Chapter 10

Social Protection in Vietnam: Current State and Challenges

Giang Thanh Long
National Economics University, Vietnam

March 2010

This chapter should be cited as
Giang, T. L. (2010), 'Social Protection in Vietnam: Current State and Challenges', in Asher, M. G., S. Oum and F. Parulian (eds.), *Social Protection in East Asia – Current State and Challenges*. ERIA Research Project Report 2009-9, Jakarta: ERIA. pp.292-315.

CHAPTER 10

Social Protection in Vietnam: Current State and Challenges

GIANG THANH LONG

National Economics University, Vietnam

This chapter provides an analysis of the developmental path for, current state of, and challenges facing social protection in Vietnam, with a special focus on the social insurance and health insurance schemes. We reveal that Vietnam has achieved remarkable results in providing social protection to its citizens, particularly since Doi moi. At the same time, however, Vietnam also faces a number of challenges resulting from rapid changes in social, economic and health factors. Low coverage, poverty during old age and vulnerability, inefficient health care delivery and limited accessibility are some of emerging issues. To deal with these issues and to adapt to expected challenges such as an aging population, the chapter also provides some reform directions and proposals, such as transforming the current pay-as-you-go defined benefit (PAYG DB) pension scheme to a system of individual accounts via a notional defined contribution (NDC) scheme as a transitional step, and providing universal social assistance to the elderly to reduce incidences of poverty.

1. Introduction

After about 20 years of the implementation of *Doi moi* (renovation) programs, Vietnam has changed, since 2008, from one of the poorest countries in the world to a low middle-income country.[1] The average Gross Domestic Product (GDP) growth rate was about 7.4 percent during 1991-2009, which helped to increase GDP per capita to from $US 98 in 1990 to $US 1,064 in 2009. Thanks to this remarkable economic growth, the national poverty rate decreased significantly from 58.1 percent in 1993 to 14.5 percent in 2008. The poverty gap, measured as a percentage of the poverty line, was also substantially decreased from 18.5 percent in 1993 to 3.8 percent in 2006 (World Bank, 2007). In terms of region, incidences of poverty in all eight economic regions have been reduced over the course of time. Along with remarkable social and economic achievements, social protection system in Vietnam has been developing with considerable progress in terms of important aspects such as: poverty reduction, job creation and income maintenance for various groups of Vietnamese people. The country also has reached most of the Millennium Development Goals (MDGs) ahead of schedule (Gaiha and Thapa, 2007).

At the same time, however, such impressive economic growth has relied mainly on natural resources, capital and external financial resources (Nguyen and Giang, 2008). The areas, in which economic restructuring has been slower than expected, are within groups of the population, particularly ethnic minority people who are still living in disadvantaged conditions, and the inequality between areas and regions is widening, which is proving to be an emerging social concern. Along with this context and weak self-protection mechanisms, the most challenging policy issue is related to the fact that the social protection system in Vietnam has not been well developed and is characterized by a number of drawbacks, including a lack of coverage, insufficient funding sources and inefficient institutions. As such, the socio-economic development

[1] In 2008 GNI data, the World Bank classifies economies as follows: low income countries ($975 or less); low middle-income countries ($976-$3,855), upper middle-income countries ($3,856-$11,905); and high income countries ($11,906 or more). As such, in 2009, Vietnam was ranked as a low middle-income country.

of Vietnam in the near future may be facing more risks from changing economic, social and environmental conditions along with deeper regional and global integration.

As Vietnam enters the ranks of middle-income countries, it needs to lay the foundations to support a more dynamic and sophisticated economy, which in turn will result in new and more complicated challenges in developing appropriate policies. As such, without appropriate changes, the current social protection system may not be able to deal with new challenges, which in turn may have a negative impact on economic growth in the long-term.

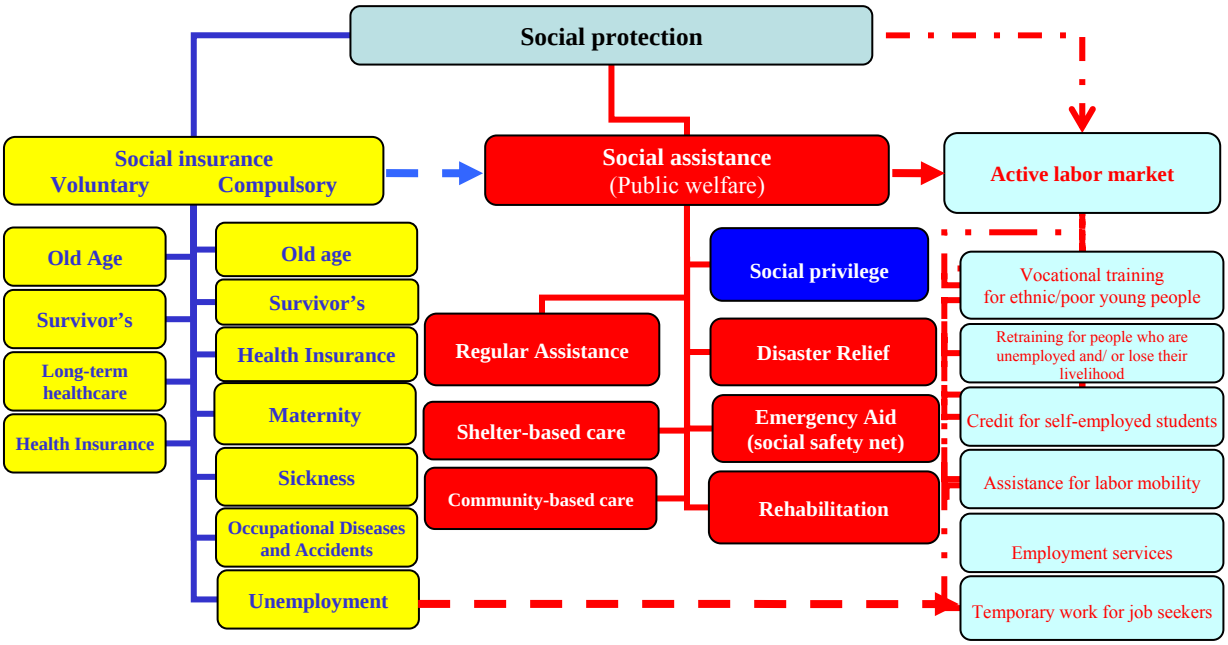
The main objectives of this chapter are to (i) provide an overview on the current state of development of the social protection system in Vietnam; (ii) point out challenges of these schemes during a time of swift socio-economic change in the country; and (iii) provide some policy suggestions to reform the current system which will help in adapting to the forthcoming expected changes. The paper is organized as follows: in the next section, we will provide information regarding the recent development and challenges of the social protection system in Vietnam with a special focus on social insurance and health insurance; along with these issues, reform proposals will be discussed. In the third part of the chapter, we will provide some concluding remarks for the chapter.

2. Social Protection in Vietnam: Development and Challenges

So far, the term "social protection" has not been well defined in Vietnam. Depending on the scope of policies and programs, this term is sometimes alternatively used with "social security" or "social safety net". According to the draft of the Social Protection Strategy 2011-2020, social protection in Vietnam includes three main pillars: (1) labor market; (2) social insurance and social health insurance; and (3) social assistance. These three pillars aim to deal with various risks which are present in a person's life. For instance, the labor market policies are to prevent risks; social insurance and social health insurance policies aim to mitigate risks once they occur;

while social assistance policies help people overcome their risks if they are unable to cope by themselves (Figure 1).

Figure 1. Structure of the Social Protection System in Vietnam



Source: Adapted from the draft of the Vietnam's Social Protection Strategy 2011-2020.

In this chapter, however, we will focus on social protection in Vietnam through two pillars (social insurance and health insurance) in order to see the current state of their development and challenges they may be facing in the coming time, as well as some policy proposals to reform the system.

2.1. Social Insurance Scheme

2.1.1. Current State

The social insurance scheme has been in operation since the early 1960s. Prior to 1995, social insurance only covered employees in the state sector and it was managed by different public agencies under the supervision of the government. The benefits were paid from a pooling fund, which was funded by contributions from employers and government subsidies. The fund was managed and guaranteed by the government. For about thirty years, the scheme contributed significantly to the income and living

standards of the insured people. However, dramatic changes in the economy and society along with the growing private sector resulting from the *Doi moi* (renovation) programs forced the government to reform the scheme. The reform led to the establishment of Vietnamese Social Security (VSS), which is responsible for administration of this scheme under the guarantees of the government. The social insurance scheme has taken a further step in development since 2007, when the first Social Insurance Law was put into effect. Under this Law, there are five mandatory components: sickness, maternity, occupational accidents, occupational diseases, and retirement and longevity. In addition, the scheme has also been diversified with a new voluntary social insurance covering retirement and survivorship with a special focus on people working in the informal sector.

With such changes, the current social insurance scheme includes both pre-1995 and post-1995 contributors and beneficiaries. The following discussion will mention only the post-1995 scheme.

Table 1. Number of Participants and Beneficiaries, 1996-2008

Year	Number of participants (1,000 persons)	Labor force (1,000 persons)	Participation rate (%)	Number of beneficiaries (persons)	Ratio contributor-beneficiaries
(1)	(2)	(3)	(2) : (3)	(4)	(2) : (4)
1996	3,231	35,866	9.0	1,769	1.8
1997	3,572	36,896	9.7	1,758	2.0
1998	3,765	37,207	10.1	1,752	2.1
1999	3,860	37,583	10.3	1,754	2.2
2000	4,128	37,610	11.0	1,761	2.3
2001	4,376	38,563	11.3	1,778	2.5
2002	4,445	39,508	11.3	1,801	2.5
2003	4,987	40,574	12.3	1,840	2.7
2004	5,820	41,586	14.0	1,890	3.1
2005	6,190	42,527	14.6	1,967	3.1
2006	6,747	43,339	15.6	2,058	3.3
2007	8,179	44,174	18.5	2,132	3.8
2008	8,539	44,916	19.0	2,205	3.9

Source: Own compilation from VSS reports (various years).
Note : The number of beneficiaries includes those belonging to pre-1995 scheme.

Table 1 shows that the number of participants of the social insurance scheme has increased over time. This expansion has been attributed to an increasing participation

from private sector institutions. However, the participation rate, measured by the number of participants as a percentage of the total labor force, has been small, at only 19 percent in 2008. Data from VSS (various years) show that the participants from the public sector account for a large proportion, meaning that many people from the private sector have not yet participated in the system.

At the same time, the number of beneficiaries has grown at a slower pace than the number of contributors. As a result, for the whole social insurance scheme, the contributor-beneficiary ratio has increased and reached about 4 in 2008. For the pension scheme alone, however, this ratio was about 17 in 2008.

Prior to 2007, benefits were adjusted in line with minimum wages. Since the first Social Insurance Law, benefits have been adjusted in line with the Consumer Price Index (CPI). In 2008, the average pension benefit (except those for armed-force pensioners) was about 78 percent of GDP per capita, and the average replacement rate was about 68 percent.

Table 2. Social Insurance Fund Balance and Accumulation, 1995-2008

Year	Previous year balance (VND billion)	Investment return (VND billion)	Revenue (VND billion)	Payments (VND billion)	Fund accumulation (VND billion)
1995	0	0	789	42	747
1996	747	18	2,597	383	2,968
1997	2,968	191	3,446	594	5,743
1998	5,743	473	3,876	752	8,888
1999	8,888	666	4,186	940	12,241
2000	12,241	824	5,298	1,334	16,285
2001	16,285	865	6,348	1,936	21,690
2002	21,690	1,606	7,777	2,960	26,507
2003	26,507	1,911	10,984	3,792	33,699
2004	33,699	2,604	12,520	4,866	41,353
2005	41,353	3,086	15,522	6,766	51,108
2006	51,108	4,081	20,290	11,045	61,838
2007	61,838	4,794	27,591	14,465	74,958
2008	74,958	7,357	30,939	21,360	91,522

Source: Own compilation from VSS reports (various years).
Note: These numbers include only those from VSS fund and exclude those from government budget. Numbers are rounded.

The expansion of the social insurance system has also resulted in a swift accumulation of funds. By 2008, the fund balance was about VND 9.6 billion (US$ 570 million) but the fund accumulation was VND 91,522 billion (or about US$ 5 billion, equivalent to 6 percent of GDP in 2008).

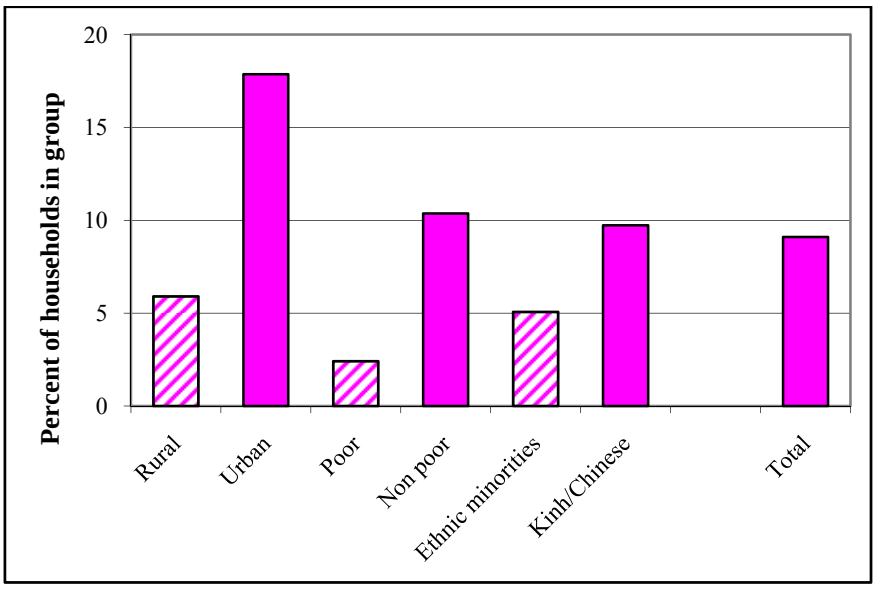
2.1.2. Challenges

The pension scheme is operating under a pay-as-you-go (PAYG) financing mechanism, in which benefits are pre-determined by given formulas based on the number of years of contribution and historical contributions. Under expected demographic and economic changes, as well as administrative capacity, the main challenges for the scheme result from the current design and implementation capacity.

First, the coverage rate of the scheme has been persistently low; particularly the coverage rate for the informal sector workers via the voluntary scheme is negligible. The main problems include: (i) regulations that focus mostly on formal sector workers; and (ii) it is difficult for the voluntary scheme to be articulated with the mandatory scheme, which in turn makes it difficult for workers to move between these two schemes.

In addition, among the mandated participants, the compliance rate (or active rate) has been low, especially for the private sector. In general, the compliance rate was only 65 percent in 2008 (meaning only 8.5 million out of 13 million workers made contributions to the scheme) while the compliance rate in the private sector was only 50 percent. There are a number of reasons for this; for instance, World Bank (2007) shows that low participation is mainly due to a lack of information and low incentives resulting from complicated regulations.

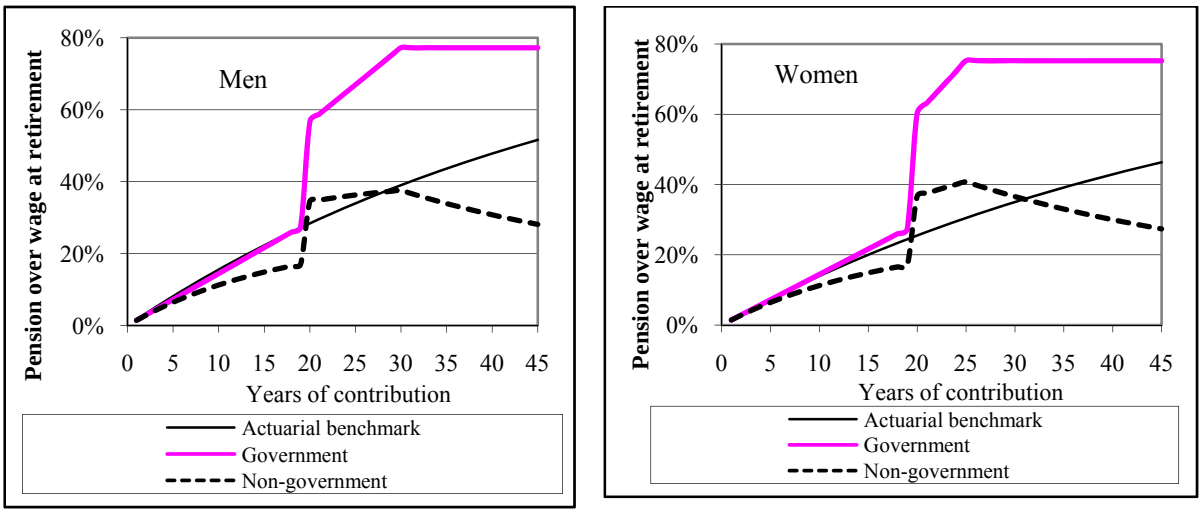
Figure 2. Large Participation Gaps in the Social Insurance Scheme



Source: World Bank (2007).

Second, in addition to the low coverage rate, Figure 2 shows that there have been wide participation gaps between rural and urban, between poor and non-poor, and between ethnic minorities and Kinh/ Chinese. The latter groups are usually more vulnerable to risks than the former, so that such a low participation may not be able to help them to mitigate risks since more than half of their income sources are mainly from household business or agricultural production (Evans *et al*., 2007). Recent estimates by the World Bank (2007) indicate that the social insurance benefits, especially pensions, are not pro-poor, since almost half of pension spending goes to the two richest quintiles, and only 2 percent go to the poorest. In fact, Giang and Pfau (2009a) show that there are only 35 percent of old-age persons receiving social protection benefits and most of them are from urban areas. This means that a great number of people, who are more vulnerable to poverty, are not covered by the current scheme.

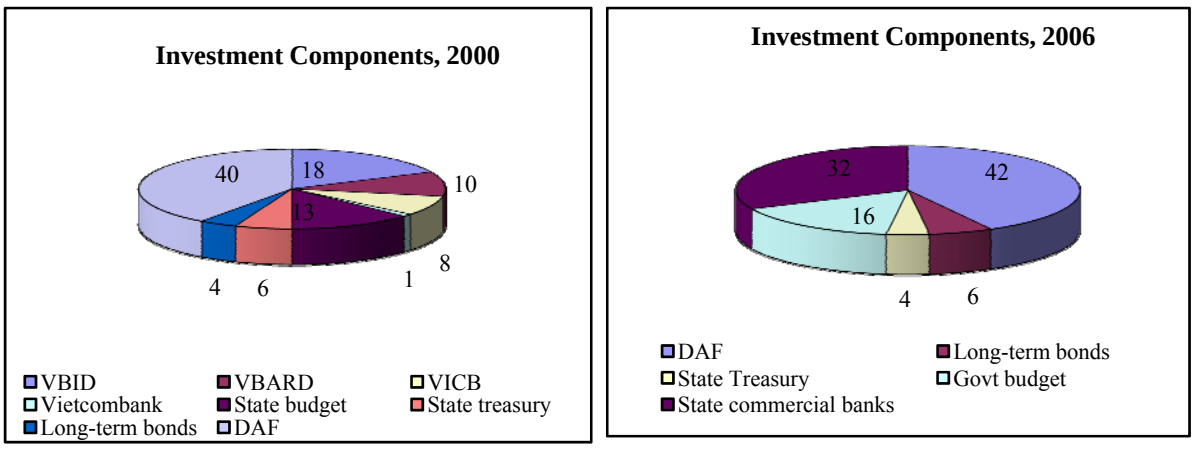
Figure 3. Unfair Benefits between the Public and Private Sector



Source: World Bank (2007).

Third, the current formulas to estimate benefits are unfair, particularly between males and females, and between the public and private sector. Figure 3 implies that workers in the private sector should not contribute for more than 28 years (for males) and 26 years (for females), since the expected additional benefits will be reduced overtime. Even with the same actuarial benefits, private sector workers may get lower levels of benefits, while those from the public sector may get higher levels of benefits. In addition, various reports from VSS show that the average pension benefit is only about 70-75 percent of GDP per capita, which is still low.

Figure 4. Investment Portfolio of the Social Insurance Fund



Source: Own compilation from VSS reports (various years).

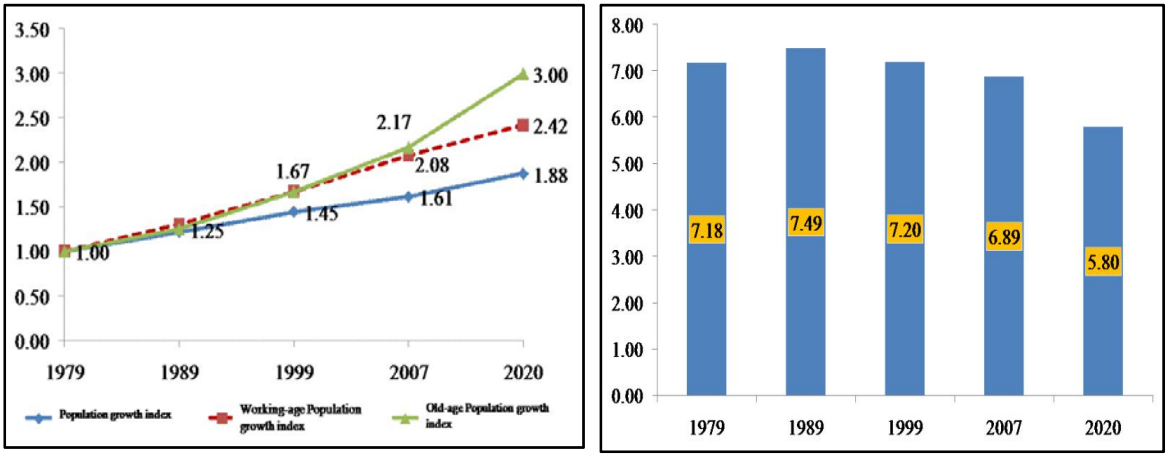
Table 3. Rate of Returns on Social Insurance Fund Investment

Year	NOMINAL				Inflation	REAL			
	T-Bill	Deposit	Lending	SI Fund		T-Bill	Deposit	Lending	SI Fund
1997	10.83	8.51	14.42	6.46	2.87	7.96	0.55	13.87	3.59
1998	11.44	9.23	14.40	8.23	7.30	4.14	5.09	9.31	0.93
1999	9.12	7.37	12.70	7.49	-1.80	10.92	-3.55	16.25	9.29
2000	5.42	3.65	10.55	6.73	-0.99	6.41	-2.76	13.31	7.72
2001	5.49	5.30	9.42	5.31	0.25	5.24	0.06	9.36	5.06
2002	5.92	6.45	9.06	3.76	2.96	2.96	3.49	5.57	0.80
2`003	5.83	6.62	9.48	4.53	2.06	3.77	2.86	6.62	2.47
2004	5.75	6.14	9.65	5.43	8.45	-2.69	8.84	0.81	-3.02

Source: Own estimates from IMF's financial statistics and VSS reports (various years).

Fourth, although the fund accumulation is getting larger, an important concern surrounds the low rate of returns on fund investment. The current reports by VSS show that over the years most of the social insurance fund investments are going to state financial institutions (Figure 4) and producing a lower rate of return that the market rate (Table 3). As discussed in Nguyen Tue Anh (2006) and Giang and Pfau (2009b), investments can be a crucial determinant in maintaining fund accumulation. As such, an improvement in the management of fund investment must be an urgent requirement in order to provide long-term stability of the fund in terms of finance.

Figure 5. Rapidly Aging Population and Potential Support Ratio



Source: Adapted from Nguyen Dinh Cu (2009).

Fifth, the long-term financial sustainability of the fund may be deteriorated by the aforementioned factors along with an expected rapidly-aging population. As indicated in a number of recent annual surveys by the General Statistics Office (GSO), the population in Vietnam has entered an aging phase in 2008 when the percentage of old-age persons (60 and over) accounted for 10 percent of the total population. Nguyen Dinh Cu (2009) shows that the growth rate of the old-age population has been much faster than those of the working-age population and the whole population (Figure 5, left). As such, we expect that the potential support ratio will decrease substantially in the future (Figure 5, right).

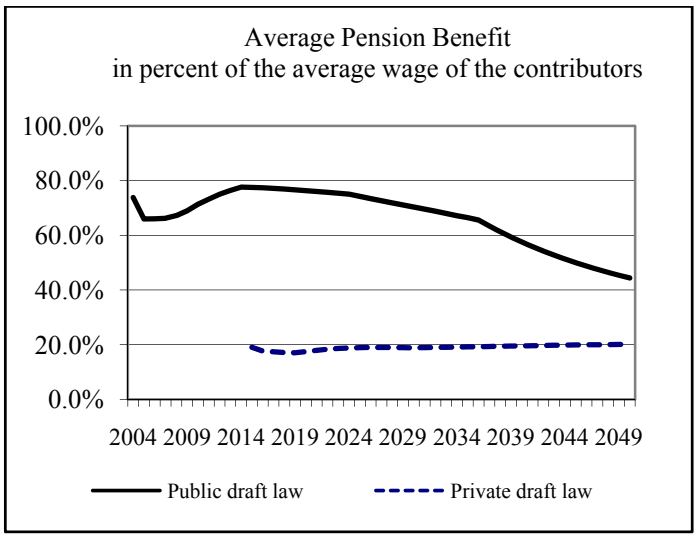
Assuming that the current social insurance regulations remain, the pension scheme dependency ratio (measured by the ratio between the number of beneficiaries and number of contributors) will increase swiftly. This ratio decreased from 34 in 2000 to 19 in 2004, and to 6 in 2020 (Castel and Rama, 2005).

Furthermore, as the population ages, life expectancy of elderly people at retirement will also increase. If the trend of early retirement for both males and females continues to persist in the future, then this will increase the number of years that benefits are paid. A recent report by VSS shows that the average actual retirement age is 53, of which males are 55 (compared with a normal retirement age 60) and females are 51 (compared with a normal retirement age of 55). In addition, the average life expectancy of retirees is 72.5 years, in which 71.1 years for males and 73.9 years for females. As a result, the average number of years for receiving benefits is about 19.5 years, in which 16.1 years are for males and 22.9 years for females. However, this report also indicates that a 28-year contribution can cover pension benefits for 10 years, meaning that the additional costs for the remaining 9.5 years of benefit receipts must be requested from the government budget or other sources. Otherwise, balancing the social insurance fund requires reducing replacement rates and/ or increasing contribution rates. Nevertheless, the current average pension is only $US 50-70 per month (Nguyen Thanh Tra, 2009) or the contribution rate must increase to 30 percent in order to balance the fund until 2045 (Giang, 2008). Both are infeasible under the current economic context.

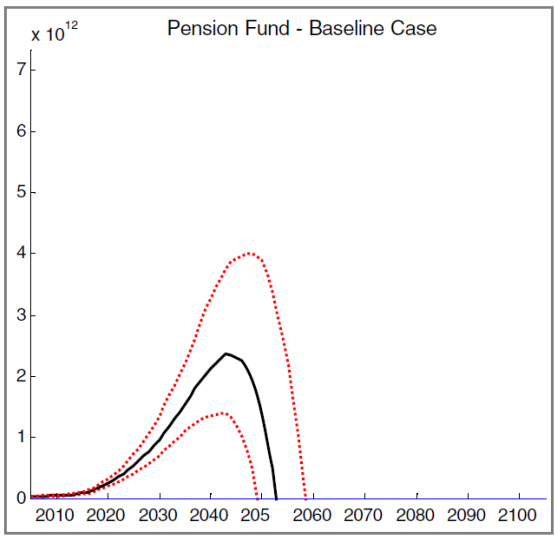
Overall, the current operation of the social insurance scheme in general and the pension scheme in particular, will not bring sustainability, as they will involve in both unsuitable benefits and financial instability. Castel and Rama (2005) show that the

replacement rate will be reduced significantly and the replacement rate for workers in the private sector will be substantially lower than that of workers in the public sector (Figure 6, left). Giang and Pfau (2009b), meanwhile, show that the pension fund will be completely depleted in about four decades (Figure 6, right).

Figure 6. Projections for Replacement Rate and Long-term Pension Fund Balance



Source: Castel and Rama (2005)



Source: Giang and Pfau (2009b)

2.1.3. Reform Proposals

These above challenges require Vietnam to reform social insurance, particularly the pension scheme, so as to achieve long-term sustainability. Following are some policy suggestions to reform the current social insurance scheme.

First, promoting the participation and accessibility to compulsory social insurance for employees in various types of enterprises. Under "demographic bonus", which will happen from 2010 onwards, job creation and promotion of participation in social insurance will ensure an increase in the number of contributors, so as to reduce the burden on contributions once the number of beneficiaries increases.

Second, clearly differentiate financial mechanisms for short-term and long-term social insurance. This will distinguish payments, investments, as well as the responsibilities of different parties in the social insurance system. One suggestion for the pension scheme is to transform the current PAYG DB scheme to a notional defined contribution (NDC) scheme as a step in moving closer to a scheme of individual

accounts. As discussed in Giang (2004, 2008), this transformation will help to avoid a huge amount of pension liabilities resulting from directly moving PAYG-DB to individual accounts. Given that the external debt reached 43 percent of GDP in 2007, moving directly from PAYG DB to individual accounts would add about 80-108 percent of GDP as pension debt[2] to the total government debt, which in turn would create substantial troubles for financial stability in the medium and long terms. In addition to such an expected advantage from NDC, reforming the PAYG alongside a rapidly aging population will also help Vietnam to remedy both intra-generational and inter-generational equity between participants.

It is worth noting that the social insurance scheme has covered a small part of the total population in general and the old-age population in particular, so that a social assistance scheme as a supplementary pillar is also needed. A research by Weeks *et al.* (2004) show that a universal pension scheme, which provides benefits to all old-aged persons from the age of 65 years and over, would cost less than 2 percent of GDP. Giang and Pfau (2009c) indicate that a universal pension providing benefits to all old-age persons in Vietnam that costs less than 3 percent of GDP, and, more importantly, provide benefits to rural and elderly females, who are persistently more vulnerable than other groups of people, will have high impacts on poverty reduction with lower costs.

Third, besides the mandatory social insurance scheme, policies aiming to promote participation in voluntary social insurance should be strengthened, including:

- Allow workers to buy the missing years in order to be eligible for social insurance benefits; flexible design of contributions and payments which reflect income to attract workers in the informal sector;
- Develop links between mandatory and voluntary social insurance in order to develop a common premium and benefit;
- Formulate a pilot support policy for vulnerable groups and ethnic minority people to participate in voluntary social insurance by sharing the social insurance premiums between the government and the participants to reduce the government budget burden for retired workers without pension benefits.

[2] For detailed discussion on how to measure pension liability/debt, refer to Holzmann *et al*. (2004) and Franco *et al*. (2004).

In addition to a formal social insurance scheme, it is also necessary to promote the development of a community-based and informal social protection model, in which families should be the core self-protection for people.

2.2. Social Health Insurance Scheme

2.2.1. Current State

The initial stages of the health insurance scheme in Vietnam involved a series of experimental local schemes in selected provinces in the late 1980s. In 1992, Vietnam introduced a mandatory scheme at national level as a means to raise funds for health care and to provide a mechanism against financial risks related to health. By 2008, about 47 percent of the populations were covered by the social health insurance scheme. The covered groups included formal sector employees, the poor, elderly persons, students and children under six years old. Nevertheless, the majority of social health insurance participants are those who cannot afford to make contributions or those who can barely make ends meet. The limited number of employed persons participating in the scheme results in a limited revenue, which in turn requires increasing governmental responsibility to maintain the balance of health care financing.

Table 4. Summary of the Vietnam Social Health Insurance Scheme, 2009

Schemes	Programs	Target groups	Financing
Mandatory	Social health insurance (SHI)	Formally employed	3% payroll tax (2% employers and 1% employees)
	Health care for the deserving people	Retirees, disabled (unable to work), the meritorious people, and others	3% of pension or state assistance, General government revenues and provincial resources
	Health care funds for the poor	The elderly, the poor, the ethnic minorities in mountainous areas, and inhabitants in disadvantaged communities	148,000 VND (per year)
	Free health care	All children under 6 years of age	Government revenue
Voluntary	Students	Students and school children	100,000-120,000 VND (per year)
	Other	Self-employed, informal sector workers, dependents of SHI members	300,000VND (per year)

Source: Adapted from Cha (2009).

There are two sub-schemes in the social health insurance system of Vietnam: the mandatory scheme and the voluntary scheme. Health insurance regulations, issued on 15 August 1992, provide mandatory health insurance for employees in enterprises, socio-economic organizations, civil servants, pensioners, early retirees due to loss of workability, and national devotees. The Vietnamese government has continuously included the specific target groups in response to their needs. In 2005, for example, all children under six years old became eligible for free health care in public health facilities (Giang, 2007). As such, the mandatory social health insurance scheme in Vietnam currently includes three different programs: (i) employment-based program; (ii) health care funds for the poor; and (iii) free health insurance program for children under six years of age. Table 4 summarizes the Vietnamese social health insurance system by sub-schemes, programs, ratios, target groups, and contribution levels.

Table 5. Coverage Provided by Social Health Insurance, 1993-2008

Year	Total participants (mil. persons)	Coverage rate (as % of total population)	Categorical participants (mil. persons)	
			Mandatory	Voluntary
1993	3.8	5.4	3.5	0.3
1998	9.7	12.5	6.1	3.6
2003	16.0	20.0	11.1	4.9
2004	19.0	23.1	13.6	6.4
2005	23.5	28.4	14.0	9.5
2006	34.5	41.0	25.0	9.5
2007	36.6	43.0	25.6	11.0
2008	41.0	47.2	30.0	11.0

Source: Own compilation from VSS (various years).

Table 5 shows the numbers and ratios of insured people in both mandatory and voluntary health insurance schemes. The government plans to expand the coverage up to 100 percent by 2015. As clearly shown in the table, the voluntary health insurance scheme will be diminished and eventually be obsolete by the end of 2014. It seems that the voluntary population groups will be mostly assigned to either the health care for the deserving poor or the health care funds for the poor.

The number of individuals insured through the voluntary scheme remains low. Most of the current insured participants in this scheme are school children who are strongly encouraged to purchase insurance by school authorities (Giang, 2007). By 2008, the voluntary scheme covered only 11 percent of the targeted population and school children were the primary focus of the voluntary scheme. There are a number of factors for such a low coverage figure, including low income; poor quality of public health services; poor marketing of the scheme; contribution levels and payment inflexibility; and aversion to collective state approaches (Cha, 2009).

Health Care Funds for the Poor was introduced in October 2002 to provide full health services for free to the poor. Initially, the government mandated all provinces to provide free health care to three groups: (i) households defined as poor according to the official government poverty standard; (ii) all households, regardless of their income, living in extreme disadvantaged communes; and (iii) ethnic minorities living in the mountainous provinces. The borderline poor people are also encouraged to join the scheme. The hardest task, however, is to identify the poor. The enrolment and screening procedures are so complicated that some groups of poor people, such as migrants, are obviously excluded from this package.

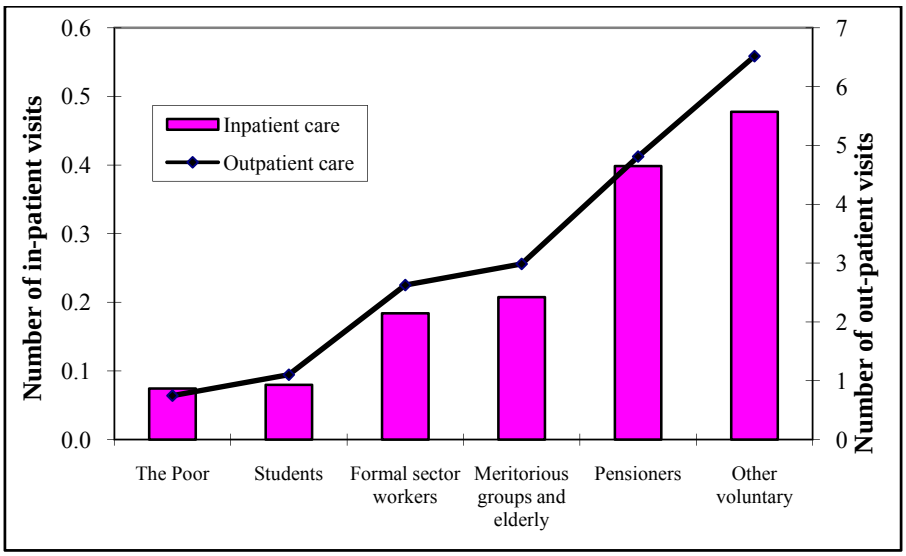
In terms of financing, as well as expanding the coverage, financing the programs is a critical issue within the current social health insurance scheme. In the case of a mandatory health insurance system, the social health insurance program is financed by 2 percent of employers' and 1 percent of employees' contributions. In addition to the employed, other population groups, such as retirees, the disabled and meritorious people, also have contribution rates of 3 percent either taken out of their pensions or the minimum government subsidies in the case that they receive social benefits.

The program for the poor is financed by central government funds. The funds are allocated to the provinces, which are also obligated to fund the balance by using their own resources. The program for the children under six years old is also financed by the central government funds mobilized from general revenues. In 2008, health insurance on average accounted for only 13 percent of the total health expenditure of a Vietnamese household.

2.2.2. Challenges

Given progresses in health insurance and health care services achieved in recent years, Vietnam will face a number of policy issues in reaching a state of universal coverage and financial stability for the social health insurance scheme.

Figure 7. Total Number of Inpatient and Outpatient Visits



Source: World Bank (2007).

First, the issue of limited accessibility for more vulnerable groups. Figure 7 provides a general overview of the average number of hospital visits, both inpatient and outpatient, according to their health insurance status and economic status. There should be caution in interpreting the outpatient hospital visits of the voluntary insures, because the majority of them (students and pupils) never received reimbursement for their treatment (Giang, 2007). As shown, however, hospital visits and admissions are disproportionate among health insurance participant groups. Although the number of hospital visits (outpatient) of the poor has increased over time, the poor made 60 percent less hospital visits than the mandatory participants in 2004. In terms of inpatient hospital use, the poor used 65 percent less than the mandatory participants in 2004. The significant lower hospital use, both inpatient and outpatient, is due to financial burden, difficulties in getting to hospitals in terms of distance and transportation, and distrust and attitudes of the service providers. A report by the United Nations (2003) shows that

hospital providers discriminate against people from whose fees are waived and those with free insurance cards and even sometimes against those who hold insurance cards.

In addition to the poor, another vulnerable group, i.e., rural-urban migrants, are also unlikely to be covered and able to access health services. World Bank (2007) shows that 87 percent of migrants, who were sick and treated at health facilities, had to pay for the cost of services and medications out of their own pockets; only 12 percent had the cost covered by their families and none of them had health insurance.

Table 6. Social Health Insurance Fund Balance, 2003-2008

Year	Participants (mil. persons)	Average cost (VND/person/year)	Healthcare fund (bil.VND)	Payments (bil.VND)	Balance (bil.VND)
2003	16.0	126.688	2,027	1,179	848
2004	19.0	136.842	2,600	2,133	467
2005	23.5	137.400	3,229	3,251	- 22
2006	34.5	125.507	4,330	5,805	-1,475
2007	36.6	162.630	6,224	8,124	-1,900
2008	41.0	230.000	9,000	10,400	-1,400

Source: Own compilation from VSS reports (various years).

Second, like many other developing countries, Vietnam has a strong commitment to extending access to a more comprehensive range of health services to a greater proportion of the population. In particular, universal coverage will be achieved by 2015. In this process, also the same as many developing countries, Vietnam may face various challenges to have financial viability for the health insurance scheme.

Table 6 presents the general collection and spending of social health insurance during 2003-2008. The debt accumulated since the beginning of the health insurance system is due to the lack of people contributing to the system, fixed contribution rates of 3 percent since 1992, and difficulties in collecting contributions.

The health insurance system in Vietnam has three funds: the social health insurance program, the health care for the poor and the voluntary health insurance fund. The major deficits occur in the free health care for the children under six and the voluntary health insurance fund. There are four main reasons for the deficit in the Vietnamese health insurance system: (1) relatively low health insurance fees; (2) frequent hospital

use; (3) abuse of the system by both providers and patients; and (4) inclusive health care packages. Cha (2009), however, provides careful analysis of these reasons. First, the current health care system has already proven to be burdensome to the poor. Therefore, increasing contribution levels and/ or the co-payment is unlikely to provide a solution to this problem and is against the purpose of implementing the pro-poor health policies. Second, the majority of the population groups, namely young children, in the voluntary health insurance scheme are usually the most frequent hospital users, except for the elderly. This means that voluntary health insurance is under a great deficit because it consists mainly of a target group that is prone to illness and hospital use. However, children are obviously an important part of the population from a policy and economic perspective of health care delivery and we cannot exclude them from the health insurance system. Third, there was some concern by health experts that abuse of the health insurance card was an eminent problem with respect to the health insurance fund. The average number of hospital visits per health insurance card was only about two times a year in 2008. A relatively and significantly lower rate of hospital use somewhat suggests that the abuse of the health insurance card by patients rarely happens. Lastly, developing an inclusive health care package is an on-going project of the Vietnamese government in order to protect the poor and the borderline poor from the financial shocks associated with severe illness. Needless to say, there was some concern expressed by health insurance experts that maintaining equilibrium between improving services to a satisfactory level and managing a sustainable health insurance fund would be a big challenge. However, there are great horizontal and vertical regional inequalities in terms of the allocation of the state budget for health insurance.

Third, without changing the current operation of the health insurance scheme, an aging population will create critical pressures on health care provision and financing. The World Health Statistics 2008 shows that Vietnam may become old before becoming rich, as the percentage of old-age persons (aged 60 and over) will reach 10 percent from 2010, while GDP per capita was just above $US 1,000. A research by Pham and Do (2009) also indicates that old-age persons in Vietnam are bearing “double health burdens” (both old and new diseases) and the average health care cost for an elderly person is 7-8 times that of a child. Such trends will obviously influence health insurance in coming times.

2.2.3. Reform Proposals

There are three key issues in sustaining a health insurance scheme in Vietnam, which aims to universally cover its citizens: efficiency (financial sustainability), effectiveness (access to and quality of care) and equity (health care status, fair financing and risk protection).

First, financial sustainability refers mainly to the long-term ability and potential to generate sufficient resources to support health while containing costs. The current scheme has faced significant financial challenges. There will be a range of possible responses, including further government subsidies, a reduction in reimbursable services and changes to the provider payment mechanism. However, considering the financial burden already imposed on patients coupled with the recent increase in the contribution rate from 3 percent to 4.5 percent (effective from 1 January 2010 by Decree 62), any possibility of a reduction in reimbursable services should be ruled out.

Second, to reach financial sustainability, policy makers should reduce supplier-induced costs by encouraging the providers to introduce a payment mechanism, which can share risks and rewards, as well as a monitoring mechanism to control under-utilization of services. Equally as important, policy makers also need to reduce consumer-induced costs by allowing consumer cost-sharing through deductibles and co-payments but while still having unlimited access to services with adequate financial protection.

Third, to make improvements in service delivery. An effective health system provides timely access to the full array of needed services, together with efficacious and safe care leading to an improvement in health, continuity of care and respect. To enhance accessibility to care and quality of care, Vietnam needs, firstly, to ensure the availability of health care by (i) increasing the number of physicians, nurses, and hospitals across all regions/ provinces; and (ii) requiring all private health care providers to join the social health insurance system. As such, patients can choose any health care services regardless of whether they are private or public. In addition, there is an urgent needed to monitor the quality of care via appropriate prescription guidelines, treatment

completion rates, re-admission rates, rate of avoidable hospitalizations and rate of follow-up visits, etc.

Fourth, equity should be promoted via improvements in resource mobilization and allocation to the extent that favors the poor and vulnerable groups. To reach equity, private health insurance should not be widely encouraged; rather, private health insurance can be supplementary to the mandatory health insurance scheme in order to reach the entire population. In addition to this initial policy direction, policy makers should also pay attention to (i) minimize adverse selection and encourage broader risk pooling via mandating insurance to all, encouraging collective enrolments, and creating incentives for low-risk individuals to join the insurance pool; (ii) minimize risk selection along with broader risk pooling; (iii) ensure financial stability with sufficient minimum capital and reserve requirements, and (iv) ensure that insurance packages provide adequate financial protection by defining a universal package for all people along with specific packages meeting demand.

3. Concluding Remarks

In this chapter, we review the developmental path, the current status, as well as challenges of the social protection system in Vietnam with a special focus and discussion on the social insurance scheme and the social health insurance scheme. We have shown that, along with notable socio-economic achievements from *Doi moi*, Vietnam has drawn a great deal of attention by providing social protection to all citizens, and some important social indicators are comparable with more economically advanced countries. However, at the same time, the chapter also implies that social protection policies have not been well adapted with swift changes in social, economic and health conditions, which in turn require comprehensive reforms of both schemes. Given such changes, the chapter also proposed some policy proposals, such as transforming the current PAYG DB pension scheme to a system of individual accounts via an NDC scheme, as well as providing a universal social assistance scheme to elderly people in order cope with a number of risks that could push them into poverty.

References

Castel, P. and M. Rama (2005) "Comments on the New Social Insurance Law", mimeo. Hanoi: World Bank Vietnam.

Cha, T. (2009) "Promoting Sustainability of Health Insurance System in Viet Nam", Ministry of Finance Project Paper on Financial Policy for Sustainable Social and Health Insurance Schemes (unpublished manuscript).

Evans, M., I. Gough, S. Harkness, A. McKay, T. H. Dao, and L. T. N. Do (2007) "The Relationship between Old Age and Poverty in Viet Nam". United Nations Development Program (UNDP) Vietnam Policy Dialogue Paper No. 2007-08. Hanoi: UNDP Vietnam.

Franco, D., Marino, M. R., and Zotteri, S. (2004) "Pension Expenditure Projections, Pension Liabilities, and European Union Fiscal Rules". Paper presented in the International Workshop on the Balance Sheet of Social Security Pensions, Hitotsubashi University, Tokyo, 1-2 November 2004.

Gaiha, R., and G. Thapa (2007) Growth, Equity, and Poverty Reduction in Vietnam: Prospects and Challenges. In Giang, T. L (ed.) *Social Issues under Economic Transformation and Integration in Vietnam*, *Volume 2*: 7-50. Hanoi: The Publishing House of Social Labour.

Giang T. L. (2004) "The Pension Scheme in Vietnam: Current Status and Challenges in an Aging Society", Vietnam Development Forum (VDF) Discussion Paper No. 2. Hanoi: VDF.

_____ (2007) "Vietnam's Social Health Insurance: Current Issues and Policy Recommendations". ILO Paper No. 33, Series on Social Security Extension Initiative in East Asia. Geneva: ILO.

_____ (2008) "Aging Population and the Public Pension Scheme in Vietnam: A Long-term Financial Assessment", *East & West Studies*, Vol. 20, Issue 1 (June 2008): 171-193.

Giang T. L. and W. D. Pfau (2009a) "The Vulnerability of the Elderly to Poverty: Determinants and Policy Implications for Vietnam", *Asian Economic Journal*, Vol. 23, No.4: 419-437

_____ (2009b) "Demographic Changes and the Long-term Pension Finances in Vietnam: A Stochastic Actuarial Assessment", *Journal of Population Ageing*, Vol. 1, No. 2: 125-151.

_____ (2009c) "Aging, Poverty, and the Role of a Social Pension in Vietnam", *Development and Change*, Vol. 40, No. 2: 333-360.

Holzmann, R., Palacios, R., and Zviniene, A. (2004) "Implicit Pension Debt: Issues, Measurement, and Scope in the International Perspectives", Social Protection Department, Working Paper No.0403, the World Bank.

Ministry of Health and Health Partnership Group (2007) *Joint Annual Health Report 2007*. Hanoi: Ministry of Health.

Nguyen Dinh Cu (2009) "Nhung dac diem dan so cao tuoi o Vietnam" (Characteristics of the Old-age Population in Vietnam" (unpublished manuscript).

Nguyen, K. M., and T. L. Giang (2008) "Factor Productivity and Efficiency of the Vietnamese Economy in Transition" *Asia-Pacific Development Journal*, Vol. 15, No. 1 (June 2008): 93-117.

Nguyen Thanh Tra (2009) "Cai cach bao hiem huu tri: Nhin tu goc do lap phap" (Reforming the Pension Scheme: An Institutional Aspect), unpublished manuscript. Hanoi: National Assembly.

Nguyen Thi Tue Anh (2006) "Du bao tai chinh quy bao hiem xa hoi Vietnam" (Projection of the Vietnamese Social Insurance Fund), unpublished manuscript. Hanoi: Social Insurance Department, MOLISA.

Pham, T. and Do, T. K. H. (2009) "Review of Healthcare Policies in Response to Age Structure Changes in Vietnam" (manuscript).

United Nations (2003) "Health Care Financing for Vietnam". United Nations Country Team Vietnam Discussion Paper No. 2. Hanoi: United Nations Vietnam.

Weeks, J, T. Nguyen, R. Roy, and J. Lim. (2004) *The Macroeconomics of Poverty Reduction: The Case of Vietnam*. Hanoi: United Nations Development Programme.

World Bank (2007) *Vietnam Development Report 2008: Social Protection*. Hanoi: World Bank Vietnam.