CHAPTER 2

Master Plan Goal 1: Increasing Enrollment Rates

This chapter examines how to increase the share of the population enrolled in social health insurance (SHI) and ensure that enrollment translates into effective coverage. Vietnam faces the "missing middle" problem in that enrollment rates are highest among low- and high-income groups, but persistently low among groups in the middle such as non-/near-poor and informal sector workers, with associated problems of adverse selection and a fragmentation of risk pools. Increasing general revenue subsidies for SHI and fully subsidizing the premiums for the near-poor would be critical for expanding coverage for these groups. This strategy is administratively more efficient than attempting to expand contributory SHI for these groups and an effective means to address adverse selection. Providing financial incentives to encourage family enrollment and introducing measures to enforce enrollment compliance among the mandated enrolled groups would further increase enrollment rates. Strengthening the demand side, particularly by enhancing information, education, and communication about health insurance would be vital for ensuring that those enrolled do make effective use of SHI when seeking care.

Understanding Where the Gaps in Coverage Are

Increasing the proportion of the population enrolled in SHI is a key policy goal for the Government of Vietnam (GoV). GoV has set a target of achieving at least 70 percent and 80 percent coverage by 2015 and 2020. The Master Plan (MoH 2012) includes explicit enrollment rate targets for the different groups. This chapter examines how to increase enrollment rates efficiently and equitably, maintain enrollment rates among those who are already enrolled, and ensure that those who are enrolled actually use the health insurance.

About 31.9 million Vietnamese were not enrolled in SHI in 2011.[1] Of these, 15.7 million were the largely non-poor informal sector workers and their families, who belong to the voluntary enrollment group; 7.4 million were the near-poor and students, whose enrollment is partially subsidized by the state;

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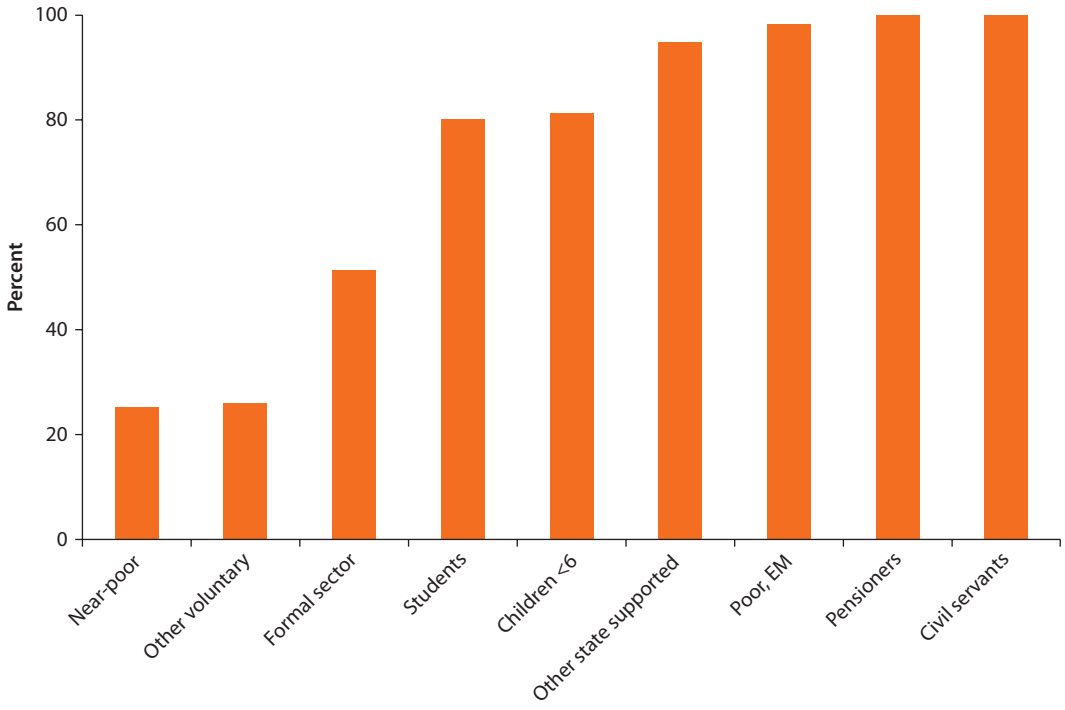
6.2 million were formal sector workers, whose enrollment ought to be paid for by the employers; and 1.9 million were children under six whose enrollment is fully subsidized by the state. Of the 14.3 million population that is classified as poor or belonging to ethnic minorities, whose enrollment is fully subsidized by the state, less than 0.3 million were not enrolled (figure 2.1).

Vietnam faces the "missing middle" problem typical of most countries in the region in that insurance enrollment rates are highest among the lower- and higher-income groups, and lowest among the middle-income groups (figure 2.2). This middle consists largely of the nonpoor informal sector. Families of formal sector workers belong in this group since SHI for formal sector workers is limited to individuals only. Individuals engaged in the agriculture, forestry, and fisheries sectors also belong in the missing middle. Under the SHI Law, all of these groups are classified under the voluntary, contributory subcategory. Enrollment remains low among this group—26 percent in 2011—because the cost is too high and/or the value of health insurance is not perceived as being commensurate with the cost of enrollment.

Enrollment rates among the near-poor have risen only slowly despite a 50 percent (increased to 70 percent in 2012) government subsidy toward the

Figure 2.1 Enrollment Rates as a Share of the Population



Source: Calculations based on data from VSS 2012.
Note: "Other voluntary" includes farmers and other similar groups who are voluntarily enrolled. "Other state supported" includes commune officers entitled to state allowance, meritorious people, war veterans, members of the National Assembly and People's Council, social beneficiaries, dependents of the military and public security officers, and intelligence agents.
EM = ethnic minorities.

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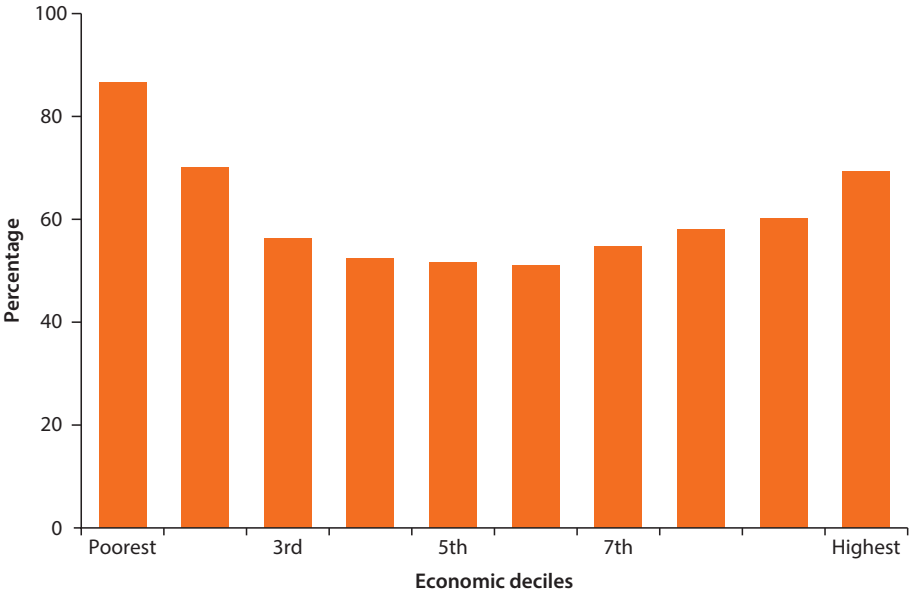
Figure 2.2 Health Insurance Coverage by Economic Decile (2010)



Source: Estimates based on data from the Vietnam Living Standards Measurement Survey, 2010.
Note: Economic deciles are based on household consumption per capita. The poor and near-poor are defined as the bottom three economic deciles of the population.

health insurance premium. Although enrollment is mandatory for these groups, in practice enrollment is largely voluntary. Anecdotal evidence suggests that affordability is the main reason why enrollment rates are low among this group. Under the World Bank's Central North Region Health Support Project, the subsidy for the near-poor was increased to 80–90 percent and coverage has risen to 74 percent. Under the World Bank's Mekong Region Health Project, the subsidy for the near-poor was increased to 70 percent. In project areas, coverage rose to 50 percent. By contrast, the government subsidy for the near-poor was 50 percent (until 2012), and the national average coverage rate is 17 percent. The reality is that, with a low poverty line, the near-poor are not all that different from the poor. To these groups, affordability is probably the most important constraint for enrolling into contributory insurance schemes, no matter how large the subsidy is.

Enrollment among formal sector workers, a mandated enrollment group, is also low—59 percent in 2011—primarily due to weak enrollment compliance. While the Vietnam Social Security agency (VSS) has jurisdiction over many critical elements of health insurance in Vietnam, it is not legally empowered to conduct inspections of SHI compliance (that is, to ensure that companies register all employees). This is a function left to other government agencies, which lack adequate financial and human resources to fulfill this role. As a result, private enterprises are not monitored or inspected thoroughly for compliance.

Adverse selection is a major threat to the financial sustainability of SHI because many groups in the population belong in the voluntary enrollment

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category and enrollment compliance is weak even in the mandatory enrollment category. There is evidence of adverse selection among the voluntary, contributory subgroups. Vietnam Household Living Standards Survey (VHLSS) data show that among people who do not fall into any of the mandatory groups, illness during the previous four weeks and previous year significantly increases their motivation to enroll. Families of formal sector workers have a higher probability of enrolling in SHI when they have been ill during the past 12 months (Lieberman and Wagstaff 2009). Indeed, average SHI expenditures per capita far exceed the premium for the voluntary insurance groups. Reducing the size of the voluntary enrollment group is therefore critical not only for improving coverage, but also addressing the problem of adverse selection.

Enrollment rates are high among the fully subsidized and mandated enrollment groups—92 percent in 2011—but this does not translate to effective coverage. Nearly 27 percent of all children under six do not have their health insurance cards (HICs), with the rate even higher for ethnic minority children and children without birth certificates. The enrollees do not always receive the HIC, and are not aware of their entitlements or able to use services. The Knowledge, Attitudes and Practices (KAP) survey carried out by MOH and UNICEF (2012) identified several reasons for this in relation to children under six (box 2.1).

The lack of portability of health insurance is another factor that undermines effective coverage. Internal migration has increased in recent years. The National Census in 2009 showed that the number of registered migrants aged five and above rose from 4.5 million in 1994–1999 to 6.6 million in 2004–2009. Current SHI Law does not allow the insured to seek care outside the locality where they are registered except in the case of emergencies. A 2011 study of migrants showed that less than 15 percent of migrants owned a HIC. When ill, 78 percent of migrants paid out of pocket for health care. For SHI beneficiaries among the

Box 2.1 Survey of the Knowledge, Attitudes, and Behavior of Parents Related to the Use of SHI for Children Under Six Years of Age in Vietnam

In 2012, Ministry of Health (MoH) and UNICEF conducted a study to better understand the constraints and bottlenecks in the implementation of SHI and identify ways of increasing coverage and uptake of services covered for children under six. A representative sample of urban, rural, and ethnic minority households was selected from four provinces (Ho Chi Minh City [HCMC], Ninh Thuan, Kon Tum, and Dien Bien). The sample consisted of 450 households or 1,800 families. In addition to administering questionnaires, 80 in-depth interviews and a dozen focus group discussions with policy makers, service providers, and parents were conducted.

Survey findings

1. *Not all eligible families own health insurance cards.*
   About one-quarter of families surveyed did not own the card even though they were eligible, with the proportion of households without a card highest among ethnic minority

box continues next page

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Box 2.1 Survey of the Knowledge, Attitudes, and Behavior of Parents Related to the Use of SHI for Children Under Six Years of Age in Vietnam *(continued)*

groups and migrant populations in HCMC. Reasons include: (a) poor knowledge about services covered for children under six; (b) being able to use the birth certificate instead of the insurance card; and (c) a perception that services at government health centers at the district level are of poor quality.

2. *Not all families who own cards actually use them.*
   Only one out of five survey participants actually used the card. The rate of nonuse of the card was especially high among migrant populations and ethnic groups residing in remote mountainous areas in Dien Bien. Families lack knowledge on how the health referral systems work and parents preferred to take their sick children directly to a district facility rather than a commune or village health center. Hidden costs related to transport, seeking alternative childcare, and accessing services also deterred families from using government facilities. Some families preferred to use private facilities, as they could be accessed in the evening when government centers were closed.
3. *Communication about health insurance cards remains weak.*
   Families learn about the services covered by health insurance for children under six from health workers, population collaborators, local authorities, TV, and social workers, respectively. Yet, families who had a permanent residence had more knowledge and access to additional information than migrant families. Parents and families are not fully knowledgeable about all services that are covered under the health insurance scheme for children under six, as only one-half of surveyed families were ever counseled.

Recommendations from the survey include:

a. Improve cooperation between health sector and social affairs to improve the procedure of issuance and payment.
b. Provide greater flexibility for migrant families to access health facilities in different provinces or districts.
c. Improve counseling to parents in relevant ethnic minority languages as part of routine outreach and campaigns around child health.
d. Communication needs to go beyond awareness raising to address confidence and self-esteem to obtain, use, and demand services.
e. A communication plan should be linked to the overall system of improving access and use of health insurance for children under six.

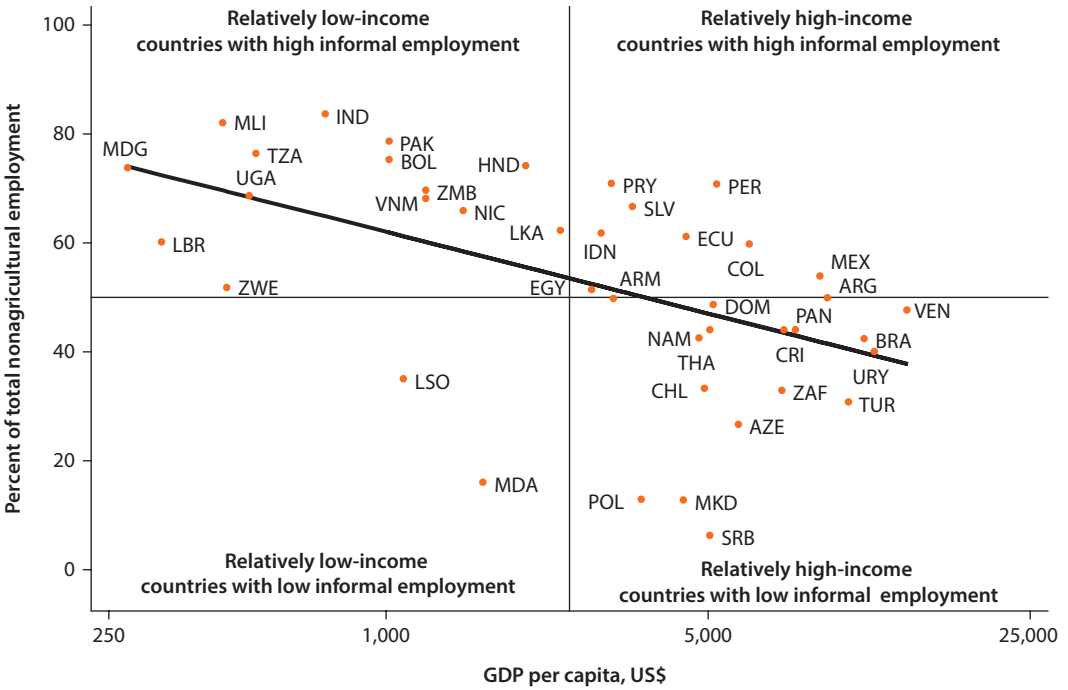
Source: MoH and UNICEF 2013.

migrants, SHI only covered 10 percent of total costs, while nearly 60 percent of migrants did not seek care at all.

Global Experiences with Increasing Enrollment Rates and Coverage

Enrolling the informal sector is not simply a short-term problem. Globally and historically, richer countries have tended to have lower levels of informality (the proportion of labor force in informal employment) than poorer countries

Figure 2.3 Informal Employment and GDP Per Capita in 41 Countries



Source: Based on data from the ILO Department of Statistics (2012) and the World Bank's World Development Indicators.
Note: x-axis in log scale. Countries represented on the chart: ARG: Argentina, ARM: Armenia, AZE: Azerbaijan, BOL: Bolivia, BRA: Brazil, CHL: Chile, COL: Colombia, CRI: Costa Rica, DOM: Dominican Republic, ECU: Ecuador, EGY: Egypt, Arab Rep., HND: Honduras, IDN: India, IND: Indonesia, LBR: Liberia, LKA: Sri Lanka, LSO: Lesotho, MDA: Moldova, MDG: Madagascar, MEX: Mexico, MKD: Macedonia, FYR, MLI: Mali, NAM: Namibia, NIC: Nicaragua, PAK: Pakistan, PAN: Panama, PER: Peru, POL: Poland, PRY: Paraguay, SLV: El Salvador, SRB: Serbia, THA: Thailand, TUR: Turkey, TZA: Tanzania, UGA: Uganda, URY: Uruguay, VEN: Venezuela, RB, VNM: Vietnam, ZAF: South Africa, ZMB: Zambia, ZWE: Zimbabwe.

(Bonfert, Martin, and Langenbrunner 2013) (figure 2.3). Economies such as Japan, the Republic of Korea, and Taiwan, China, saw dramatic reductions in informality alongside rapid economic growth. This trend has been questioned of late, particularly in the East Asia Pacific region, where informality has proved to be more persistent.

Like many other developing countries in this region, Vietnam is expected to have a large informal sector over the next few decades and face associated problems of limited ability to raise public revenues from income and labor-related taxes. Problems usually encountered with providing health insurance for the informal sector, such as low enrollment rates, difficulties in assessing income and collecting payments, and adverse selection are likely to persist. Thus, strategies are needed to enroll the informal sector, as well as other hard-to-reach groups such as the near-poor more quickly and cost-effectively.

General Revenue Financing to Subsidize Enrollment

Expanding coverage, particularly for the near-poor and informal sector, will require significant additional general revenue financing. At present, the strategy

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for expanding coverage to the informal sector and the near-poor relies largely on voluntary enrollment. To date, no country has ever achieved universal coverage (UC) by relying mainly on voluntary contributions (Kutzin 2012). Instead, most countries that have successfully expanded coverage to the hard-to-reach near-poor and/or informal sectors have done so by mandating enrollment and financing it through general revenues, either in whole or in part (box 2.2). Compulsion, with subsidization for the poor, is a necessary condition for universality (Fuchs 1996).

Subsidizing coverage through general revenues may imply moving away from the idea of a purely or even a predominantly contributory basis for entitlement and coverage. In the case of Japan, rapid economic growth and dramatic reductions in the size of the informal sector made it possible to achieve UC on a largely contributory basis. In the case of Korea and Taiwan, China, the combination of rapid economic growth and authoritarian political regimes made it possible to enforce mandatory enrollment and ensure employers complied with the law to meet one-half of their employees' contribution (Kwon 2011). In present-day low- and middle-income Asian countries, economic growth has been curtailed by the global economic crisis, and informality is quite persistent, as already noted. In this context, countries would need to expand coverage on a noncontributory basis to achieve UC.

Relying on general revenues to enroll the informal sector has several benefits including administrative efficiency, avoidance of the risk of adverse selection, and

Box 2.2 The Role of General Revenues in Subsidizing Enrollment: The Global Experience

China: The National Cooperative Medical Scheme (NCMS) for the rural population in China provides an 85 percent subsidy toward premiums, and has achieved over 90 percent coverage.

Germany: Allocates general government revenues to subsidize coverage for those who cannot afford to enroll.

Hungary: Increasingly relying on general revenues to cover the informal sector.

Japan: Introduced the Citizen Health Insurance Scheme in 1958, and made enrollment mandatory for those not employed in the formal sector. Although this was initially a community-based insurance scheme, increasingly local governments subsidize enrollment.

Republic of Korea: Partial general revenue subsidy for informal sector workers.

Mali: Subsidizes premiums at 50 percent.

Moldova: Increasingly relying on general revenues to cover the informal sector.

Taiwan, China: Partial general revenue subsidy for informal sector workers.

Thailand: Extended SHI coverage to 90–100 percent of the population despite its lower-middle-income status. Sixty percent or more of the insurance fund was from general revenues.

United States: Administers subsidies on a sliding scale for the nonformal sector.

Source: Bonfert, Martin, and Langenbrunner 2013.

Moving toward Universal Coverage of Social Health Insurance in Vietnam
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the fact that it is more progressive financing. Given the mobility and high degree of fluctuation of their incomes, the administrative costs of enrolling, monitoring, and collecting contributions are high for informal sector workers. Second, mandatory enrollment of the population through transfers from general revenues effectively reduces the risk of adverse selection, which occurs under voluntary enrollment. Box 2.3 provides two examples from this region where the costs of voluntary contributory enrollment proved high. Third, general revenue taxation is a more progressive source of financing than SHI, as the contribution for SHI is either proportional to current income and subject to a cap, or levied at a flat rate (Kwon 2009).

There are also two drawbacks to consider: the budgetary impact and the risk of the sector expanding. In the absence of any new tax revenues, the general revenue-financed coverage expansion will have an immediate budgetary impact, thus reducing fiscal space across sectors. This increases SHI's dependence on allocations from MoF, potentially jeopardizing financial sustainability (Bonfert, Martin, and Langenbrunner 2013). Korea and the Philippines are addressing these issues through the introduction of a so-called sin tax (see chapter 5). Secondly, tax financing for the informal sector may increase informality: as health insurance for informal sector workers is provided at no cost or reduced cost, there is an incentive for employers and/or workers to stay or even switch to informal arrangements to avoid paying the mandatory contributions associated with formal employment (see box 2.4).

Box 2.3 Challenges of Voluntary, Contributory-Based Enrollment in the Philippines and Thailand

Philippines: In 1999, PhilHealth launched the Individually Paying Program (IPP) in order to extend SHI coverage to all nonpoor informal sector workers. Enrollment was mandatory for individuals not covered by any other program. From 1999 to 2012, despite various attempts to enforce enrollment of the near-poor and nonpoor informal sector (for example by (a) requiring proof of PhilHealth membership to obtain a new driving and other professional licenses, and (b) the SHI fund providing religious and cooperative organizations with group discounts to encourage them to enroll their entire membership), two-thirds of the voluntary enrollees did not pay their premiums on a regular basis. Moreover, IPP enrollees were more likely to be chronically ill and have higher utilization rates than the average beneficiary of PhilHealth. Under the 2013 amendment to the health insurance law, the near-poor are now eligible for coverage under the subsidized Sponsored Program.

Thailand: Starting in 1991, the Voluntary Health Card Scheme attempted to expand coverage to informal sector workers. The scheme failed largely due to adverse selection and abuse (for example, through enrollment following diagnosis of a condition). The scheme was abandoned in 2007 and replaced by the fully subsidized Universal Coverage Scheme (UCS; Hsiao and Shaw 2007).[2]

Source: Bonfert, Martin, and Langenbrunner 2013.

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Box 2.4 Evidence That Tax Financing for the Informal Sector Increases Informality

Colombia: An increase in informal sector employment of 2–4 percent was attributable to the design of the health sector reform, which included subsidized premiums for the poor and nonworking populations (Bitran 2013).
Thailand: The introduction of UCS increased informal sector employment by 2 percent after the reform, growing to 10 percent over the first three years (Wagstaff and Manachotphong 2012).

Box 2.5 Experience with Family-Based Enrollment from the EAP Region

China: The NCMS in rural areas provides family enrollment, but the other two schemes do not.
Japan: Insurance was extended to dependents of formal sector workers as early as 1939.
Republic of Korea: The SHI scheme adopted family-based membership early on, with dependents becoming members of the scheme that the head of household was enrolled in. To ease the financial burden on small business, employers of firms with fewer than five employees were exempted from paying their contribution for their employees until 2000 (Kwon 2009).
Philippines: Each membership category of PhilHealth entitles the legal dependent[3] of the principal member to standard benefits (Obermann et al. 2006).
Thailand: The Civil Servants' Medical Benefit Scheme (CSMBS) covers civil servants as well as their dependents.[4] Enrollment into CSMBS is free and is seen as a fringe benefit for government employees who receive lower wages than private sector employees. While the health insurance scheme for all other formal sector workers—the Social Security Scheme (SSS)—does not cover family members, the latter are entitled to join the UCS, enrollment of which is entirely free of charge. With nearly two-thirds of the Thai workforce in the informal sector, enrolling the informal sector as well as the family members of formal sector workers in UCS proved to be the most efficient way to expand coverage.

Family Enrollment

Family-based enrollment increases risk pooling and addresses the problem of adverse selection. It typically involves enrollment of the employee's immediate family consisting of spouse and children, however, it can also include other members of the family. It reduces the size of the informal sector by extending coverage to spouses and family members of formal sector workers. It also expands the risk pool and assists in spreading health risks more widely across the population. By reducing the share of the population that would otherwise have been voluntarily enrolled, it also reduces the risk of adverse selection. East Asia and Pacific (EAP) countries that have successfully expanded SHI to achieve UC have tended to encourage family-based enrollment (box 2.5).

Family enrollment does, however, imply greater spending, with contributions typically having to double to cover workers' dependents (Hsiao and Shaw 2007). In Thailand, coverage was extended to dependents only after SHI accumulated a large surplus. The majority of family members are now covered through UCS. China's NCMS membership for family members is subsidized, but family members still need to pay the same premium as the main enrollees to enroll.

Enforcing Mandatory Enrollment in the Formal Sector

Weak enrollment compliance is a characteristic of many SHI systems and is widely recognized as a barrier to increasing coverage rates among the near-poor and formal sector workers, and achieving UC generally. In Colombia, evasion in the contributory scheme was estimated to cost US$836 million in forgone revenues (2.75 percent of GDP) mostly due to underreporting of income and nonpayment (Escobar and Panopoulou 2003). Evasion is also a problem in the Philippines among small businesses, with only 30 percent of those who should be contributing actually paying (Jowett and Hsiao 2007). Good information systems and strong governance and organization of all payment collection, including payroll taxes and SHI payments, are vital for ensuring enrollment compliance.

Information, Education, and Communication

The decision to enroll in, and use, health insurance is strongly influenced by perceptions, education, and cultural factors. In Kenya, for instance, the most important factor preventing enrollment is informal sector workers' lack of awareness about the National Hospital Insurance Fund (Mathauer, Schmidt, and Wenyaa 2008). In Indonesia, the main barrier to accessing health insurance was simply a lack of information about available options (Bappenas 2012). Thus, information dissemination and sensitization about health insurance entitlements are critical for ensuring effective coverage. Such information and social marketing have indeed played a critical role in expanding coverage in several countries (box 2.6).

Box 2.6 The Role of Information, Education, and Communication in Expanding Coverage

China: For rural residents, media advertising is used to encourage voluntary enrollment. Reimbursement of claims for individual patients is posted on village bulletin boards to publicize the tangible monetary benefits of health insurance (Liang and Langenbrunner 2013).

Thailand: Mass media coverage played a crucial role in expanding coverage rapidly (Van Lente, Pujiyanto, and Thiede 2012).

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Recommendations

Short Term

Recommendation 1: Substantially increase general revenue financing to subsidize enrollment for the near-poor and/or informal sector. This includes raising the subsidy for the near-poor to 100 percent.

Vietnam has already acknowledged the important role of general revenues by fully subsidizing the cost of insurance premiums for the poor and other vulnerable groups, and raising the subsidy for the near-poor to 70 percent in 2012. To achieve UC, these subsidies will have to be expanded further. The subsidy for the near-poor will have to be increased to 100 percent in the short term. The government should also incrementally increase the subsidy for the premium for those in the agriculture, fisheries, and forestry sectors who, although not poor, may face significant barriers to purchasing health insurance and accessing health services. The fiscal implications of this recommendation are estimated and discussed in chapters 4 and 5.

Recommendation 2: Strengthen the demand side by enhancing information, education, and communication (IEC) about health insurance.

When households/individuals still fail to register or use the HIC despite facing zero costs of enrollment, more clearly needs to be done to strengthen information and education about SHI, and invest in behavior change communication. Understanding what beneficiaries are entitled to, and how health providers actually use and process SHI, is important.

The KAP survey report (UNICEF 2012) points out that making sure that the population comprises informed users of SHI who know what they should expect would also make providers more accountable to their beneficiaries. The recommendations from the KAP survey, particularly in relation to children under six, are:

1. There needs to be a more effective communication strategy which focuses on parents and caregivers; includes a mix of approaches and channels; is sensitive to the needs of specific groups like ethnic minorities, and includes monitoring and evaluation indicators to measure changes in knowledge, attitudes, and practice. The evaluations should be used to modify and improve the communication strategy.
2. Better communication is needed to make sure users understand the use of referral services.
3. Better communication is needed on the scope of the package that is covered by SHI, so as to dispel any misperceptions about hidden costs.
4. Issues such as delays in obtaining cards for enrollees need to be addressed by VSS.

Medium Term

Recommendation 3: Provide financial incentives to encourage family-based enrollment.

Vietnam SHI can extend family enrollment in two ways. Firstly, it can provide additional incentives to the near-poor to enroll their families in health insurance. The subsidy for family enrollees (initially defined as the spouse and children under the age of 21) could be increased to 80–90 percent, instead of the 70 percent for individual enrollees. The World Bank's Central North Project provided a 10 percent additional subsidy for family enrollment and resulted in a higher take-up than under the individual policy. This indicates there is demand for family enrollment. Secondly, family membership could be offered to formal sector workers, and employers could be encouraged to provide for family enrollment through tax breaks. Payroll taxes will have to increase to cover the costs of family enrollment; however, the increase in enrollment rates and, consequently, in premium revenues could have a beneficial impact on SHI more broadly. Preliminary estimates indicate that the costs to GoV of increasing family enrollment would range from VND 4,838 billion to VND 7,221 billion under different assumptions of how much of the premium of the different groups is subsidized by the government (table 2.1).

Recommendation 4: Enforce enrollment compliance in the mandatory enrollment group, particularly formal sector workers. This would include implementing the decree stipulating penalties for violation of health insurance regulations, and increasing the penalties for noncompliance.

In Vietnam, increasing compliance with SHI enrollment could mitigate adverse selection in the mandatory SHI scheme, maximize premium contributions, and reduce fraud and abuse. A government decree stipulating penalties for violation of health insurance regulations has been issued now but penalties are too low to enforce compliance with SHI regulations. Good information management systems are needed to significantly increase compliance. This would ideally include unique identifiers, the ability to carry out real-time coverage checks between provider and VSS, and a revenue collection database which would link

Table 2.1 Simulations of the Incremental Costs of Covering All Eligible Families

Assumption number	*Chapter 2 health insurance premium*	*Features*	*Incremental cost (VND)*
1	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor and 30% of the premium for nonpoor farmers. Civil servants pay for dependents.	4,838 billion
2	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor, 100% for the poor, and 30% of the premium for nonpoor farmers.	4,902 billion
3	4.5% of the basic salary	GoV subsidizes 70% of the premium for near-poor, 100% for the poor, and 50% for nonpoor farmers.	5,493 billion
4	4.5% of the basic salary	GoV subsidizes 100% of the premium for near-poor, 100% for the poor, and 50% for nonpoor farmers.	7,221 billion

Source: Hanoi Medical University and World Health Organization 2013.

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individual identifiers to the employer identifier. The organization, management, and governance of SHI more broadly are also critical, as discussed further in chapter 7.

Notes

1. In 2013, during the regular supervision of health insurance (HI) implementation in 42 provinces, it was found that about 800,000 HI cards (about 2 percent of the total number of cards issued) were duplicated. Some enrollees were found to have up to five cards each. This was almost always for groups whose insurance enrollment is fully subsidized by the government, including the poor, war veterans, meritorious people, and children under 6. Since the total number of enrollees and the enrollment rate are both calculated on the basis of the number of cards issued rather than the number of people actually registered, the existence of multiple cards per enrollee implies that the enrollment numbers/rates may be overestimated. This issue is currently under review by GoV.
2. UCS is a tax-funded health insurance scheme, targeting 47 million people who were not covered by the existing Civil Servants' Medical Benefit Scheme (CSMBS) or Social Security Scheme (SSS).
3. Legal dependents are spouse and children below 21 years of age, as well as children and parents over 21 years of age with physical or mental disabilities.
4. Dependents are spouses, parents, and children under 21.

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