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Paying for Health Care in Vietnam: Extending Voluntary Health Insurance Coverage

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DISCUSSION PAPER 167

**PAYING FOR HEALTH CARE IN VIETNAM:
EXTENDING VOLUNTARY HEALTH INSURANCE COVERAGE**

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PREFACE

This discussion paper aims to synthesise a variety of reports and research projects conducted by the International Programme at the Centre for Health Economics, concerning the Vietnamese health system, over the past 4 years. In particular it focuses on the development of the state voluntary health insurance scheme which is the subject of a current DFID-funded research project. Previous work conducted by the members of the International Programme includes an investigation into the impact of economic reforms on the health system, an evaluation of the impact of user charges on access to health services amongst the poor, and a report providing an analysis of the state health insurance programme.

The aim of the current research project is to analyse the experience of voluntary health insurance to date, making recommendations to policy-makers on its future development. A large household survey will form part of the investigations. The paper presents the situation to date, highlighting major developments, successes and failures, and the main challenges facing the scheme. The research project started in July 1998 and is due to be completed in March 2000.

1. INTRODUCTION

In 1986 the Vietnamese Government announced a series of renovation policies (*doi moi*) marking the transition of Vietnam from a planned to a market economy. An important feature of *doi moi* has been the reduction in public sector funding, not least within the health sector. An examination of alternative sources of income have thus been at the forefront of policy debates in recent years, not least in the health sector.

Compulsory health insurance was introduced in 1993 for government workers and those employed in the formal sector. A voluntary health insurance scheme targeting the large informal and agricultural sector was introduced in the same year. Presently nearly 6 million individuals are registered with the compulsory scheme and 4 million with the voluntary scheme.

It is unlikely that the compulsory scheme will cover more than 10% of the population as the bulk of workers are employed in the agricultural and informal sectors and are thus eligible for voluntary insurance. Approximately 38 million individuals are eligible for voluntary insurance. This is a mammoth task not facilitated by the widespread poverty in Vietnam. Recent estimates put the figure at 50 percent. In addition there is widespread dissatisfaction with the public health service with more and more people turning to the private sector.

This discussion paper examines the progress of health insurance in Vietnam. Following a brief overview of the characteristics of the health care system and recent health care reforms it describes the key features of the voluntary health insurance scheme. It then focuses on a number of key issues relevant to the development of the scheme. Finally, the paper describes the focus of our research and the approaches that will be used for the fieldwork and in the analysis.

2. BACKGROUND

Eighty percent of Vietnam's 78 million population live in rural areas where agriculture, notably rice production, dominates. The country is classified as low income with a GNP per capita of \$US 220 in 1994. According to the World Bank (World Bank 1995) over 50% of the population are classified as poor¹.

Despite the high level of poverty the country's human development position, as calculated by the UNDP is favourable. Infant and under-five mortality rates are relatively low at 38 and 49 per 1000 respectively, adult literacy rates are almost 90% and vaccination coverage is reported to be high. In addition 90% of births are attended by a qualified health worker and have been preceded by ante-natal care. Maternal mortality however is less favourable with up to 250 deaths per 100,000 births in some areas of the country. Furthermore only 24% of the population have access to safe water and only 14% of families in rural areas have adequate sanitation facilities (Thompson 1995).

Prior to *doi moi*, basic health care was formally free to all, regardless of a patient's ability to pay. Current government health expenditure, as a percentage of GDP, is around 1% which is lower than the average for low income countries but higher than some neighbouring countries.

Table 1: Comparative Health Care Spending

Country	Government	Private
Cambodia (1994)	0.7	6.5
China (1993)	1.8	1.9
Lao PDR (1995)	0.8	1.4
Myanmar (1993)	0.5	0.4
Vietnam (1993)	1.1	4.1

Sources: World Bank 1997

Estimates of private spending are notoriously unreliable in low income countries however it is clear that this type of expenditure contributes significantly towards total health expenditure in Vietnam. The World Bank (1997) estimates that over 4% of GDP is spent on private health care. This compares with 1.9% in China and 1.4% in Laos. This higher level of private expenditure is supported by information on utilisation of public and private health care facilities. Catford et al (1997) state that less than 20% of medical treatment involves contact with public providers. The proportion of physicians active in the private sector is between 28-56% in the whole country and as high as 90% in Ho Chi Minh City (Gellert et al 1995).

¹ The Vietnamese Government classifies 'poor' as those with an income of less than US\$ 7 per month. Those with an income of less than US\$5 per month, are classified as 'hungry'.

As in most low income countries government spending is hospital dominated. In 1993 over 90% of the state health budget was spent on hospitals (World Bank 1995). Staffing levels and beds are high compared to most countries in the region (Table 2). The hospital network is supported at the primary level by Commune Health Centres (CHCs) of which there is an extensive national network of over 10,000 facilities. CHCs are funded through commune generated taxes. Studies at the beginning of the 1990s found that CHCs received between 27 and 77% of total expenditure from the commune, the remainder coming from user fees and district / province level sources.

Table 2: Population per bed and physician

Country	Population per physician / year	Population per bed / year
Cambodia	9,544 ('94)	453 ('88)
China	1,063 ('93)	612 ('93)
Lao PDR	4,446 ('90)	405 ('90)
Myanmar	12,528 ('89)	1,605 ('90)
Vietnam	2,279 ('93)	261 ('90)

Sources: World Bank 1997

A recurring criticism of state health care is the poor quality of services, particularly at the commune level. Factors behind the poor quality are many. A 1991 MoH survey showed an overwhelming majority (91%) of providers citing low salaries, inadequate equipment (87%), and inadequate drugs and medicine supplies (82%) as problems affecting the quality of services. As more and more patients seek private health care, utilisation of state facilities has fallen significantly from 2.10 CHC consultations per person in 1987 to 0.93 in 1993 (World Bank 1995).

A number of important health care reforms have been introduced in recent years in an effort to increase revenue, improve the quality of services and address equity concerns. User charges have been introduced for out-patient consultations, private medicine is being promoted and private pharmacies are increasing rapidly. A key reform has been the introduction of the compulsory and voluntary insurance schemes in 1993. Health insurance has been widely adopted by many low and middle income countries around the world, such as Thailand, Turkmenistan and China, as a result of economic transition, falling government income, and a drive for efficiency through the restructuring of health services provision and financing. A further aim has been to encourage greater awareness amongst populations of the costs and benefits of publicly financed health care (Ensor and Thompson 1998).

The target groups for each of the schemes are shown in Figure 1. The process of developing both schemes has presented a considerable challenge to decision-makers. Whilst it was reasonably easy to compel government workers to join the scheme, it has been difficult to get enterprises to register their employees. This is largely because the premium is split between the employee (one-third) and employer (two-thirds). The employers consider this an

additional tax and there are anecdotal reports of some concealing the numbers of workers they employ. One survey found that 30% of enterprises could not afford to pay the premium (Thompson 1995).

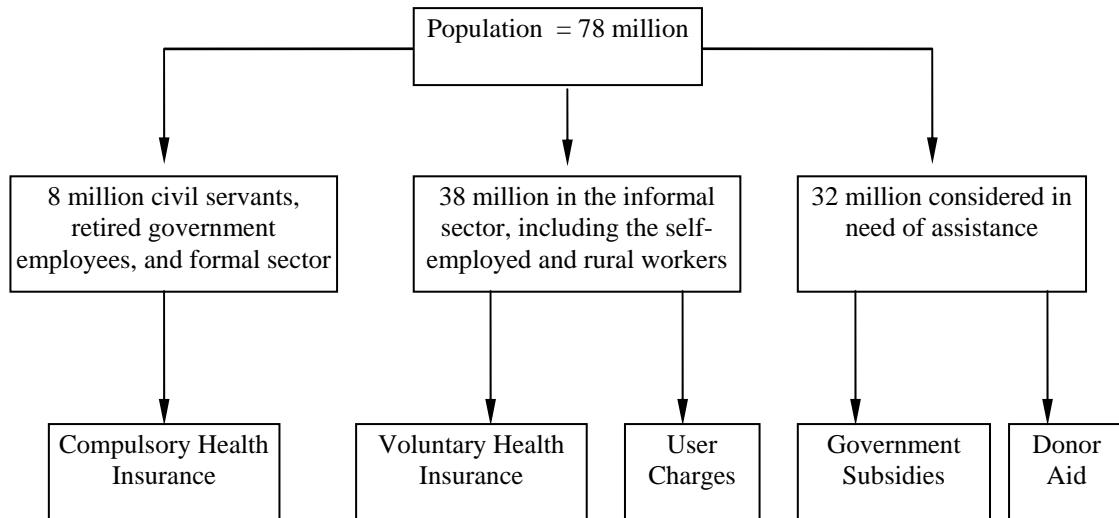


Figure 1: Target groups for the compulsory and voluntary schemes

A key criticism of the compulsory scheme is that workers dependants are not covered. This issue is presently under review by the Central Health Insurance Office. Benefit entitlements include most in-patient services yet exclude primary health care resulting in inappropriate utilisation of services and access problems for insured individuals from rural areas. The problems of registering the formal sector within the compulsory scheme are less problematic than attempts to attract the informal and agricultural sector to the voluntary scheme. This issue is considered in the following section.

3. THE VOLUNTARY HEALTH INSURANCE SCHEME

The following section examines the organisation and development of the state voluntary health insurance scheme to the present day. It analyses the key design issues including target population, coverage, premia and benefits, provider reimbursement, administration and the issue of non-renewals.

Target population and coverage

The state voluntary health insurance scheme specifically targets several distinct sections of the population including:

- schoolchildren
- dependants of members of the compulsory scheme
- workers in private enterprises with less than 10 employees
- the self-employed (e.g. farmers)

The scheme has grown since its inception at the end of 1992 to cover 3.8 million people at the end of 1997. Table 2 provides a breakdown of membership figures. Ensor (1995) suggests that given the experience of other countries at a similar stage of development, compulsory insurance is unlikely to cover more than 10% of the population. The reasons for this include a low proportion employed in the formal sector, the high rural population, and low incomes.

It is also the intention of the government to incorporate all those eligible for free health care into the scheme, amounting to 44% of the population. Families of war veterans are included in this category. On this basis the target population of the voluntary insurance programme is the 90% of the total population not likely to be in the compulsory scheme.

Table 3: Target population for voluntary health insurance

Year	Population ('000s)	Target population ('000s)	Number insured ('000s)	% target population insured
1993	70,960	63,864	326	0.5%
1994	72,384	65,146	535	0.8%
1995	73,793	66,413	2,234	3.4%
1997	76,548	68,893	3,812	5.5%

The figures presented in Table 3 chart the growth of voluntary insurance with nearly 326,000 members in its first year and 3.8 million members by 1997. In relation to the target population there has been a steady increase from 0.5% in the first year to 5.5% in 1997. One striking figure is the substantial jump in membership of over 300% between 1994 and 1995. This increase is explained by the figures in Table 4 which provides a breakdown by

population subgroup of those joining the scheme. The significant rise in schoolchildren enrolled in the scheme from 238,000 in 1994 to 1.8 million in the following year largely accounts for the increase. This development was principally due to the priority given to enrolling schoolchildren, and the organised effort to get them into the scheme, given the relative ease of identifying them and collecting premia. The financial incentives for teachers to collect contributions aided this process.

Table 4: Breakdown of membership by sub-group

Year	Schoolchildren (‘000s)	Humanitarian ² (free cards) (‘000s)	Other members (e.g. farmers) (‘000s)
1993	0	85	241
1994	238	33	264
1995	1,800	434	not available
1996	2,000	134	45
1997	3,460	209	143

Table 4 also shows that schoolchildren comprised 91% of total membership at the end of 1997. Commentators often refer to the ‘schoolchildren scheme’ separately, pointing out that it is better described as a ‘soft compulsory’ rather than voluntary scheme. Many parents also indicate pressure to contribute to the scheme by teachers, through their children. There are 16 million schoolchildren nation-wide of which 22% are currently covered.

Box 1: Expanding schoolchildren insurance coverage in Ninh Binh Province

Voluntary insurance was introduced at the end of 1992 in this northern province of 900,000 people. Schoolchildren were made a priority for enrolment with parents currently pay VND 50,000 for an annual policy for their child. Policies can be bought twice a year, after harvesting. In those schools where enough children are members of the scheme, care is provided on-site. At other schools children must use the local commune health centre. In 1995, 45% of schoolchildren were members of the scheme with 52% enrolled in 1997. The target is to reach 100% by the end of 2000.

The ‘other members’ category in Table 4, which includes mostly subsistence farmers, has seen a decrease in membership, falling from just over 241,000 in the first year, to 143,000 in 1997; 43% of this group are in Hai Phong Province which was the main pilot site for the development of the scheme. The difficulties in assessing income and collecting premia from the self-employed, in particular given the lack of insurance-related administrative infrastructure at the commune level, has slowed down the incorporation of this group into the scheme in most of the country. In Hai Phong however extra effort has been put into

² Insurance policies for the ‘poor’ are provided by a variety of organisations, including government at the national and local level, and donor/charity organisations such as the Red Cross.

improving the quality of health services, as well as education campaigns. One problem is the difficulty of assembling data at the national level, with a variety of different schemes developing under the decentralised system. In order to improve information for national planning a computerised database system is now being introduced across the country.

Premia and benefits

At the scheme's inception a guideline premium of VND 50,000 was suggested (equivalent to US\$ 5). However each province has the authority to vary the levels of premia and benefits, in order to meet the needs and ability to pay of its population. For example in Hai Hoa District in Nam Dinh Province in north Vietnam, a range of premia between 5-20,000 VND are currently being offered, in order to make the scheme more accessible to poorer sections of the population. Under this scheme contributions determine the level of benefits. The rationale for this is unclear, but appears to address the issue of ability to pay. It is likely that such packages however will appeal to more 'healthy' individuals who are less likely to seek health insurance. Attracting such people assists in tackling the problem of adverse selection, whereby only sick people join the scheme. This issue is further discussed later in the paper. A similar situation exists in Ninh Binh Province where there is a choice of two premium rates, US\$ 2.50 or US\$ 3.50. Under the first premium only hospital-based treatment is provided free of charge, whilst under the second option providers also conduct home visits where necessary.

For schoolchildren the insurance policy covers both outpatient and inpatient care. Outpatient services are only available at the school the child attends however, and a specific hospital is nominated at which the relevant services must be received. Schools retain 35% of the revenue from premia for the provision of care. The remainder goes to the provincial insurance fund and is used to reimburse hospitals for the services they provide. For adult members of the scheme, only hospital care is covered under the policy, again with a specific hospital designated for each policy holder. In-patient benefits generally include the cost of examinations, drugs, blood transfusions and infusions. Surgery is paid for independently of the insurance scheme, through general tax-funding. Outpatient services at hospital and commune level facilities cover consultations and medicines. No co-payments or deductibles are built into the scheme at present.

Whilst designing the benefit package principally around hospital care makes sense, given that the cost of services here are more likely to be catastrophic for patients, some negative observations have been made. First many of those with insurance policies are using hospitals for basic outpatient services, hence pushing primary care away from commune health centres, up the system to more costly hospital facilities. Secondly, in doing so patients often travel further to obtain this care. Whilst the costs in terms of official charges are reduced, the indirect costs in terms of travelling and waiting are greater. Informal discussions with members have revealed dissatisfaction with benefits being located at large distances from home.

Provider reimbursement

Whilst primary level care provided at schools is paid for by the retention of a proportion of the money collected during enrolment, hospitals are reimbursed by the provincial insurance fund. On arrival at a health facility, insured patients are registered by a dedicated administrative clerk, and a detailed record is kept of length of stay, operations and diagnostic tests conducted, and all medicines administered. Then using a price list provided by the Ministry of Health, a total amount is calculated for providing this care, which is then submitted to the provincial health insurance fund in the form of a claim.

Initially hospitals were reimbursed for services provided on a fixed daily allowance basis. Whilst this method of provider payment creates incentives for patients to be kept in hospital for longer periods, it avoids incentives that promote the unnecessary provision of medicines and medical procedures. This system however was changed in late 1995 to a fee-for-service basis, combining a flat fee for accommodation (depending on the department to which the patient is admitted) and a fee for each test and medical procedure conducted. The reason for this switch was a combination of dissatisfaction amongst patients and providers. From the providers' perspective reimbursements were too low to cover the costs of providing similar quality of care as for fee-paying patients. As a result insured patients were discriminated against, receiving a poor quality service, and were also dissatisfied (Thompson 1995).

Reimbursement for hospital outpatient services are made on a capitation basis. Currently this stands at 45% of the premium paid, having been adjusted upwards four times since its initial level of 13.5% in 1992. This revenue must cover all care and medicines provided to outpatients.

Administration

The Vietnamese Health Insurance Agency (VHIA) is the body that co-ordinates both compulsory and voluntary health insurance schemes in Vietnam. It is overseen by three state bodies including the Ministry of Health, the ministries responsible for the four key economic sectors (transport, communications, oil and coal), and the 61 provincial people's committees. Each province and the four key industries operates its fund independently and contributes 2% of revenue towards central administration of the scheme.

The VHIA provides assistance in terms of planning and actuarial assessments, information, public relations and the enrolment process, and the processing of claims. In October 1998 a decree was passed that allows for the establishment of a fund to facilitate risk-sharing between provinces, although the mechanics of this redistributive mechanism have yet to be finalised.

Non-renewals

Despite the substantial increase in membership since the introduction of the scheme, several provinces have seen significant numbers of members dropping out of the scheme, although data on this group is difficult to obtain. These non-renewals however appear to predominate amongst 'other members' made up largely of the self-employed and dependants of compulsory members. For example a voluntary insurance scheme set up in Dong Thap Province in the Mekong Delta in 1994, collapsed following changes in administrative boundaries; the scheme not been revitalised since.

4. KEY ISSUES IN THE DEVELOPMENT OF VOLUNTARY HEALTH INSURANCE

The development of health insurance in Vietnam is being supported by the World Health Organisation through an ongoing collaborative project with the VHIA. The project has identified a number of priority areas for development of the scheme. These focus on extending coverage to target groups, improving the quality of care, further modification of the provider payment scheme, and strengthening overall management.

Extending coverage

The number of individuals insured through the voluntary scheme remains low. In 1996 only a few provinces had voluntary health insurance members. Out of 53 provinces, 38 still had no voluntary insured at all (Ron et al 1996). Currently nearly 4 million individuals are registered with the voluntary scheme. Extending voluntary health insurance coverage is crucial if the scheme is to be sustainable.

Most of those presently insured through the voluntary scheme are schoolchildren who, through their parents, are strongly encouraged to purchase insurance (soft compulsory). Few individuals actively seek voluntary health insurance. Anecdotal reports suggest that this is due to a number of factors including:

- the general level of poverty
- the poor quality of public health services
- poor marketing of the scheme
- hospital rather than health centre-based benefits
- individual rather than family-based insurance
- premium levels and payment inflexibility
- aversion to collective state approaches

In fact several provinces suspended the sale of policies in 1997 to voluntary members of the scheme, i.e. not schoolchildren or those falling under the humanitarian scheme. The reason for this was one of adverse selection, that only the sick were joining the scheme creating financial problems. Legislation is now being developed in response to this situation. It is however important that the scheme attracts and retains each year significantly more individuals from the current target population of 38 million individuals. The MOH/WHO Project in Health Insurance has identified three target groups for extension of coverage. These include:

- low-income and very poor populations in urban and rural areas
- family members and schoolchildren of the compulsory insured
- mid-level income self-employed

Perhaps one of the greatest challenges in extending coverage is how individuals living below, or near, the poverty line can be encouraged to join the scheme. One might consider that future health care costs are not a high priority for individuals on low incomes. There is evidence however to suggest that the poor do save for future health care needs. Ensor and San (1996), in a study examining access and payment for health care in Northern Vietnam, found that around 70% of savers mentioned future health care charges as a major reason for saving. There is also evidence that discounted premiums for the poor have increased membership (Solon and Tien 1997). Payment flexibility may also encourage individuals to register, particularly if they are linked to harvests. Other countries such as Thailand, have attempted to attract low risk individuals through offering members cheap loans. The assumption here is that younger, entrepreneurial and hopefully healthier individuals will find this appealing.

The scheme needs to attract low risk individuals if the scheme is to be sustainable. This may be achieved by giving premium discounts or by raising the value of the benefit package for those who have demonstrated themselves to be low risk over a period of time. This is however problematic within a system of state health care that is generally of poor quality. Many of the insured do not use their entitlement when they are ill, preferring to bypass the poor quality public sector in favour of private provision. If the scheme is not to be discredited it will need to tackle the problem of poor quality public sector provision.

Two important issues relate to benefit entitlement and the level of benefits. Benefit entitlement is currently limited to individual policy holders. Family membership is being promoted in some provinces however progress is slow. Benefits focus on hospital care and do not include services offered below this level (e.g. commune health centre consultations). This has led to inappropriate use of hospital services and furthermore discriminates against those individuals living in rural areas who might have to travel long distances to obtain care. If the large rural sector is to be encouraged to register, the benefit package needs to be reviewed with an examination of the feasibility of primary level benefits.

Equity and access

Since the introduction of *doi moi*, access to health services has increasingly depended on income (Witter 1996). The introduction of user charges and evidence of rapidly increasing unofficial charges has meant that on average poor families are spending significantly greater proportions of disposable income on health services, in particular hospital services. At present however little is understood about the extent and magnitude of unofficial payments, and the way in which they impact on equity in access (Thompson 1998). What is clear however is the growing disparity in provincial income levels since economic liberalisation. Provinces such as Ho Chi Minh City are able to spend up to three times more per capita than other provinces in terms of public health expenditure. Further research (Ensor and San 1996) found that in northern Vietnam the poor generally end up paying more per episode of health services than those with greater incomes, largely due to the failure of the exemption system.

The introduction of user charges for health services, and the problems of effectively implementing exemption mechanisms, has provided the opportunity for insurance to play a key role in improving financial access to health services. By reducing the direct official costs, in particular of hospital care, insurance can significantly improve access. In certain provinces poverty alleviation funds at the commune level are being used to purchase health insurance cards on behalf of the poor. The extension of this system across the country is critical for the protection of low income groups and improving equity in access to health services.

Two further recent developments are important with respect to equity in access. First the Vietnamese government recently announced that it was setting up a fund of 3 billion VND to subsidise free cards for the poor and is currently negotiating the price with the VHIA. It is estimated that the fund will cover approximately 10 million people.

The second development is the recent approval of legislation to set up a mechanism for the redistribution of funds between provinces in order to allow inter-provincial risk-sharing. The mechanics of the fund, in terms of criteria for contributions and receipt of funds, have yet to be established. The effective functioning of this mechanism is another important development in the attempt to limit and reduce inequalities in access to health services across the country.

Cost escalation

The scheme has faced serious financial problems to date, with 21 province funds reported as over-spending in 1997 (VHIA 1998). In such circumstances there are several possible responses, including further government subsidies, the reduction in reimbursable services, and changes to the provider payment mechanism.

Several aspects of the system contribute to cost-escalation. First, many provinces operate with little regulation of the quantity of services delivered. Furthermore few schemes have introduced co-payments at the point of service, or limited the number of procedures a member is eligible to receive. Some schemes however are beginning to impose such limits, with others offering two free renewals if no claims on the policy are made. Without such financial incentives the phenomenon of 'moral hazard' will remain endemic.

A second aspect of the system that contributes to escalating costs is that membership is based primarily on individuals rather than groups. Apart from the schoolchildren scheme, which aims to capture groups of both healthy and sickly individuals, albeit with a little coercion, membership can only be taken out on an individual basis. Under such a system there is a tendency for those with existing health problems rather than the healthy to join the scheme, making them a disproportionate percentage of members. This leaves little room for the sharing of risks between the sick and the healthy, with high utilisation rates resulting and upward pressure on premium levels. One problem however in the current transition period, since the dismantling of agricultural co-operatives, is that the idea of groups or 'co-operatives' is not popular and so other ways of marketing the scheme to this end must be sought.

Finally, experience from other countries has shown that using fee for service as the method of reimbursing providers, pushes up the level of unnecessary care, and hence the size of claims substantially. Only strong regulation on the behaviour of health professionals, or switching to an alternative payment mechanism can overcome this problem. A recent decree allowed for the introduction of co-payments and several provinces are currently in the process of introducing them.

Understanding attitudes to risk and risk-sharing

One area that is understudied is the attitude towards risk amongst the Vietnamese, a culture that has evolved under a variety of influences including communism, Buddhism, Confucianism and Taoism. Some have recognised the 'pervading fatalism' of the Vietnamese, also noting that the presence of informal risk-sharing schemes within communities may reduce the demand for institutionally run schemes, in particular if there are widespread fears of corruption amongst the officials responsible for their organisation. The concept of social capital, or trust either between individuals at the community level, or between communities and state institutions, can provide a useful tool in analysing these issues³.

In addition north and south Vietnam have had significantly different recent histories, with the two populations often referred to as having different attitudes towards money e.g. southerners are more likely to have surplus income but are less likely to save. This is an area that clearly merits greater analysis, and will be important for development of marketing strategies to extend the schemes in different parts of the country.

³ The influence of attitudes towards risk, levels of social capital, and the existence of informal risk-sharing mechanisms on the demand for state voluntary health insurance in Vietnam, are currently being investigated as part of a DFID-funded research project in Vietnam. Please contact the authors for further information.

5. CONCLUSION AND PRIORITY AREAS FOR RESEARCH

The Government of Vietnam are committed to developing health insurance as a long-term approach for sustainable health care financing. The main strategy is to extend coverage to the large rural agricultural sector and growing urban informal sector, whilst targeting specific subgroups such as schoolchildren. To date the scheme has made good progress, yet the challenges remain considerable. The suspension of the scheme in many provinces is a setback, with the development of legislation such as the introduction of co-payments, crucial to the future broadening of the scheme.

A number of factors make rapid extension of the scheme problematic. The large number of poor, low quality public health services, coupled with a rapidly growing private sector against which public services are competing, cannot easily be overcome. Yet innovative efforts to extend insurance can still yield significant results. The decentralised nature of the scheme has led to significant diversity in the design of premia and benefits offered. It is important that the successes and failures of these developments are observed and findings disseminated throughout the country. A number of areas of research are important, at this stage of the schemes developed, to inform future policy development.

The International Programme at the Centre for Health Economics is currently conducting a research project funded under the British Governments aid programme (HP-ACORD research fund of the Department for International Development). The focus of the research project is the voluntary health insurance programme in Vietnam. There are three key themes to the research which aim to assist in the development and extension of the scheme. These include:

What motivates people to buy health insurance?

The reasons for very few people actively seeking health insurance requires greater investigation. A variety of techniques will be used to assess determinants of demand for voluntary health insurance. A conjoint analysis will be conducted to elicit the key preferences towards the scheme, amongst both members and non-members, with respondents making trade-offs between key attributes. In addition qualitative research methods will be used to investigate attitudinal factors in more depth, such as cultural attitudes towards savings and risk. This information will be used to inform policy-makers responsible for the future design of the scheme, and those charged with the marketing of health insurance.

Financial sustainability

Experience from other insurance schemes shows that under a third party payment system, moral hazard on both provider and user sides, creates pressure for cost escalation. Current research being conducted by the Centre for Health Economics will explore changes in utilisation patterns amongst members of the scheme. Research into this issue will be

conducted in two ways. First a household survey will interview comparable samples of members and non-members of the voluntary insurance scheme, and establish differential rates of utilisation, controlling for confounding factors. This will be supplemented by data collection at hospital facilities. It is anticipated that this information will contribute towards future design of regulatory mechanisms to improve the financial sustainability of the insurance fund.

Equity in access to health services

Given the large number of poor in Vietnam, the Government sees health insurance as an important strategy for promoting equitable access to health services. An analysis of the extent to which the scheme has contributed to this goal will be conducted. A comprehensive household survey will assess payments for health care within the context of the household economy, and its impact on health seeking behaviour.

REFERENCES

Catford J, White L, Richardson J, Annear P, Remenyi J. (1997). *Health Insurance for Developing Countries*. Deakin University Report for The Australian Agency for International Development.

Ensor, T, (1995). Introducing health insurance in Vietnam. *Health Policy and Planning*, 10(2); 154-163.

Ensor T, Thompson R. (1998). Health insurance as a catalyst to change in former communist countries? *Health Policy*, 43; 203-218.

Ensor, T, San P. (1996). Access and payment for health by the poor in Northern Vietnam, *International Journal of Health Planning and Management*, 11(1); 69-84.

Gellert G. et al (1995). The Influence of Market Economics on Primary Health Care in Vietnam. *Journal of American Medical Association*, 273(19); 1498-1502.

Ron, A. Carrin, G. and Tien, T. (1996). *The Development of National Health Insurance in Vietnam*. WHO Technical Paper. Macroeconomics, Health and Development Series, 23.

Solon, O & Tien, T. (1997). *The Challenges of the Vietnam Health Insurance Programme* VHIA.

Thompson, R. (1995). Social Health Insurance in Vietnam MSc dissertation (unpublished).

Thompson, R. (1998). Informal Payments for Health Care in Transitional Economies. *CHE News*, No. 6; Centre for Health Economics, University of York.

VHIA (1998). *Annual Report of Implementing Activities in 1997 and Planning for 1998*. Voluntary Health Insurance Agency, Ministry of Health.

Witter, S. (1996). Doi Moi and Health: The Effect of Economic reforms on the Health System in Vietnam. *The International Journal of Health Planning and Management*, 11(2).

World Bank. (1995). *Vietnam Poverty Assessment and Strategy*. Washington.

World Bank. (1997). *World Development Indicators* CD-ROM. Washington.