio of the old-age pension is set at 45% of the standard remuneration. For an additional year of premium payment, the ratio increases by 2% for men and 3% for women. Though 75% of the minimum wage is set as the upper limit, the replacement ratio is very high[28]. For example, the average pension in Ho Chi Minh City is around VND 2 million.

(5) How to Receive Pension

Pensioners withdraw via automated teller machines (ATMs) the money deposited to their bank accounts or they receive pension at a counter of the people's commission in each district or village. In 2013, some regions started to make payments at post offices also. For pensioners living in remote areas, the post office delivers the cash according to contract with the provincial SS[18].

(6) Pension Financing

The old-age pension is operated as a pay-as-you-go system. According to the estimates by the International Labor Organization (ILO) and VSS, expenditure might exceed the revenue even if reversal of the reverse fund supplement the income from premiums by 2034 in case the pension contine to be managed in current rate (22%). A cited reason for this, in addition to the aging population, is that the period of premium payment is shorter than that of beneficaries, as the average retirement age is early compared with the life expectancy. MOLISA, with support from the ILO, is working to revise the Law on Social Insurance including extension of the payment period. However, government ordinances and guidelines have to be drawn for actual policy implementation.

A survey made by GIZ showed that only 19.3% of the workers have joined the pension scheme and only 21.9% of the elderly receive pension. While 18.5% of the elderly are on social assistance, the remaining 60% of them receive no social assistance. As more people are recognizing the significance of accurate management of pension records such as premiums paid and payment periods, VSS has made some actions to shift from paper recordkeeping to computer management.

[17] According to an interview with VSS.
[18] According to an interview with the Dien Bien Province DSS.

3.3.2 Social Assistance

(1) Free Health Insurance Card

The elerly without any relatives to support him/her, in poor household and aged 80 and over are issued free health insurance card. Their burial cost is also covered by public fund. It might be expected to contribute the coverage of health insurance, however the coverage among the near poor aged 60 to 79 is still low.

(2) Senior Welfare Benefits

1) Eligibility and standard payment

A standard monthly amount of VND 180,000 is given to people of ages 80 years or older as old-age benefit regardless of their family conditions and income. A monthly payment of VND 180,000 is made to single or poor persons aged 60 to 80 years, while twice the amount, i.e., VND 360,000 a month, is given to people aged 80 years or older who are living alone or in poverty[19]. To the elderly with severe disability, 2.5 times the standard amount, i.e., VND 450,000 a month, is paid according to the Law on Persons with Disabilities[20]. The problem is that the monthly standard amount of VND 180,000 is only 25% of the estimated amount of expenditure for minimum living standards[29], and such amount is increased to VND 270,000 a month in 2014[21].

2) Payment

The old-age benefit is first paid to DOLISA from the provincial Department of Finance (DOF) through the finance department of the prefectural people's committee[22]. Executives of each village receive the cash and deliver to the elderly. Since the money sometimes fail to reach those who need it in some regions, all the provinces started to pay benefits through post offices in 2013. This payment method was started in 2011 and is now being applied nationwide after its viability had been confirmed in some provinces during trials[23]. But in mountainous areas this method are not used because of the difficult access to post offices[24].

3) Number of the elderly on benefits

About 4.7 million elderly people, more than half of the total, live on pension or old-age benefit[18]. However, some of the elderly have failed to receive these benefits because they do not have certification or identification.

3.3.3 Benefit for the Disabled Elderly

The rules for the disabled elderly persons are provided by the Law on Persons with Disabilities (51/2010/QH12), which was revised in 2010. The law covers not only the elderly but also all disabled

[19] 06/2011/ND-CP
[20] 28/2012/ND-CP
[21] 136/ND-CP/2013
[22] According to an interview in Nam Dinh Province
[23] By 136/ND-CP/2013, the use of post office is recommended.
[24] According to an interview in Dien Bien Province.

persons including children with physical, sensory organ, visual, psychological, and intellectual disabilities. There is no definition of "elderly person requiring nursing care" as in the law in Japan. They are protected as the elderly with disabilities. The Vietnamese law stipulates that disabled persons should be taken care of by their own family members.

The severity of disabilities is generally determined by the council for disability certification. When it is difficult to determine the severity or if a disabled person or their agent refuses the decision, or the decision is obviously biased or wrong, the decision is up to the medical diagnosis council. The council for disability certification is set up by the people's committee chairman of the commune, ward, or town.

Disabled elderly persons are given priority for treatment at medical institutions, and the content of the treatment is also better than disabled persons in other age brackets[25].

3.3.4 Congratulatory for Longevity and Discount on Public Transportation Fares

(1) Celebrate Longevity

On Elderly Day every year, the prime minister celebrates the elderly aged 100 years by giving them VND 500,000 each. Those aged 90 years receive congratulatory money from the chairman of the Provincial People's Committee. People's committee chairpersons of some regions give celebration money to those aged 70, 75, 80, 95, and 100 years or more[26]. Compared to other policies for the elderly, the implementation of this celebration on longevity of the elderly has been done well. The amount of reward money varies depending on the economic conditions of each region[18].

(2) Discount on Public Transportation Fares and Entrance to Facilities

Those aged 60 years or more are eligible to avail a discount of at least 15% to vessel, train, airline, and other transportation fares and at least 20% to entrance fees of cultural sites, museums, and other sightseeing spots[27].

3.4 Elderly Care Services

3.4.1 Types of Elderly Care Services

Elderly care service providers include public institutions, home-based care serivice providers at the community level, and private institutions as the follwings [30]. An eldery care center can be established by applying to Department of Planning and Investment or DOLISA at the province where the facility would like to establish with fulfilling the criteria of the facility standards.

- Public institutions at the central and the provincial level
  - Social protection center, charity house for disadvantaged, solitary elderly

[25] The details are explained on the Law on Persons with Disabilities, Decree Detailing and Guiding a Number of Articles of the Law on the Disabled (28/2012/ND-CP) and On Guiding a Number of Articles of Decree No. 28/2012/ND-CP (26/2012/TT-BLDTBXH) . The amount of allowance for the disabled elderly is 2.5 times the standard amount for the disabled in order to avoid overlapping allowance if eligible to multiple requirements.

[26] 06/2011/ND-CP

[27] 06/2011/ND-CP

  - Elderly nursing home: for revolutionary veteran, patriotic martyr's parents, people of merit, solitary elderly
- Care service providers at community level for the elderly in difficult condition (mental patient, badly sick, lonely person that needs help)
  - Social home
  - At-home care by volunteers
  - At-home care services
- Private institutions
  - Social home in community for the elderly who have mental disorders or serious illnesses, and are alone and require care

3.4.2 Social Protection Centers/ Nursing Homes for the Elderly

(1) Residents

There are 432 social protection centers nationwide that accommodate 41,400 people; however, these centers are not necessarily exclusive for the elderly, and also target other people who require support, such as orphans and patients with mental disorders. In addition, there are also other regions where there are no centers which can accommodate the elderly[18].

There are two types of residents, one uses the facility free of charge and another with payment. The former includes the elderly in poor household and without family to support him/her, then DOLISA approved along with the criteria to stay. The later includes the elderly who have family but he/she wants to stay at the facility, DOLISA examine the criteria including income before approval. Short-term stays for a period of one week are also possible[28].

Accrding to the Survey, the number of the non-paying residents has been almost same, while the paying ones have been increasing recently[29]. The major reasons are business of the family, human relationship in the family, and sometimes, they want to enjoy their life with the same generation.

(2) Management

Cost for the non-paying residents are generally subsidized by the government, while a user fee is collected from the paying residents. For example, in Ho Chi Minh, the local government subsidize VND 1,200,000 per person per month for non-paying residents, while VND 3,000,000 is collected per person per month from paying residents. In addition, they are supported with food through donations such as rice or noodles from the community. Furthermore, in addition to the support for daily life, light recreation is offered such as exercise and brief excursions.

(3) Human Resources

Helpers called 'Ho Ly' provide support for daily life such as meals and house keeping. Most of Ho Ly are secondary education graduates and learn necessary skills through on-the-job training. Because such a

[28] According to an interview with the Hoa Binh Province DOLISA.
[29] According to interviews with the Nam Dinh Province DOLISA and HCMC DOLISA.

work is not much respected but require heavy mental and physical burden as well as low salary, the turnover rate seem to be high. Therefore, the facilities have to keep training new Ho Ly.

(4) Founder of the Facility

The founders and governing bodies are both from public and private sectors. Among all the social protection centers in Viet Nam, there are 182 institutions funcded and operated by public and 250 by private[18].

There are no plans to increase the government budget for the maintenance of nursing homes for the elderly, and might be able to invite private establishment through provision of incentives such as real estate tax in future[30]. The Ministry of Construction has proposed the establishment of centers in each province capable to house approximately 50 people, however the assumption is that centers aimed at contributors to society and the elderly who are alone or poor will be established publicly, while all others will be established privately[31].

Example of a Public Institution for the Elderly：Thi Nghe Nursing Home (HCMC)

There are 15 residential buildings and one medical center on a plot of 14,000 m^2. Each residential building has five rooms. There are 63 non-paying residents, and 75 paying residents. Each person resides in a room that is 17 m^2 in size and is equipped with a toilet and shower.

The medical center has a 24-hour system, and most of the costs could be covered by health insurance. The major health problems of the residents are diabetes, hypertension, and dementia. In general, the residents seemed to active and be able to do basic daily activities independently. The spirit of dedication is the mainstay of the management, and there are also donations such as food.

Exterior

Living Room

3.4.3 Private Institutions for the Elderly

There are few private institutions for the elderly. Through the Survey, it was found that there are ten institutions (eight institutions exist in Hanoi, one institution exists in Ho Chi Minh, and one institution exists in Nghe An). A culture of family care is deeply ingrained, meaning that senior citizen homes have

[30] According to an interview with the Ministry of Finance.

not yet become prevalent; however, due to an advancement in the level of recognition for senior citizen homes, there are also institutions that are fully occupied (refer to the following example).

Under government ordinances, the time, location, method, and fees for the condition of health and care of the person who receives the services are to be stipulated in the agreements with nursing care services for the elderly[31]. However, when it compared with Japan, personnel standards and institution standards seemed not to be tangibly defined at several privately established institutions for the elderly, and it cannot necessarily be said that there is a high level of quality of care[32].

[31] 06/2011/ND-CP

Example of a Private Institution for the Elderly : Thien Duc Health Care Center for the Elderly (Hanoi)

The center was established in April 2001. It has 45 rooms and 150 beds. There are four types of living rooms by capacity; for eight, four, two and one resident(s). And there is an intensive care unit, a rehabilitation room, and terminal care room. Recently, the applicants have been increasing as public awareness for the center has been increased. There are currently 162 residents, and more people on the waiting list.

The regular activities include physical exercises, reading the newspaper aloud, rehabilitation exercises, recreational activities (enjoying TV and games), eating of three meals a day, and various excursions.

Although one of the criteria for the residents is good health conditoin, 60% of the residents seem to have some sort of physical difficulty. Residents with dementia or who are bedridden is 10% each, and the healthy residents is about 10%. The user fee is from USD 250 to USD 650, depending on the type of room and services provided. The income levels are; 50% is moderate or above, 35% is less than moderate, and 15% is poor. Most of the residents are paid the user fee by their children, while the poor stay free of charge as a part of social contribution of the institution.

There are two doctors and 65 nurses, and the average wage is USD 300 per month. Because of the low respectatoin to such works and mental and physical burden, staff retentoin rate is rather low. And that regulations within the institutions are strict, such as ban on possessing mobile phones. The job turnover rate has risen to 60%, and about 50% of people have been working three or more years. In particular, most of stff are from rural areas, not urban. They do not provide home care or visiting services, because it is concerned that some staff might offered bertter condition to work in the patient home when they visited.

Living room (for four persons)

Residents

3.5 Health Care Policy and Services

3.5.1 Health Care Policy

(1) Law on the Elderly and the Implementation Guidelines for Health Services for the Elderly

Non-communicable diseases (NCDs) have been increasing due to changes in the disease structure in Viet Nam. Given that the elderly tend to have multiple chronic diseases, as their number will increase in the future, it is expected that conventional medical departments specialized in infectious diseases will not be able to fully respond to their needs. Therefore, medical care systems tailored to an aging society need to be developed, such as measures to respond to chronic diseases and disease prevention.

Health care policy for the elderly is implemented by MOH, among others, based on Circular No. 35 of the Implementation Guidelines for Health Services for the Elderly (35/2011/TT-BYT). This circular consists of three chapters and 11 articles about elderly health care at medical facilities, elderly health care and management of chronic diseases in communities, and enforcement system. The contents of the circular include the following: 1) preferential medical consultations for the elderly; 2) establishment of departments of geriatrics at the provincial level hospitals; 3) human resources development for departments of geriatrics; 4) development of family doctors and home care medicine; 5) implementation of regular health checkups; 6) implementation of care prevention and rehabilitation; and 6) financial support for hospital visits. However clear instructions are not issued to services of the department of geritrics[32].

3.5.2 Medical Care for the Elderly

With regard to the establishment of departments of geriatrics, the National Action Program on the Vietnam Elderly 2012-2020 provides the following targets: 25% of the central and provincial level hospitals will have established departments of geriatrics by 2015; and 90% of the central level hospitals and 100% of the provincial level hospitals will have established them by 2020[33]. However, progress at the provincial level hospitals has been slow due to the lack of finance and medical experts. A survey conducted by MOH targeting 15 provinces in 2013 revealed the following results: only two provinces out of the 15 have hospitals with departments of geriatrics; the hospitals of six provinces have established departments of geriatrics in conjunction with departments of cardiology and internal medicine; four provinces merely have beds reserved for the elderly without establishing departments of geriatrics; and three provinces have neither departments of geriatrics or beds for the elderly[34]. It is also an issue that the definition of service of geriatrics is indistinct.

(1) National Geriatric Hospital

The National Geriatric Hospital (Figure 3-19) is a hospital established by separating the department of geriatrics from the Bach Mai Hospital in 2006. It has eight departments (inspection department, intensive care unit, neurology department, diabetes department, cardiology department, internal medicine

[32] According to an interview with Cho Ray Hospital.
[33] Thong Nhat Hospital in HCMC has established a department of geriatrics.
[34] According to an interview with Cho Ray Hospital.

department, self-pay care department, rehabilitation department, pharmacy department, and examination department) and 200 beds. The hospital has 200 hospitalized patients and 300 visiting patients each day. The hospital has 44 doctors and 117 nurses.

Common diseases among the patients include cerebral stroke, dementia, heart disease, hypertension, diabetes, and osteoporosis. Most of such are acute diseases and require complicated treatment. The average hospitalization period is about 11 days, but the elderly generally need long-term care and hence are often re-hospitalized; therefore, facilities for patients with chronic diseases will be needed in the future.

The hospital also functions as an education center of gerontology. It thus provides technical guidance and training for provincial level hospitals, including on gerontology in cooperation with the Hanoi Medical University.

Due to a recent increase in patients, they plan to extend the hospital to accommodate 300 beds in 2014 and build two hospitals with 500 beds each and near Hanoi. Moreover, there is a plan to build satellite hospitals in Ho Chi Minh and Danang in 2020.

Exterior

Department of Rehabilitation

Figure 3-19 National Geriatric Hospital

(2) Provincial and District Hospitals

It is often the case that medical care for the elderly is provided as part of the services of departments of internal medicine and cardiology. Given that the proportion of elderly patients is not very high and that they tend to get hospitalized only after they have become seriously ill and thus pass away relatively quick, the awareness on the need to respond to elderly medical care is still low. However, since patients are generally taken care of by their family members in Viet Nam, there is a view that taking care of the elderly at hospitals is becoming an issue of concern as their children are moving to the urban areas[35].

[35] According to an interview with Mai Chau Hospital.

Example of Department of Geriatrics at a provincial level hospital：Nam Dinh Hospital

The Department of Geriatrics of Nam Dinh Hospital has 40 beds and 37 patients; and the bed occupancy rate is kept below 100%. Each room is shared by four people. Many of the patients have heart diseases, and the average period of hospitalization is about nine days. Thus, even those patients who should stay in hospital are obliged to leave the hospital. Five doctors and ten nurses are working, but they have not received any education on gerontology. Rehabilitation is practiced according to the instructions of the doctors at the Department of Rehabilitation. Common diseases include shoulder joint disease, knee pain. Bone fracture due to accident is also one of the major problem.


Department of Rehabilitation

(3) Human Resources for Elderly Medical Care

1) Doctors

Education on elderly medical care is provided mainly at medical universities and the National Geriatric Hospital, where gerontology is included as one of the courses on internal medicine in the training curriculum for doctors. The Hanoi Medical University and the Ho Chi Minh University of Medicine and Pharmacy plan to separate their departments of gerontology from their internal medicine departments. Also, their graduate schools have a curriculum for doctors specialized in gerontology. Furthermore, the Medical Service Administration (MSA) of MOH and the National Geriatric Hospital are in the process of developing guidelines for medical care for the elderly.

However, while the establishment of departments of geriatrics has been set as a target, there is an overwhelming lack of medical experts in geriatrics. The total number of doctors and nurses that have gone through gerontology education is not more than 1,400, and is concentrated in large cities[18]. Moreover, there are very few medical experts who have received gerontology education in rural areas.

2) Nurses and care workers

There is no profession related to elderly care; and nurses and “Ho Ly” mainly take charge of elderly care. It should be noted that there is no certification that corresponds to certified care worker in Japan. MOH plans to introduce subjects of gerontology to nursing education. Also, with support from the United

Nation Population Fund (UNFPA), MOH has developed a manual on elderly care and has been distributing copies of it to doctors and care workers working at the ward and district levels in rural areas.

Ho Ly helps the elderly with housekeeping and other daily activities. Generally, graduates from secondary education are hired and learned necessary skills through on-the-job training. Some private nursing homes have certain requirements for Ho Ly. Since elderly care is not recognized as a profession yet and the actual situation of elderly care is severe, the retention rate of human resources in both public and private facilities is low.

3) Japan-Viet Nam Economic Partnership Agreement

The Vietnamese candidates for nurses and certified careworkers is going to be received in accordance with the Japan-Viet Nam Economic Partnership Agreement. The conditions of acceptance specify that the candidate must take a 12 month Japanese language course and obtain level N3 or higher in the Japanese-Language Proficiency Test[33]. The first group will arrive in Japan in June 2014.

(4) Support for Welfare Tools

Devices such as wheelchairs and walking frames can be purchased at one's own expense from general drugstores. Although official regulations for welfare tools have not been specifically established, there are organizations that accept the provision of welfare tools from the government and various types of donors. DOLISA compiles lists of targets of welfare tools for various locations, and makes requests to MOLISA and NGOs such as the Red Cross. Because there are multiple organizations providing welfare tools, there are cases that three wheelchairs are provided to a single person[36]. Furthermore, in cases of regions with minority groups, it is difficult to provide wheelchairs due to constraints in their living environments, such as raised floor dwellings[37].

3.5.3 Home Based Care and Nursing

It is common in Viet Nam that family members take care of the elderly as described in Section 3.2.2 (4). Therefore, the elderly is accompanied to the hospital by his/her family member, and he/she receives home care after leaving the hospital in most cases. In the event that the elderly requires long-term care due to dementia and becomes bedridden, his/her family members take care of him/her for as many as five to ten years until the last moment.

In the event that the elderly becomes bedridden, a doctor visits his/her home to give guidance on ulcer prevention methods such as how to roll over. Although a system for home-visit medical care is yet to be established, it is usually the case that the family requests an acquainted doctor to visit and examine the patient once a week or month. Home visits are mostly conducted by hospital-based doctors as a side business or by private practitioners. Retired doctors also make home visits as volunteers[38]. It is difficult for doctors working for CHCs and hospitals to conduct medical visits due to the lack of employees of

[36] According to an interview with the Hoa Binh Province DOLISA.
[37] According to an interview with the Dien Bien Province DOLISA.
[38] According to an interview with VAE.

such institutions[39]. As for medical expenses, insurance can be applied in case a patient visits a hospital, whereas it cannot be applied in case a doctor visits a patient.

While home nursing care is usually provided by family members, there is a growing number of cases in urban areas in which housekeepers specialized in elderly care provide home nursing care to the elderly who are bedridden due to causes such as cerebral infarction. It costs about USD 150 per month to employ such a housekeeper, which means that a certain level of income is required to use this kind of service. Also, while some training courses on nursing techniques are provided for housekeepers at some national hospitals specialized in elderly care, most of housekeepers provide their services based on their experience. Some families become poor when a familly member has to leave his/her job due to family care.

Training for village health workers is under consideration in rural areas so that they will be able to assist in family home care in order to improve its quality[40].

3.5.4 Health Promotion and Disease Prevention for the Elderly

(1) Health Promotion Activities of CHCs

CHCs are responsible for preventive medicine, health promotion and primary care for the population. CHCs conduct health care activities such as health management of the elderly. Since CHCs only have very common types of medicine, they refer patients with chronic diseases that require medication to district level hospitals (or higher level hospitals).

The main activities conducted by CHCs on health management of the elderly are regular health checkups as stipulated in Circular No. 35. Some regions carry out comprehensive medical examinations, including checking of blood pressure and blood sugar as in the example below. On the other hand, most of the regions conduct only simple checkups, such as measurement of blood pressure. CHCs develop elderly health management books for the purpose of conducting regular health examinations; however, these are in most cases nothing more than lists of subjects without significant information on health conditions.

As for the implementation of regular health checkups, according to results of a survey focusing on 15 provinces conducted by MOH in 2013, while all of these provinces carry out regular health checkups, the implementation ratio at the commune and ward levels is below 10% on average (the figure is 22.7% in the province where the implementation ratio is the highest). Lack of budget is the main reason for non-implementation[41]. Moreover, many of the elderly cannot go through health checkups in remote areas because there are no means of transportation available.

[39] According to an interview with the Dien Bien Province DOH.
[40] According to an interview with MOH-MSA. The task of village health workers is dissemination of sanitation, first aid, monitoring of epidemics, population management (prevention of pregnancy), and consultation for the elderly.
[41] According to an interview with Hanoi Medical University.

Example of health promotion activities (Nam Dinh Province)

Health promotion activities are being conducted at the commune level in Nam Dinh Province for the purpose of improving the quality of life of the elderly. Approximately 200 people have participated in the program implemented for the elderly as well as their family members. Also, 24,000 brochures have been printed and distributed to raise awareness of the population about the elderly. Furthermore, health care equipment including blood pressure measuring devices, blood sugar meters, and scales have been provided to two CHCs; and training on how to use and manage these devices have been also carried out. The project is conducted by Nam Dinh University of Nursing.

(2) Efforts at the Community Level

Some communities are implementing pilot health care projects for the elderly. Specifically, health promotion activities (light exercise) and cultural activities (such as singing and dancing) are being conducted in conjunction with poverty reduction activities. However, most pilot projects encounter issues such as low population coverage rate and little continuity. The causes for these challenges include the following: the model does not respond to the needs of the elderly; lack of technical health service networks and facilities at the commune and district levels; lack of management functions of government institutions; lack of education of health care personnel; and lack of policies that could foster the development of health service networks[42].

(3) Intergenerational Self-help Clubs (ISHCs)

Intergenerational Self-help Club (ISHC) are projects supported by HelpAge International (see Chapter 6). Their objective is to organize multigenerational clubs mixing both senior and young generations at the community level to reduce poverty and improve the status of socially-marginalized people. ISHCs have very comprehensive purposes, such as self-help, health activities, social participation, cultural activities, home care, micro finance, disaster prevention, advocacy, health insurance, and responding to issues on gender and the elderly.

Each club has 50 to 70 members, of which the elderly account for about 70%. The total number of clubs in the country is approximately 700; this figure has been growing year by year. With regard to financial sources, the clubs collect small membership fees of approximately VND 2,000 to 5,000 per month from its members, and are also supported by the UNFPA as well as regional governments. The mutual aid system thus helps realize continuity of activities.

Currently, only unpaid volunteers are supporting the activities of the ISHCs, but the pilot activity of paid care services (such as toileting assistance and health management) has been started in some clubs.

[42] According to an interview with Hanoi Medical University.

Figure 3-20 Regular Meeting of Intergenerational Self-help Club (ISHC)

3.6 Dissemination and Statistical Survey

(1) Dissemination and Enlightenment

The Vietnamese government, designating June 6 of each year as Seniors' Day according to the Law on the Elderly, holds workshops nationwide throughout the year and promotes dissemination/enlightenment campaigns via television and radio[43]. However, those saying that they have never heard about measures for the elderly still account for 23.2% of the population. As sources of information about measures for the elderly, socio-economic organizations (e.g., VAE and Vietnam Women's Union (VWU)) are most widely recognized by 45.2% of the population, followed by mass media with 28.8%, local authorities with 21.4%, and neighbors with 17.6%. Thus, dissemination/enlightenment activities in various forms should be continued in the future.

(2) Statistical Survey

Few national statistical surveys have been conducted with respect to the elderly in Viet Nam. There have been surveys conducted by researchers but they are insufficient in the number of samples. In VHLSS and health statistics, where data are collected periodically at the national level, elderly-specific compilation and analysis are very limited. Under such circumstances, VNAS 2011 is the first survey that has comprehensively clarified the current status of the elderly.

Because of fiscal restrictions, however, periodic national statistical surveys are difficult to conduct. Government statistics depend on reports from rural areas and are not adequately reviewed for data reliability and validity. Although it is considered practical and efficient to introduce elderly-related items

[43] MOH held 125 workshops and 40 TV programs in 2013.

to existing statistical surveys conducted by the General Statistics Office (GSO) and MOH for their effective use, changing the designs of existing surveys is less feasible[44].

3.7 Issues in the Aging in Viet Nam

The keys for Viet Nam to combat rapid aging of its society that it will face in the near future include secure implementation of existing policies as well as improvement of data collection systems and statistics to monitor the progress of their implementation and use of collected data in updating and developing policies and the enhancement of medical and welfare services for the elderly with institutional improvements for this purpose. Possible challenges in developing measures against society aging in Viet Nam are summarized below.

(1) Improvement of Implementation of Guidelines/Manuals and Policy Evidence

With a considerable number of government ordinances and guidelines issued according to the Law on the Elderly, the improvement of legal systems for the elderly has relatively been advanced. However, their coherence and consistency may not be maintained because of their considerable number due to their independent issuance by relevant organizations. There is also a delay in their implementation mainly in rural areas due to the lack of funds and human resources. Moreover, it is hard to concretely grasp the current status and progress because statistical data for policy evidence and necessary for monitoring the progress of policy execution are yet to be improved.

(2) Enhancement of Medical Services for the Elderly

To respond to the increase of patients with multiple chronic diseases typically diagnosed of the elderly, setting up of geriatrics departments that provide comprehensive medical care as well as health promotion and disease prevention through regular health checkups are being planned. However, their execution is delayed mainly in rural areas due to the lack of funds and human resources. Although healthcare professionals remain less alarmed for measures for the elderly, it is necessary to prepare for the aging of society by promoting the development of human resources in medical schools and central and ministry level hospitals.

(3) Improvement of Welfare Facilities and Nursing Care Services for the Elderly

While the elderly have traditionally been cared for by their families in Viet Nam, there is an increasing need for support systems for the single elderly and abandoned aged households in rural areas as working people flow into urban areas. Given fiscal restrictions, it is necessary to enhance support systems by effectively using local communities and self-help of elderly people.

In urban areas, where there are signs of changes in views of the family, nursing care is likely to be increasingly outsourced. It is therefore necessary to improve not only support by communities but also welfare facilities and nursing care services for the elderly. For improving facilities, efforts to reduce fiscal burden by employing private functions are also needed.

[44] According to an interview with the National Economics University.

To sustain these tasks, the development of human resources involved in elderly care and nursing care education for communities and families should also be encouraged.

(4) Correction of Social Assistance and Pension Systems

Elderly people receiving social assistance and/or pensions total 4.7 million, which account for more than half of the entire elderly population. While those living alone, in poverty, or aged 80 years or older receive certain amounts of assistance, there are also elderly people who do not receive assistance despite their eligibility because of inadequate data management for personal identification. To improve such situation, an integrated benefisialy management system should be developed.

According to the estimates by the ILO and VSS, expenditure might exceed the revenue even if reversal of the reverse fund supplement the income from premiums by 2034 in case the pension contine to be managed in current rate (22%). Because, in addition to the aging population, the period of premium payment is shorter than that of beneficaries, as the average retirement age is early compared with the life expectancy.The underlying causes include not only aging of the population but companies' failure to pay the premium. Although a revision of the Law on Social Insurance is now underway, the improvement of pension coverage rates is necessary.

While VSS has started IT-based management of pension subscription records such as the amount of pension payment and the subscription period, it is a challenge to develop a system to accurately manage such subscription records on a permanent basis.

Chapter 4 Situation Analysis of the Universal Health Coverage (UHC)

4.1 Health Service System in Viet Nam

(1) Human Resource for Health

Human resource for health (HRH) per 10,000 population was 2.9 in 2009 and increased to 39.7 in 2010 as shown in Table 4-1. The Master Plan on Human Resource Development 2011-2020 aims to make it to 54 by 2020.

Table 4-1 HRH per 10,000 Population

HRH	Per 10,000 Population
Doctor	7.20
Nurse and Midwife	9.35
Pharmacist	1.76
Assistant Doctor	6.22
Total HRH	39.7

Source: Health Service Delivery Profile Viet Nam 2012 [34]

The pre-service educational institutions are the following: 32 universities, 42 special universities, 66 secondary medical schools (SMS), and eight research institutions. In addition, 11 university hospitals, three national hospitals, and two traditional medicine hospitals collaborate in developing HRH[34].

The Law on Medical Examination and Treatment in 2009 (40/2009/QH12) obligates clinical practice after graduation in order to become a licensed HRH. The outline of the clinical practice is as follows:[45]

- Eighteen months in a hospital or an institution with beds for doctors;
- Twelve months in a hospital for assistant doctors;
- Nine months in a hospital with maternaty department or maternity clinic for midwives; and
- Nine months in medical facilities for nurses and medical technicians.

During the Survey, the provincial and district health facilities seemed to recognize the insufficiency of human resources; however, additional recruitment is difficult due to budget constraint. Whereas, Ministry of Health (MOH) is concerned that the number of HRH seems to exceed the number of posts; therefore, a lot of new graduates do not have job opportunities. In order to balance the demand and supply of HRH, a human resource information system could contribute to the analysis of the current situation and project future demand. However, it seems difficult to develop this system because a holistic data collection system including the private sector has not yet been established.

There seems to be a gap in the quality of HRH between top referral and lower level facilities or between urban and rural areas. In order to fill this gap, MOH established the Direction Office for Healthcare Activities (DOHA) in order to provide technical support from upper hospitals to lower ones through trainings and instructions[46] [35].

[45] The implementation of the law is guided by MOH Circular No. 41/2011/TT-BYT.
[46] MOH Decision No. 1816/2008

(2) Health Facilities

Table 4-2 presents the number of health facilities according to type. Public hospitals mainly provide inpatient services, and there are about 188,613 beds in a total of 1,087 hospitals. On the other hand, private hospitals are mainly located in urban areas and their number has been increasing. The total number of beds are 7,124 in 102 private hospitals. National special hospitals and some provincial and private hospitals provide specialized and advanced medicine.

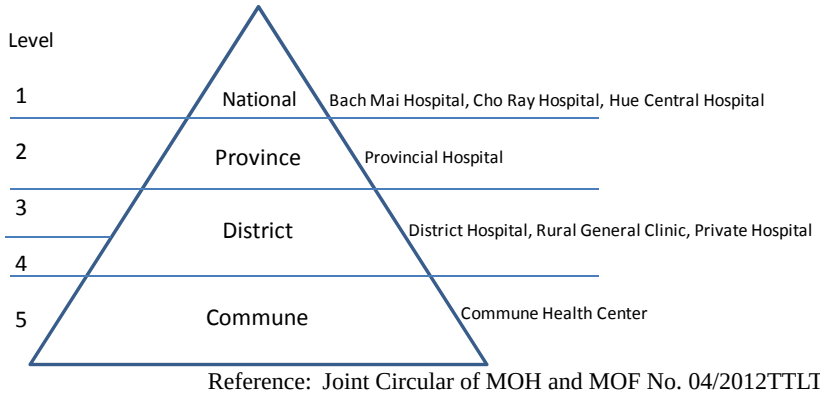
Table 4-2 Types and Number of Health Facilities

Level/Category	Types	Numbers
Commune	Commune Health Center (CHC)	10,926
District	Regional General Clinic	686
	Hospital	615
	Maternity Home	18
Province	Hospital	376
	Traditional Medicine Hospital	53
	Special Clinic	47
National	Hospital	44
Special Medicine	Hospital	52
	Clinic	759
Private	Hospital	102
	Clinic	N/A
	Traditional Medicine Hospital/Clinic (registered)	Approx. 10,000

Source: Health Service Delivery Profile Viet Nam 2012, WHO and MOH 2012 [34]

(3) Referral System

There are five levels in the referral system in Viet Nam as illustrated in Figure 4-1. The level is determined according to number of beds and staff. Level 1 includes three major hospitals; Level 2 are provincial hospitals wherein four to five are allocated per province; Level 3 and 4 are district hospitals which are distributed to one per district; and Level 5 are commune health centers (CHC). CHCs generally provide outpatient and preventive medicine. The level and type of services depend on each hospital according to their local needs.



Reference: Joint Circular of MOH and MOF No. 04/2012TTLT-BYT-BTC29/02/2012

Figure 4-1 Referral System in Viet Nam

Despite of the official referral procedure from CHCs to top referral hospitals, people tend to directly seek care from higher levels as they tend not to trust the lower level public hospitals. Many lower level hospitals such as district hospitals cannot improve their quality of services because of budget constraints

in maintaining quality HRH and medical equipment. Consequently, top referral hospitals tend to receive patients more than their capacity.

Another possible bottleneck in the referral system is health insurance. An insured patient can seek care only in registered hospitals which should be located within a province wherein the patient's workplace or school exists. Therefore, people living in the border areas of the province cannot choose the hospitals in the neighbouring provinces even if it is much nearer.

4.2 Health Insurance

4.2.1 Policies in Health Insurance

(1) Implementation of Health Insurance

Health insurance was first introduced in Viet Nam during the economic reform in the late 80s to early 90s known as Doi Moi. It was associated with the liberalization of healthcare and pharmaceutical markets, and the introduction of user fees in public health facilities.

The first government decree on health insurance (Decree No. 299/1992/HDBT) was promulgated in 1992 in order to establish the compulsory health insurance scheme. Civil servants, workers in companies with ten or more employees, pensioners, public assistance recipients, and workers in foreign companies were to be covered by the scheme. It was implemented in all provinces under the supervision of the provincial health authorities.

As a result of those reforms, patients' out-of-pocket (OOP) spending increased. In 2000, private spending on health accounted for 70% of the total health spending of the nation, with OOP contributing 66% of them[36].

In 1998, the new Decree No. 58/1998/ND-CP was issued to unify provincial health funds into a single national fund. The coverage was further extended to pre-school teachers, persons of merit, socially protected people, dependents of army officers and soldiers, foreign students, and members of the Congress and People's Council.

Decree No. 63/2005/ND-CP, promulgated in 2005, stated that the poor were to be covered by the health insurance through the appropriation of government funds for their insurance premiums. Currently, the insurance scheme covers 15 million poor and minority people, successfully reducing the burden of health spending among the low income class. Around the same time, the 2005 Law on Education, Healthcare, and Protection of Children was passed to give free medical treatment to children less than six years old.

In 2008, the Law on Health Insurance was passed and enacted on October 1, 2009. It is the first time that the health insurance scheme, which had been administered by ministerial decrees, gained legislated status. The law ensured that children less than six years old, the elderly, and the poor would gain full public support and that partial support would be given to the near poor as well as students.

Achieving universal health insurance was one of the goals of Viet Nam's Socio-Economic Development Strategy for 2011-2020 (SEDS 2011-2020), along with controlling population growth, and improving longevity (see Chapter 2).

(2) Roadmap towards All-People Health Insurance for the Period of 2011-2015 and by 2020

The decree on the approval of the road map plan toward universal health insurance for 2012-2015 and 2020 (538/QD-TTg) was promulgated in March 2012. It set up the coverage goal of 70% in 2015, and 80% in 2020 as well as the reduction goal of OOP down to 40% level by 2020. In July, Viet Nam Social Security (VSS) drafted the action plan, setting up the coverage goal for each province. Table 4-3 presents the outline.

Table 4-3 Outline of the Roadmap towards All-People Health Insurance for the Period of 2011-2015 and by 2020

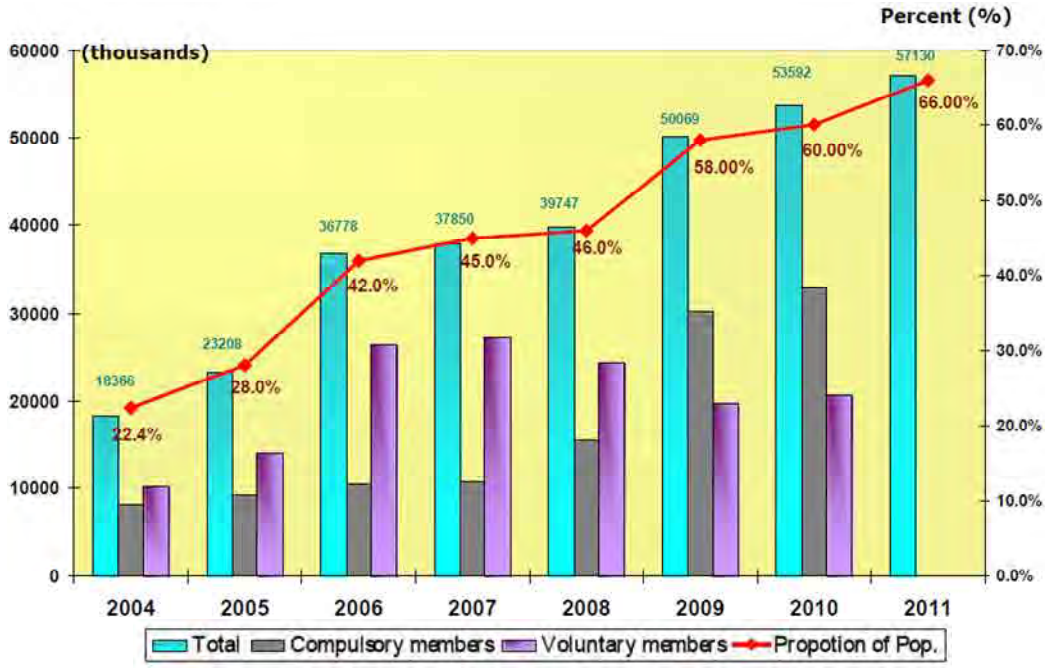
Period	Target	Activities
2011-2015	- Coverage: >70%	1. Draft revision of the Law of Health Insurance by 2014 2. Involvement of local governments 3. Expansion of the coverage ・ To Enhance control of participation of private companies and premium payment ・ To increase subsidy for premium of students and the near-poor ・ To introduce Household participation ・ To share list of the targets of subsidization among concerned organizations 4. Improvement of quality of insurance covered medical services and patient satisfaction ・ To improve payment process, introduce information technology (IT), review the beneficially package, study on pharmaceutical cost control, technical transfer to lower level hospitals, etc. ・ To allocate physicians to all commune health center (CHC) to provide insurance covered medical services, design incentive system aiming to ensure quality human resources at lower level health facilities ・ To promote participation of private health facilities 5. Promotion of preventive medicine and primary health care (PHC) 6. Awareness raising on the Law on Health Insurance 7. Improvement of financial mechanism and payment system of remuneration ・ To shift from fee-for-service to capitation or case-mix payment ・ To provide incentive to beneficiaries who do not use insurance covered medical services ・ To study on benefit of health insurance appropriate to the premium amount 8. Enhancement of inspection and examination 9. Strengthening of management capacity of the government agencies 10. Maintenance of health insurance fund 11. Application of IT ・ To study on smart card system for health insurance card from 2013 12. Research and international cooperation
By 2020	- Coverage: >80% - Out-of-pocket expenses: <40% - Improvement of insured medical services	Development of health care network including specialized medical services (in regards to "4. Improvement of quality of insurance covered medical services and patient satisfaction")

Reference: 538/QD/TTg[37]

The activities will be implemented by 2015 and revised according to revision of the Law on Health Insurance to be done within 2014.

(3) Trend of Insurance Coverage

Figure 4-2 shows the trend of insurance coverage from 2004 to 2011. As of 2011, the total number of insured is 571.3 million which is about 66% of the population. In an interview conducted in January 2014, VSS told that the number reached 615 million as of 2013, indicating that the overall coverage steadily increases. However, a closer look on the trend reveals that the number of voluntary members who pay premiums on their own actually decreases while the number of compulsory members who receive government or employers' support increases. In order to achieve universal health insurance, the Vietnamese health insurance scheme needs to reach the voluntary sector.



Source: Introduction of Vietnam Social Security [17]

Figure 4-2 Trend of Health Insurance Coverage (2004-2011)

(4) Amendment of the Law on Health Insurance

Since the enactment of the Law on Health Insurance in 2009, Vietnamese health insurance has shown remarkable achievments; one of which is that its coverage sharply increased from 46.0% in 2008 to almost 70% in 2013. Another significant features are that the centrally supervised benefit package and unified insurance fund are being managed by a single provider, namely VSS.

However, some issues still need to be addressed. The scheme must find a way to reach the voluntary sector in order to achieve UHC and should improve cost control mechanism in the provision of medical services and medicines in order to ensure its sustainability.

MOH, in cooperation with World Health Organizatoin (WHO), is currently revising the Law on Health Insurance[47]. Although the details of revision have not yet been available as of March 2014, the discussion appears to focus on the following points:

- To abolish the current voluntary scheme and incorporate them into the compulsory scheme;
- To include dependents into compulsory members, as a first step of shifting from individual-based coverage to household-based coverage;
- To revise the current 25-member group classification;
- To clarify the financial responsibility of the provincial government regarding health insurance fund; and
- To clarify the benefit package.

(5) Other Related Policies

Many ministerial decisions and notices regarding health insurance have been issued. Presented below are some of the important related policies:

1) Decree on Implementing the Law on Health Insurance (62/2009/ND-CP)

The decree gives details on the law on health insurance and explains the rights as well as responsibilities of the insured and co-payment mechanism (see Section 4.2.4(2)).

2) Circular on Promulgating and Implementing Guidelines on the List of Major Medicines Used in Medical Facilities with the Health Insurance Fund Reimbursement, Ministry of Health (31/2011/TT-BYT)

The circular determines pharmaceutical drugs covered by the health insurance. The list includes the names of more than 900 active ingredients. The prices of drugs are subject to bidding for each health institution (see Section 4.2.4(2)) .

3) Inter-ministerial Circular on Promulgating the Maximum Price of the Medical Examination and Treatment Services in Public Facilities, Ministry of Health and Ministry of Finance (04/2012TTLT-BYT-BTC 29/02/2012)

Circular No. 4 sets the maximum prices of 447 medical examinations and treatments provided at VSS-contracted public health facilities. Based on this circular, each health facility will make their lists of services and prices which are subject to ministerial approval (see Section 4.2.4(2)).

The circular also revises the previous service list, eliminating 80 medical services that were listed in the preceding 2006 circular (3/2006/TTLT).

[47] Based on the interviews with MOH (Department of Health Insurance), World Bank, and WHO in Hanoi.

4) Decree on the Operational and Financial Regimes Applicable to Public Health Non-business Units and the Prices of Medical Examination and Treatment Services of Public Establishments (85/2012ND-CP October 15, 2012)

The decree sets up the financial autonomy of health institutions and provides a guideline on financial operation for public health institutions.

It also determines government budget allocation to health institutions. Currently, 100% of payroll at district hospitals, and 50% of payroll at provincial hospitals are covered by the government budget. The government funds for payroll will be gradually decreased and will be substituted by health insurance.

In 2013, the price of insurance-covered medical service is calculated based on the following direct expenses: drugs, utilities, maintanance of equipment, and allowance for surgery. Beginning in 2014, expenses on salary, expenses for outsourced workers, depreciation of fixed assets, and indirect expenses will be accounted for calculation.

Governmnet spending on health will be gradually decreased while VSS health insurance spending will increase in 2014 onwards. As the scheme changes, co-payment fees of health insurance albeit fixed rate is expected to increase.

4.2.2 Organizations

As described in Section 2.4, MOH and VSS are the major responsible agencies at the central level and DOH and SS at the provincial level. Other related authorities are the Ministry of Finance (MOF), which sets up medical service fees in cooperation with MOH, as well as proposes, reviews, and operates government budget; and the Ministry of Planning and Investment, which reviews policies and investments, including ODA and the health and social security sectors.

The Committee on Social Affairs of the National Assembly supervises the health insurance and health care services. The committee is reported by MOH and VSS and its members visit the provinces every year. The recent focus are on the operation of Law on Health Insurance, coverage status, and access and quality of health care services [38].

(1) Outline of Health Care Facilities

Health insurance can be used in VSS-contracted health care facilities[48]. The number of contracted facilities are 2,303 as of 2011, with 1,922 public (83.5%) and 381 non-public (16.5%) facilities [18].

Central, provincial and district hospitals work with provincial and district SS offices in processing health insurance. while community health centers report to district hospitals in health insurance matters.

Insurance subscribers must register either in public district hospitals or community health centers within their residential areas. They are supposed to seek medical services at their registered facility. Level 1 central hospitals do not accept registrations. Level 2 institutions sometimes only accept registrations from provincial government employees and hospital staff. The registration scheme, however, does not seem to be working. Moreover, patients tend to concentrate on upper levels of hospitals.

[48] The number of VSS-contracted facilities likely includes the hospitals listed in Table 4-2 as well as the clinics with out-patient care only.

Several private medical facilities are available mainly in the urban area. Private facilities are classified as Level 3 at most (Table 4-4).

Table 4-4 Outline of Health Care Facilities

Levels	Category	Facilities Visited	Application of Health Insurance
1	Central Hospitals	Back Mai Hospital (Hanoi) and Cho Ray Hospital (Ho Chi Minh)	○
2	Provincial Hospitals	Nam Dinh General Hospital, Dien Bien General Hospital, Hoa Binh General Hospital and Mai Chau Hospital (Hoa Binh)	○
3	District Hospitals	Da Bac Hospital (Hoa Binh) and Die Bien District Hospital	○
	Private Hospitals	Hong Ngoc Hospital (Hanoi) and French Hospital (Hanoi)	—
4	District Hospitals/ Community General Clinics	—	○
5	Commune Health Centers	Hop Hung CHC (Nam Dinh) and Thanh Luong CHC (Dien Bien)	○

Source: Survey Team

4.2.3 Memberships and Contribution Rates

Insurance subscribers are classified into 25 groups, depending on profession, financial situation, and personal background[49]. Those 25 groups could be organized into five groups based on the types of contribution (Table 4-5).

Table 4-5 Outline of Membership Groups

Group	Premium
Salary contribution (civil servants and company employees)	Salaried workers in formal sector paid 3% of the salary (2% by the employer and 1% by the employee) during 1992 to 2009. The rate has increased to 4.5% (3% by the employer and 1.5% by the employee) since the enactment of the Law on Health Insurance in 2009.
Full contribution by VSS (social security recipients)	The recipients of VSS social security allowance pay 4.5% of the allowance.
Full contribution by government (persons of merit, poor and minority groups, children under 6 years old)	Government pays 4.5% of the minimum monthly salaries for the poor and minorities, the persons of merit, and children under six years old. The minimum salary is currently VND 1,150,000. The poverty line differs in regions: VND 1,200,000 in Ho Chi Minh, VND 600,000 in other urban areas, and VND 400,000 in rural areas.
Partial contribution by government (near poor and students)	The near poor pay 4.5% of the minimum monthly salary while the government contributes more than 50% of the premium. Students pay 3% of the minimum monthly salary while the government contributes more than 30% of the premium.
Full personal contribution (farmers, self-employed, dependents of employees and civil servants)	Workers in the informal sector (e.g., farmers and self-employed) voluntary pay 4.5% of their minimum monthly salary. Dependents of civil servants and employees voluntarily pay 3% of their monthly salary.

Source: Survey Team

The average amount of premiums per person was estimated at VND 380,000 as of 2010 [39]. Table 4-6 presents the membership groups and their contribution rates.

[49] According to the interviews with the World Bank and WHO in Hanoi, reorganizing the insured groups is one of the issues in the revision of the Law on Health Insurance.

Table 4-6 Contribution Rates and Membership Groups

	Source of Contribution	Contribution from Government/ Employer	Self-contribution Rate	Membership Group
Compulsory	Salary	3% of the salary	1.5% of salary	- Employees in the private sector - Civil servants
		100% of the premiums	4.5% of minimum salary	- Foreign students on government scholarship
		30% of the premiums	4.5% of salary	- Commune civil servants (elected)
	VSS	4.5% of the allowance	-	- Pensioners - Recipients of social security allowance - Recipients of unemployment allowance
	Government (full support)	4.5% of the minimum salary	-	- Commune civil servants - Persons of merit - Veterans - People who contributed to the revolution - Members of the National Assembly and of people's committees - Recipients of social protection allowance - Poor and minority groups - Dependents of persons of merit - Dependents of officers of the Ministry of Defense and Ministry of Public Security - Children under six years old
	Government (partial support)	More than 50% of the premiums	4.5% of minimum salary	- Near poor
		More than 30% of the premiums	3% of minimum salary	- Students
Voluntary	Personal	-	3% of minimum salary	- Dependents of salaried workers and civil servants
		-	4.5% of minimum salary	- Farmers - Member of cooperatives, household-enterprises

Note: Besides the abovementioned membership, the Law on Health Insurance refers to organ donors and workers on sick leave.
Source: A Health Financing Review of Viet Nam with a Focus on Social Health Insurance [39]

4.2.4 Benefit Package of Health Insurance

(1) Applicable Healthcare Facilities

Health insurance can be used at the VSS-contracted health care facilities. As of 2011, the number of contracted facilities are 2,303, where 1,922 are public facilities (83.5%) and 381 are non-public (16.5%) [17].

(2) Service Scheme of Health Insurance

The decree on implementing the Law on Health Insurance (62/2009/ND-CP) explains the rights and responsibilities of the insured as well as the co-payment mechanism.

1) Rights of the insured members

The insured members are entitled to have medical services including examination, treatment, rehabilitation, maternity check, delivery, other services approved by MOH, and prescription and provision of drugs. They have the right to be transferred to an advanced level of hospital for a more specialized treatment when necessary.

2) Co-payment

The insured members are to register either at the district hospitals or at the commune health centers within their neighborhoods. The name of registered facility should appear on the health insurance card (Figure 4-3). The subscribers must first seek medical services at their registered facilities. Pensioners, the poor, and the recipients of social security allowance pay 5% while the rest of the members pay 20% for medical fees at the registered facilities regardless of the type of medical services received. When they seek medical services outside their registered facilities without a formal referral, they are obliged to pay 30% of the medical fees at the district hospitals, 50% at the provincial hospitals, and 70% at the central hospitals.

This system sometimes makes its convenient for those who reside in remote areas. To cite a case, a neighboring hospital is just 7 km away from home across the district border, while the registered hospital within the residential district is 150 km away[50]. It takes cost and time to travel to the registered hospital because the insurance does not cover transport fees. Likewise, it also takes cost to travel to a neighbouring hospital due to a high co-payment fee for a non-registered facility.

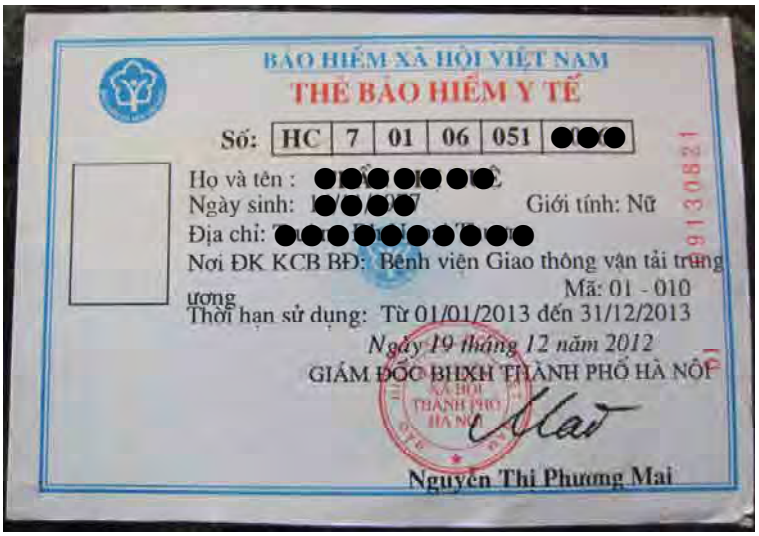


Figure 4-3 Sample Health Insurance Card (Employee)

Some members, including children under six years old and persons who contributed to the revolution, are exempt from co-payment and are entitled to free medical services. No fees will be charged to insurance subscribers when the fee is less than 15% of their minimum salary (VND 1,150,000 as of March 2014) ,

[50] Based on an interview with Mai Chau Hospital, Hoa Binh Province.

which amounts to VND172,500 for one episode of medical service. Health care services at the community health centers are also provided free of charge.

The limit of insurance reimbursement shall not exceed the 40-month minimum salary, which amounts to VND 46 million for one episode of medical service. Patients are responsible for paying the fees exceeding the limit. No measures have been taken to alleviate the burden of catastrophic medical fee payments. For instance, a cardiac patient is obliged to pay high surgery fee as well as pre-and post-surgery hospital fees.

At non-VSS-contracted facilities, the insured members must pay all medical fees in advance, and later claim reimbursement. The limit of insurance reimbursement is VND55,000 at the district hospital, VND120,000 at the provincial hospital, and VND340,000 at the central hospital for outpatients. It is VND450,000, VND1,200,000, and VND3,600,000 accordingly for inpatients.

3) Responsibilities of the insured members

The insured members shall not lend the insurance card to others, observe hospital regulations, and pay obliged medical fees.

(3) Medical Services Covered by Health Insurance

MOH determines the insurance covered services and their maximum prices. The MOH-MOF interministerial circular on the medical examination and treatment services (04/2012TTLT-BYT-BTC 29/02/2012) [40] lists 447 services (Table 4-7). Based on this circular, each health institution makes its own service list and prices which are subject to ministerial approval. The insurance covers a wide range of services, including general examinations, emergency, rehabilitation, advanced imaging technology such as MRI, and state-of-art medical technologies such as organ transplants.

Table 4-7 Insurance-covered Services

Category	Services	Notes
A	Examinations and health checks	Maximum fees are determined according to levels of institution and purpose of health checks.
B	Hospitalization	Maximum fees are determined in each department according to levels of institution.
C1	Diagnostic imaging	Maximum fees are set for 62 services, in each target part of the body, by ultrasounds, and x-rays.
C2	Medical procedures and endoscopy	Maximum fees are set for 77 services, in each target part of the body.
C3	Surgeries, procedures in each department	Maximum fees are set for 128 services in each department.
C4	Specialized surgeries and procedures	Maximum fees are set for 8 services for expensive surgeries and procedures other than category C3.
C5	Tests	Maximum fees are set for 148 tests including those for blood, immunology, urine, stool, and pathology.
C6	Explorative examinations	Maximum fees are set for 11 services including electrocardiogram.
C7	Tests and treatments with radioactive isotopes	Maximum fees are set for 11 services.

Reference: Circular 04/2012TTLT-BYT-BTC 29/02/2012） [40]

Table 4-8 presents some examples of medical fees. The limit of general examination fee is set according to the levels of health institutions: VND 20,000 at the central hospitals, VND 15,000 at the provincial

hospitals, VND 7,000-10,000 at the district hospitals, and VND 5,000 at the community health centers. The insured members should pay either 5% or 20% of the fees, according to their membership.

Table 4-8 Sample Medical Fees

Category	Levels of Institution	Maximum Fees (VDN)
A1 General examination	Level 1	20,000
	Level 2	15,000
	Level 3	10,000
	Level 4	7,000
	Level 5	5,000
B1 Hospitalization at ICU bed (/day)	Levels 1 and 2	335,000
B2 Hospitalization at emergency unit (/day)	Level 1	15,000
	Level 2	10,000
	Level 3	70,000
	Level 4	50,000
C1.2.4 Chest x-ray	Cardiopulmonary (frontal)	42,000
C1.2.6 Other x-ray	PET/CT	21,320,000
	CT64~128	2,130,000
	CT256	3,400,000

Reference: Circular 04/2012TTLT-BYT-BTC 29/02/2012） [40]

As mentioned in Section 4.2.1(4), the ongoing change in the calculation method of medical fees would likely lead to a substantial increase in the abovementioned fee limits. Consequently, the amount of copayment, albeit fixed rate, is expected to increase.

The medical services and fees are publicly displayed at each hospital as shown in Figure 4-4.

Figure 4-4 Sample Display of Medical Fees (taken at Dien Bien General Hospital)

(4) Pharmaceutical Drugs Covered by Health Insurance

Insurance-covered pharmacheutical drugs are regulated by the Ministry of Health Circular 31/2011/TT-BYT. The circular includes a list of more than 900 drugs. The prices of these listed drugs are subject to bidding at each health care institution.

According to WHO [39], in Viet Nam, drugs are highly priced by international standards. While the fees for medical examination and treatment are under supervision of MOH, the fees for drugs are up to the bidding at each hospital without a centrally-controlled mechanism. According to an interview with MOH, reviewing the national drug list based on its cost performance is one of the priority issues in the health insurance reform.

4.2.5 Status of Health Insurance Coverage

(1) Status of Coverage

According to VSS, the number of insurance subscribers in 2011 was 571.3 million, which was 66% of the population; and reached 615 millions in 2013. Table 4-9 presents the details in the status of coverage.

Table 4-9 Status of Coverage in Membership Groups (2010)

Category	Member Group	Population (1,000)	Insured (1,000)	Coverage rate (%)
Compulsory	**4.5% Salary Contribution**	**15,238**	**9,506**	**62.4**
	Civil servants	3,142	3,142	100.0
	Employees in the private sector	11,911	6,361	53.4
	Foreign students on government scholarship	3	3	100.0
	Commune civil servants (elected)	182	0	0
	VSS Contribution	**2,305**	**2,174**	**94.3**
	Pensioners	920	920	100.0
	Recipients of social security allowance	1,305	1,254	96.1
	Recipients of unemployment allowance	80	0	0
	Government Contribution (full support)	**30,561**	**24,675**	**80.7**
	Commune civil servants	41	40	97.6
	Persons of merit	1,791	1,791	100.0
	Veterans	374	350	93.6
	People who contributed to the revolution	322	0	0
	Members of the National Assembly and people's committees	123	119	96.7
	Recipients of social protection allowance	843	384	45.5
	The poor and minority groups	13,945	13,511	96.9
	Dependents of persons of merit	869	0	0
	Dependents of officers of the Ministry of Defense and Ministry of Public Security	1,281	297	23.2
	Children under six years old	10,103	8,183	81.0
	Government Contribution (partial support)	**19,879**	**10,499**	**52.8**
	The near poor	6,081	692	11.4
	Students	13,798	9,807	71.1
Voluntary	**Personal Contribution**	**18,552**	**3,917**	**21.1**
	Dependents of salaried workers and civil servants	6,820	0	0
	Farmers, members of cooperatives, and household-enterprises	11,732	3,917	33.4
Total		**86,866**	**50,771**	**58.5**

Reference: A Health Financing Review of Viet Nam with a Focus on Social Health Insurance [39]

As of 2010, there were 373.5 million members who were supported by either the government or VSS, totaling to 70% of the insured. Low subscription rates seem to appear in both low-income and high-income groups. The former would be unemployment allowance recipients, the near-poor, and, farmers; while the latter would be self-employed and employees in the private sector.

Despite obligation, employees in the private sector show a low subscription rate. It reflects a low compliance by micro and small enterprises which comprise 95% of the Vietnamese companies[51].

In July 2013, VSS drafted its action plan that sets its coverage goals in 2013, 2015, and 2020 for all provinces. Table 4-10 presents these goals in the Survey area. The coverage rates are high in regions with many people under minority and low-income groups due to subsidies, while the rates are low in urban areas.

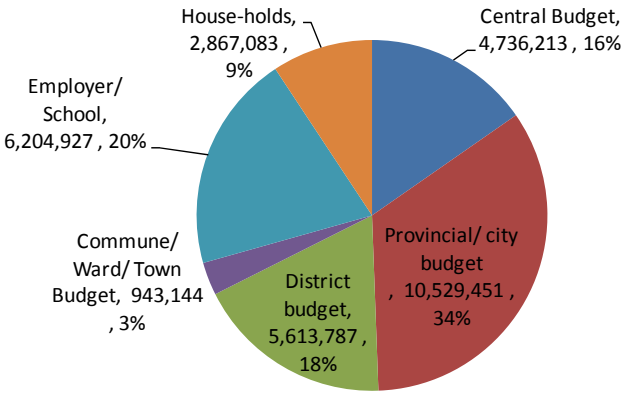
Table 4-10 Insurance Coverage Goals (2013-2020)

Province/City	2013		2015	2020
	Population	Coverage	Coverage	Coverage
Hanoi	6,742,416	72.6%	77.2%	81.1%
Ho Chi Minh	7,457,730	68.1%	71.8%	81.0%
Dien Bien	523,562	96.7%	99.1%	99.6%
Hoa Binh	822,790	92.1%	94.3%	94.8%
Nam Dinh	1,908,888	60.0%	70.0%	80.0%
Total	**89,724,394**	**70.9%**	**77.3%**	**84.0%**

Source: VSS No. 2961/KH-BHXH [41]

(2) Enrolment Process

Figure 4-5 presents the financial sources of health insurance as of 2010. Public sources constitute 70% of the total health insurance fund because more than 70% of the insured members have their insurance premiums on public support.



Total: VND 30,894,605 million
Reference: National Health Account (NHA) 2011 [42]

Figure 4-5 Sources of Health Insurance (2010)

[51] Micro enterprises are the ones with less than 10 employees. Small enterprises in agriculture, manufacture, and construction sectors are defined by the capital of VDN 200 million and the number of employees being 10 to 200. Small enterprises in wholesale, retail, and service sectors are defined by the capital of VDN 100 million and the number of employees being 10 to 50 (JICA, (2012) "JICA project on empowering the support to SMEs in Viet Nam.", original data is from "White Paper on Viet Nam SMEs 2011.").

SS offices at the provincial/city level are in charge of collecting insurance premiums. Out of the collected premiums, 10% goes to the central reserve fund[52] while 90% is despensed locally.

For employees in the private sector, the companies collect their employees' premiums from their salaries and, together with the employers' contributions, pay VSS every month. SS offices at the provincial/city level supervise large companies while those in the district level are in charge of small and medium companies. Delinquent companies will be warned for the first offense, and then be sued thereafter. In Ho Chi Minh, the city SS issues a warning against companies holding up to three months past due. After that, the city SS and DOLISA jointly issue warnings. When no action or improvement occurs after six months past due, the city SS will sue that company. In 2013, about 500 companies were one month overdue while 398 cases resulted in lawsuits.

The Law on Health Insurance states that VSS should pay the premiums every month for those on VSS support, such as pensioners and other social security recipients. The government should pay the premiums annually for those on government support, including persons of merit and veterans.

For school children and students, the schools collect premiums and pay for district SSs. After being examined by SS at the provincial level, 12% of the collected premiums would go to a primary care fund for students. In Nam Dinh Province, 4% of the premiums are sent back to the schools.

Because the poor and the near poor are offered various public assistances, candidates are subject to means tests conducted by the people's committees and DOLISAs every year. Commune people's committees survey the financial status of candidates, then make a list and send it to the district offices of DOLISA during October and November of every year. The district offices of DOLISA approve the list of candidates, and make contracts regarding health insurance with the district SS. The district SS issue then health insurance cards and send them to the district offices of DOLISA. The DOLISA commune offices deliver the health insurance cards to the candidates.

Insurance premiums are collected by agents at the commune level, where there is one agent per commune. Agents receive 4% of the collected premiums as incentives.

(3) Duplication of Health Insurance Cards

In the current health insurance scheme, the insured members are clasified into 25 groups according to occupation, financial status, and personal background. A person could belong to multiple groups, such as a child or a student in poor household, and a member of the minority group who is also an invalid veteran.

Usually, the criteria that allows the largest support is applied. However, there is a risk that a person may redundantly be nominated on several candidate lists. It is not clear whether the transfer of member group is immediately processed when a person's occupation or financial status changes[39].

Duplicate issuance of health insurance cards seems to be prevailing because of ambiguous membership classification, multiple authorities involved, multiple channels of premiums collection, and absence of a

[52] According to the interviews with the provincial SSs, the central reserve fund is used for financial adjustment.

centrally-managed database for the insured. There were 6,000 duplications in Hoa Binh in 2013, and 4,000 duplications in Dien Bien for the past two years.

(4) Efforts to Extend the Coverage

Every reachable sector has already been covered because the Vietnamese government has provided full support to pay the premiums for socially disadvantaged groups. The coverage goal of 80% in 2020 seems to be difficult as there is not enough room to extend the coverage.

Table 4-9 presents the low coverage rates for both low-income and high-income classes. According to the interviews, the main reason of the near poor not subscribing for health insurance is due to financial difficulties, while that of the rich are due to the low reputation of public health service and their preference for private health service.

The reason of voluntary members for subscribing to health insurance is immediate health risk. This means that healthier persons do not subscribe for insurance.

Ongoing discussion on revising the Law on Health Insurance in the central level includes an extended support for the near poor, abolition of voluntary scheme and shifting to a compulsory one, and more responsibility of local governments in terms of insurance coverage.

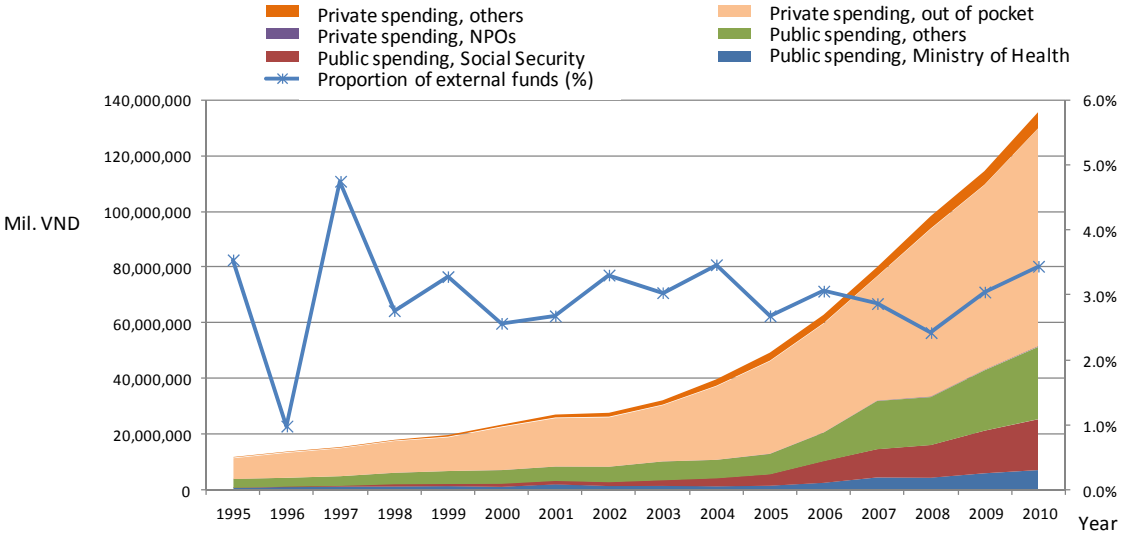
Various efforts to expand insurance coverage have been taken in the provincial level. In Nam Dinh Province, the local government extends its full support by paying premiums for the near poor so that they will have insurance without self-contribution. Another effort is to reform the current agent scheme. Change from a system of one agent per commune to multiple agents in one commune would create competitive environment among agents, eventually contributing to extend the insurance coverage.

However, raising the coverage by extending governmental support inevitably strains public financial resources. In order to achieve sustainable UHC, it is necessary to ensure the quality of public medical service and convince the current non-subscribers to join the insurance scheme.

4.2.6 Spending of Health Insurance

(1) Expenditure of Health Insurance

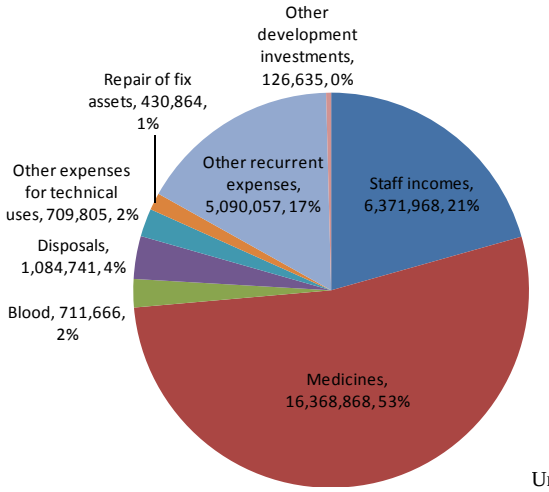
Figure 4-6 shows the trend of the total health spending in Viet Nam. The figure shows that the contribution of VSS (health insurance fund) to the total spending is increasing, from 8.8% in 2005 to 13.6% in 2010 after the implementation of the Law on Health Insurance.



Note: External funds are based on OECD/DAC data set. It is included in the total health spending.
Source: Analysis Report of the Health Sector in Viet Nam [36]

Figure 4-6 Trend of Health Spending

Figure 4-7 presents the details of insurance spending in 2010. Medicines cover the largest component, accounting 53% of the total spending. Control of drug prices would make a significant contribution to the financial sustainability of health insurance. Currently, the prices of medicines are not supervised by MOH nor VSS. They render bidding for each hospital, making it difficult to control the cost.

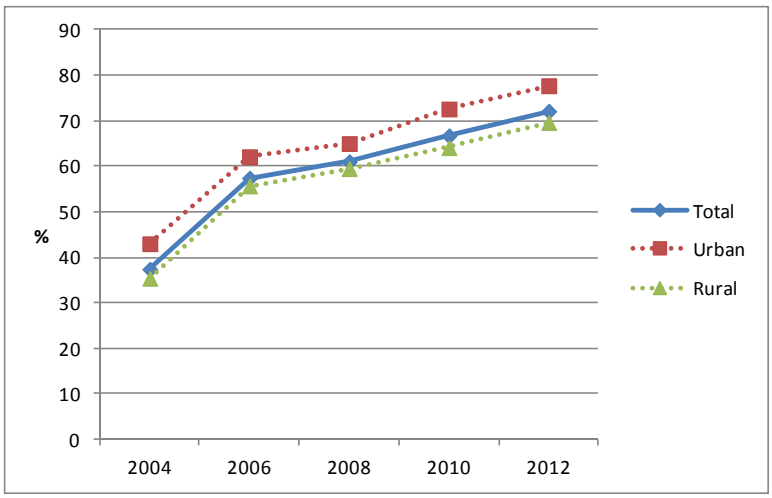


Unit: VND million
Reference: NHA Data 2011, Table 6.1 "Health Financing of Health Financing Facilities by Expenditure, 2010" [42]

Figure 4-7 Segments of Health Insurance Spending (2010)

The proportion of insured members among the patients who have visited the hospitals in the past 12 months was 72.1% in 2012, growing from 37.4% in 2004 [43]. It is high at 77.7% in urban area while it is relatively low at 69.6% in rural area (Figure 4-8). The insurance coverage rate itself is inversely lower in urban area than in rural area (see Table 4-10). These data may suggest that the insured members in urban area visit hospitals while those in rural area less likely seek medical services[53].

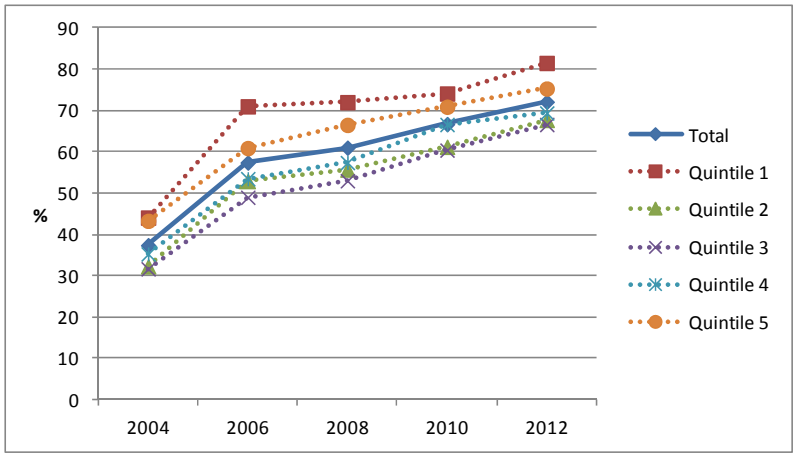
[53] According to an interview with DOH in Dien Bien, the residents are reluctant to visit hospitals even if they have health insurance.



Reference: VHLSS 2012 [24]

Figure 4-8 Proportions of Insurance Members among Hospital Patients in the Urban and Rural Areas

Figure 4-9 presents the proportions of insured members among the patients who have visited hospitals in the past 12 months, according to income class. The low-income class (Quintile 1) shows the highest rate of insured members at 81.5% while the lower- middle income class (Quintiles 2 and 3) tend to be lower.



Reference: VHLSS2012 [24]

Figure 4-9 Proportions of Insured Members among Hospital Patients according to Income Class

There is a more than 13% gap in the rates of insured members between the lowest (81.5%) and the lower-middle (67.7%) income classes. The government fully subsidizes the poor for their insurance premiums that leads to almost 100% coverage, while the assistance to the near poor is partial that yields to a less coverage as well as less insured members.

(2) Private Insurance

Several private companies in Viet Nam offer health insurance. Those in the upper-middle income class seem to consider having private health insurance, although no data is available for the number of

subscribers. Some companies subscribe for private health insurance for their employees[54]. In this case, the employees have both public and private health insurances.

The reason for having private insurance is that the reputation of public medical service covered by public health insurance is not so high. Rather, negative impressions are associated with public hospitals being always crowded while patients have to wait for a long time; patients have to share beds with other patients; and bribing medical staff prevails.

Private insurance offers benefits of going to the private practice reception, as patients immediately have their examination and treatment. On the other hand, public insurance offers lower fees for hospitalization. Therefore, patients usually move from private to public hospitals when hospitalized for a long time[55].

(3) Process of Outpatient Service

1) Insurance-covered Outpatient Service

Figure 4-10 presents the process of outpatient service.

[54] French Hospital (private hospital) offers both public and private health insurances for their employees. The insurance covers hospital employees. Many employees subscribe private health insurance for their families.

[55] According to an interview with the French Hospital.

① First reception: pick up the ticket with number.

② Second reception: when the number is called, go to the second reception for ID check and present the health insurance card and a valid ID. Usually, advanced full payment is required when seeking service at a non-registered hospital without a formal referral.

③ Waiting room at a department: after being assigned to a particular department, the patient still has to wait for a long time.

④ Pharmacy: obtain medicine at the hospital pharmacy, if necessary.

⑤ Accounting: pay the bill at the counter.

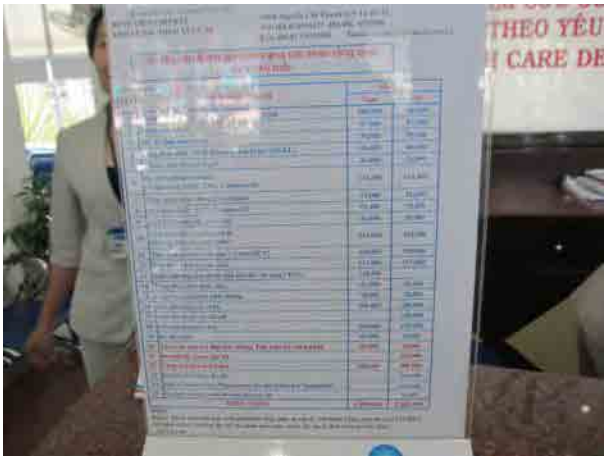
Figure 4-10 Process of Outpatient Service (Cho Ray Hospital in Ho Chi Minh)

2) Private Service

Some public hospitals have a private practice department (Figure 4-11 ①). This department is targetted for the high-income class and is very different from the insurance-covered service at the same hospital.

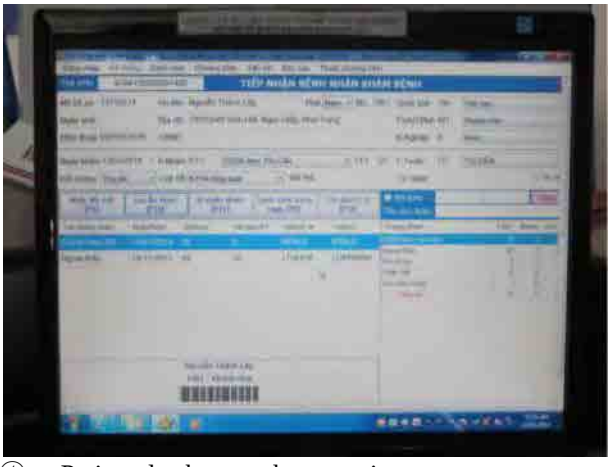
The medical fees of private practice are dessiminated to the patients at the reception (②). Currently, Cho Ray Hospital and Vietin Bank are conducting a pilot project for distributing ATM hospital cards (③). In this project, the patient opens a bank account to deposit money enough to pay his/her medical bills. When visiting a hospital, that patient can show this card at the reception and the staff will use this card to access the database to check the patient's information (④).

① Reception of the private practice department



② Table of medical fees

③ ATM hospital card



④ Patient database at the reception

Figure 4-11 Private Practice Department at Cho Ray Hospital in Ho Chi Minh

There are some private hospitals in urban areas that offer a more favorable environment than public hospitals. Nevertheless, private hospitals are ranked Level 3, which is the same as public district hospitals. Figure 4-12 shows some of the sections found inside a private hospital in Hanoi.

① Reception

② Waiting room at a department

③ Patient room

④ Pharmacy

Figure 4-12 Hong Ngoc Private Hospital in Hanoi

4.2.7 Provider Payment Mechanism

(1) Basic Concept

The Law on Health Insurance determines the health insurance fund to be reimbursed through either of three provider payment mechanisms: fee-for-service, capitation, and case-mix payment [44].

1) Fee for Service

In the fee-for-service method, medical fees are paid for each service provided, according to the fees approved by the Ministry of Health. This method is predominantly used at the central and provincial hospitals.

2) Capitation

In the capitation method, insured members are classified into several groups, with each of them being assigned specific rates. Medical fees are paid per service rendered. The method is used mainly by community health centers and some district hospitals. MOH intends to expand this method to all district

hospitals[56]. In 2011, 13.7% of the insurance-registered facilities were adopting the capitation method, which increased up to 42% in 2012 [13].

Also in the capitation method, insured members are classified into the following six groups: 1) civil servants and employees in the private sector; 2) pensioners, persons of merit, and recipients of social security allowance; 3) the poor and the near poor; 4) children under six years old; 5) students; and 6) voluntary members.

The group-specific rate is calculated by the following formula:

$$Rij = (Expij / Nij) \times K$$

The total health spending of group i in the province j for the previous year (Expij) is divided by the number of the insured members in that group (Nij), then multiplied by the coefficient (K). K is set to 1.1, allowing a 10% cost increase every year. Thus, a high capitation rate is the outcome of high spending of a particular group.

Table 4-11 presents the capitation rates at Da Bac District Hospital in Hoa Binh Province. It shows high capitation rates in pensioners and voluntary members. The elderly tend to have health problems associated with old age and are generally considererd as high risk. In the latter voluntary case, only those who have immediate health risk are likely to subscribe for health insurance[57], resulting in high spending and high capitaton rate for the voluntary group.

Table 4-11 Capitation Rate (Da Bac District Hospital, Hoa Binh Province)

Group	Number of Insured (person)	Average Premiums (VND)	Capitation Rate (VND)
1) Civil servants and employees	2,902	439,170	146,373
2) Pensioners	1,894	251,451	387,180
3) The poor and the near poor	41,973	155,078	44,217
4) Children under six years old	4,685	153,756	79,246
5) Students	521	94,500	33,193
6) Voluntary members	276	141,750	295,293
Total	**52,251**	—	—

Source: Hoa Binh SS

3) Case-mix Payment

In the case-mix payment method, a standard fee is set for the treatment of a certain disease. Standard fees are paid for the whole treatment regimen regardless of specific treatment and duration of therapy. In 2009, a pilot was undertaken at two hospitals in Hanoi for acute pneumonia, childhood pneumonia, appendicitis surgery, and normal delivery. However, neither MOH nor the health institutions have plans to apply case-mix payment[39].

[56] Inter-Ministry Circular 09/2009/TTLT-BYT-BTC by the Ministry of Health and the Ministry of Finance, clearly states this policy.
[57] According to an interview with VSS in Ho Chi Minh.

(2) Effect of Referral on Capitation Payment

The insurance budget of district hospitals that applies capitation payment method includes both medical fees at their own hospital and the ones at the referral hospitals when transferring registered patients. Table 4-11 presents an example of the effects of referral at a district hospital in Hoa Binh Province.

First, the budget for a district hospital (I) is determined either by calculating the total capitation rates (Table 4-12, column 2), or by calculating the premiums collected from registered patients, whichever is lower (Table 4-12, column 4). Then, from that calculated budget (I＝VND 2,989,864,633), payments to other referral hospitals which the registered patients have been transferred (II ＝VND 1,917,435,623) will be subtracted. The remaining (I—II＝1,072,429,010 VND) will be the final budget assigned to the district hospital, meaning that over half of the budget goes to the expenses in other referral hospitals.

Table 4-12 Sample Budget of a District Hospital

I Maximum Budget of Medical Examination and Treatment

Group	Fund based on the Premiums (VDN)	Fund based on Capitation Rate (VND)	Other Expenses by Notice No. 1267 (VND)	Fund Limit based on No. 126 (VND)	Maximum Limit of Budget (VND)
	1	2	3	4=(1-3)	5=2 if 2≦4 5=4 if 4<2
1)	1,032,321,785	424,774,446	52,880,244	979,441,541	424,774,446
2)	385,761,037	733,318,920	83,464,792	302,296,245	302,296,245
3)	5,272,362,004	1,855,920,141	215,699,247	5,056,662,757	1,855,920,141
4)	583,480,957	371,267,510	41,302,960	542,177,997	371,267,510
5)	35,094,352	17,293,553	906,540	34,187,812	17,293,553
6)	31,689,630	81,500,868	13,376,892	18,312,738	18,312,738
Total	**7,340,709,765**	**3,484,075,438**	**407630,675**	**6,933,079,090**	**2,989,864,633**

II Expenses used in Other Hospitals

Category	Outpatient		Inpatient		Total	
	Number	VND	Number	VND	Number	VND
Payment to referral hospitals within the province	409	105,693,010	283	1,183,902,912	692	1,289,595,922
Payment to referral hospitals outside the province	148	45,470,309	85	606,369,392	233	651,839,701
Direct payment	0	0	-1	-24,000,000	-1	-24,000,000
Total	**557**	**151,163,319**	**367**	**1,766,272,304**	**924**	**1,917,435,623**

Groups 1) to 6) correspond to the groups 1) to 6) in Table 4-11
Source: Survey Team

Spending of medical fees tends to be higher at top-ranked hospitals because the more services that they provide, the more they gain profits through the fee-for-service payment mechanism. Low-ranked hospitals have no way to control the cost at the referral hospitals. This payment system results in the reluctance of district hospitals to refer their patients and the tendency of patients to skip their registered facilities and directly go to top-ranked hospitals without referral.

(3) Process of Insurance Reimbursement

Health care institutions that accept health insurance should enter into a contract with VSS at the beginning of the fiscal year. The contracted institutions quarterly submit their spending data to VSS in order to claim for reimbursement. VSS inspects the submitted data and then reimburses insurance funds.

At the same time, VSS pays in advance 80% of the current spending for the next term. VSS and its contracted institutions adjust accounts on a quaterly basis.

VSS staff usually station at the central and provincial hospitals to examine spending data. (Figure 4-13 and 4-14 presents the relevant documents in the hospitals.) The applicability of insurance to a particular treatment or medication and the adequacy of claimed prices are the points to be examined. However, no manuals or guidelines have been issued for inspecting insurance reimbursement. Accordingly, the methods of inspection vary per region. Ho Chi Minh city SS adopts a 10% sampling method, Nam Dinh SS does a 30% sampling method, while Hoa Binh SS focuses on cases with particularly expensive bills.

The inspection team includes medical doctors in order to conduct proper judgement on the medical spending. According to the interviews, mistakes in calculation, redundancy in claims, and over provision of medical services are common. VSS has been engaged in pilot projects where the VSS inspector found errors at 10% of the sampled data, which VSS subtracts 10% of the amount from the claimed reimbursement. VSS is currently waiting for the prime minister decision for a nationwide deployment for this inspection method.

Figure 4-13 Medical Spending Data (at Bach Mai Hospital)

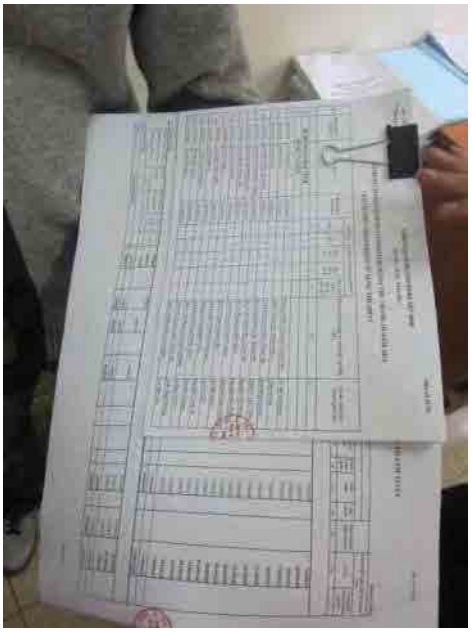


Figure 4-14 List Submitted to VSS (at Dien Bien General Hospital)

The hospitals make a summary list of medical spending and submit it to VSS for reimbursement. Although the list is automatically made by computer software, the claim process is not computerized and is all paper-based. As financial documents must be reserved for 20 years in Viet Nam, some local authorities are considering outsourcing for document storage and digitizing[58].

According to the interviews with selected hospitals, payment from VSS is sometimes delayed. A delay of two months is common, and sometimes delay up to one year occurs especially when the spending exceeds

[58] According to an interview with VSS in Dien Bien Province.

the limit of the assigned budget. Split disbursement sometimes occurs. Although hospitals receive 80% of budget in advance, they must bear the remaining 20% themselves for a certain period of time. This becomes a burden especially when the payment is delayed. Because of this uncertainty, some hospitals prefer monthly payment over the current quaterly arrangement so as to reduce financial burden.

(4) Cost Control Mechanism

VSS has several ways to control the cost by setting caps on hospital budget. First, VSS sends 10% of the collected premiums to the central reserve fund and dispenses the remaining 90% in the province. When the actual spending exceeds the budget, fees would be paid from the reserved fund. In this case, VSS pays up to 5% of the premiums for outpatient fees, and 10% of the premiums for inpatient and outpatient fees.

In a capitation-based budget, the limit is set to lower than 90% of the collected premiums. The capitation fund is designed to cover both medical fees at a designated hospital and a part of fees at other referral hospitals.

However, there is no mechanism for controlling the budget of hospitals under fee-for-service scheme and the price of medicines is subject to bidding at each hospital, which constitutes 53% of the total health insurance.

4.2.8 Issues on Health Insurance in Viet Nam

The Vietnamese government has been committing to achieve UHC by setting a goal of 80% insurance coverage by 2020. Currently, substantial government support to the poor has led to an insurance coverage of 68%. However, as 70% of the insured members are on public assistance, it would be harder to further increase the coverage. Achieving the set goal seems to be difficult.

As for voluntary members, only those who have immediate health risk subscribe for insurance while healthier people do not. This adverse selection of membership makes it difficult to sustain the health insurance scheme.

The main reason for the poor not subscribing for health insurance is due to financial difficulties, while that for the rich is due to the low reputation of public health service and their preference of private health service. Thus, the improvement of public medical service quality is of utmost importance in order to incorporate the high income class to the insurance scheme.

The following are the current concerned issues in Vietnamese health insurance scheme:

(1) Improving Policy and its Implementation

Many decrees and notices have been issued regarding health insurance but some are inconsistent with each other. For instance, the government intends to increase the financial autonomy of health institutions on one hand and implement capitation payment system to all district hospitals on the other. The former policy would likely lead to over provision of medical services at top-ranked hospitals with fee-for-service scheme, while the latter policy would force district hospitals with capitation scheme to suffer from high spending by top-ranked referral hospitals. It would be beneficial to pull all these policies together to review each consequence and clarify the policy line.

(2) Improving Scheme Design

1) Enhancing Coverage

There are three concerned issues in terms of insurance coverage. First is that 70% of the insured members are on public assistance, leaving no room to increase the coverage. Current low coverage groups are compulsory members including workers in private sector and the near poor, as well as voluntary members including farmers and self-enterprises. Second is the adverse selection of voluntary members. Only those who have immediate health risk subscribe for insurance while healthier people do not. Finally, the classification of 25 membership groups is obscure and redundant.

There are several reasons for not subscribing insurance; a low reputation for public health care service in general; financial burden to pay premiums for the near poor and farmers; government and health care service providers are neither able to ensure the quality of their health care service nor persuade people to understand the benefit of having health insurance. Insufficient regulations and organizational capacity to enforce compliance are another problems.

In order to enhance the insurance coverage, the improvement of public medical service quality is of utmost importance (see (3) below). It would also be effective to develop specific approaches targeted to each low coverage group. For instance, to study the possibility of government support to the near poor, to abolish voluntary scheme and implement compulsory scheme,and to enforce compulsory subscription of private companies by examining the regulations and severely handling violation. It is also necessary to clarify the redundancy in the classification of membership groups, making the scheme easier for the citizens to understand and easy for the government to operate.

2) Adjusting Benefit Package

There are two concerned issues in terms of benefit package. First, the prices of drugs, which constitute 53% of the insurance spending, are subject to bidding at each hospital without any mechanism to centrally control their costs. Secondly, although the reimbursement of insurance has a cap, there is no limit for the patients' co-payment fees.

In order to adjust the benefit package, the government may shift from the current bidding system to either group procurement or a standard price system in order to control the drug prices more effectively. Some measures to cap patients' co-payment should be taken in order to reduce the patient's OOP spending.

3) Improving Provider Payment Mechanism

Amid facilitating financial autonomy of hospitals, top-ranked hospitals adopt fee-for-service payment scheme. These hospitals may provide more medical services in order to gain more profits, eventually leading to stressing the insurance finance. On the other hand, low-ranked hospitals are supposed to adopt the capitation scheme and they must absorb referral cost. These mechanisms would result in district hospitals being reluctant to refer their patients to other hospitals, and patients prefering to skip district hospitals and go directly to top-ranked hospitals without formal referrals.

In order to improve the provider payment mechanism, setting the cap for fee-for-service scheme and introducing the case-mix payment system are viable options.

4) Incorporating Private Healthcare Facilities

Currently, most public hospitals join the insurance scheme while private hospitals do not. High-income people prefer private hospitals and they tend not to subscribe for public insurance.

In order to achieve UHC, the public insurance scheme should incorporate private hospitals and their clients. In order to incorporate private hospitals in the scheme, the benefits of public insurance scheme for health care providers must be clarified. Prompt and proper reimbursement from the health insurance fund should be observed in order to expand the providers.

(3) Improving Quality of Healthcare

Insured members must register at their neighboring public health facilities. They should pay a higher co-payment fee when they seek medical service without formal referral at a non-registered facility. However, this arrangement does not seem to function as expected as top-ranked hospitals are always overcrowded with patients. Among the reasons behind this is a low reputation for public health care service provided at local primary care facilities.

The reason for high-income people to prefer private practice is that their perception of the reputation of public medical service covered by public health insurance is not so high. Rather, negative impressions are associated with public hospitals being always overcrowded and therefore the patients have to wait for a long time, a patient has to share a bed with other patients, and bribing medical staff prevails.

In order to address these issues, the government should organize medical services depending on the level of facilities and improve the quality of primary care, particularly at the local level.

(4) Improving Access to Healthcare

Some residents in remote areas have experienced problems in accessing medical facility. They have two options: either travel to a nearby/neighboring hospital across the border and pay a higher co-payment fee or travel to a registered hospital in a far distance and pay transportation fee. Nevertheless, neither option is desirable.

In order to address these issues, applying a more flexible registry system and supporting transportation fees should also be taken into account.

(5) Improving Efficiency in Insurance Administration

Duplication of health insurance cards is rather common in Viet Nam. Complex classification of membership, involvement of multiply authorities, multiple channels of premium collection, and the lack of a database of the insured subscribers all lead to the duplication of health insurance cards.

The exchange of data between health care facilities and VSS offices is not computerized and the insurance claim process is manually being executed. Financial documents must be kept for 20 years and the storage of the bulk of medical expenses data poses a big problem.

In order to improve the efficiency of insurance administration, central data management of the insured members and computerization of insurance claim process are viable approaches.

Chapter 5 Situation Analysis of Health Finance

5.1 Policies on Health Finance

The Government of Viet Nam has recognized that health sector is a sector with higher priority to increase the proportion of state budget allocation. The followings are policies related to health financing.

5.1.1 General Polices, Development Strategy and Plan

Politburo Resolution No. 46-NQ/TW, dated 23 February 2005, on protection, care and promotion of people's health in the new situation, highlights the need to review of health financing policy to decline direct payment of out-of-pocket by patients and to increase the proportion of the public expenditure share (state budget and health insurance) [45]. The National Assembly Resolution No. 18/2008/NQ-QH12, on "strongly promoting the implementation of policies and legislation on social mobilization to improve the quality of health care for the people", clearly stipulated that the Government should increase the share of the annual state budget expenditure for health care, ensuring that the growth rate of health spending is higher than the growth rate of overall spending from the state budget and reserving at least 30% of the state health budget for preventive medicine [46]. According to the Politburo Conclusion No. 43-KL/TW, on three years of implementing Resolution No. 46-NQ/TW and five years of implementing Directive 06-CT/TW directing strengthening the grassroots health network, restructuring of health financing sources with the goal being that public expenditure on health should account for at least over 50% of total health expenditures (THE) from different sources.

Based on these policies, it is also highlighted objectives in Five-Year Health Sector Development Plan 2011-2015; to raise the proportion of public share out of total expenditure on health to over 50% and to achieve 30% of the state budget for health for preventive medicine work [47].

In the National Strategy for the protection, care and promotion of the people's health for the period 2011–2020, with a vision to 2030, it is also specified the following objectives [48];

- Increasing annual state budget spending on health, ensuring higher rate of increase of state budget health spending than the average rate of increase of overall state budget spending
- Spending at least 30 percent of state budget health spending on preventive medicine
- Ensuring adequate funds for recurrent spending of commune health stations and for salary supplements for village health workers
- Striving to achieve a minimum of 10 percent of total state budget spending for health

5.1.2 Relevant Policies and Strategies

(1) Investment for Health Facility Development

Decision No.60/2010/QD-TTg on principles, criteria and standard of state budget allocations for capital investment stipulates budget allocation during the period 2011‐2015. The state budget will be invested in health through approved national target programs, and supporting investments for specialist hospitals and

provincial and district health facilities. The investment support prioritizes mountainous areas of the North and Central Highlands [50].

(2) Relating with Human Resource for Health (HRH)

Decree No.64/2009/ND-CP is a policy on incentives for health workers and officials working in socio-economically difficult areas. The Joint Circular No.06/2010/TTLT-BYT-BNV-BTC, dated 22 March 2010 provided detailed guideline for supplemental salary. The salary supplement to attract health workers to these areas is 70% of the salary, in addition there are other subsidy regimes such as subsidies for staff development, upgrading professional skills, travel costs, etc [49].

(3) Relating with Health Insurance

Regarding health insurance, it is stated that the insurance premium increased from 3% to 4.5% of salary, wage, pension, stipend or minimum salary; whereas for students and dependents of workers, the premiums are 3% of the minimum wage (see Sectoin 4.2.3). Those are stipulated in Decree No.62/2009/ND-CP guiding implementation of the Law on Health Insurance, starting from 1 January 2010. The Government issued Decree No. 92/2011/ND-CP regulating penalties for administrative violations in health insurance, according to which violations, depending on severity, will be punished with warnings or fines, with the highest fines reaching 40 million VND.

In addition to these policies, there is a Joint Circular of Ministry of Health (MOH) and Ministry of Finance (MOF) (Joint Circular No. 39/2011/TTLT-BYT-BTC, on 11 November 2011) guiding procedures for health insurance claims for people with health insurance who suffered from traffic accidents has also been issued [49].

(4) Relating with Elderly Care

The MOF issued Circular No. 21/2011/TT-BTC dated 18 February 2011 regulating the management and utilization of primary health care (PHC) funds for the elderly where they live. The Circular guides that commune health centers (CHCs) are responsible for primary health care for the elderly. Expenses for relevant activities such as dissemination of general knowledge, necessary materials, regular medical examination, for transportation fee of health workers from CHC to residences of the elderly who are seriously ill and/or lonely[59] are supported from state budget paid through People's Committees at commune level.

5.2 Concerned Agencies

5.2.1 Central level

MOF and Ministry of Planning and Investment (MPI) are concerned central agencies in addition to MOH and Vietnam Social Security (VSS) (see Section 2.4).

[59] 3,000VND/km for mountainous area and 2,000VND/km for other areas.

(1) Ministry of Finance

In MOF (Figure 5-1), each department has responsibilities on specific issue on health financing, for example, Department of Investment is in charge of investment on health, Department of Debt Management and External Finance is in charge of external assistance on health.

Regarding to policy development on health insurance, MOH has the main responsibility and MOF has few relation on it. However in general, MOF is one of the stakeholders for health finance. MOF issued joint circulars on health finance with the MOH such as No. 04/2012/TTLT-BYT-BTC, on establishment the maximum price level of the medical examination and treatment services in public hospitals, No.33/2013/TTLT-BYT-BTC, on establishment funds for medical examination for poor, No.25/2013/TTLT-BYT-BTC, which is about financial management regime applicable to social marketing activities for contraceptive and HIV/AIDS and sexual transmitted disease prevention and control products.

(2) Ministry of Planning and Investment

Major responsibilities of MPI are as follows[60];

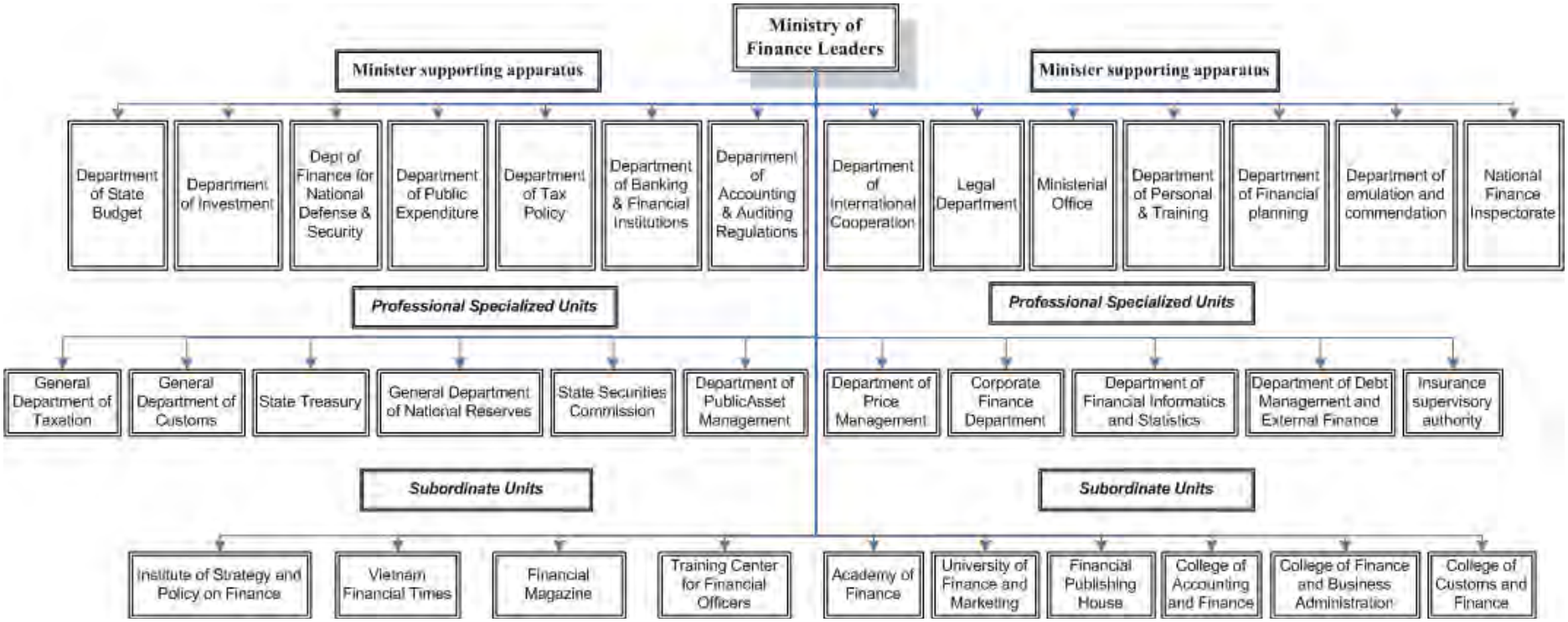
- Regarding submission of the Government national strategies and five-year and annual plans on socio-economic development
- Regarding development investment ,
- Regarding management of Official Development Assistance (ODA) and non-governmental assistance
- Regarding bidding management, etc.

A main department dealing with health issues out of 25 departments is Department for Labor, Culture and Social Affairs. Same as MOF, each department responsible for specific health issue. Department for National Economic Issues and Finance and Monetary Department are in charge of the state budget on health, Department for Service Economy takes care of medical services, Foreign Economic Relations Department deals with external assistances for health sector, Department for Science, Education, Natural Resources and Environment is in charge of issues on human resource development for health (HRH), Foreign Investment Agency is responsible for foreign investment.

5.2.2 Local Level

At the Provincial People's Committee, there are departments which have the same function and responsibility as the central level (e.g. Department of Health (DOH) under the MOH, Department of Finance (DOF) under the MOF). Administrative management at district level is supervised by the Provincial People's Committee.

[60] http://www.kenfoxlaw.com/resources/legal-documents/governmental-decrees/1868-vbpl.html



Source: MOF website [50]

Figure 5-1 Organization Structure of the Ministry of Finance

5.3 Overview of Health Finance

5.3.1 Situation on Health Financing

(1) Transition of Health Financing

THE in Viet Nam has been increasing significantly: in 2011, it was 7.5 times higher than that in 2000. General government expenditure on health shared 39.9% out of THE in 2011 and Out-of-pocket (OOP) expenses shared 56.1% in 2011 (Table 5-1).

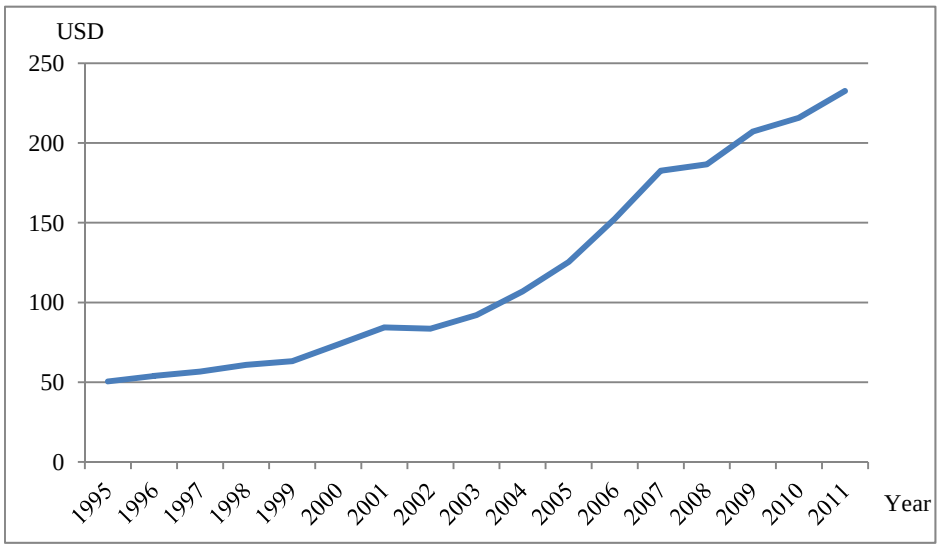
Table 5-1 Transition of Health Expenditure

Unit: Million VND

	1995	2000	2005	2011
General government expenditure on health	4,023,607	7,215,164	12,974,880	69,665,524
Ministry of Health	544,300	880,375	1,295,041	4,722,000
Social Security funds	283,000	1,418,010	4,340,499	27,076,000
Other sources	3,196,307	4,916,779	7,339,340	37,867,524
Private expenditure on health	7,850,191	16,097,199	36,167,870	104,806,202
Non-profit institutions serving households (e.g. NGOs)	18,969	31,861	103,233	306,800
Out of pocket expenditure	7,463,789	15,392,472	33,239,505	97,947,527
Total Health Expenditure	11,873,798	23,312,363	49,142,750	174,471,726
General Government Expenditure	54,589,000	109,633,000	247,749,000	738,800,000

Source: Global Health Expenditure Database [51]

The share of THE out of general government expenditure in 2011 was 9.43%[61]. Health expenditure per capita has grown and it becomes four times higher than 1995. In 2011, per capita total expenditure on health was 233 USD[62] (Figure 5-2).



Source: Global Health Expenditure Database [51]

Figure 5-2 Transition of Per Capita Total Expenditure on Health

[61] (General government expenditure on health) / (General Government Expenditure)×100
[62] (Purchasing Power Parity)PPP int. $

(2) Recent Situation of Health Finance

The latest National Health Account (NHA 2011) is now under finalization process. According to the draft NHA 2011, two thirds of the state budget in 2010 was allocated to provincial DOH and Provincial Social Security (SS) (Table 5-2).

The factors push up THE could be cost for medicine: Doctors do not tend to prescribe generic medicines but the original medicine and give unnecessary prescription of antibiotics. Medicine purchase costs account for 35% of THE and for 53% of social security funds.

Table 5-2 State Budget Allocation by Administrative Level (2010)

Unit: Million VND

	Central Level	Provincial Level	District Level	Commune Level	Total
MOH/DOH	3,874,287	32,965,180	5,874,749	439,947	43,154,163
Social Security (SS)	4,736,213	10,529,451	5,613,787	943,144	21,822,595
Total	8,610,500	43,494,631	11,488,536	1,383,091	64,976,758
% of total state budget on health	13.25	66.94	17.68	2.13	100.00

Reference: NHA 2011 data [42]

Table 5-3 shows source of health finance per activities in 2010, and Table 5-4 show source of health finance per service providers in 2010.

According to the Joint Annual Health Review (JAHR) 2013, the share of the state budget spent on health has risen by 34.2 percent. It was higher than the growth in general government spending (20 percent) over the period 2008‑2013. In recent years, the state budget allocations to health have increased considerably in order to implement full or partial subsidies to health insurance premiums of different benefit groups according to the Law on Health Insurance, including the poor, the near poor, the ethnic minorities, children under six, social assistance beneficiaries, students and pupils [52].

Table 5-3 Source of Finance per Health Activity in 2010

Unit: Million VND

	State organizations					Non government			Total
	Central (MOH, other ministries)	Provincial/ City DOH	District DOH	Commune/ Ward/ Town DOH	VSS/SS	Households	Employers/ Schools	Charity organization	
Direct Health Activities	**5,746,033**	**33,684,137**	**5,902,368**	**452,592**	**130,070,563**	**78,570,549**	**15,230,900**	**620,824**	**170,277,967**
Medical services activities (incl. sale of medicine for self medication)	2,402,949	6,532,167	3,405,026	441,955	30,070,563	78,570,549	-	620,824	122,044,033
Health prevention and public health	3,311,176	27,034,195	2,497,342	10,637	-	-	15,230,900	-	48,084,250
Rehabilitation and nursing	26,697	66,721	-	-	-	-	-	-	93,418
Quality control of drugs, foods, quarantine	5,211	51,054	-	-	-	-	-	-	56,266
Indirect Health care activities	**626,845**	**669,134**	**-**	**-**	**824,042**	**-**	**-**	**-**	**2,120,020**
Health management and administration	77,973	547,229	-	-	824,042	-	-	-	1,449,243
Health personal training	463,299	110,745	-	-	-	-	-	-	574,044
Health scientific research	85,573	11,160	-	-	-	-	-	-	96,733
Total	**6,372,878**	**34,353,271**	**5,902,368**	**452,592**	**30,894,605**	**78,570,549**	**15,230,900**	**620,824**	**172,397,988**

Reference: NHA 2011 data [42]

Table 5-4 Health Finance Source per Service Provider in 2010

Unit: Million VND

	State organizations					Non government			Total
	Central (MOH, other ministries)	Provincial/ City DOH	District DOH	Commune/ Ward/ Town DOH	VSS/SS	Households	Employers/ Schools	Charity organization	
Hospital and health facilities (excl. private drug store)	2,402,949	6,532,167	3,405,026	441,955	30,070,563	44,228,081	-	620,824	87,701,565
Private retail medicine and chemists' shop	-	-	-	-	-	34,342,468	-	-	34,342,468
Diseases and pandemic prevention unit and public health	3,316,387	27,085,249	2,497,342	10,637	-	-	15,230,900	-	48,140,516
Rehabilitation and nursing institutions	26,697	66,721	-	-	-	-	-	-	93,418
Administrative units and SHI	77,973	547,229	-	-	824,042	-	-	-	1,449,243
Health personal training institutions	463,299	110,745	-	-	-	-	-	-	574,044
Scientific research institutions	85,573	11,160	-	-	-	-	-	-	96,733
Other establishments	-	-	-	-	-	-	-	-	-
Total	**6,372,878**	**34,353,271**	**5,902,368**	**452,592**	**30,894,605**	**78,570,549**	**15,230,900**	**620,824**	**172,397,988**

Reference: NHA 2011 data [42]

(3) Comparison with Neighboring Countries

Table 5-5 shows a comparison of the health expenditure in 2009 with neighboring countries and Japan. The proportion of THE to gross domestic product (GDP) was higher than neighboring countries and lower than Japan. The general government expenditure on health to the total is not higher than neighboring countries, expect Thailand. The social security expenditure on health accounted 36.0% of general government expenditure on health, which was higher than Thailand and Lao PDR.

It could be noted that OOP accounted the highest proportion of private expenditure, whereas WHO recommends 30 to 40% [52].

Table 5-5 Comparison of Health Expenditure with Neighboring Countries and Japan (2009)

Indicators	Viet Nam	Thailand	Cambodia	Lao PDR	Japan
Total expenditure on health as % of gross domestic product	6.9	4.2	5.3	4.3	9.5
General government expenditure on health as % of total expenditure on health	37.5	74.6	36.6	28.3	82.3
Private expenditure on health as % of total expenditure on health	62.5	25.4	63.4	71.7	17.7
General government expenditure on health as % of total government expenditure	7.8	13.3	9.8	5.9	18.4
External resources for health as % of total expenditure on health	3.0	0.3	22.0	18.8	0
Social security expenditure on health as % of general government expenditure on health	36.0	10.1	NA	5.0	87.7
Out-of-pocket expenditure as % of private expenditure on health	92.7	59.6	66.8	70.7	82.1
Private prepaid plans as % of private expenditure on health	0	28.5	0	0.5	12.7
Per capita total expenditure on health at average exchange rate (USD)	77	160	41	39	3,754
Per capita government expenditure on health at average exchange rate (USD)	29	119	15	11	3,090

Source: WHO Global Health Expenditure Atlas [53]

(4) Situation on External Assistance

According MPI, the external assistance has been decreasing since Viet Nam became a lower middle income country in 2010[63]. However, MOH reported that external assistance for health has increased. There were 52 ODA projects/ programs under MOH in 2012 with total funds of approximately 1.5 billion USD. For the health sector, more than 50% of total ODA funds are provided by the World Bank and The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). In addition, there are 106 health projects/ programs funded by NGO with a total amount of 256 million USD [1].

[63] Classification of the World Bank

5.3.2 Medium and Long Term Prediction on Health Finance

The National Strategy for the protection, care and promotion of the people's health for period of 2011-2020, with a vision to 2030 (No. 122/QD-TTg) aims to rapidly increase public investment to health sector. To achieve it, the following solutions and indicates are set [1];

- Proportion of health expenditure to the state budget should be maintained more than ten percent..
- To increase annual state budget allocated to health sector, the average rate of increase should be maintaied higher than the total average.
- To secure sufficient budget for CHC and incentives for human resource for health involved in commnunity heatlh, at least 30 percent of health sector budget shoucl be allocated to preventive medicine.

To achieve the above, medium/long term prediction on THE might be useful. Table 5-6 shows actual expenditure during 2003-2010 and forecast during 2011 - 2015 and 2016 - 2020 on health insurance and care.

Comparing to the annual average amount during 2003 to 2010, 2011 to 2020 is forecasted 5.4 times higher and 10 times higher during 2016 to 2020. It could be suggested that health sector might cause financial burden in future.

Table 5-6 Social Budgets for Health Insurance and Health Care, Actual 2003-2010 and Forecast 2011-2015, 2016-2020

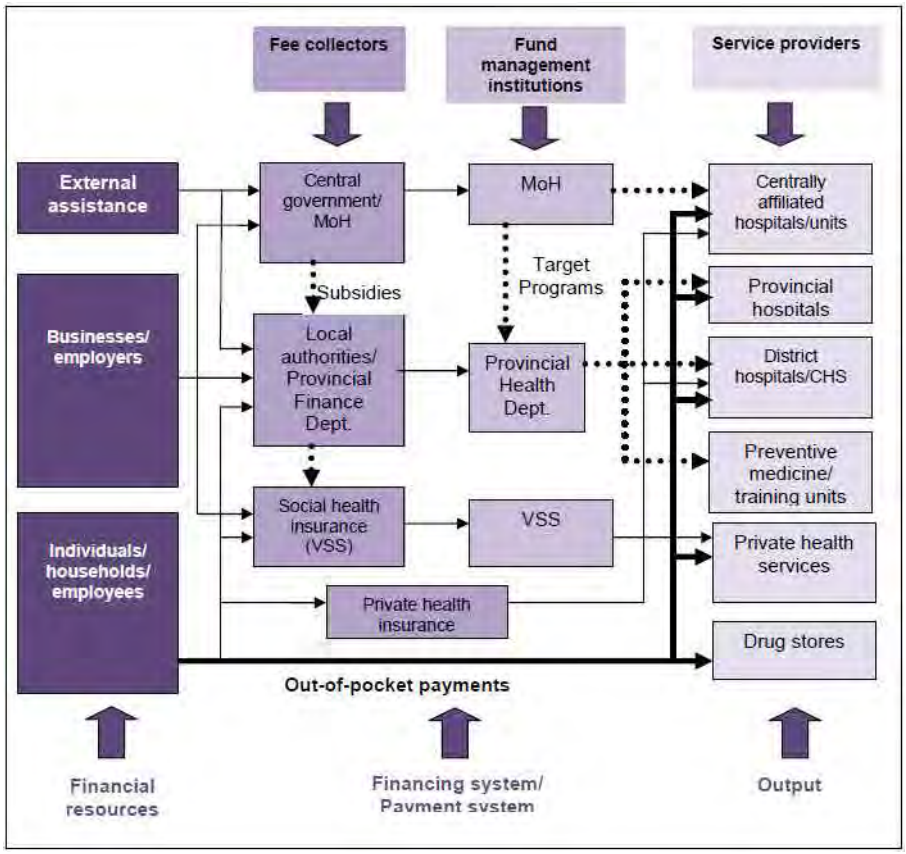
Unit: Billion VND

	Actual 2003-2010		Forecast 2011-2015		Forecast 2016-2020	
	Total	Annual	Total	Annual	Total	Annual
Health insurance and health care	126,753	15,844	427,109	85,422	795,942	159,188

Source: Analysis of the Viet Nam National Social Protection Strategy (2011-2020) in the context of Social Protection Floor objectives [54]

5.3.3 Flow of health financing sources

Due to the reforms during the *Doi Moi*, the health finance made transition from tax-based system to multiple sources financing system. Today, the major sources of health finance are the state budget, health insurance funds, and OOP expenses. Others are external assistance including ODA and private health insurance (Figure 5-3) [39].



Source: A Health Financing Review of Viet Nam with a Focus on Social Health Insurance [39]

Figure 5-3 Channels of Health Finance Sources in Viet Nam

5.4 Income Sources of Health Facilities

5.4.1 Hospital

According to hospitals visited during the Survey, there are three major income sources for public hospitals, which are the state budget, health insurance funds and OOP payment. The others include service fees such as car parking, canteen, etc. Apart from that, central hospitals are provided with free medicines from private sectors, for example, medicines for cancer from pharmaceutical companies.

(1) State Budget

Percentage of the state budget to total budget in a public hospital is 1 to 2% at central level and 20 to 30 % at provincial and district level.

The reason why central hospital shows extremely low rate is that central hospitals can be expected to get revenue from other sources (health insurance fund and OOP payment) since they have more patients, and the MOH policy shows the state budget is allocated more on provincial level hospitals.

The most of the state budget is allocated to labor costs. The salary supplements are allocated by using profit of the hospital through regulation of each hospital.

Hospitals submit annual budget plan for coming year by the end of December to the People's Committee. For provincial level hospitals, about 80% of applied budget are approved and allocated, and

approximately 60 to 70% are provided to district level hospitals. For example, according to the Survey, the state budget was allocated 40 million VND per bed in Hoa Binh Provincial Hospital and 36 million VND per bed in Mai Chau District Hospital.

Standard of the budget allocation is revised every three years. The state budget is paid every month without being late from DOH.

(2) Health Insurance Funds

Percentage of health insurance funds to total income in a public hospital is about 40% at central level and 50-60 % at provincial and district level.

Remuneration is claimed by hospitals to VSS quarterly. Usually, 80% of expenses in the previous quarter are prepaid and it will be settled after VSS approve the claim. However, this system might be burden especially to lower level hospitals with less number of patients as they sometimes have to pay the expenses by their own financial sources in advance.

Moreover, the payment is sometimes delayed since it takes longer time to process and approve the claims in local SS. According to the Survey, when the claims exceeded the maximum amount set by the legislation, the payment from VSS was sometimes delayed for one to two years.

(3) OOP Payment and Others

Percentage of OOP payment and the others to total revenue in a public hospital is 50 to 60% at central level hospitals and 10 to 20 % at provincial and district level.

Patients without health insurance must pay all the expenses for the health services by themselves. Despite of being insured, if they directly seek care to upper level hospitals which is not registered in their health insurance card, they have to spend more proportion of medication cost than when they seek care to the registered hospital or go through official referral procedure. According the Survey, people tend to seek care to upper level hospitals regardless the cost and it seemed to make major hospitals over capacity. Therefore, upper level hospitals could obtain get more income from OOP payment than the lower level.

In addition, at central hospitals, in particular, such as Bach Mai Hospital and Cho Ray Hospital, there are other sources of income such as service fees from car parking, canteen, etc.

5.4.2 Commune Health Centers (CHC)

(1) State Budget

The state budgets are paid through DOH of the District People's Committee. It covers personnel expences, costs for prevention actiivities, allowance for village health workers, and so forth and the distribution depends on each district. In general, most of the state budgets are allocated as saraly. As OOP is much less than hospitals in CHC, it seems to be difficutl to earn additional income or profit to provide incentives to the staff.

(2) Health Insurance

Remuneration payment procedures are done through district hospitals. As described in Chapter 4, capitation is applied for CHC. CHC sends list of services provided to district hospital and the hospital claim to local SS.

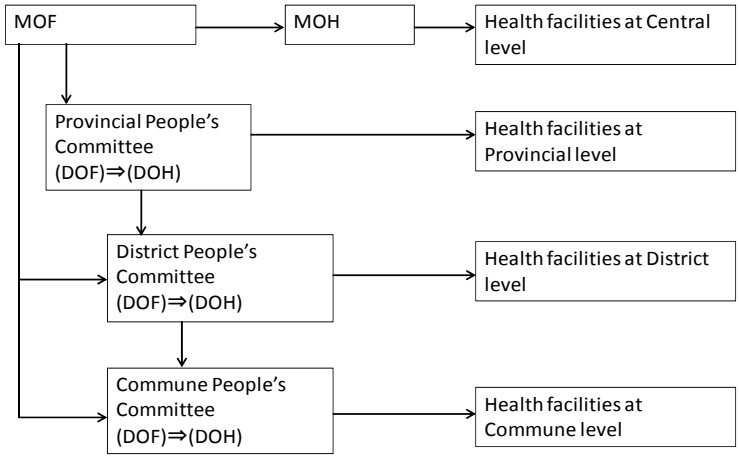
(3) OOP Payment and Others

Patients without health insurance cards have to pay all the cost. The insured ones pay according to OOP payment ratio set for each group. Generally, basic consultation fee is set 3,000 to 5,000VND[64] and OOP payment ratio is 5% to 20% becomes OOP payment. Therefore, the insured patient quite small amount when they have health services in CHC.

However, some of CHC services require a certain amount of payment even for the insured, such as normal deliverly (260,000VND in Nam Dinh Province) and heatlh checkup for employment (10,000VND in Nam Dinh Province).

5.4.3 State Budget Allocation Flow

The budget request is made from the minitsries to MOF in every June. After deliberation, the general budget framework is determined in every September, and the state budget is approved by the National Assembly in every November. Afterwards, it is distributed to each agencies and facilites through the flow shown in Figure 5-4. Additional budget for the national program or other important expences are allocated upon approval of MOF or the Prime Minister. Then, it can be distributed directly from MOF to concerned agency/ facility.



Source: The Survey Team

Figure 5-4 Flow of State Budget to Health Facilities

5.4.4 Autonomous Financial System

(1) Situation of Autonomous Financial System

Public hospitals has to be operated according to the Decree No. 43/2006/ND-CP, on providing for the right to autonomy and self-responsibility for task performance, organizational apparatus, payroll and

[64] According to the Joint Circular by MOH and MOF, No. 04/2012/TTLT-BYT-BTC, the upper limit is 5,000VND.

finance of public non-business units. However, basic salaries as personnel expenses come from the state budget, which is guided by the Decision No. 59/2010/QD-TTg, on norms on the allocation of cost estimates of the state budget. Therefore, it is not complete self-supporting accounting system, but "autonomous financial system", that can be considered as partially self-supporting accounting system.

Major expenses of hospitals are made for medicine and medical supply; procurement, maintenance and repair of equipments; and personnel expenses. It is required to pay for saraly incentives and utility expences from profit of the hospitals. According to the Survey, income and expenditure is basically balanced in each hospital. However, the financial situations vary by hospitals and some experienced deficit in the past[65].

It is concerned that the autonomous financial system might cause unnecessary examinations to increase income of hospitals. Although upper level hospitals recognized that the autonomous financial system and referral system needed to be improved to make number of patients appropriate to their capacity, few solutions have been taken. Then, the upper level hospitals are always overcrowded while lower level ones cannot maintain service quality due to financial constraint. However, no appropriate measures are taken to secure their revenue. Furthermore, as the stae budget for personnel expenses allocated to lower level hospitals are insufficient, those could not hire and maintain quality human resources, then it might affect on service quality.

Service fee of each hospital depends on management capacity of the hospital and economic status of the coverage areas within the maximum amount stipulated in Joint Circular of MOH and MOF (No. 04/2012/TTLT-BYT-BTC). This variety of service fee might make health insurance operation complicated. Although MOH recognizes that it is necessary to set unified price standard, it has to develop standard clinical procedure and medication to minimize gap of service quality among hospitals.

(2) Revision of Remuneration of Medical Services

Remuneration of public hospital was revised 2012 to include three costs (medicine and medical supply, utility cost and maintenance cost of equipments) to calculate unit service price. It will be revised again to include seven costs (in addition to the above three, personnel expenses, depreciation cost, equipment procurement cost, and operation cost) to the unit service price step-by-step from 2014 to 2018. The roadmap is presented in Decree No. 85/2012/ND-CP as summarized below;

- From 2014, inpatinet bed and a part of surgery fees will be charged.
- From 2015, costs for medical consumables and hospital operation and management 20 to 30% of basic saraly will be charged in provincial hospitals in mountainous and Central Highland Region, as well as district hospitals in Hanoi and Ho Chi Minh Cities.
- From 2016 to 2017, basic salary will be charged in provincial and central hospitals as well as district hospitals in Hanoi and H Chi Minh City.
- After 2018, the full cost recovery policy in the medical service will be applied to all public hospitals.

65 The survey team could not get the details of hospitals expenditure.

By the above revision, the state budget for personnel expenditure for the hosptials could be declined and more budget could be allocated to support for vulnerable people such as the poor, ethnic minority and children.

5.5 Issues on Health Finance

The World Health Report 2010 clearly indicated that the mobilization of sufficient financial resources alone cannot ensure achievement of the UHC but it should be utilized efficiently and effectively. Through the Survey, it is suggested that there might be some issues on efficient and effective utilization of available financial resources.

(1) Optimization of Medical Service Provision

Fee-for-service payment system is popular at upper level hospitals. However, that system may lead to an unavoidable increase in health care costs as previously mentioned at Chapter 4.

As stated in 5.3.1(2), purchase costs of medicines give high burden on health expenditure. It seems to be caused by over prescription and tendency to avoid generic medicines. In addition, MOH reported that the fee-for-service payment system might lead unnecessary examination/ treatment to earn more profit [52].

To control the increasing health expenditure, it is recommended that medical services should be provided appropriately with avoiding over prescription and over treatment.

(2) Appropriate Control of OOP Payment

Increase of health care costs results increase in OOP payment. According to WHO, it is difficult to achieve UHC if the OOP payment accounts over 30% of total health care expenditure. Whereas, it is 58% in Viet Nam.

The higher OOP payment might cause the lower the possibility of financial risk management, i.e., people do not enroll to health insurance for future possible risk. Then, it makes more difficult for the poor to access to health services. In addition, OOP expences may lead households to cut expenditure for other necessary items such as food and education.

To achieve UHC, it might be necessary to reduce the proportion of OOP expenditure in THE up to 30-40% as recommended by WHO.

(3) Mid- and Long Term Health Finance Forecast

The Government indicates concrete objectives on health finance such as to raise the proportion of public health expenditure in the total to over 50%, to allocate 30% of the state budget for preventive medicine, and to allocate at least 10% of total state budget for health sector. Subjective data might be useful to monitor those progress and achievement, predict future needs for health finance, develop and revise relevant policies and strategies.

Chapter 6 Relevant Activities of Major Development Partners

In general, the World Health Organization (WHO) and the World Bank are the major partners in achieving universal health coverage (UHC) and health insurance. These donors provide technical support to develop relevant policies as well as financial support for the development of the health insurance system. Regarding social protection, there are informal donor groups[66] coordinating and collaborating relevant activities. Although some of these activities include the elderly as one of the target groups, any specific activity focused on the elderly has not been initiated. Currently, supports have been provided to conduct research on the elderly and dispatches missions of Vietnamese officials for them to learn relevant policies and activities related to aging in developed countries. However, it is noted that the HelpAge International (NGO) has been providing community programs involving the elderly as one of the main players of community development.

Relevant information on major development partners are summarized as follows.

(1) The World Bank

The World Bank provides financial assistance aiming to improve the coverage of health insurance and technical assistance for modification of the Law on Health Insurance in cooperation with WHO and other partners. A project for improvement of the payment system for medical services is also planned with the technical assistance of the United States Agency for International Development (USAID). It also supports the Joint Learning Network of nine countries[67]. Also assessment of divisional hospitals will be considered to improve quailty of services. Regarding cooperation for social assistance, it prioritizes the elderly and children. It has been supporting integration of social insurance (including pension) beneficialy data, awareness of the beneficialies, and pilotting of pension payment through post office.

(2) WHO

WHO has been providing technical assistance on health finance and health insurance from multiple dimensions including policy development, management of service providers, and hospital autonomy. Currently, it supports modification of the Law on Health Insurance, where the draft will be submitted in April 2014[68]. It also provides technical assistance for drug procurement system reform and development of human resources for health to achieve UHC. Technical support for the development of clinical guidelines of NCDs is relevant to aging. This will be initiated in 2014.

(3) International Labour Organization (ILO)

ILO is assisting MOLISA for policy implementation, monitoring and evaluation of social protection and pension system, as well as pension system reform including modification and development of relevant legislations[69].

[66] The group co-chaired by GIZ and UNICEF. The members are UNDP, AusAID, Irish Embassy, and Spain Embassy.
[67] The nine countries are Viet Nam, Ghana, Mali, Nigeria, Kenya, India, Indonesia, the Philippines, and Malaysia. (http://jointlearningnetwork.org/)
[68] Refer to Chapter 4
[69] Refer to Chapter 3

(4) United Nations Population Fund (UNFPA)

UNFPA has been supporting research activities on the elderly and aging as well as conducts relevant seminars. It also provides financial assistance for the Intergenerational Self-Help Club (ISHC) conducted by HelpAge International.

(5) Asian Development Bank (ADB)

To improve access to health services in remote areas, it has been supporting to upgrade Commune Health Center (CHC), District and Provincial Hospitals, health human resource development and outreach services in 5 provinces in Central Highland. Assistance for human resource for health will be commenced from 2016 [55].

(6) Bilateral Donors

GIZ assisted in the establishment of the social security strategy in 2012 based on accumulated experiences since 2008 through its poverty alleviation programs. As the program shifted its focus to social protection since 2010, the strategy prioritizes social protection and the vulnerables (women, the minority, and the poor). A pilot project has been conducted in Thanh Hoa Province to introduce community-based microinsurance to cover miscellaneous health expenses not covered by the health insurance such as transportation.

The Korean government has provided financial assistance to the ASEAN programs on aging and HelpAge International (see (7) below). The Korean International Cooperation Agency (KOICA) will provide assistance for policy development and management of health insurance [56].

(7) Non-Governmental Organizations (NGOs)

NGOs have been providing grastoors level assistance such as community empowerment focusing on the elderly and providing welfare tools such as wheel chairs. Also, the International Federation on Aging (IFA) facilitate concerned ortanizations to share information and experiences[15].

HelpAge International has the headquarters in London and established Hanoi office in 2011. The goal of their activities is to be able to contribute to society while respecting the elderly. There are currently 11 staff, and they cooperate with VAE through support of policy decisions, as well as supporting decisions on laws for the elderly and elderly national activity programs for MOLISA, and preparing Viet Nam country reports.

They are currently developing intergenerational self-help clubs (ISHCs) that leverage self-help for the elderly, based on a style of thinking which says that focusing on a community base of prevention and care is more effective and has a lower cost than establishing institutions for the elderly (see Section3.5.4).

Chapter 7 Conclusion

All the information collected were integrated and analyzed to draw issues in the social security sector in Viet Nam. The roadmaps are suggested to have a holistic approach for medium term. In addition, relevant Japanese experiences were introduced. These might contribute in providing an inspiration and/or technical assistance to incorporate necessary activities in the roadmaps.

7.1 Issues in the Social Security Sector, especially on Aging and Health Insurance, in Viet Nam

Table 7-1 shows a summary of the issues drawn by the Survey. In general, relevant policies and legislations have been developed. However, these seemed to have not been well implemented because there are insufficient practical guidelines or understanding at the operational level. Thus, these might affect the service providers and users.

The Survey Team found that necessary data on the eldery and health insurance are collected sofar. However, routine statistics has not been compiled and the Survey Team could obtain limited subjective data. As such routine statistics will contribute to provide policy evidence and monitor its progress, it might be reccomended to develop routine statistics system in future.

Table 7-1 Situation Analysis on Aging and Health Insurance in Viet Nam

	Aging	Health Insurance
Policy	- Policy and legislations have been developed. - However, the number of legislations is so many and not systemized that the concern might be on the consistency of each other. - Policy evidence such as national statistics or large-scale regular survey on the elderly and health insurance has not been established. This might also be useful for monitoring.	- Categorization of the beneficiaries is too complicated. - Drug price is not controlled by the government and therefore, could be unbounded.
Implementation	- Implementation guidelines and/or standard of services/facilities are not sufficiently provided. - Concrete and standardized guidelines pertaining to geriatrics in the hospitals and educational institutions have not been developed. - Routine statistics or survey on the elderly and aging are not available. - Geriatric care management is not less prioritized than other health issues such as maternal and child health especially at the local level. - Local government does not ensure sufficient human resource and/or budget in the implementation of the policy on the elderly. - Management system of pension and other allowances for the elderly is not sufficiently developed. - It is projected that social protection fund will run out because of unpaid premiums.	- Compulsory scheme has covered most of the targets. - List of insured services has not been reviewed based on changing health needs. - Payments to health facilities are sometimes delayed because invoicing, examination, and payment procedures are not efficient. - Although user data has been collected, it is not effectively analyzed and utilized. - Use of health facilities is not flexible for the patients. - Double registrations have been observed because unified database is not available.

		Aging	Health Insurance
Providers	Service	- Human resources who have knowledge and skills about elderly care are not sufficient. - Private facilities do not have sufficient support and supervision from the government. - Needs for elderly care services and necessary human resources have been increasing.	- As more patients bring more benefits, hospitals tend to have as many patients as possible even if they experience over capacity, and provide overmedication. - Lower level hospitals tend to avoid patient referrals to upper level hospitals because they will have to pay for the medication costs of the referred patients.
	Users	- Generally, home-based care by family members, especially women, is valued and there is a negative perception in relying on external service providers. - However, the needs for external service providers on elderly care have been increasing because of economic constraints, personal relationship, and changing family values.	- Generally, people prefer top referral hospitals than district hospitals nearby because lower level hospitals are not providing quality and reliable services. - People with no health problems tend to hesitate to have health insurance. - The rich self-employed people tend not to have public health insurance but prefer to have private insurance. - Especially in the remote areas, physical access to health care affects the willingness of people from using the health facilities because the patient and his/her family will be burdened with transportation costs.

7.2 Roadmaps for Mid-term Development of the Social Security Sector

7.2.1 Logic Models

To prepare the roadmaps, the Survey Team developed two logic models, i.e.,, dealing with aging and achieving universal health insurance.

Figure 7-1 presents the logic model in dealing with aging based on the active aging model recommended by WHO. Aging should be dealt with multisector participation to protect the elderly from various risks and to improve their quality of life. Among six determinants, four of them, such as health and social services, economic, social and physical determinants, should be handled by the government. Some factors, including behavioral and personal determinants, could be approached through social and health services. Gender, as a cross-section issue, should be considered to fill the economic gap in pension. Another cross-section issue, culture, should be observed from a viewpoint of family value and family structure which might be changed in the future.

To develop the necessary policy/program, subjective and systematic situation analysis should be done to predict the future aging population in Viet Nam. Therefore, an implementation manual should be developed and extended at the operational level to deliver effective programs.

As non-communicable diseases (NCD) incidence tends to increase among the eldery, geriatric departments should be introduced both in the hospitals and educational institutions armed with concrete technical guidelines. These are stated in the government action plans. In addition to curative services, prevention of NCD and physical/functional disability will be important so as to avoid explosion in medical costs. Also, the pension system should be reformed to unify the management of beneficiaries in order to make the system efficient and to ensure premium collection and benefit payments. Regarding

home-based care, external support system for family members should be established, such as nursing facility and skilled human resources.

Pension system could be improved by the integration of data of beneficiaries. And it will contribute to providing the economic stability of the elderly. Regarding social determinants, support system for families should be included in home-based care for disabled elderly people. It is also necessary to develop facility standards for the protection of the elderly against fall which would affect their quality of life. Also, the development of elderly care facilities should be prepared for the increasing needs in the future.

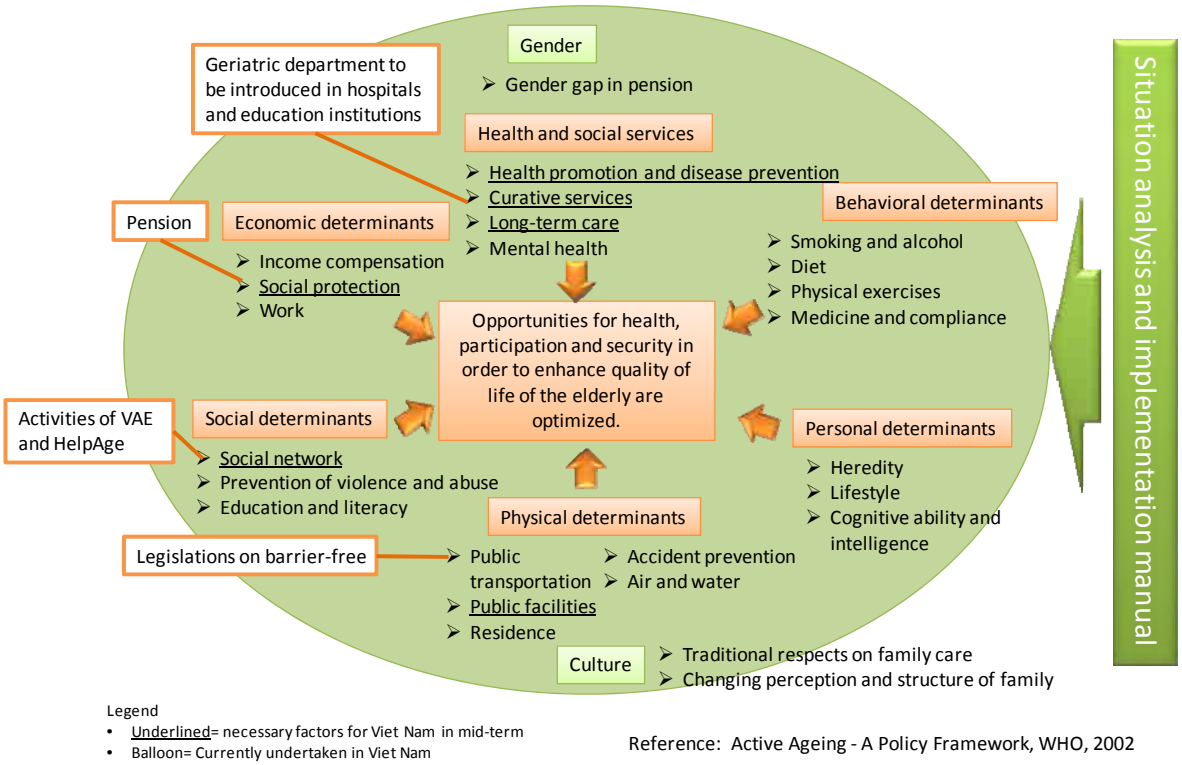


Figure 7-1 Logic Model to Deal with Aging

Health insurance is regarded as one of the important factors to achieve universal health coverage (UHC). As shown in Figure 7.2, three stakeholders, insurers, service providers and service users should play their respective roles to improve health insurance system. For that, the Law on Health Insurance should be revised as planned to expand coverage. Regarding the scheme design, the categorization of beneficiaries should be simplified and the inspection system should be made more efficient for timely and appropriate payments.

Improvement of the inspection system could also contribute to controlling medical expenses to avoid overmedication. In addition, some measurements are necessary to reduce overloading in state hospitals and promote the participation of private hospitals. High-cost medical care benefits could be considered when the curative services are more advanced in the future. To increase and maintain coverage and appropriate premium collection, some penalty for unpaid premium or linkage with tax collection system might be effective.

Most of the compulsory and subsidized groups have already been covered, therefore, it is important to understand how the government could make the voluntary group be interested in public health insurance. This could be one of the solutions to expand the coverage of public health insurance to private hospitals, where the rich people prefer to seek medical care.

To expand the coverage of public health insurance to private health facilities, benefits of the public health insurance should be strengthened and reliability of Vietnam Social Security (VSS) should be improved. With this move people might be encouraged to enroll in public health insurance. In order to improve the remuneration payment to health facilities, operations in invoicing, examination, and payment procedure should be more efficient and transparent. This might lead the health facilities to enter into a contract with VSS. In that case, the beneficiaries can receive quality health services in the convenient facilities at reasonable cost.

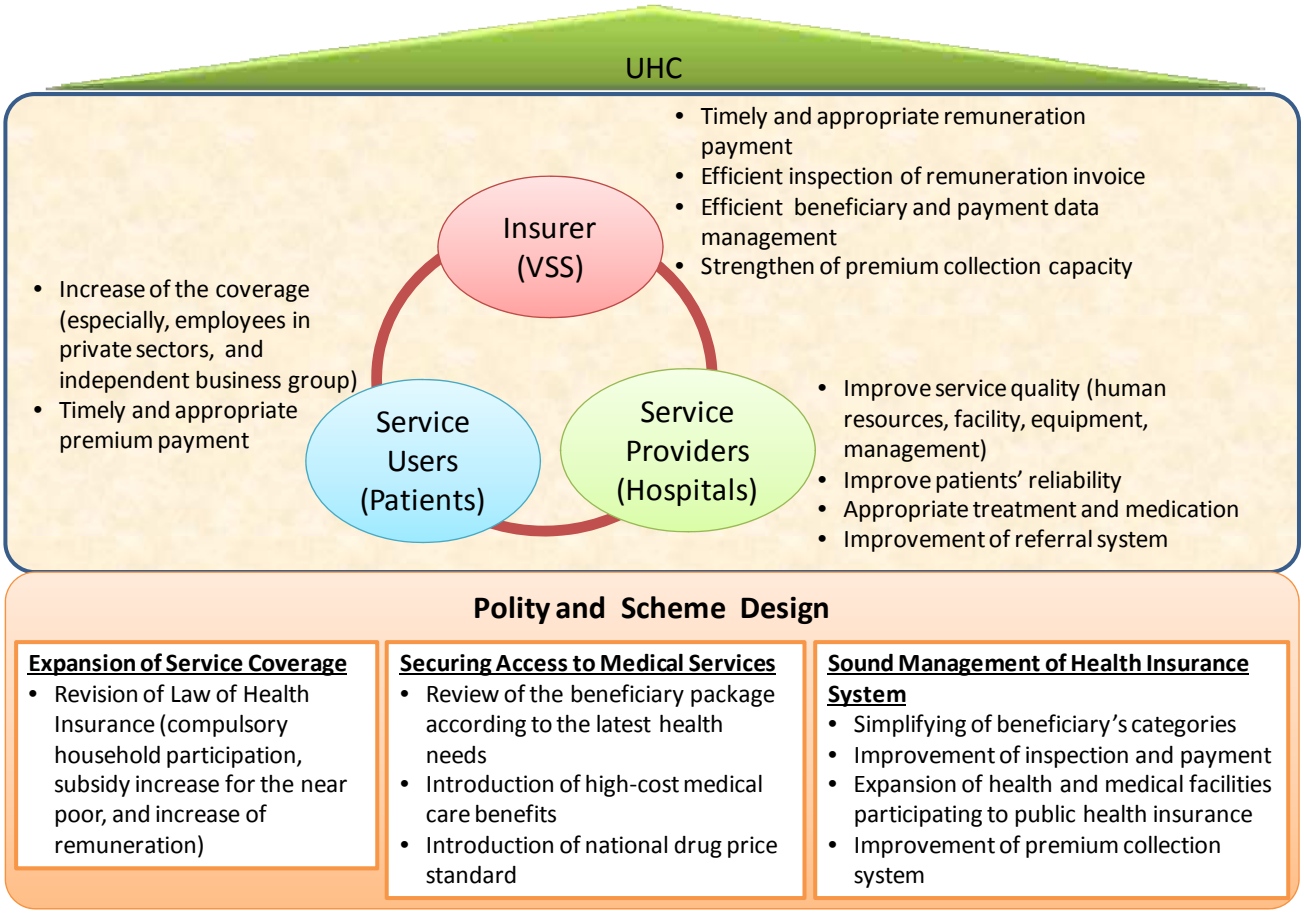


Figure 7-2 Logic Model to Achieve Universal Health Insurance

In addition, service improvement in lower level facilities is essential in order to increase the reliability of public health services to the people. This depends on various factors such as the facility, equipment, human resources, and physical access. The government has been dealing with it for a long time, also it was under the Socio-Economic Development Strategy (SEDS). Upgrading of such lower level hospitals might aid to mitigate the overload of top referral hospitals and increase health insurance coverage.

7.2.2 Proposed Road Maps

Table 7-2 and 7-3 present the proposed road maps in preparation to aging and achieving universal health insurance, respectively. The activities to be delt with the Vietnamese government are prioritized in accordance with the survey results and categorized short, mideam and long term ones.

Based on the aging rate, the current situation of Viet Nam could be considered close to the period from the late 1960s to 1970s in Japan, but compared to Japan at that time, the growth of aging rate was faster, but the GDP growth rate was predicted as lower. Therefore, it can be said that Viet Nam is getting old before it becomes rich.

In order to provide for the elderly welfare and medical expenses that are expected to increase in the future, necessary actions should be completed by 2020, the target year of SEDS. In that case, continous monitoring of the implementation programs should be done. Through monitoring, necessary modifications, and improvement could be carried out in a timely manner. Primarily, it would be essential if modification of the Law on Social Insurance and the Law on Health Insurance could progress successfully and brought into the operation with practical instruction and manuals.

Table 7-2 Proposed Roadmap for Aging in Viet Nam

Term	Activities	Relevant Activities
Short term (2015)	**Policy** - Systemize and integration of existing policy and legislations	MOLISA, GIZ (revision of social protection policy)
	- Awareness rising on importance of dealing with aging for stakeholders at central and local governments and concerned agencies	-
	- Revision of Law on Social Insurance	MOLISA、ILO、GIZ
Mid term (2020)	**Policy** - Development and extension of policy implementation manual and guideline - Large scale data collection survey on aging - Forecasting of aging, medical and welfare needs and public expenditure based on the survey results - Identifying of scale and source of finance - Development of monitoring system on policy implementation	-
	Health and Social Services - Introduction of geriatrics department to state and provincial hospitals - Introduction of geriatrics to faculties of medicine and nursing - Strengthening of disease prevention and expansion of preventive long-term care for the elderly	MOH circular No. 35 World Bank / AHP
	- Development of facility and service standard of elderly homes and supervision system at provincial/ city level	-
	Economic Determinant - Integration of beneficiary information system - Improvement of benefit payment system	GIZ
Long term (2030)	**Policy** - Introduction of aging-related items to existing information management system and regular statistics - Review of strategy, financial plan and resources according to the latest situation of aging	-
	Health and Social Services - Introduction of long-term care to nursing department	Da Nang Technical University of Medicine and Pharmacy
	- Introduction of support for long-term care to scope of work of community health nurses	-
	Social Determinants - Development of human resources for home-based care support at community level such as village health worker - Establishment of community support system for home-based care	HelpAge

Table 7-3 Proposed Roadmap for Health Insurance Improvement in Viet Nam

Term	Activities	Relevant Activities
Short term (2015)	**Policy** - Systemizing of existing policy and legislations	MOH, WHO
	Scheme Design - Revision of the Law on Health Insurance ・ Compulsory household participation ・ Increasing of subsidy for the near-poor and students ・ Increasing of remunerations ・ Increasing of responsibility of local governments	MOH, WHO, Korea
	Service Providers - Allocation of health human resources to difficult areas	MOH
Mid term (2020)	**Policy** - Development and extension of policy implementation manual and guideline - Forecasting of future budget scale for government subsidy for premium and if necessary, review financial sources and criteria	-
	System Design (Expansion of Service Coverage) - Achievement of 80% coverage	MOH
	Scheme Design (Securing Access to Health Services) - Development of technical standard of insured health services	-
	- Review of list of beneficially package - Situation analysis on health problem and services and projection of future health needs in each region	MOH -
	Scheme Design (Sound Management of Health Insurance System) - Improvement of remuneration payment system	World Bank, USAID
	- Review on beneficiaries' categories - Strengthening of supervision capacity of local governments	-
	Insurer - Increasing efficiency of inspection and payment system	VSS
	- Strengthening of beneficiary management system - Capacity strengthening on inspection and premium collection	-
	Service Providers - Improvement or upgrading of district hospitals - Improvement and strengthening of referral system	-
Long term (2030)	**System Design (Expansion of Service Coverage)** - Promotion of participation of private hospitals to public health insurance system **System Design (Securing Access to Health Services)** - Preparation of regional health service development plan based on the situation analysis and projection - Study on high-cost medical care benefits - Study on national drug price standard - Reduce congestion of patients at top referral hospitals **Service Providers** - Quality improvement of medical and patient services at district hospitals	-

7.3 Relevant Experiences in Japan

Japan had experienced a rapidly aging population, population influx to urban areas, and respect to home-based care by family members in the 1970s. These experiences are similar to the current situation in Viet Nam. In Japan, GDP per capita in 1977, when the aging rate was over 8%, was USD 6,000, and

universal health insurance had been achieved. Also, the health service network had been expanded even in the rural areas. While in Viet Nam, GDP in 2020 will be less when the aging rate will be at the same level.

(1) Health and Welfare Services for the Elderly

In 1973, free medicines for the elderly encouraged old people to seek medical care in health facilities. They developed some hesitation to go to the hospitals that prioritized younger generations[58]. While, the health facilities require them to undergo extensive examination and treatment that results to unnecessary visits of the patients, the national health expenditure grew 36.2% in 1974. Since then, aging in Japan progressed so rapidly that health expenditure for the elderly pressured the national health finance. Therefore, the elderly health system was introduced in 1983 to let the elderly care be part of the medical costs[59]. From these experiences, various efforts have been taken to reduce health expenditure such as improvement of the inpatient system, prioritizing home-based care, and prevention of diseases, disability, and dementia[60].

Regarding welfare, nursing facilities and services have been expanded under the Gold Plan (1989) and New Gold Plan (1994). However, as the aging progressed more than the projection, the long-term care insurance was introduced in 2000 to involve the private sector and enhance home-based care to socialize the elderly care. Currently, Japan is still facing various issues. The long-term care insurance has been deteriorating every year and it caused a sharp increase in the premium. Social culture has also been changing that human relationship has been diluted and community support has been difficult to provide. To deal with these issues, it has been promoting “complehensive community care” which involves local government, health and welcfare service providers, and volunteers to encourage the edlerly and his/her family to design support services which they receive according to their preferences and situation.

(2) Health Insurance

Table 7-4 summarizes the history of health insurance in Japan. Universal health insurance was achieved in 1961. Japanese health insurance system has the following characteristics:

Table 7-4 History of Health Insurance in Japan

Year	Events
1905	Medical benefits started as part of the Civil Servants Association support.
1922	Health Insurance Law is based on the German model that both employee and employer operate the health insurance body.
1938	National Health Insurance Law
1943	Coverage of health insurance was achieved at 70%.
1958	National Health Insurance Law was reformed – compulsory participation
1973	Free medicine for the elderly (70 and over), set ceiling of OOP for high cost medical care
1983	OOP of the elderly was introduced.

Source: *Nihon no kaihoken seido no hensen, seika to kadai* [61]

- Both employee insurance (operated by the company) and local insurance (operated by the local government) were established. Local insurance involves the self-employed group.
- Compulsory participation is applied to household members.

- Public health insurance was applied to both public and private health facilities with the same remuneration system.
- Out-of-pocket (OOP) is 30% expected for the elderly and children and it has a ceiling. When the medical costs exceed the ceiling, the local government will provide the subsidy.

Since 1966, usage of health services had been increasing and health expenditure had been soaring, accordingly. These were immaterial before the economic crisis in 1973 as the economic growth had also been increasing rapidly. The low birth rate and longevity have been affecting the financial status of the health insurance fund and government subsidy has been increasing. Although the elderly insurance system was introduced to solve the situation, it made premium collection and fund management system complicated and operation cost has been increased. In addition, there are many insurers[70] and premium rate varies among them.

Since 2000, due to reduce medical costs and financial burden of the government, the remuneration system has been reformed several times, OOP has been increased and the former and old health care system was introduced. However, the national health expenditure has been increasing and was reported at USD 340 billion in 2009 [61].

7.4 Possible Strategies of JICA's Cooperation

From the proposed roadmaps (Section 7.2) and Japanese experiences (Section 7.3), the following strategies might be suggested for future cooperation on the social security sector.

(1) Aging

In prior to determine the detailed cooperation program, it could be suggested to implement nationwide situation analysis and master planning to review existing policy and legislations based on subjective evidences such as large survey on the eldery and relevant services. As there are geriatrics departments in several hospitals in Japan, it may be possible to provide technical assistance for human resource development in order to provide medical care for the elderly and to develop the technical guidelines needed for the geriatric departments in the hospitals. Also, Japanese experiences in NCD prevention could be referred to decline disease burden of the elderly in Viet Nam in the future. In addition, Japan had experienced in the involvement of the private sector in elderly care services both in facility-based and home-based.

(2) Health Insurance

It might be useful to share Japanese experiences in terms of household enrollment, remuneration examination and payment system, and holistic approach to achieve universal health insurance. Also, technical support could be possible to improve the effectiveness of operation and management of the system.

[70] Insurer is one in Korea and Viet Nam.

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Attachment 1 : Field Survey Itinerary and List of Interviewees

Attachment 1-1：Field Survey Itinerary

(1) First Field Survey

Date	Task
5 Jan.	Arrive at Hanoi
6	JICA, Japanese Embassy, Medical Service Administration (MSA) - Ministry of Health (MOH)
7	Health Insurance Department and Health Finance Department - MOH
8	Ministry of Labour, Invalid and Social Affairs (MOLISA)、Vietnam Social Security (VSS)
9	World Bank (social security), World Health Organization (WHO), GIZ Move to Ho Chi Minh
10	Ho Chi Min City Department of Labour, Invalid and Social Affairs (DOLISA), Social protection center (elderly)
11	
12	
13	Cho Ray Hospital, Ho Chi Minh City Social Security (SS) Move to Hanoi
14	Bach Mai Hospital, Vietnam Association of the Elderly (VAE), United Nations Children's Fund (UNICEF), Hanoi Medical University, JICA Move to Nam Dinh
15	Department of Health (DOH), DOLISA, VSS and Provincial Hospital in Nam Dinh
16	Provincial Hospital, Mai Cau Hospital, Da Bac Hospital Move to Hoa Binh
17	DOH, VSS, and DOLISA in Hoa Binh
18	
19	
20	HelpAge International, ILO, Vietnam National Committee on the Aging (VNCA), National Geriatric Hospital
21	Administration of Science and Technology Training (ASTT) and General Office of Population and Family Planning – MOH, Japanese Embassy Leave Hanoi

(2) Second Field Survey

Date	Task
16 Feb	Arrive at Hanoi
17	JICA, JICA Projects, World Bank (Health Finance)
18	Private Hospitals
19	Documentation, Team Meeting
20	Ministry of Planning and Investment (MPI), Ministry of Finance (MOF), MSA and Administration of Preventive Medicine - MOH
21	International Cooperation Department (ICD) – MOH, Private elderly home, Commune Health Center in Nam Dinh Province
22	
23	
24	HelpAge International (Project site in Hai Duong Province), JICA
25	JICA
26	Team Meeting
27	National Economic University, Japanese Embassy, JICA
28	Leave Hanoi

Attachment 1-2：List of Interviewees

Organization	Interviewees
Japanese Embassy	・ Yoko Tsuruya, First Secretary
JICA Viet Nam	・ Fumihiko Okiura, Senior Representative ・ Ai Miura, Senior Project Formulation Advisor ・ Ms. Chu Xuan Hoa, Senior Program Officer ・ Ms. Dao Thi Khanh, Program Officer
Project for Improvement of the Quality of Human Resources in Medical Services System, JICA	・ Toshiyasu Shimizu, Chief Advisor
Project for Strengthening Medical service in Northwest Provinces, JICA	・ Masahiko Doi, Chief Advisor ・ Miho Kyoguchi, Project Coordinator ・ Yumiko Haneishi, Technical Advisor
Ministry of Health (MOH)	
Department of Health Insurance	・ Le Van Kham, MD.MA, Deputy Director ・ Phan Van Toan
Department of Planning and Finance, MOH	・ Hoang Kim Ha, MSc. HE, Chief of General Plan and Health Policy Division
Medical Service Administration	・ Dr. Nguyen Trong Khoa, Deputy Director General, MSA (Medical Service Administration) ・ Ths. Bs. Nguyen Thi Thanh Ngoc, Director ・ Bs. Nguyen Thanh Tung, Head of Elderly Division ・ Ms. Tran Thi Ha, Head of Health Professional Management division (License) ・ Mr. Cao Die Phuong, Medical and Pharmaceutical Division (Hospital Management)
Administration of Science, Technology and Training	・ Dr. Nguyen Minh Loi, Deputy Director General ・ Dr. Nguyen Viet Cuong, Head, Education Management Division ・ Thi Kim Thuy, Official, Education Management Division ・ Thi Kim Thanh, Deputy Head
General Office of Population and Family Planning	・ Nguyen Xuan Truong, Deputy Director General, Population Constituent and Quality Department ・ Le Minh Hai, Deputy Director General, Planning and Finance Department ・ Pham Anh Ngoc, Official, Population Constituent and Quality Department ・ Tran Duc Quang, Official, Population Constituent and Quality Department ・ Tran Thi Quynh Mai, International Cooperation Official, Personnel Department.
Administration of Preventive Medicine	・ Dr. Hoang Minh Duc, Head of Planning and Finance Division ・ Dr. Phan Tien Hung, Planning and Finance Division ・ Dr. Vu Vi Quoc, Planning and Finance Division
International Cooperation Department	・ Dr. Tran Thi Giang Huong, MD, MPH, PhD
Ministry of Finance (MOF)	
	・ Tran Thi Phuong Linh, Official, Dept. of Public Expenditure ・ Phuong Thao, Official, Dept. of Public Expenditure ・ Nguyen Thi Lan Phuong, Official, Dept of State Budget ・ Vuong Doan Trung, Official, Dept. of State Budget
Ministry of Planning and Investment (MPI)	
	・ Nguyen Tuong Son, Deputy Director, Department of Labour, Culture and Social Affairs (DLCSA) ・ Pham Lan Phuong, Official, DLCSA ・ Pham Thi Ha, Official, DLCSA

Organization	Interviewees
Ministry of Labour, Invalid And Social Affairs (MOLISA)	
International Cooperation Department	・ Cao Thi Thanh Thuy, Deputy Director General ・ Vu Lan Huong, Director-Bilateral Cooperation Division
Department of Social Protection	・ To Duc, Director of Social Work/ Activity Division
Department of Social Insurance	・ Pham Truong Giang, Deputy Director General
Institute of labor Science and Social Affairs	・ (n.a.)
Vietnam Social Security (VSS)	
International Cooperation Department	・ Nguyen Vinh Quan, Director ・ Tran Thi Thu Tra, Head of General Issue, ASEAN Division
Social Insurance Implementation Department	・ Dieu Ba Duoc, Director
Department of Health Insurance	・ Le Van Phuc, MD, MPH, Deputy Director ・ To Hong Luong, IT Division ・ Nguyen Thanh Ha, Appraisal Division
Donors/ Development Partners	
GIZ	・ Brigitte Koller, Chief Technical Advisor, Social Protection Project ・ Nguyen Thi Nga, Project Manager, Social Protection Project ・ Sandra Uyen Nguyen, Intern
The World Bank	・ Nga Nguyet Nyuyen, Senior Economist ・ Kari L. Hurt, Senior Operations Officer, Human Development Sector Unit
WHO	・ Dr. Socorro Escalante, Technical Officer, Pharmaceutical ・ Ngyen Kim Phuong, National Professional Officer, Health Financing ・ Benedicte Galichet, Advisor, Donor Coordination/ Health System
UNICEF	・ Ms. Yoshimi Nishino, Chief, Social Policy and Governance Program
ILO	・ Gyorgy Sziraczki, Country Director ・ Doan Thuy Quynh, Programme assistant
HelpAge International Vietnam	・ Ms.Tran.Bich Thuy, Country Programme Manager
Hanoi City	
Vietnam National Committee on Ageing Office (VNCA)	・ Le Minh Giang, Director of the Office
Bach Mai Hospital	・ Do Doan Loi, Deputy General Manager/ Head of Cardiosurgery ・ Do Van Thanh, Head of International Cooperation Division ・ Nguyein Thi Kim Thanh, Deputy Head of Financial and Planning Division ・ Dinh Kim Chi, General Affairs Department ・ Tran Thai Son, In-charge of Health Insurance, General Affairs Department
National Geriatric Hospital	・ Pham Thang, Director ・ Tran van leic, Head of General Planning Department ・ Nguyen Thi Ngoc, Head of Nursing Department ・ Nguyen Thu Hoai, Department of Training & Scientific Research
Vietnam Association for the Elderly	・ Dinh Van Lanh, Committee Member, Head of VAE Office ・ Nguyen Thi Kim Lien, Deputy Head, Elderly Care Department ・ Duong Viet Anh, Official, International Cooperation Department ・ Dang Tai Tinh, Head, International Cooperation Department
Hanoi Medical University, EVIPNet Secretariat	・ Dr. Le Van Hoi, Professor/ EVIP Net Coordinator/ Head of Central Health Information Technology Institute
French Hospital	・ Nguyen Thi Phuong Chang, Japanese Customer Care Executive
Hong Ngoc Hospital	・ Nguyen Ngoc Long, Van Tuan Nhat, Managing Director
National Economic University	・ Giang Thanh Long, PhD, Associate Professor

Organization	Interviewees
Ho Chi Minh City	
Department of Labour, Invalid And Social Affairs (DOLISA)	・ Nguyen Thi Tuyet Nhung, Vice Director ・ Vu Dinh Son, Head, Health Division ・ Vo Minh Hoang, Deputy Head, Social Protection Division ・ Le Chu Giang, Head, Social Protection Division ・ Nguyen Thi Phuong, Official, Social Protection Division ・ Huynh Khac Hieu, Deputy Head, Policies For People With Meritorious Services Division
Thi Nghe, Old People's Home	・ Ngo Thi Van Anh, Vice Director ・ Le Thi Kim Hanh, Head of Logistic Division ・ Duong Van Tuoi, Deputy Head, Health Division ・ Nguyen Thi Bich Tranh, Deputy Head, Personnel and Administration Division ・ Le Thi Mai, Official, Medicine/Drug Management
HCM VSS	・ Ms. Luu Thi Thanh Hyuen, Deputy Director (Health Insurance) ・ Ms. Do Thi Thy Hong, Deputy General Manager, Health Insurance Certification Department I (Pharmacist) ・ Ms. Tran Ngoc Giao Chau, Deputy General Manager, Social Insurance Premium Collection Department
Cho Ray Hospital	・ Head of International Affairs Division, Health Care Department/ Head of Optional Medical Service ・ Huynh Kim Phuong, Head, International Affairs Division, Health Care Department/ Optional Medical Service Division ・ Hai, Head of Accounting Division, Financial Department
Nam Dinh Province	
Department of Health (DOH)	・ Bui Thi Minh Thu, Director ・ Truong Tien Lap, Vice Director ・ Do Ngoc Dung, Head, Planning and General Affairs Division ・ Khuong Thanh Vinh, Head, Medicinal Professional Division ・ Tran Bich Lien, Deputy Head, Medicinal Professional Division ・ Tran Thu Huong, Deputy Head, Finance and Accounting Division ・ Doan Thi Nga, Head, DoH Office
DOLISA	・ Le Hong Lam, Head, Social Protection Division ・ Do Thi Lan Huong, Deputy Head, Social Protection Division ・ Ha Duc Hoang, Official, Services for Elderly
Nam Dinh VSS	・ Nguyen Luong Ba, Vice Director） ・ Tran Ngoc Hoa, Deputy Head, Health Insurance Appraisal Division ・ Duong Cong Hai, Deputy Head, Social Insurance Benefits Division ・ Nguyen Thuy Duong, Deputy Head, Planning and Finance Division ・ Hoang Thi Minh Thuy, Deputy Head, Collection Division ・ Trinh Van Anh, Deputy Head, Personnel and Administration Division
Nam Dinh General Provincial Hospital	・ Pham Thanh Nam, Vice Director ・ Tran Minh Chau, Head, Planning and General Affairs Division ・ Tran Thi Minh Ha, Deputy Head, Planning and General Affairs Division ・ Hoang Thu Hong, Deputy Head, Finance and Accounting Division ・ Bui Thi Thanh Thuy, Deputy Head, Administration Division

Organization	Interviewees
Hop Hung CHC, Vu Ban District	・ Bui Xuan Binh, Official, Nam Dinh DOH ・ Pham Van Hien, Director, ・ Vu Ban District Health Center ・ Nguyen Van Khanh, Director, Hop Hung CHC ・ Pham The Quyet, Acc. Doctor ・ Vu Ban District Health Center ・ Nguyen Thi Lan, Acc. Doctor, Hop Hung CHC ・ Do Thanh Hoa, Nurse, Hop Hung CHC ・ Duong Thi Lien, Acc. Doctor, Hop Hung CHC ・ Nguyen Thi Nguyet, Nurse, Hop Hung CHC ・ Tran Thi Ngoc, Midwife, Hop Hung CHC
Hoa Binh Province	
Hoa Binh Hospital	・ Hoang Dinh Khieu, Vice Director ・ Do Dinh Van, Vice Director ・ Chu Thi Hoai, Deputy Head, Planning and General Affairs Division ・ Nguyen Thi Thuy, Head, Pharmacy Division ・ Dang Van Nam, Official, DOHA office ・ Nguyen Thi Yen, Deputy Head, Finance and Accounting Division
DOH	・ Bui Thu Hang, Vice Director ・ Tran Hong Quan, Head, Medicinal Professional Division ・ Nguyen Thi Thu Hien, Official, Medicinal Professional Division
Mai Chau Hospital	・ Pham Van Cuong, Director ・ Tran Thu Hong, Head of Finance and Accounting Division
Da Bac General Hospital	・ Dr. Thi, Director
DOLISA	・ Dang Xuan Tuu, Head, Social Protection Division ・ Tu Thi Kim Nhung, Deputy Head, Social Protection Division
Hoa Binh VSS	・ Dr. Luu Viet Tinh, Director ・ Nguyen Thi Thuy, Head, Planning and Finance Division ・ Doan Duc Thang, Deputy Head, Health Insurance Appraisal Division ・ Trinh Tuyet Nhung, Deputy Head, Health Insurance Appraisal Division ・ Nguyen Van Hai, Head, Social Insurance Benefits Division
Dien Bien Province	
Dien Bien Province General Hospital	・ Pham Van Man, Director ・ Vo Thi Ninh, Vice Head, Planning and General Affairs Division Le Thi Thanh, Head, Finance and Accounting Division ・ Le Quoc Khanh, Head, Medicine material and equipment Division ・ Dang Duc Hung, Head, Personnel and Administration Division ・ Nguyen Thi Phuong, Head, Nursing Division
DOH	・ Luong Duc Son, Vice Director, DB DOH ・ Nguyen Chau Son, Vice Head, Medical Profession ・ Nguyen Hong Thanh, Vice Head, Planning and Finance
Dien Bien District Medical Center	・ Ca Van Noi, Director, Dien Bien District Medical Center ・ Luong Hau Tan, Vice Director ・ Hoang Van Chuong, Vice Director ・ Vo Thi Thanh Mo, Head, Nursing Division
Thanh Luong CHC	・ Do Thi Toan, Head of CHC
DOLISA	・ Ha Van Tan Vice Director, DOLISA ・ Phane Quang Hung, Vice Head, Invalid/ Martyr and Social Protection Policy Division ・ Le Thi Huong Lan, Official, Policy Division

Organization	Interviewees
	・ Nguyen Manh Dung, Vice Director, Dien Bien SS ・ Luu Thi Quy, Vice Director, Dien Bien SS ・ Tran Thi Thu, Head, Collection Division ・ Tran Thi Phuong, Head, Health Insurance Appraisal Division ・ Pham Manh Dang, Vice Head, Card/handbook Issuance Division ・ Nguyen Thi Ngoc, Vice Head, Planning and Finance Division ・ Tran Thi Hong Gam, Vice Head, Personnel and Administration Division
Hai Duong Province	
Hai Duong Province (HelpAge Project)	・ Nguyen Ngoc Truyen, Chairman, People Elderly Association (PEA) ・ Nguyen Thi Lien, Vice Chairwoman, (PEA) ・ Nguyen Thi Huyen, Head of Social Protection Division, Hai Duong DOLISA ・ Nguyen Trung Hieu, DOH Project Coordinator (funded by UNFPA) ・ Nguyen Thi Muoi, Vice Chairwoman, (PEA) ・ Dam Trac, Reporter, Hai Duong Television Station

Attachment 2 : Record of Seminar on Universal Health Coverage and Aging Population

Record of
Seminar on Universal Health Coverage and Aging Population
at Hanoi

13:00 – 17:30, 21th April 2014

1. Agenda:

(1) Seminar Purpose and Participant Introduction:	Organizer
(2) Opening speech of the Chair:	Assoc. Prof. Pham Le Tuan, Vice Minister of Health
(3) Opening speech of the Co-chair:	Mr. Chikahiro Masuda, Senior Representative, JICA Vietnam.
(4) Presentation on JICA survey's findings:	Ms. Keiko Nagai, Team Leader of Consultant Team
(5) Progress of Aging Policies of Japan & Promotion of "Active Aging" in ASEAN countries:	Dr. Yutaka Horie, Deputy Assistant Minister for International Affairs, Minister's Secretariat, Ministry of Health, Labor and Welfare of Japan
(6) Aging Population in Vietnam - Current situation, challenges and solutions:	General Office of Population and Family Planning
(7) Health Insurance - Japan's experience and Challenges:	Prof. Takahiro Eguchi, Professor of Law, Kanagawa University, Faculty of Law
(8) Vietnam challenges in achieving UHC by 2020:	Health Insurance Department, Ministry of Health
(9) Open Discussion:	All participants
(10) Conclusion and Closing:	Chair and Co-chair

2. Summary of Open Discussion

(a) Ms. Kha from Vietnam National Assembly

Ms. Kha visited Japan twice, one of which to attend a workshop chaired by former PM Fukuda. She was very impressed with what she learnt in Japan, such as mandatory health insurance, family based health insurance (both the employer and employee contribute to purchase health insurance for employee's family)

Ms. Kha is concerned about the current requirement that initial medical examination must be done at lower level health stations, because it is conflicting with the freedom on health care and medical treatment. However, if not, then patients would concentrate at central hospitals and overload these hospitals. So allowing the patient to freely receiving medical service at good facility is preferred by both the State and the citizens, but Vietnam has not been able to solve this problem.

Regarding the UHC, currently 70% has health insurance, but it is still difficult to cover those who are partially covered by the government such as near poor or agricultural households. For example, the near poor families receive 70% of health insurance fee, but it is difficult for them to pay the rest 30% if there is no other source of support.

Regarding elderly care in Japan, she was impressed that within 30 minutes care (even meals) can be given even to those living area accessed through narrow streets by non-profit social enterprises. However, this is difficult in Vietnam because they will have to access through springs/river in case they live in faraway area.

However, Vietnam would want to have the service level of Japan, and she and her colleagues are brainstorming on these issues with the role as the advising entities to the National Assembly regarding law and policies on these issues. (Currently it is very difficult to implement the law, which in Vietnamese it is said that "the law has not entered everyday life" or "the resource is too

few comparing to the will")

Regarding UHC, it is better that there should be a good plan and roadmap, such as gathering people into fewer categories, better management to eliminate duplicate cards, better access to health services.

(b) Dr. Tuan (vice minister) commented that even though Japan has a good model but how to apply to Vietnam is another problem.

(c) General Binh from the military

Mr. Binh raised two questions.
First, how Japan manages so that people will not concentrate at large/good hospital. This question was answered by Prof. Eguchi.

The second question is about how the health insurance for military soldiers in Japan integrated into the national health insurance system (in the past Japan has the "strong soldier, strong citizen"). Dr. Horie answered this question.

Dr. Tuan commented that there is a free in access to healthcare service in Japan. But we must get over a misunderstanding that in Vietnam it is not possible to directly receive medical treatment in big hospitals. In fact, it is possible, just that the patient will have to pay higher fee. Also, in Vietnam all emergency cases will be covered the same by health insurance, no matter which hospital the patient is brought in. So it is very important to distinguish between freedom of choice of hospital and the problem of overload at big hospital

(d) Mr. Vinh from VEA

Mr. Vinh commented that the seminar was very fruitful and helpful (providing both theory and practice)

The reports has explained about health care for the Elderly, but other important aspects such as feeding, caring, promoting the role of the Elderly must also be taken into account.

Currently, over 80% of Elderly still have to earn their living, some of them are owner of business or plantations. So it is also important to amplify the promotion of the roles of the Elderly. Because the Elderly has a shortage of capital, equipment so such support are needed to promote the role of the Elderly.

Another comment from Mr. Vinh is about the rate of purchasing Health Insurance of the Elderly is actually decreasing. Because the rate is 4% or 5% of basic wage, so for many Elderly it is difficult to pay for the Health Insurance premium, so he suggested supporting the poor Elderly to purchase health insurance.

(e) Dr. Tuan commented that people over 80 years old, or who contributed to the independent wars are support to purchase the Health Insurance. Also, for poor household health insurance premium is supported 100%, and near poor is 70%. However, the difficulty is it is difficult to specify the poor level income. So it might be needed to redefine the criteria, and to purchase per household.

(f) Doctor Thanh from National Geriatric Hospital

Dr. Thanh was also impressed by the presentations. She also stressed the issue that the medical cost for the Elderly is 5 times that of other patients. However, the good point is that 70% to 80% of the Elderly are healthy, only 20% need to stay in hospitals.

Dr. Thanh also praised the multi-packages treatment from Japanese model. For example, in Japan, the patient stays short-time in the hospital, and as soon as their conditions are stable they are discharged from the hospitals and being transferred to intermediate centers (such as rehabilitation centers), where the cost is lower, and then being released back to the community. This kind of multiple package can reduce the total treatment cost, and therefore Vietnam should follow this example.

Also, in Japan, health insurance also pays for home care, so that spouse/child will care for the Elderly and being paid by the health insurance system, and the medical staff needs to care for the Elderly in daytime only, so it can reduce the number of patient that must stay in the hospital. So this kind of health care package should also be introduced into Vietnamese Health Insurance System.

Another issue was that in Vietnam the caring for Elderly is overlapping among government agencies. In Japan, they have merged Health Care and Welfare into one ministry, so the caring for the Elderly is unified. Also in Vietnam the government has no nursing home for the Elderly, only currently caring for the everyday life.

Dr. Thanh also explained that the tendency for the people to prefer higher-level health facilities also comes from the fact that the payment limit for lower level is low, so that complex medical service cannot be done at lower level health facilities. Also, it is important that lower level medical facilities can receive professional guidance and training to update their skill/knowledge to improve their service quality.

(g) After the explanation of Prof. Eiguchi and Mr. Matsuda closing remarks, Dr. Tuan also commented that he fully agreed with the conclusions of Mr. Matsuda. He also thought that the seminar was very success and helpful in the sense that most people stayed until the end. He noted that all the presentations were well prepared, with much valuable information.

He commented that the aging process in Vietnam is very fast. Also, the Elderly is not healthy, infected with many diseases (many of which are chronic diseases), so this will be a big burden and without careful preparation will cause a lot of problems.

He also raised the issue of how to prepare in term of policy. If we only depend on the hospitals, it will be very costly. In this point, Japan has many experiences and caring model for the elderly, which showed that in Japan the law and its implementation come together hand in hand (such as law on welfare or Elderly care). Vietnam has promulgated law, but has not yet being enforced properly to support the Elderly life. So it is a major task to develop law and strategy in this area.

Regarding UHC, Mr. Takemi (senate from National Diet of Japan) visited Vietnam and gave a lecture that said in Japan in 1961 has issued the UHC law, so the situation in Japan in 1961 is similar to that of Vietnam now. But the advantage of Japan at that time was that Japan had been industrialized since 1938 with most of it labour force working in companies, but Vietnam is still an agricultural country, so it is a problem to solve the problem for workers in the informal sector in Vietnam.

MoH has 5 seminars on UHC, and from those seminars, it seems that mandatory health insurance is a must (lessons learnt from other countries). Also, it is necessary to have participation per household. If not, it is also difficult to reach the target of 80% in 2020. (Japan has a strong commitment from both central and local governments, as well as from the businesses)

Regarding Vietnam-Japan cooperation, MoH and Ministry of Health, Labour, and Welfare of Japan has signed cooperation document. So MoH would like to propose to JICA and Ministry of Health, Labour, and Welfare of Japan to develop project regarding the caring model for the Elderly. (it is said that Japan does healthcare for the Elderly since they are 40 years old, not until they are actually old). And based on specific projects, we can exchange and advance the profession of staff, so that we can improve health care quality from the lower level. So Vietnam must learnt and follow the healthcare model of “everyone, everywhere, every time” of Japan.