

2006 | ASIAN DECENT
2015 | WORK DECADE



International
Labour
Organization

SERIES:

SOCIAL SECURITY EXTENSION
INITIATIVES IN EAST ASIA

A large rectangular area with a vibrant, multi-colored abstract background in shades of orange, purple, green, and blue. The text is overlaid on the right side of this area.

VIETNAM:
SOCIAL HEALTH INSURANCE:
CURRENT ISSUES AND POLICY
RECOMMENDATIONS

ILO Subregional Office for East Asia



Decent Work for All

Asian Decent Work Decade

Social Health Insurance in Vietnam: Current Issues and Policy Recommendations

GIANG THANH LONG*

Vietnam Development Forum (VDF)–Tokyo
National Graduate Institute for Policy Studies (GRIPS)
7-22-1 Roppongi, Minato-ku, Tokyo 106-8677
Email: gtlong@vdf.org.vn

ABSTRACT

This paper aims to provide an overview of the social health insurance scheme in Vietnam, including historical development and current policy issues. It shows that the scheme has significantly contributed to the impressive progresses of the country's health sector, but it also will face a variety of administrative and financial challenges posed by labor mobility, widening inequality, poverty severity, and expected aging population. The paper also discusses some policy recommendations to improve effectiveness of the scheme, as well as to cope with challenges for further development.

Keywords: social health insurance, health care financing, Vietnam

JEL Classification: I18, I19

Note: This paper only provides information as of the end of 2007. Further changes in the social health insurance policies starting from the year 2008 will not be included or analyzed.

* I would like to thank many colleagues from the Health Strategy and Policy Institute (HSPI) and the Vietnam Social Insurance (VSI) for providing related documents. Special thanks go to Professor Nguyen Bach Ngoc (HSPI) for exchanging views and valuable sources of information. However, I am solely responsible for the contents of this paper.

1. INTRODUCTION

The *Doi moi* (renovation) programs in 1986 have shifted Vietnam from a centrally-planned economy to a market economy, in which remarkable achievements in both economic and social aspects have been observed. Such transformation process, with an average annual economic growth rate of more than 7 percent during the past decade, has resulted in substantial improvements in well-being for most of the people in Vietnam. The country even has emerged as an early achiever in a majority of Millennium Development Goal (MDG) targets, including more than halving of poverty from 58 percent in 1993 to 19.5 percent in 2004 (GSO, 2006; McCarty, 2007).

Along with the dramatic changes of all sectors in the economy, Vietnam's health sector also has made remarkable progresses. Although Vietnam is still a low-income country, most of the vital health indicators are better than would be expected for a country at its development level, and some indicators are even comparable to those of much wealthier countries (Adams, 2005). The health sector has also been successful in providing preventive health services and controlling key communicable diseases (United Nations, 2003). These outcomes have resulted from a widespread health care delivery network, an increasing number of qualified health workers, and expanding national public health programs. Within the health care system, the social health insurance scheme (SHI) has played an increasing role in terms of coverage and financing. For about 14 years of operation, the SHI in Vietnam has covered about 36 percent of the total population, and become an important financing source for the health care system. Along with recent changes in policy formulation, the SHI is expanding coverage, and providing more health care services to the beneficiaries, especially the poor and vulnerable people.

At the same time, however, the health sector in Vietnam also faces several challenges in making further progresses. High prevalence of chronic malnutrition among the under-five population and high rate of induced abortions are some of many examples. Furthermore, large disparities existing in many health indicators between regions, income quintiles, and ethnicities are also posing various policy challenges in health care equity, efficiency, and development, which are the main objectives of the Party and Government towards 2010. For the SHI, rapid expansion in coverage without much financial improvements is also making a lot of administrative and financial pressures. Therefore, evaluating the current policy issues and proposing appropriate policy recommendations for further development of the SHI in particular and the health care system in general are necessary.

This paper aims to pursue such purposes by providing an overview of the historical development and current policy issues, and then discussing policy challenges and recommendations in achieving sustainable development for the SHI in Vietnam.

2. DEVELOPMENT AND POLICY ISSUES OF THE SHI: AN OVERVIEW

Coverage and Compliance Rates

The SHI has been introduced since the early stage of economic renovation in Vietnam. The SHI was piloted for the first time in 1989, when the government recognized the importance of health care accessibility for those who could not afford user fees at health facilities. The first SHI regulation, i.e. Decree 299/HĐBT dated on 15 August, 1992, marked further changes in health care policies of the government.

The current SHI comprises three sub-schemes: the compulsory SHI, the voluntary SHI, and the SHI for the poor. Under the current regulations, compulsory participation is applied to all active workers and retired people in the public sector, as well as salaried workers in the private sector regardless the size of enterprises. In addition, some groups of people, such as foreign students in Vietnam, advanced aged people (90 years old and over), and veterans and dioxin victims, are also included in this scheme. In particular, the poor have also been included to the compulsory scheme since 2005.

The regulations of the voluntary SHI were not significantly changed until 2006. The Circular 22/2005/TTLT-BYT-BTC dated on 24 August, 2006 provided crucial requirements on coverage, i.e. the minimum rate of participation. For instance, a household can participate in the scheme only when at least 10 percent of the number of households in their community has participated in the scheme. This is also the required minimum rate in the voluntary SHI for association-based members, as well as pupils and students.

At the end of 2004, about 18 million people were covered by SHI. After the issuance of the Decree 63/2005 and supplementary regulations, the number of participants in the SHI substantially increased to 23.4 million (or equivalently the coverage rate increased from 22 percent to 28 percent of the whole population). In 2006, the total number of SHI members reached 30.5 million, in which 11.2 million (or about 37 percent) were poor people (Table 1).

Table 1. Number of SHI members, 2000-2006 (million people)

<i>Year</i>	<i>Voluntary</i>	<i>Compulsory</i>	<i>The Poor</i>	<i>Total</i>	<i>As percentage of</i>
-------------	------------------	-------------------	-----------------	--------------	-------------------------

					<i>the total population</i>
2000	6.469	3.089	0.841	10.399	13.4
2001	6.979	3.089	1.488	11.556	15.8
2002	6.977	4.393	1.655	13.025	16.5
2003	8.124	4.847	3.253	16.224	20.0
2004	8.142	6.245	3.889	18.276	22.2
2005	9.295	9.228	4.847	23.370	27.7
2006	9.700	9.600	11.200	30.500	35.8

Source: Author's compilation and estimates using HSPI (2006) and Tran (2007).

Although the number of participants in the compulsory SHI increased over time, their average compliance rate was still low in comparison with the eligible population. While the compliance rate of the public sector was almost 100 percent in 2005, the private sector has compliance rate of only 20 percent. The estimates by HSPI (2006) even show that the salaried workers, who were obviously administered in the formal labor markets, had compliance rate of only 50 percent (about 5.75 million active participants out of 11 million eligible people) in 2005. According to many studies, the main reasons for such low compliance rates include weak labor registration and enforcement measures, especially for the private sector.

Table 2. Participants of the voluntary SHI, 2005

<i>Participants</i>	<i>Number of people</i>	<i>As percentage of the total</i>
Pupils and students	7.700.000	83.4
Household-based and association-based	1.267.000	13.7
Dependents of compulsory members	268.000	2.9
Total	9.235.000	100

Source: Author's estimates using HSPI (2006)

In the voluntary SHI, pupils and students have been dominant (more than 80 percent) since the establishment of the scheme, followed by the household-based and association-based participants (Table 2). Although the number of participants in this scheme also increased over time, the coverage for pupils and students was still low, at only 41 percent of the whole pupils and students in Vietnam in 2005. The total number of household-based and association-based participants was really limited (only at about 1.3 million people) in comparison with the potential eligible population. As argued by previous studies, such as VSI (2006) and HSPI (2006), the regulation on minimum rate of participation really limits coverage. Such regulation, on the one hand, probably results in adverse selection, in which most of the participants may be people who have high

demand for health care services, such as disables or old aged people. On the other hand, it also may not encourage healthy people to participate in the scheme, as they might have to pay more heavily to cover costs for other people under risk-pooled basis.

Contributions, Benefit Packages, and Payments

The current contribution rate in the compulsory SHI scheme is 3 percent of the salary for salaried workers, in which employers pay 2 percent, and employees pay 1 percent. Over time, the average contribution increased from VND 135,000 per capita per year in 2000 to VND 290,000 per capita per year in 2005, but this increase was mainly due to salary adjustments in 2001 and 2003.

In comparison with other compulsory participants, the required contribution for the poor was much lower, at only VND 60,000 per capita per year in 2006. Table 3 provides statistics for the contributions of these groups in the period 2000-2005.

Table 3. Average contribution to the compulsory SHI (VND per capita per year)

<i>Year</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>
Compulsory participants	135,570	150,451	162,964	217,214	227,589	286,354
The poor	30,916	20,161	21,752	30,741	43,907	42,366

Source: VSI (various years), as quoted by HSPI (2006)

Table 4. Current required contributions to the voluntary SHI

<i>Participants</i>	<i>Urban</i>	<i>Rural</i>
Location or association-based	VND 160,000-VND 320,000	VND 120,000-VND 240,000
Pupils and students	VND 60,000-VND 120,000	VND 50,000-VND 100,000

Source: VSI (2007)

In the voluntary SHI, the contribution bases were largely changed to meet financial requirements. The Circular 77/2003/TTLT-BTC-BYT dated on 7 August, 2003 required contributions from VND 25,000 to VND 140,000, depending on categories of participants and residential areas. However, the Circular 06/2007/TTLT-BTC-BYT dated June 20, 2007 substantially revised these contribution levels, which currently vary from VND 50,000 to VND 320,000 (Table 4).

The benefit packages provided to the participants of the compulsory SHI include inpatient and outpatient services at all health care levels, laboratory exams, x-ray, and other diagnostic imaging procedures. Some expensive high-tech health services, such as open-heart surgery, are also covered by the compulsory SHI. Even though the poor have low contribution, they also have the same benefit packages as other compulsory

participants. There is also a list of reimbursable drugs, which is comparable with those in some developed countries (HSPI, 2006). The preventive care services, however, are not covered in the SHI benefit packages, and they are paid by either government budget via national preventive care programs or by out-of-pocket money of the beneficiaries.

Members of the voluntary SHI are also entitled to both inpatient and outpatient cares at all health care levels. For the outpatients, VSI will cover 100 percent of medical cost of less than VND 100,000, and only 80 percent of medical cost of more than VND 100,000. The reimbursement rate for inpatients is 80 percent for the cost of less than VND 20 million per case. For pupils and students, in addition to the aforementioned packages, they will also receive 17.4 percent of the total collected premium for health promotion and first-aid activities (VSI, 2007).

Regarding health facilities, the insured participants are eligible not only for the public health facilities, but also for the private facilities which have contracts with the health insurance agencies.

Table 5. Average number of visits or hospital admissions, 2000-2004

<i>Participants</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>
<i>Outpatients (number of visits per capita per year)</i>					
Compulsory	2.04	2.21	2.28	2.28	2.60
The poor	0.55	0.64	0.74	0.75	1.03
Voluntary	0.40	0.44	0.44	0.50	0.61
<i>Inpatients (number of hospital admissions per 100 members per year)</i>					
Compulsory	16	18	17	16	17
The poor	5	6	5	5	6
Voluntary	4	6	6	5	5

Source: Author's compilation using Tran (2007)

Nevertheless, accessibility to the health care services provided by the SHI has not been equal among participants, especially for the poor. Table 5 provides statistics for the average number of visits (for outpatients) and number of hospital admissions (for inpatients) to health care facilities. Note that the numbers for outpatients in the voluntary scheme are not comparable, because previously the health care costs for pupils and students, who were major members, were not paid.

It is shown that the poor had a higher utilization rate of health insurance services over time. Such increase was due to a variety of government policy measures to provide health care services to the poor, including user fee exemption and free health cards under the Decision 139/2002/QĐ-TTg. Though, their utilization rate was still significantly

lower than that of other compulsory members. Such low utilization rate could be first attributable to lack of awareness of the poor about the SHI benefit packages, and their own barriers in health care access, such as numerous unofficial payments for hospital services, income opportunity cost of hospitalization, and transportation and accommodation costs. At the same time, overloading status in most of the health care facilities also has prevented the eligible people, including the poor, from accessing health care services. More seriously, “the hospital providers discriminate against people from whom fees are waived and those with free insurance cards (the poor) and even sometimes against those who hold insurance cards” (United Nations, 2003: 2)

Regarding provider’s payment under the current regulations, the health care facilities can choose one of the two following mechanisms to have contracts with the health insurance agency: (i) fee-for-service payments, in which the maximum payment will not be more than 90 percent of the health care fund of the facilities operating with both inpatients and outpatients, or more than 45 percent of the health care fund of the facilities operating with only outpatients; and (ii) case-based payments with the same maximum payments as those of fee-for-service payments. In practice, the former mechanism has been popularly used in most of the health care facilities at all levels. As such, a lot of problems have limited the eligible participants to access health care services. For instance, low maximum levels of payment cannot cover all the necessary health care costs, and thus quality of services is low and unsatisfied. Also, such mechanism provides strong incentives for the health care facilities to generate excessive and unnecessary services to increase their revenues, which in turn put more burdens on patients.

Due to expansion in coverage and more generous benefit packages, the SHI is facing severe financial problems. A number of reports recently show that the total expenditure of the whole SHI has substantially increased since 2003. For instance, the total expenditure in 2005 was about triple of that of 2003, but the number of participants only increased by 40 percent. The excessive expenditure was VND 1,800 billion in 2006, and this will increase in the coming years if the current benefit packages and payments will not be revised. Without systematic revisions of both expenditure and revenue, fund depletion is foreseen.

Administration of the SHI

In terms of administration, the SHI has three milestones: (i) the first period from October 1, 1992 to October 1, 1998; (ii) the second period from October 1, 1998 to January 1, 2003, and (iii) the third period from January 1, 2003 to date.

In the first period, the SHI was administered at the provincial level. Each province was responsible for human resources and financing sources to operate the SHI under health insurance regulations and Ministry of Health's technical guidance.

In the second period, the SHI fund was administered at the national level, but the central-run cities could manage their SHI funds under some circumstances.

The third period marked substantial changes in both administration and financing of the SHI, in which it was merged with other social insurance schemes under a unified social insurance system. The whole system is now centrally managed by the Vietnam Social Insurance (VSI) under various regulations on administration and financing. The VSI is vertically organized at central, provincial, and district levels with a workforce of about 15,000 staff.

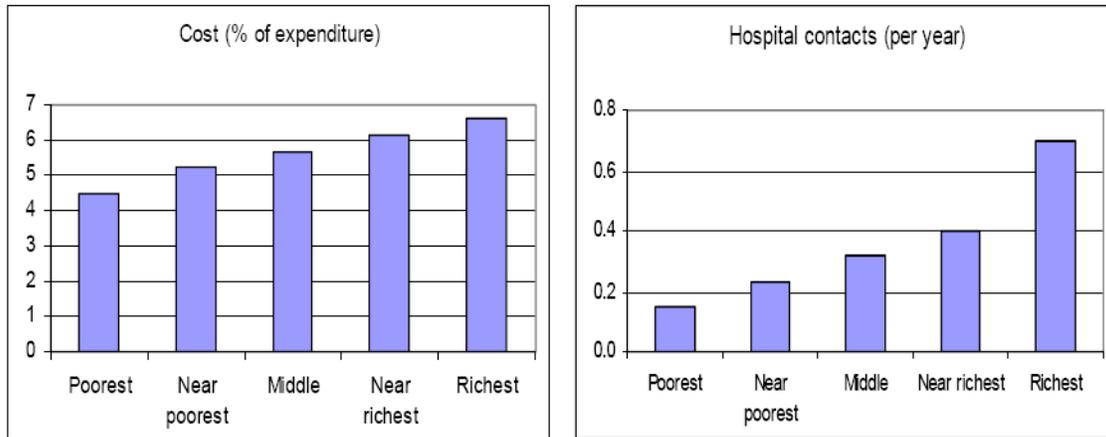
3. POLICY CHALLENGES AND RECOMMENDATIONS

The above section provided an overview of main policy changes and issues since the establishment of the SHI. On the one hand, the SHI has become an important channel for the whole health care system in expanding coverage and mobilizing financial sources. Under swift socio-economic changes stemming from economic transformation and integration, on the other hand, the SHI is also facing a number of administrative and financial problems. In the following paragraphs, we will discuss policy challenges and recommendations for further development of the SHI in the coming years. The discussion focuses on three main aspects, including coverage, administration, and financing.

Policy Challenges

Since 2005 the compulsory SHI has extended coverage to the poor, as well as the workers of private enterprises regardless the number of workers. Under the new MOLISA poverty standard, the number of poor people will be about 21 million. This number will rapidly increase the number of compulsory participants, and pose critical challenges to the SHI operation in administration (increasing number of health cards to be managed), financing (due to very low contributions of the poor), and deteriorating quality of health services (which is partially resulted from overloading situation).

Figure 1: Widening inequalities in health care

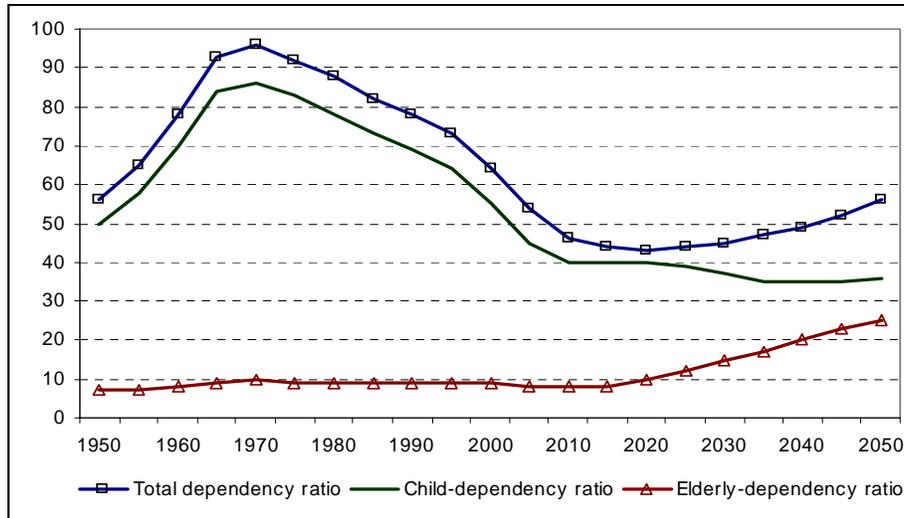


Source: Rama (2007).

More importantly, the question is whether all the poor people can access the health care services provided by the SHI benefit packages. Recent reports show widening inequalities in health care access between the rich and the poor. For instance, Rama (2007) shows that the poor use and spend health services much less than do the rich (Figure 1). The poor usually access poor quality health services and find that these services are not responsive to their needs (United Nations, 2003). In terms of regions, Tran (2007) shows that only 17.4 percent and 13.9 percent of the poor people living in the Northwest and the Central Highlands, respectively, are covered by the SHI. For the whole country, only one-third of the eligible poor are currently covered by the SHI.

In addition to the poor, policy strategy aiming to provide free health services to all the children of less than 6 years old in the coming years will also make significant financial pressures to the SHI. If all the eligible poor and children are included, they will account for almost two-thirds of participants, and the compulsory scheme will be characterized by low-paid and highly vulnerable participants. Estimates indicate that if all poor people are included in the scheme, the average contribution per participant will be only VND 110,000 per capita (or US\$ 7), while the average medical cost in Vietnam in 2006 was already US\$ 26 (HSPI, 2006).

Figure 2: Population projections for Vietnam, 2005-2050



Source: Author's compilation using United Nations (2007)

Another challenge for the compulsory SHI is an expected aging population in the coming decades. United Nations (2007) indicates that the percentage of elderly population will significantly increase from 7.6 percent in 2005 to 26 percent in 2050, and the total dependency ratio will be mostly driven by the elderly dependency ratio (Figure 2). Giang and Pfau (2007) even show that the rate of aging in Vietnam is more rapid than the estimated figures, and the group of advanced aged people (90 years old and over) continuously increase over the past decade. More severely, the advanced aged people had higher poverty rates than did other elderly groups. Providing free health care services to this group will protect millions of elderly with healthy aging lives, but it also put more financial burdens on other groups of people if related policies are not carefully considered.

The compulsory SHI will also face a big challenge in administering the workers of private sector, who are playing an increasing role in the formal labor markets. As shown in World Bank *et al.* (2005), there has been a massive geographic and occupational mobility under rapid economic transformation of the country, in which the number of private sector workers is significantly increasing in terms of both absolute number and percentage of the labor force. However, the participation rate of these workers to the social insurance scheme is inherently limited (Giang, 2006). Improving labor registration and enforcement is imperative to attract more private sector workers to participate in the scheme.

To get an ambitious policy aiming at a universal social health insurance by 2010, Vietnam is also facing a variety of difficulties in extending voluntary coverage to rural people, who currently account more than 70 percent of the total population. Among the rural population, farmers and self-employees account for a large proportion. Currently, the number of rural people participating in the voluntary scheme is less than 3 percent of the total rural population. Evaluations of previous reports indicate that most of the voluntary SHI programs in rural areas are not sustainable in both coverage and financing, because of such reasons as people's lack of knowledge on health insurance, unaffordable payments without assistance from other financial sources, and low quality of services provided by local health facilities.

Along with the expansion of coverage, there are also many challenges in terms of administrative capacity. The SHI is now centrally managed by the VSI, which is also responsible for managing other social insurance schemes having different characteristics, including pensions and other short-term benefits. Lack of professional administration and weak information network will prevent the VSI from operating the SHI effectively. Moreover, under an increasing trend of financial decentralization in all sectors of the country, especially in health financing, such a central administration of the VSI might be not appropriate in the long-term view.

The most concerned challenge for the sustainable development of health sector in Vietnam is financing. Currently, most of spending is based on government budget and user fees, while the SHI fund still plays a limited role. For example, government budget and user fees contributed respectively 42 percent and 36 percent to the funding sources for hospitals in 2005, while the SHI contributed only 16 percent (Rama, 2007). However, government spending on health is low in comparison with GDP, at only 3.5 percent (IMF, 2007). As such, under increasing medical costs and the emergence of private health providers and pharmaceutical dealers, out-of-pocket spending on health of patients is increasingly high. This is one of critical causes of the fact that many eligible participants, in which poor and vulnerable people account for a large proportion, cannot access health care services. Without increasing government spending on health, revising user fees, and increasing contribution rates to the SHI, it will be infeasible to have a widespread health care system reaching all citizens.

Policy Recommendations

Based on the previous analyses, we argue that achieving universal health insurance coverage by 2010 with an equitable and effective health care system is a great challenge to the development policy and strategy of Vietnam in the near future. Growing inequalities and financial imbalances are some of the possible obstructive factors for further development of the health sector. To deal with these problems, systematic reforms of the sector, including social health insurance, are required. Some policy recommendations are as follows.

Coverage Expansion

- The compulsory SHI should be extended to the salaried workers' dependents, who currently do not have compulsory insurance. In other words, the SHI should be family-based rather than individual coverage. Also removing the required minimum rate of participation to mitigate problems related to adverse selection.
- Private sector workers should be further encouraged to participate the compulsory scheme. This will not only ensure a higher coverage rate, but also financial viability of the scheme, given their contribution rate and anticipated low health care needs. To do this, it is required that the SHI and other agencies have strong cooperation in registering the target groups and collecting their contributions without excessive administrative costs.
- Moving government subsidies from service providers to service users, especially socially prioritized groups (extremely poor and rural people, for instance). Such movement can ensure a higher health purchasing power of the poorer groups, which in turn can increase coverage of the SHI towards more effective use of financial sources.

Financial Sources and Uses

- It is obvious that financial reforms for the health sector in general and the SHI in particular will be the key for success. The most important task is to reform the current payment mechanisms of the SHI scheme. The current popular fee-for-service provider payment should be used only in special services and emergencies. Along with this, cost containment needs to be carefully

considered, because the majority of the target groups will pay relatively low contributions, and their initial health care needs may be higher than the currently covered population. To do this, the SHI must develop its capacity to ensure that appropriate contracts will be made with accredited health providers. Such contracts will in turn support quality assurance, as well as increase actuarial capacity under various financial pressures.

- The next task is to revise and update the benefit packages accordingly to the demand for health care, as well as affordability of the participants and the SHI fund. Considering specific benefits to accommodate different needs of different members (e.g., children and elderly people) will ensure effective uses of limited resources. Also, contribution rates need to be appropriately revised to cover medical costs, because the current rates are far below the sustainable rate.
- Under current financial mechanisms, only SHI fund obviously will not be able to cover all necessary costs for providing health services to the beneficiaries (in which low-paid participants account for a large proportion). Therefore, financial reforms should emphasize more roles from other sources, in which government budget and user fees are primarily important. The total government allocation for health needs to be increased along with appropriate measures to prioritize spending allocation, as well as monitor the impacts of resource allocation changes. User fees should also be reformed toward efficient uses of limited resources and essential health services. Effective administration of pharmaceutical markets should be first prioritized for these purposes.

Administration and Institutional Development

- The VSI should become an internationally professional organization in administering the whole social insurance system. As such, improvement of quality of human resources is crucial. To do so, developing information systems throughout the scheme and related entities and holding training courses will be some of the core activities.
- Systematic development and use of promotional materials via mass media will also be important tasks to disseminate and popularize regulations of health insurance to all citizens.

- Beyond these reforms, the government, Ministry of Health, and other related ministries play important roles in ensuring accessibility of people to health services, and promoting quality of services, especially via financial promotion. Moving towards decentralized health sector planning and finance while maintaining minimum standards in key areas will be important steps for achieving desired outcomes.
- Above all, a comprehensive social health insurance law should be drafted and discussed among various stakeholders. Without such law, continuously amended regulations via decrees and circulars make participants confusable and unpersuadable.

4. CONCLUDING REMARKS

Although Vietnam has obtained a lot of remarkable achievements in providing health care to its citizens, especially the poor and vulnerable groups, there are still many problems that can impede further development of the health sector, including social health insurance. Vietnam urgently needs to make a variety of decisions on health financing and administration in order to protect the past achievements and provide more health accessibility and services to the people. In other words, stable financial mechanisms under sound legal framework and strong institutional development in the health sector will be challenges, but key for success, toward an equitable and effective health system. More importantly, the health system alone cannot ensure the desired health outcomes, and thus it needs to be integrated into comprehensive social and economic development policies and strategies, in which reducing poverty and inequalities is first and foremost prioritized.

References

- Adams, S. J. 2005. "Vietnam's Health Care System: A Macroeconomic Perspective". Paper was presented at the *International Symposium on Health Care Systems in Asia*, Hitotsubashi University, Tokyo, Japan on 21-22 January, 2005.
- Giang, T. L. 2006. "Pension Liabilities and Generational Relations: The Case of Vietnam". Oxford Institute of Ageing (OIA) Working Paper No. 106. Oxford: the University of Oxford.
- Giang, T. L; and W. D. Pfau. 2007a. "The Elderly Population in Vietnam during Economic Transformation: An Overview." Chapter 7 in Giang Thanh Long and Duong Kim Hong (eds.) *Social Issues under Economic Transformation and Integration in Vietnam, Volume 1*: 185-210. Hanoi: Vietnam Development Forum.
- GSO (General Statistics Office, Vietnam). 2006. "Vietnam after 5 Years Implementing the Millennium Development Goals" (mimeo). Bangkok: United Nations Statistical Institute for Asia and the Pacific.
- HSPI (Vien Chien luoc va Chinh sach Y te-Health Strategy and Policy Institute). 2006. *Bao cao danh gia tinh hinh thuc hien chinh sach bao hiem y te* (Evaluation Report on Implementation of Health Insurance). Hanoi: HSPI.
- IMF (International Monetary Fund). 2007. "Vietnam: Statistical Appendix". IMF Country Report No. 07/386. Washington D. C: International Monetary Fund.
- McCarty, A. 2007. "Vietnam: Beyond Transition". Presentation at *The Third Vietnam Development Forum (VDF)-Tokyo Conference on the Development of Vietnam*, June 2, 2007. Tokyo: National Graduate Institute for Policy Studies (GRIPS).
- Rama, M. 2007. "Social Protection and Labor Markets in Vietnam". Presentation at *Commission on Growth and Development: Labor Markets and Growth*, October 15, 2007. Washington D. C: World Bank.
- Tran, V. T. 2007. "The Inclusion of the Poor in a Social Health Insurance Framework: The Strategies Applied in Vietnam", in *Extending Social Protection in Health: Developing Countries' Experiences, Lessons Learnt and Recommendations*: 63-70. Eschborn: GTZ.
- United Nations. 2003. "Health Care Financing for Vietnam". United Nations Country Team Vietnam Discussion Paper No. 2. Hanoi: United Nations Vietnam.
- _____. 2007. *World Population Prospects: The 2006 Revision Population Database*. Retrieved from <http://esa.un.org/unpp/> on January 10, 2007.

VSI (Vietnam Social Insurance). 2006. "History Development and Expanding Program of Voluntary Health Insurance in Vietnam". Presentation at *The 17th ASEAN Social Security Association (ASSA) Board Meeting* (March 2006). Manila: ASSA.

_____. 2007. "Extending Health Insurance Coverage for the Informal Sector: The Vietnam Experience". Presentation at *The 20th ASEAN Social Security Association (ASSA) Board Meeting* (October 2006). Manila: ASSA.

World Bank *et al.* (2005). *Vietnam Development Report 2006: Business*. Hanoi: World Bank Vietnam