CHAPTER 8

Strengthening the Organization, Management, and Governance of Social Health Insurance

The previous chapters have shown that the performance of the social health insurance (SHI) system would need to improve in many respects to meet the universal coverage (UC) goals set out in the Master Plan. SHI manages large amounts of financial resources that are mobilized through a myriad of contracts with public and private providers and suppliers that require sufficient and sophisticated management skills. To address the current set of challenges, the SHI system has to be clearly defined, regulated, and supervised. This chapter examines the organization, governance, and management of SHI in Vietnam with the aim of identifying the tools and processes that are already in place and/or are needed to keep the actors involved in SHI accountable.

The organization, management, and governance of SHI need to be analyzed critically in order to address the structural and operational issues facing SHI in the immediate future. For UC to be achieved within the timeframes that the government has set forth, bold decisions have to be taken and translated into providing SHI with a road map for success. This includes revising the SHI Law, which the government has set out to do in 2014 (WHO 2013). It also implies revising the roles of Vietnam Social Security (VSS) and of the Ministry of Health (MoH) regarding SHI. In particular, it is essential to have one specialized and dedicated entity for SHI with its own SHI Board to ensure rational decision making, transparency, and accountability.

To begin with, two basic questions need to be addressed:

1. Who, or which entity, will be responsible for making participation in SHI universal with properly financed quality health care goods and services? and
2. Which changes in SHI administration are necessary to expand enrollment and increase financial protection and access to universal health care (UHC) services?

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UC for the population is an explicit policy goal of the Government of Vietnam (GoV) enshrined in the Constitution: "The State… ensures health care insurance and creates favorable conditions for all people to enjoy health care." In this constitutional context, GoV has given high political and institutional priority to SHI as the main legal and financial instrument for financing access to available health care goods and services for the population and to achieve UC.

In the endeavor for financial protection and UC, it is important to have an approach that is innovative, integrative (that is, it effectively assembles and converges all available resources—legal, financial, institutional, and human), and timely (within the timetables of the Master Plan for UHC from 2012 to 2015 and 2020 submitted by the MoH to the prime minister in 2012.

Problem Diagnosis

Design Failure

Current SHI organization and management present problems that serve to explain the relatively low performance of SHI in terms of enrollment, financial protection coverage, and actual access to quality health care goods and services. The overall problem has to do with the current structure for SHI administration and management. The nature of this problem is simple. The SHI Law has a good design for SHI administration and management, but an independent social health insurance agency (SHIA) has not yet been implemented. Instead, some features of SHI administration and management have been entrusted to VSS, and others to the MoH. Failure in design is the cause of most inefficiencies and low performance in any organizational endeavor, be it public or private. In the case of SHI in Vietnam, which is a financial venture of major proportions, failure in the interim design is the prime cause of current implementation problems.

Institutional Fragmentation

The consequent institutional fragmentation prevents a coherent implementation of SHI functions, for example, on the critical function of purchasing of health care goods and services and contracting with providers and suppliers. In the Vietnam institutional public system, VSS is considered an implementer organization, but with no implementing powers. This means that VSS does not have the ability to control the implementation process with implementing regulations, inspections for regulatory compliance, follow up of contract compliance, and resolving conflicts with providers and among providers and beneficiaries. VSS is assigned responsibility for purchasing health services but cannot operate as a strategic purchaser to effectively manage some of the risks involved in the health insurance scheme, including the fundamental risk of overexpenditure.

Institutional fragmentation causes gaps in managerial and technical capacity related to monitoring and enforcement of enrollment and collection of contributions, financial and claims management, actuarial analysis, benefit package design, and setting of payment mechanisms and remuneration rates. Other important tasks such as accreditation, costing of health services and monitoring,

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cost projection, actuarial analysis, monitoring of key system performance indicators, as well as guidance and assistance to employers and beneficiaries have been largely overlooked.

The MoH and the Ministry of Finance (MoF) are responsible for setting SHI rules and regulations including both "health insurance (HI) policies" and implementation regulations. Within MoH, SHI rule-setting responsibilities are divided across several departments, with each department dealing with a very specific task and issue (WHO 2013). Effective operation of the health insurance scheme is, therefore, compromised because policies and rules are not adequately integrated. MoH competes with VSS as SHI implementer rather than providing the overall SHI policy vision.

Different Management Structures

Differences in management structures and levels of authority between VSS and MoH make communication and collaboration difficult. VSS is vertically organized, with a central agency and provincial and district agencies that are highly dependent on central instructions and decisions (WHO 2013). The role of VSS includes all social insurance schemes—pension insurance, health insurance, and other short-term allowances such as sickness and maternity. Health insurance is one of many VSS responsibilities (WHO 2013).

The technical competence to administer a complex health insurance system is underestimated and made even more difficult to manage when health financing/insurance functions within VSS are internally fragmented and intermingled with those functions pertaining to other social insurance schemes. At the MoH, three central departments deal with, and are in charge of, health insurance matters. The critical task of local oversight of health insurance is devolved to the provincial level. Both the central MoH and provincial Departments of Health (DoH) have direct oversight and ultimate responsibility for the operations of all government health care service providers, with limited coordination and uniform oversight approaches. In all, the problem of SHI governance is imbedded in the present institutional configuration.

While there are no formal/legal "veto powers" of VSS, experience over the past five years indicates that the MoH always has to negotiate with VSS to get an agreement on legal and regulatory provisions before submitting them to government, be it the cabinet or the prime minister (WHO 2013). As a result of the current decision-making structures and rules, legal and regulatory provisions around health financing sometimes turn out to be incoherent or vague. The VSS Director-General is responsible to the government, the prime minister, the VSS Management Council, and relevant cabinet members. These multiple layers of responsibility weaken overall accountability. There are no legal specifications of the implications of this responsibility other than reporting requirements (WHO 2013).

Reporting and Transparency

The SHI Law does not adequately outline reporting requirements. Minimal reporting requirements, therefore, result in minimal reporting by VSS. Of critical

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importance for SHI is the fact that VSS reporting is aggregated for all funds under VSS management, rather than a disaggregated one for each social insurance component (WHO 2013). Thus, the uniqueness of SHI financial management performance cannot be properly understood or assessed—resulting in an outcome that lacks transparency.

Weak Supervision

The only mechanism for oversight is the VSS Management Council, which is in charge of overseeing all social insurances under VSS. The roles and functions legally ascribed to this body are limited. For instance, the VSS Management Council has no decision-making powers other than decisions on investments. Hence, it does not perform in practice as a strong supervisory or oversight body. Most critically, the VSS Director-General himself is the Standing Vice Chairperson of the Management Council (WHO 2013). There is a conflict of interest, in that the key person in charge of oversight is supervising himself.

The VSS Management Council does not allow for wider stakeholder participation and key actors (providers, beneficiaries) are not represented. For instance,

- at the provincial level, there is no mechanism for stakeholder participation;
- accountability of VSS and of government with respect to implementing HI is rather weak; and
- there are few consequences for poor performance. It is also difficult to pinpoint the responsible actor.

Overall Diagnosis

The resulting diagnosis is that organization, management, and governance of SHI are fragmented and dysfunctional. This scenario makes SHI implementation slow, complex, and inefficient. To meet GoV's policy goals as set out in the Master Plan and move rapidly toward UHC, the present institutional setting for SHI needs to be assessed and changed. This chapter elaborates on these issues and proposes some corrective courses of action.

Brief Overview of the Social Health Insurance Law of 2008

The SHI Law sets up the general framework for health insurance in Vietnam and aims to ensure financial protection for the population in accessing available quality health care. Subsequent implementing regulations (Circular 09, Circular 10, Circular 11) seek to clarify and guide implementation of the SHI Law. The SHI Law defines the scope (Article 1) and principles of health insurance (Article 3), identifies the subjects and beneficiaries, both mandatory and voluntary, and their contribution, and state subsidies when applicable (Articles 12–15). It also deals with the health insurance card (Articles 16–20), health insurance benefits in general terms (Articles 21–23), and rights and obligations of the insured, providers, and the SHIA, although these are yet to be established (Articles 36–44) (WHO 2013).

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The definition of SHI as "the non-profit type of insurance that is implemented in the health care sector by the State, and involves the participation of responsible parties under the provision of this law," does not define the "type of insurance" nor make explicit the objective of SHI. SHI is a specialized type of insurance and is different to private indemnity health insurance (WHO 2013). Its specific purpose is to provide financial protection to the whole population for accessing health care goods and services. In the SHI Law, the objective of SHI has either not been stated or is stated inadequately.

The first health insurance decree in 1992 stated: "SHI is established to mobilize contribution from individuals, collectives, community and society, to improve quality of health care". This was revised in two subsequent decrees as: "the purpose of SHI is to mobilize contribution of employers, workers, organizations, and individuals, to pay for the cost of health care, when an HI card holder is sick." These "definitions" failed to emphasize specifically that the ultimate goal is financial protection to access needed quality health care for the population at large. Overemphasis on resource mobilization overlooked the importance of the optimal use of the resources. The Law created a single mandatory SHI scheme for pensioners, formal sector workers, socially privileged groups (such as revolution meritorious people, war widows, and orphans), the poor (previously covered by the Health Care Fund for the Poor), near-poor, children, and other social protection groups. The Law set a goal for compulsory enrollment of all population segments by 2014.

The existence of almost 30 categories of SHI beneficiaries in the SHI Law is unnecessary and an administrative burden. All beneficiaries belong to either the contributory regime (all those with ability to pay social insurance premiums/contributions based on the formal employment sector) or the subsidized regime (all those whose premiums/contributions are subsidized one way or another and in any proportion by the State or other entities). Multiple categories complicate enrollment and are a source of inefficiency, as discussed in chapter 2.

Moreover, having multiple beneficiary categories can result in the same person falling into two membership categories: a child from a poor family, for example, falls into both the children category as well as the poor. This overlap complicates the enrollment procedures, and lists end up being unreliable. There are no regulated priorities or criteria for classification. It is difficult to shift from one group to another—for instance, a person in the informal sector gaining employment in the formal sector. In addition, this process and its fragmentation also complicate the issuing of ID cards, and it is open to confusion, the issue of multiple ID cards to enrollees, and fraud and abuse (WHO 2013). Because enrollment does not mean actual access to health care coverage, these issues are of critical importance for achieving, UHC and universal financial protection. Chapter 2 elaborates further on the issues of enrollment.

Revising the Health Insurance Law Based on Experience and New Challenges

The experience of four years of implementation of the SHI Law shows institutional inconsistencies, unclear mandates, and responsibilities that limit the organization, management, and governance of SHI from being effective, efficient,

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and equitable. This, in turn, makes achieving the goals of universal enrollment, financial protection, and access to health care difficult. Based on this experience, the GoV has decided to review the SHI Law to improve the overall organization, management, and governance of SHI to achieve UC in a fiscally sustainable manner. The government acknowledges the need to introduce corrections within the present multi-institutional structure to make SHI more efficient, effective, and equitable. Revision of the SHI Law is listed for discussion by the Legislative Assembly later in 2014. Those issues related to organization, management, and governance of SHI as discussed in this chapter are critical for this review.

The following suggestions should be considered during the revision of the SHI Law:

1. Define the objective of SHI as "financial protection to access available and needed quality health care goods and services for the population."
2. Make explicit that SHI is (a) a mechanism to finance the provision of health care goods and services; and (b) that SHI administration is a financial endeavor, not a health matter.
3. Retain in the revised SHI Law the establishment of the SHIA even if it will not be implemented in the immediate future. Once the process of universalization of HI financing and service coverage increases, SHI managerial and governance tasks will be extraordinary and the need for an autonomous, specialized, and competent SHIA will become apparent.
4. Include a transitional provision that states that until the SHIA is established, VSS will perform the role of SHI administrator.
5. Eliminate the long list of SHI beneficiaries. The end purpose of SHI is UC—meaning the whole of the population regardless of classification. The only important distinction will be beneficiaries who are contributors (the contributory regime) and beneficiaries whose contributions are subsidized (the subsidized regime).
6. Include an article stipulating the principle that SHI financial resources are for the financing of health care goods and services included in the standard services package. This would allow for supplemental benefits packages (for example, a hospital package) with additional contributions in the future and for a more efficient SHI administration. There should be a limited use of SHI financial resources for building public health care sector capacity, such as capital investment in building, renovations, ambulances, and equipment. This is a duty of the MoH as owner, or a responsibility of autonomous hospitals with financial resources other than SHI funding. Diverting SHI financial resources to finance other than service packages discourages contributors, as they perceive that the money is used for purposes other than health care financing. Increased enrollment in the coming years will require increased financial resources for financing health care goods and services for more beneficiaries. SHI/VSS has to reserve sufficient financial resources to cope with incremental increases in financial demands.

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7. Include an article that stipulates the principle that other funds under VSS management cannot borrow funds from the SHI's financial resources. If this takes place, the borrowed resources should be replenished in the next fiscal year.
8. Include an article that stipulates that any financial surpluses from SHI should not be distributed. Any surplus should be added to reserves to secure financial protection for health care coverage for increased beneficiaries and toward the financing of UHC and financial health protection.

Organization of SHI

Weaknesses in the Current Organizational Framework, Roles, and Responsibilities

The SHI Law envisioned the establishment of a SHIA to administer SHI; however, to date this agency has not been established. The current administration of SHI is complex and fragmented. VSS[1] has been partially assigned the role of SHI implementer but has not been given regulatory, inspection, or enforcement functions. The SHI Law gives the MoH the mandate to manage SHI. In Vietnam the distinction between managing entities and implementing entities makes it difficult to have the unified institutional system that is critical for administering SHI. The VSS is considered an implementing agency whose role is to attend to administration functions but not to intervene in policy and regulation or in managerial decisions. The MoH's role of "managing" health insurance is not legally defined and it is not clear what it entails procedurally. Fragmentation and unclear definitions are potential sources of conflicts of competencies and make implementation performance complex and inefficient. A reformed VSS should be the entity managing health insurance with all the corresponding functions and attributions until the SHIA is established.

The important role of the MoH in SHI should be of overall SHI health policy, decision making on benefit packages (in consultation with VSS), regulating health care providers and suppliers, and supervising but not managing SHI (table 8.1). Supervision includes overseeing the effectiveness and efficiency of SHI management, and requesting, receiving, and reviewing reports from VSS/SHI on SHI performance on the different health financing/insurance functions (enrollment/registration/SHI ID cards; collection, pooling of financial resources; purchasing and contracting services and supplies; benefits package implementation; claim processing/payments, and complaints/conflict resolution). The MoH also has critical roles that affect SHI, such as health promotion and prevention, enhancing the quality and safety of the health care system by regulating health care providers and suppliers, strengthening the interests of patients, enhancing public health, preparing health care and public health legislation, developing and preparing legislation regarding standards for health care provision, and developing and overseeing the implementation of national and international public health programs.

The current fragmented organization, as illustrated in figure 8.1, generates a complex and less efficient and effective administration of SHI. In addition, this

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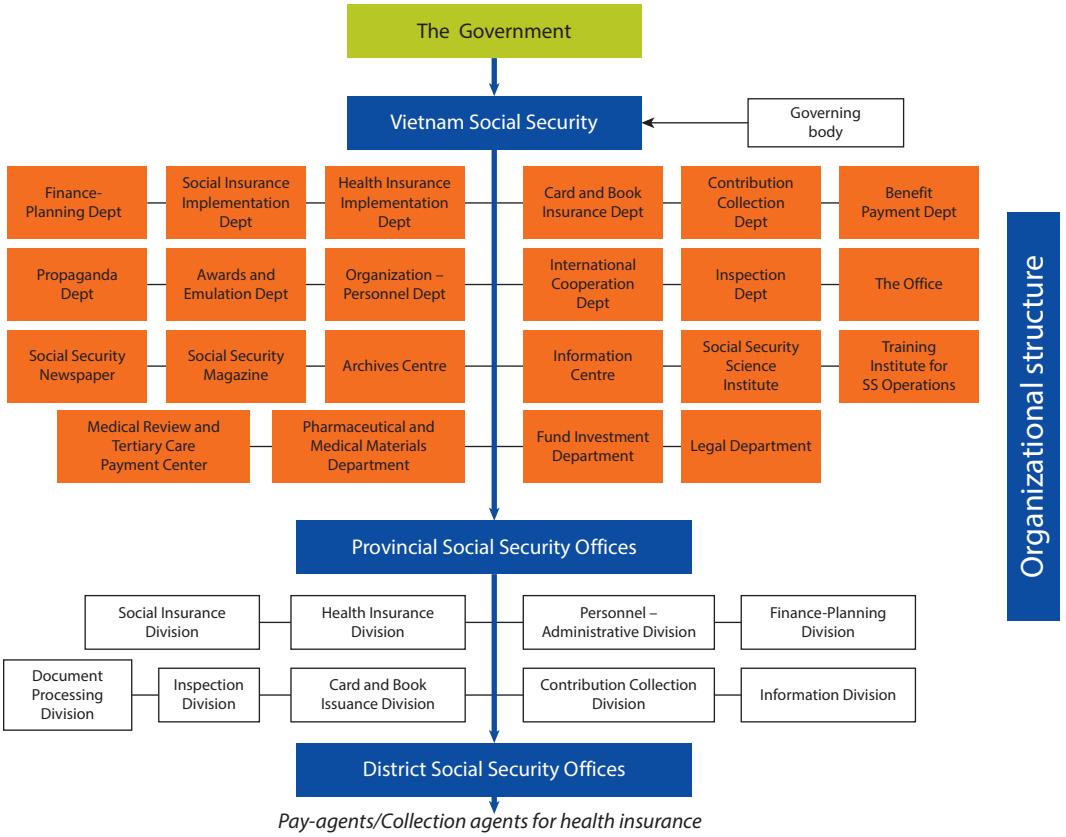
Table 8.1 Basic Roles of MoH and VSS/SHI in SHI

	Agency
MoH (Policy)	*VSS/SHI (Implementation)*
Function	
Overall SHI policy	SHI management
Decision making on benefit packages	Performing health financing functions: Enrollment Revenue collection Pooling Resource allocation Purchasing
Regulation of health care providers and suppliers	Managing conflict resolution with providers and suppliers
SHI supervision	Managing complaints from beneficiaries

Figure 8.1 VSS Organization Chart



Source: WHO 2013.
Note: Dept = Department; SS = Social Security.

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fragmented institutional environment makes it difficult to meet the main goals for health insurance in Vietnam: (a) expanding coverage to a larger section of the population; (b) deepening coverage to reduce out-of-pocket (OOP) payments by patients; and (c) containing costs.

VSS is a government agency that aggregates all social insurance schemes, managing all kinds of social security funds, such as pensions, SHI, unemployment fund, other social protection funds, and benefits (WHO 2013). VSS is vertically organized, with a central office as well as provincial and district agencies. VSS has about 20,000 staff in 63 provinces, of whom 600 are at the central office, 6,400 in provincial offices, and 13,000 in district offices. VSS staff has civil servant status. Implementing SHI is an added function to VSS and therefore not an exclusive or even dedicated institutional function. As such, Vietnam is one of the very few countries where all social welfare and social protection insurances, including health insurance, are managed by one agency.

SHI financing/insurance functions are also fragmented within VSS. Managerial tasks related to SHI such as enrollment, collection of contributions, planning, expenditures, and internal auditing cut across departments organized for all social insurance schemes, while complex technical issues related to health insurance administration—such as health insurance actuarial studies—get less attention.[2] Risk management, health care cost information and monitoring, active negotiating with health care providers, strategic purchasing, and counseling to health care users are not addressed adequately or dedicatedly. VSS has a range of health financing functions: (a) collecting SHI revenue from employers, government (central and provincial), households, and schools; (b) bringing funds together (pooling) and managing funds according to MoF's financial management regulation; (c) making payments to providers according to policies and regulations made mainly by MoH (but sometimes in collaboration with MoF for some specific financial issues); and (d) ensuring the SHI fund's solvency and fund growth (investment activities). In terms of fund management and operation, VSS is under strict and direct management of the MoF.

VSS is not an entity that is professionally and competently dedicated to SHI—with only three out of 20 VSS departments having responsibilities for SHI and limited staff numbers. These three departments include the Department of HI Implementation (with 23 staff), the Department of Pharmaceutical and Medical Materials (10 staff), and the Center of Medical Review and Tertiary Care Payment (with 100 staff, who have been moved recently from the Division of Medical Review, Hanoi metropolitan VSS agency) (WHO 2013).[3] VSS departments that also deal with other social security issues, as outlined above, are in charge of health insurance collection, enrollment, payment, and planning issues. None of these departments are, however, specifically concerned with monitoring or enforcing SHI enrollment and collection.

As the implementing agency, VSS engages in SHI administrative processes but does not directly intervene in policy and regulation or in managerial decisions proper. The MoH's role in SHI is in policy, "managing," and in rule setting or regulations (called "health insurance policies" in the SHI Law). In most countries

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this fragmentation is minimized by separating SHI financing from the functions of the MoH and entrusting them either to a separate autonomous SHIA or by clearly stipulating that the MoH supervises SHI but does not manage it, because of the potential to dilute responsibility and accountability on SHI.

One of the main responsibilities VSS has taken on is the balancing of financial resources for SHI so that total expenditure does not exceed revenues (WHO 2013). It is debatable whether this is a key role for VSS. It is not only important for the SHI Fund to remain solvent (as any financial institution has to), but also to ensure that investments to accumulate large reserves are not favored over the financing of health care services. Furthermore, it is difficult for VSS to fulfill its SHI responsibilities when it is not supposed to make any decisions on the fund's use. This includes defining benefits, contribution rates, and payment rates, as well as penalizing/sanctioning providers or patients for improper use of the funds. In this scenario, it is understandable that the MoH, MoF, and central and provincial government authorities, including the VSS, view VSS's role in SHI simply as one of a financial intermediary.

In order to enhance efficiency, effectiveness, and equity in SHI, VSS should consider introducing certain organizational changes:

- Establish within VSS an SHI Directorate/Division dedicated exclusively to administering SHI. This should be separate to other funds the VSS administers,[4] with separate accounts and separated reporting requirements, absorbing the current Health Insurance Implementation Department. One option would concentrate all SHI-related tasks presently in various VSS departments into the Health Insurance Implementation Department.
- Establish a Social Health Insurance Board to guide and supervise the SHI Directorate/Division at the level of the suggested VSS/SHI Directorate/Division with annual reporting to the VSS Management Council. Creating an SHI Board would contribute to transparency and accountability as well as bringing into SHI the voice and vote of key stakeholders. The SHI Board's main functions would be operational policy and supervision of the performance of the VSS on SHI rather than managing SHI. An independent chairperson appointed by the government should head the SHI Board. The composition of the Board is to be determined, but should include representatives of MoH, MoF, and MoLISA;[5] public and private providers and suppliers; beneficiaries, public and private; and the National Assembly's Committee on Social Affairs. The VSS SHI director/department head would serve as Secretary of the Board, with voice and no vote, and have the responsibility to implement the decisions of the SHI Board.
- Establish an SHI organizational structure based on the health insurance functions of enrollment, collection, pooling, and purchasing/contracting/claims management.
- Establish objective conflict resolution mechanisms such as an ombudsman to resolve conflicts between providers and beneficiaries/patients and a Grievances Committee for conflicts between VSS and providers and suppliers, all with independent members.

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- Establish a capacity-building and training unit for the development and implementation of a continuous training program for all VSS/SHI staff—both central and local.
- Revise the SHI Law to allow VSS to issue guidelines and regulations to implement SHI with inspection and enforcement powers.
- Develop management information systems for SHI administration.
- Develop the use of mobile transactions for SHI.
- Require post-State auditing reviews and reports on implementation of audit observations and recommendations.

Redefining the Role of the Ministry Of Health

The MoH plays various roles—including policy making, public health, regulator, owner of public health establishments, financing of tertiary hospitals (even though this is marginal with less than 10 percent of revenues coming from the MoH) (WHO 2013), and oversight. Provincial departments of health have stewardship functions, and finance provincial government health service providers.

Three MoH departments are involved in SHI: (a) Department of Health Insurance with 15 staff, many of whom are new and recruited from various provinces; (b) Department of Planning, with a newly established Division of Provider Payment, in charge of health care financing reform, formulating service price schedules, and provider payment mechanisms; and (c) the Department of Legal Affairs, which formulates and develops the legal provisions. It is important to note that SHI is a financial endeavor and not a health matter. The role of the MoH in SHI needs revision because health insurance for financing health care is not a task to be managed by any MoH.

The MoH and DoHs are concerned with ensuring the viability of government providers (especially hospitals) and the welfare of their staff, but these are separate tasks from health care financing. SHI finances the delivery of health care goods and services by providers that have to be qualified and competent. The MoH has the duty to ensure that providers and suppliers (public and public) are licensed, certified, and accredited, as appropriate. The MoH's Department of Medical Services Administration is in charge of hospital performance and quality of care and plays an indirect role because VSS has no supervisory role over the quality of care provided by the services it finances. Due to the absence or weakness of quality standards and supervision SHI entities usually ensure that performance standards will be met through terms and conditions included in contracts with public and private providers. This does seem to be the case with VSS contracts.

MoH and DoHs are involved in domestic pharmaceutical production and distribution, managing the government's substantial shareholdings in these companies. These issues might create a conflict of interest with another core function, which is "to regulate and govern pharmaceutical prices and stabilize drug prices in the market" (MoH Decree 188/2007). In this context, it might be difficult for the MoH and DoHs—as the third-party agency—to act as a neutral facilitator in disputes between providers and VSS. The steward-purchaser-provider split is thus incomplete at both the national and provincial level. In general, there is a feeling

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that it is difficult for MoH to maintain an independent or neutral position in its relationship with VSS, on one hand, and providers on the other.

VSS and MoH have different management structures that are not conducive to communication and collaboration, especially between provincial DoH and VSS agencies. This is exacerbated by the fact that within the provincial VSS agency, there is no specific department or unit in charge of health insurance, other than the Department for Medical Review and Tertiary Pay Centre ("Phong Giam dinh BHYT") (WHO 2013).

Management of SHI

Integrating SHI Management around the Key Health Financing/Insurance Functions

The institutional instruments needed to strengthen SHI management are critical. A Directorate/Division for Management of SHI within VSS would aggregate all current SHI-related functions in other VSS departments. SHI/VSS would have a director/department head and typical supporting units (legal, accounting, human resources, auditing, information, information technology (IT), and the like) and units dealing with the health financing/insurance functions. A new SHI Board would report on its work to the VSS Management Council but would not be a dependency of the Council. The SHI director/division head would be the ex-officio Secretary of the Board, preparing the agenda and reports for Board meetings as well as implementing the decisions of the SHI Board, but would have no vote. The key health financing/insurance functions to consider are enrollment, revenue collection, pooling, allocation, and purchasing.[6] Enrollment is added to the list of SHI management responsibilities explicitly in order to speed up compulsory and voluntary enrollment for universal financial protection and services coverage. Managing these functions properly is fundamental, especially when a mix of financial instruments is used. Interestingly, most if not all developing countries face constraints in their ability to manage these functions.

Enrollment Function

The enrollment function needs to be given priority to bring the whole population into the SHI system in the near future (five years). Enrollment, therefore, has to be a simple and efficient process. In Vietnam beneficiary fragmentation into different membership groups and individual membership makes enrollment managerially difficult (WHO 2013). Only in the case of the poor (as a membership group) is the enrollment unit the family. All beneficiaries fall into two categories—contributory or subsidized—making the listing of groups of beneficiaries complicated and impractical.

In spite of the mandatory enrollment requirements in the SHI Law, noncompliance is widespread. Many private employers do not enroll, or underreport the number of, employees (and/or their employees' salary). VSS monitoring of enrollment is weak due to a lack of staff and of incentives that are necessary to detect noncompliance. Unfortunately, there is little cooperation between

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the VSS and tax collection, or with provincial Departments of Industry and Commerce.

Given the need to improve enrollment in the short term, this task should be entrusted to an Enrollment/Beneficiaries Unit under SHI/VSS. Functions would include the identification of beneficiaries (and their families/households as appropriate), determination of SHI status (either contributory or subsidized), registration of beneficiaries, issuing of SHI ID cards, and keeping full databases of enrollees/beneficiaries. The database should also keep a record of beneficiaries who change their place of residence or of work to maintain the integrity of their ID card portability.

Revenue Collection Function

The revenue collection function is complex and should not be fragmented. This is an important and often underestimated function. Revenue collection in SHI is the process and procedures to receive funds from various sources: private employers (for salaried workers); government offices (for government employees); central and provincial financial departments (for children, poor, and socially assisted groups); households and schools (for informal sector and school children); and subsidies from the state budget to cover the financing of noncontributors (informal sector, the poor, the near-poor, and others as regulated).

Revenue collection is currently undertaken by the VSS and will most likely remain with VSS for the time being; however, the international trend is to coordinate and integrate tax and social contributions. The collection of social contributions should be integrated into the core processes of a tax system built on self-assessment principles (filing of returns, returns and payments processing, enforced collection, and post-assessment audit). The normal tax and employer returns are used as the basis for the information for assessment and payment collection—amended to incorporate new information fields needed for social contribution payments. Systems must be designed to capture specific information relating to contributors and transfer this to the SHIA in a form compatible with its IT systems.

While revenue collection remains with VSS/SHI, SHI revenues should be recorded and kept in separate accounts from other VSS funds. VSS/SHI should be able to contractually delegate parts of the collection process to banks, post offices, cooperatives, and others, while retaining the legal responsibility for the collection function.

Pooling Function

Funds are not currently "pooled" but are merely brought together in the absence of formal regulation or a mechanism for risk sharing across regions/provinces or beneficiary groups. This function should remain within VSS under SHI/VSS as suggested. The main technical and equitable task of risk pooling, however, has to be incorporated into the work of VSS. VSS has to acquire the expertise and competence to properly conduct this critical task of risk pooling and not merely

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distribute resources without risk pooling. In the future it may be possible to transfer the pooling function from the 63 provincial VSS agencies to the national VSS/SHIA.

Resource Allocation Function

One critical political and policy decision is to have one universal benefits package, or have a minimum package free for all that is financed by SHI and tax revenues and have additional packages with user fees. Overly generous packages are unrealistic and difficult to finance and deliver, and create false expectations in the population. In the case of Vietnam it would be politically and socially difficult to downsize and limit the current basic package in spite of the fact that most of the items included in the basic package cannot be delivered, services have limited availability, and in some cases services and supplies are not available at all. Box 8.1 provides a summary of the questions that need to be answered with regard to the benefits package.

The resource allocation function has to be vested in SHI/VSS in one Purchasing/Contracting Unit. The decision-making process for resource allocation has to be done jointly with the MoH in terms of defining health needs and services to be financed and the level of subsidies from the state budget. SHI/VSS has to have a critical role as the responsible administrator of the SHI financial resources and as a financial entity (solvency). This requires new and revised rules and regulations relating to resource allocation from the national level to provincial and provider level that ensure equitable access to, and equitable delivery of, health care services to beneficiaries. Optimal resource allocation ultimately has implications for the provider payment mechanisms, especially on the current capitation payment mechanism and the calculation of capitation amounts for

Box 8.1 Allocating Resources to Benefits Packages: Questions to Answer

- Who should determine the content of benefits packages, select the needed services, and set priorities for health insurance financing of health care goods and services?
  - MoH;
  - The VSS/ National Insurance Fund; or
  - An independent institution.
- Should there be one universal package of health care goods and services or one universal and free minimum package, with additional packages with user fees?
- Who should determine the cost of the benefits packages and which criteria should apply?
- Who should be in charge of updating the benefits packages?
- Which criteria should guide such updating?
  - A mix of available financial resources, delivery capacity, management capabilities; or
  - The addition of clinical and cost-effectiveness for health outcomes.
- Who should be in charge of assessing the effectiveness of the benefits packages in terms of population needs and epidemiological concerns?

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various membership groups. Such a shift of functions will also affect the organization and management of tasks undertaken by the provincial VSS agencies.

Purchasing Function

The purchasing function is the key to moving from "passive" purchasing (or simply paying provider invoices) to "strategic" purchasing, which means paying for performance and health needs. The purchaser needs a stable, predictable flow of funds to be able to enter into contracts with providers and suppliers that need to be honored in full and on time. The purchasing function is exercised (both in the public and private sectors) through an intricate system of contracting. SHI contracting is important (a) for more effective and efficient use of scarce public resources; (b) to incorporate flexibility into the usually rigid public sector contracting mechanisms (public procurement); (c) in attracting the participation of the private sector in the implementation of public policies more effectively (in the provision of goods and services); and (d) in making purchasing between public agencies more effective.

Contracting requires a legal framework[7] and effective mechanisms of enforcement. There is a need to minimize political interference as well as the undue influence of professional associations in decision making. Health care professionals and sector managers sometimes lack skills and understanding of the legal and financial aspects of health care contracting. Delivery of health care goods and services should take place under a clear, transparent, accountable, and enforceable contracting system (norms and procedures). Contracting implies selecting providers, defining what to purchase from whom, contract negotiations, monitoring of contract compliance (especially performance targets), claims management, inspections, and conflict resolution. In most countries, contracting is the core component in the management of the purchasing function.

The purchasing/contracting function should be fully entrusted to SHI/VSS. Performing this function requires more authority in contracting with providers and suppliers to ensure that beneficiaries receive quality health care services. This entails moving away from being a passive purchaser to become an active and strategic purchaser. Developing a competent operational capacity for the management of SHI should be an immediate priority for VSS. This has to be accompanied by eliminating the current intrinsic legal constraints to the exercise of its implementing functions. VSS needs inspection powers, operational regulations, and the attributions or powers to properly conduct a purchasing/contracting system, and process claims in a proactive manner, not just passively paying bills.

Claims review and payment to providers needs to be better organized and competently managed (WHO 2013). Provider claims review by VSS is where most of the tension arises between the VSS and providers. VSS is seen by providers simply as a payer of claims sent in by providers and providers generally believe that they should have substantial clinical autonomy in deciding what to do and what to bill for. In the absence of information technology, specific clinical guidelines, and expertise in clinical fields, it is challenging for VSS staff to review claims and conduct a dialogue with providers to control costs. A conflict

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resolution mechanism such as an independent Grievances Committee is needed to resolve disputes between VSS and providers.

Enrollment, revenue collection, strategic resource allocation with well-designed and realistic basic packages, and proper purchasing procedures all have important implications for cost, access, quality, and consumer satisfaction. For this to take place efficiently and effectively, however, the institutional setting (currently VSS) has to be revised and enhanced in terms of functions, powers, and responsibilities, but mostly in avoiding fragmentation.

SHI Governance

Governance Brings Consistency to SHI and Ensures Fairness, Transparency, and Accountability

Governance is a concept that has various meanings, but the suggestion is made to broadly define it as all the relevant factors that influence behavior of an organization. Corporate governance largely refers to the laws, entities, rules, and processes under which government and private businesses operate, are regulated and controlled. In a simpler way, governance refers to the "control" mechanisms that are used to hold the organization accountable (Savedoff and Gottret 2008). For SHI, governance is a means to "direct, administer and control the system" (Fattore and Tediosi 2013), to ensure that the objectives of the SHI system are met. Governance, therefore, can be attained using legal and financial tools, information control processes, influencing behaviors, and keeping involved actors accountable and working toward a common social goal. Governance also relates to the design and organization of the SHI system, to fair and sufficient but not burdensome regulations, and to competent supervision.

Because health insurance, public and private, is a legally regulated financial activity, the concepts and principles of corporate governance apply to the SHI or agency as well as to private health insurance companies. In Vietnam, regardless of the current structure of SHI, the administration of SHI, its organization, management, and governance are those of a financial institution, thus corporate governance rules apply.

Governance also refers to internal factors such as the conduct of management and staff, and to external forces such as consumer groups, clients, and government regulations. For the OECD (2004), "corporate governance involves a set of relationships between a company's management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined. Good corporate governance should provide proper incentives for the board and management to pursue objectives that are in the interests of the company and its shareholders and should facilitate effective monitoring."

SHI schemes pool, manage, and spend large amounts of financial resources and employ, directly and indirectly, large numbers of people in the health care and supply sectors, and conduct vast legal transactions through contracts with

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providers and suppliers. SHI performance, however, is not always satisfactory. There are concerns about the wise and prudent use of resources, operational transparency and accountability, and the quality and quantity of services financed and provided to the population. Many of the problems come from the way in which SHI is organized, managed, and governed. The legal and regulatory framework, roles of various government entities, public information, and the behaviors of SHI administrators, providers and suppliers, beneficiaries, and political parties and politicians play very important roles, positive and negative.

Good governance has to promote the rule of law and be participatory, transparent, and accountable. SHI governance involves the state, the private sector, and civil society, and has to contribute to the best use of health care financing resources for quality and equitable care for all. This is why it is so important for Vietnam to properly structure the SHI system around health financing/insurance functions and follow good standards of governance. Only then can VSS continuously monitor SHI performance to correct unavoidable deviations and distortions, which are inevitable in implementing such a massive program as SHI.

Analysis of Governance

The analysis on governance herein follows the analytical framework in Savedoff and Gottret (2008) that encompasses five main dimensions of SHI: (a) a coherent decision-making structure, (b) stakeholder participation, (c) supervision and regulation, (d) consistency and stability, and (e) transparency and information (figure 8.2). These five dimensions contain essential conditions for transparency and accountability of the SHI system to the government, beneficiaries,

Figure 8.2 Governance Analytical Framework

Source: Adapted from Savedoff and Gottret 2008.
Note: HI = health insurance.

contributors, and regulators, and are fundamental for SHI success and acceptance. At the same time, these dimensions help identify options for improving the performance of the Vietnam SHI system against the objectives of universal financial protection and access to available and needed quality health care goods and services.

Coherent Decision-Making Structure

Coherent decision making is a fundamental condition for good SHI governance. It implies that (a) the division of tasks among existing key players is appropriate, with clear definition of roles and responsibilities and minimal conflicts of interest; (b) all essential SHI functions and tasks are consistently implemented; and (c) legal, financial resources, institutional capacity, regulation, and supervision are in place. In the current structure of SHI in Vietnam the division of tasks is unclear in terms of authority and responsibility. This is particularly the case for VSS and the MoH where SHI functions are not the base for organization and management, and capacity and tools (institutional and regulatory) are scant and inconsistent.

One suggestion to make decision making more coherent is to aggregate SHI functions within VSS into a specialized Directorate/Division on SHI (SHI/VSS) with a specialized SHI Board that would greatly contribute to coherent decisions. This option could be complemented with institutional change within the MoH regarding SHI. The option could be an SHI Technical Department at the MoH that would combine the SHI functions of the three MoH departments that currently deal with SHI issues. This MoH Technical Unit could play an important role to enhance coordination and collaboration among VSS and key ministries and other stakeholders and contribute to the development of more coherent decisions on health financing rules and regulations with the final objective of enhancing financial risk protection and equitable access to services. For this option to succeed, consensus between MoH and VSS is necessary to clarify the SHI policy aspects under the MoH and the implementation process to be decided by VSS. SHI/VSS should be granted a more formal role in implementing regulations on the SHI functions, such as the design of the provider payment mechanism and in setting remuneration rates.

Stakeholder Participation

Stakeholder participation should involve SHI-related actors, the state, employers, providers/suppliers, patients, and the general public, in making decisions and in monitoring SHI implementation. Active stakeholder participation can prevent decisions being made that favor certain interest groups, thus contributing to transparency and accountability, and helping control corruption and conflicts of interest.

In Vietnam, stakeholder participation in decision making is rather limited due to the nature of government and societal organization. The posting of key policy documents on the Internet for one to two months for public comments before final approval has proven ineffective. The VSS Management Council (WHO 2013) does have members representing various ministries (government), the

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Medical Association (providers), trade union (workers), Chamber of Industry and Commerce (employers), as well as representatives of mass organizations such as women's and farmers' unions (public). Many of these latter members, however, are not active participants in decision making and in governing SHI and, because the VSS Management Council oversees all of the funds under VSS, there is no dedicated attention given to SHI. This lack of a special and specialized body for SHI may explain the apathy of the Council in SHI matters. The governance role in protecting the interests of contributors (employers) and beneficiaries is, therefore, weak.

Wider proactive stakeholder participation enhances transparency and accountability as a value in itself and as an important basis for coherent and widely accepted decisions. An SHI Board under VSS could deal with implementation issues where representation of beneficiaries, health care providers and suppliers, and patients is important. No more than 15 members would make an effective Board in terms of size.[8] The SHI Board would work specifically on SHI issues. Well-designed stakeholder participation provides possibilities for Board members and consumers to be listened to, especially in the case of conflicts of interest.

Supervision and Regulation

The SHI Law lists the supervisory bodies for HI implementation as the health inspection department (MoH), financial inspector (MoF), and Provincial People's Committee; however, their supervisory roles are not defined. Decree 94/2008 states that VSS is governed and supervised by VSS's Management Council, but the nature and extent of this supervisory role is not defined. In practice, a fundamental state activity of profound social impact like SHI is largely unsupervised. Supervision and regulation should contribute to strengthening accountability. Toward this end it is important to determine to whom VSS is accountable. It is also necessary to clarify the authority and the supervisory role of Provincial People's Committees in relation to the provincial VSS agency in terms of health insurance implementation.

Regulatory mandates are fragmented and VSS is given a regulatory mandate only on health cards. Implementing SHI requires multiple regulations that have to be updated continuously and amended, revised, and derogated as implementation proceeds and more complex issues come to attention. There are many types of regulations, some more formal than others, but all have the same purposes: to interpret, define, solve inconsistencies, and lay down rules and procedures. Regulations are necessary, but should not be burdensome, should address serious issues and not minutiae, and take into account the cost of regulatory compliance for providers and suppliers, the impact on beneficiaries, and on VSS's administration.

Consistency and Stability

Consistency and stability, including legislative and regulatory stability, are key conditions for effective governance (WHO 2013). SHI implementation is affected

by HI policies and by related health policies on hospital autonomy, as well as prices for health care services and pharmaceuticals and consumables. In pursuing increased financial protection and access to quality health care goods and services for the population at affordable cost, policies about the price of services and pharmaceuticals should be designed carefully to encourage providers to be rational and efficient in prescribing services and drugs, and not to oversupply them. Health policies in general should align and be consistent with SHI policy.

Implementing SHI is a continuous process that requires regular assessments and modifications based on experience and the ability to respond to increasing health care needs by the population as universality in enrollment and access to health care goods and services are expanded. In this scenario, SHI administration becomes increasingly more complex and legislative and regulatory changes have to be consistent, well thought out, clear, and unambiguous to avoid confusion and misunderstandings that make interpretation and implementation difficult. In the past 20 years, there has been one health insurance law and six decrees, followed by a number of circulars that also introduce a number of new rules and procedures that are normal in the process of developing and institutionalizing SHI, particularly in a large, diversified, and populous country such as Vietnam.

It is useful to regularly (for instance every three to five years depending on the number of new regulations) review the body of laws and regulations (decrees, circulars) and analyze their consistency, validity, and possible contradictions. After the review a volume of revised, consolidated, and harmonized health insurance regulations should be released.[9] To improve governance, capacity building would be needed for all health care financing actors as well as for the overall health system. Training on managerial and technical capacity with both short- and long-term training courses could be provided in the Vietnamese language for the existing VSS and MoH staff, central and local, and for providers and suppliers. Finally, the entire SHI system and its governance require sustained efforts on health financing policy and regulation, and continuous improvement of the SHI system with analyses, actuarial studies, costing, health technology assessment, and policy discussion workshops.

Transparency and Information

Transparency and information is a golden principle to follow for SHI governance to be effective. It refers to the necessary and comprehensive information made available to policy makers, financial managers, legislative bodies, payers (employers), beneficiaries, and the general public. Information provides transparency and transparency helps reduce corruption.

Since SHI objectives are not clearly stated in legal documents, it is difficult to communicate in understandable terms the meaning and scope of SHI, and information and transparency are weak. A key element of transparency and governance is informing the public about SHI, its features, benefits, procedures, rights and obligations, and how it develops in achieving the objectives of universal financial protection and access to health care goods and services. The population

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has to internalize that SHI is a tool for quality of life and be aware of its meaning and importance. The public should also be informed of fraud and abuses and how these are dealt with to ensure that SHI and its financial resources are properly used and protected. Media material should be in simple but precise language, using radio, TV, and social media.

A requirement to provide information to the public on HI benefits is not clearly stated and service providers do not communicate this information either. In the context of unregulated and unsupervised hospital autonomy and health care market liberalization, it is common for insured patients to pay out of pocket on top of copayment, even for services covered by SHI. This leads to patient confusion and distrust in the SHI system. Public information campaigns should be conducted at all levels and continuously. Information on level of service utilization by different population segments and on actual cost of health care and pharmaceutical use is limited because reporting requirements (forms/templates) are not specified/institutionalized in HI legislative/regulatory documents, which makes SHI evaluation and assessment difficult.

SHI/VSS is required to have their accounts audited by State Audit and by external auditors, publish annual financial plans accessible to the public, and develop comprehensive and clear reporting formats to increase the flow of updated information to the government, involved actors, and the public. Operationalizing SHI generates conflicts that need prompt, fair, and objective solutions. Conflicts between patients/beneficiaries and providers should be resolved by an independent SHI ombudsman financed by SHI. An independent SHI Grievance Committee financed by SHI should resolve conflicts between SHI and providers and suppliers. Improving and upgrading the IT system is critical for effective information management and increased transparency. It allows for the establishment and formalization of horizontal information exchange channels between the DoHs and provincial VSS agencies, and the collection of hospital financial data and reports with clear and timely financing information, amounts and use of SHI funds, and billing for better and more transparent hospital planning and management.

The Social Health Insurance Agency

The future SHIA—already wisely considered in the present SHI Law—is the right design for the future administration and management of SHI in Vietnam. As indicated previously, achieving universal health financial protection and universal health coverage with actual access to health care goods and services by competent providers is a challenging task. SHI requires a strong, competent, and independent agency performing its duties under simple but efficient supervision. The SHIA does not act alone but performs its duties in coordination with the MoH, the MoF, and other institutions, both central and local. What is important is that SHIA is independent and autonomous.

For the SHIA to develop to its full potential, a new SHI Law will be needed in due time defining and stipulating the functions, duties and responsibilities,

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and powers to make the SHIA operate efficiently. The new SHI Law has to define the level of autonomy of the SHIA and translate government policy in this matter into the provisions of the new SHI Law. The SHI Law will have to be complemented with rules and regulations as appropriate that will ensure that the level of autonomy is exercised according to the rule of law, and that there is no fragmentation or contradictions.

The Autonomy Arguments

For the SHIA, independence or autonomy means having legally assigned decision-making powers to properly administer and manage SHI (WHO 2013). Institutional autonomy does not imply complete independence from government and other public bodies. It refers to the power to develop and design its own institutional setting and operational methodologies and processes. The SHIA requires a reasonable level of protection against attempts by other institutions to interfere in its core tasks and to access funds under SHIA management to ensure the objectivity and neutrality of SHIA in decision making.

Institutional autonomy of the SHIA is needed for the following reasons:

- To define the internal institutional setting of SHIA for the optimal management of the health financing/insurance functions, including governance (SHI Board) and the architecture of the SHIA at all levels, national, provincial, and district;
- For objective and effective financial management of SHI funding, regardless of the source of income, contributions, budgetary transfers, and subsidies based on guidelines by the SHIA Board and not subject to external demands;
- For contractual autonomy that is indispensable to the proper exercise of the purchasing/contracting function for spending on health care goods and services;
- For the relationships with other public and private entities with formal independence from government institutions;
- To set internal and external rules or normative autonomy with regard to the core functions and to regulate relations with providers and for contract implementation;
- The SHIA needs autonomy to act objectively in the pursuit of its purposes and not be subject to politically motivated decisions or having to use SHI financial resources to purchase equipment for the MoH or for capital investments in public facilities;
- SHI is a form of prepaid insurance that is both special and specialized. SHI is special because it is different from other traditional forms of health insurance such as indemnity insurance.[10] SHI is specialized because its purpose is to finance the provisions of health care goods and services included in state health care benefit packages primarily and other related aspects such as health promotions and prevention, and lifestyle campaigns that lead to changes in behaviors.

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- Autonomy under the rule of law is critical for proper, transparent, and accountable management of the vast financial resources under SHIA management. SHI pools and manages an enormous mix of public and private income that includes budgetary transfers and subsidies, private contributions by beneficiaries, and user fees, as applicable. The amounts of financial resources are substantial, making the SHIA a foremost financial manager.
- The magnitude of the purchasing/contracting power of the SHIA is of enormous importance and, if not properly and autonomously managed, the exercise of this contracting power can be open to influence and corruption if external influences are allowed. In fact, when fully operational, the SHIA will be one of the major, if not the major, contractor of services in Vietnam with a critical indirect contribution to employment generation.
- The autonomous management of these large pools of financial resources has to be objective, clear, neutral, and conducted under guidelines and regulated standards, and not be subject to external influences to use the SHI resources to cross-subsidize other social entitlements or to finance activities outside its legal purpose and mandates.

In sum, the new SHI Law establishes and defines the autonomy of the SHIA, but this independence is not absolute. The SHIA is subject to the rule of law operating with neutrality under the provisions of the new Health Insurance Law. An SHI Board with broad representation of the government, the private sector, and beneficiaries will govern the SHIA. The SHIA will be part of the state structure. It will be supervised and subject to strict reporting, accounting, and transparency norms stipulated in the SHI Law and in internal rules and regulations. The SHIA, therefore, needs the autonomous institutional status that will allow it to perform its functions objectively without interference in decision making, with transparency under clear rules and regulations, and subject to accountability standards. This excellence cannot be attained if SHIA is a dependency of another institution that can obstruct proper management.

Road Map for Institutional Reform

SHI Reform Stages

The recommendation of this report is to reform the present SHI institutional structure in two stages as follows:

- Firstly, by consolidating all SHI functions into a VSS specialized Directorate or Department[11] called in this document SHI/VSS. These changes should be incorporated in the revisions to the present SHI Law in 2014 and come into effect six months after the amendments are approved. This process and its strengthening would take from one to three years. During this time preparation for the drafting and approval of a new comprehensive SHI Law[12] should take place.

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- The second and subsequent stage under the new SHI Law will finally establish and make operational the SHIA already envisioned in the current SHI Law as an autonomous legal person incorporating into the new SHIA the functions of the reformed SHI/VSS. The new SHI Law should take into account the positive and adverse experience of SHI/VSS in the management of the health financing/insurance functions, in particular, and in actually enhancing enrollment, the financing of health care goods and services, and in standardizing the functioning of public and private providers and suppliers under SHI/VSS purchasing/contracting. The SHIA will take one to three years to become fully operational and up to seven years in total to consolidate. Since SHI implementation is a dynamic and continuous process, there may be a need to introduce amendments into the new SHI Law to address implementation problems and to respond to increased enrollment, actual access to health care, and new health care demands.

Road Map toward a Reformed SHI/VSS

The decision of the government to amend the current SHI Law should be used to include the suggestions made in this document toward the transitional establishment within VSS of a Directorate or a Department exclusively dedicated to the management of SHI.

The following steps could be considered in the meantime:

- A joint resolution (in the appropriate legal form) by MoH and VSS to establish the SHI/VSS Directorate or Department within VSS to manage SHI. It may be possible that the MoF would also want to participate in preparing and issuing this resolution given the importance of MoF subsidies for SHI.
- The SHI/VSS will become the foundation for the new SHIA once established. This transition may take some time until a new SHI Law is approved and the SHIA is made operational. A rough time estimate would be one to three years.
- The joint MoH and VSS resolution will also establish an SHI Board at the level of the SHI/VSS Directorate/Department.
- The joint resolution should establish the composition of the transitional SHI Board and the corresponding appointments. The Board should include representation from the MoF, MoH, the VSS, the Ministry of Labor, health care providers, and beneficiaries. A membership of 15 is suggested.
- Integrate into SHI/VSS all functions and staff currently working on SHI-related matters in various VSS departments.
- Integrate into SHI/VSS all SHI financial functions and staff currently performing these functions at the MoH.
- Organize SHI/VSS along health financing/insurance functional lines.
- Prepare a set of internal rules for the operation of the SHI/VSS as a single SHI manager.
- Structure SHI/VSS into the central, provincial, and district administrative divisions of the country.
- Define the relations between SHI/VSS and the MoH, DoHs, and others.

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- Establish basic unified procedures and guidelines.
- Prepare rules for the SHI Board.

To answer the question of who should supervise SHI/VSS as a transitional entity, there are several options:

- One option is to have SHI/VSS supervised by the current VSS Management Council. As mentioned in the analysis in this chapter, the composition and role of the VSS Management Council has not, and most likely will not, make it a suitable supervisor for SHI. SHI is both a special and highly specialized type of insurance and its supervision cannot be just one more of the tasks of the VSS Management Council, which is already burdened with responsibility for supervising VSS and the management of several social insurance schemes.
- A second option is to have the MoH supervise SHI/VSS. This option will only increase tensions between VSS and the MoH. SHI is not a health entity—it finances the provision of health care goods and services. It does not provide those goods and services. Furthermore, the MoH does not have a function as a financial supervisor.
- A third option is to have SHI supervised by the Ministry of Labor. This option will create an unnecessary tension with VSS. Furthermore, SHIA is not a labor matter. It includes all of the population, those in the formal and informal labor markets, and also all dependents, the poor, and near-poor. As is the case with the MoH, the Ministry of Labor does not have a function as a financial supervisor.
- A fourth option is a compromise option for an SHI Supervisory Committee composed of the MoF, the MoH, and the VSS (figure 8.3). The Committee will have formal representation from the MoF, MoH, and the VSS, namely the Minister of Finance, the Minister of Health, and the Director-General of VSS as the primary formal representatives. Each of them can appoint a representative to participate in meetings where the principal cannot attend.

Road Map toward the SHIA

The following steps could be considered toward the establishment and operationalization of the SHIA:

- Drafting of a new Health Insurance Law that could contain some of the following:
  - A definition of the purpose of SHI;
  - Definition of the objectives of universal health financial protection and access to UHC;
  - Definitions for the purposes of the Law and specifically for the implementation and interpretation of the SHI Law;
  - Reference to SHI/VSS to be the foundation of the new SHIA and the legal transfer of functions, and staff to SHIA;

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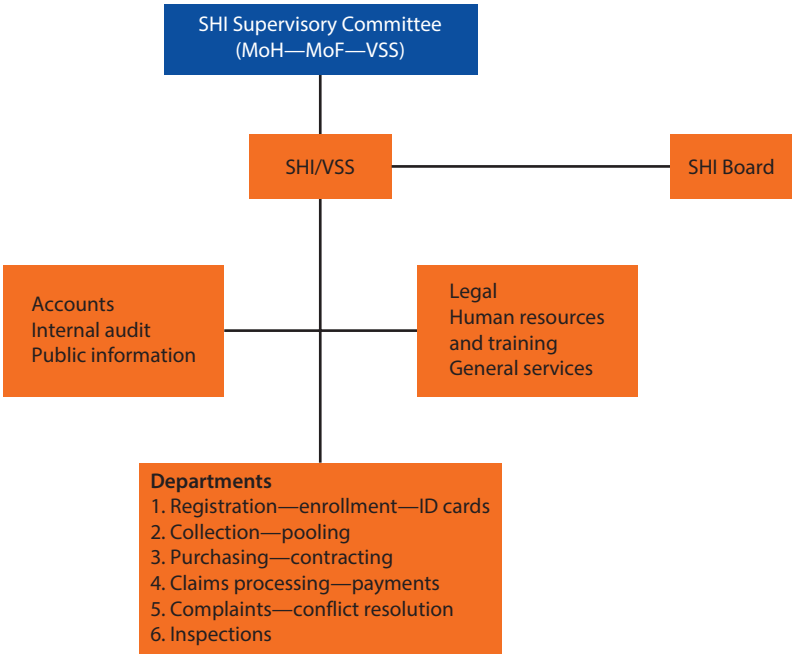
Figure 8.3 Transitional Supervision of SHI/VSS by Supervisory Committee



  - A chapter on the establishment of the SHIA, the level of autonomy, governance, functions, attributions or powers, duties and responsibilities, among others, to provide the legal, institutional, and financial foundations for the SHIA;
  - A chapter on SHI funding;
  - Supervision of the SHIA including the SHI Board;
  - A chapter on private health insurance could be considered; and
  - Some of the amendments to be included in the revision of the current SHI Law to take place in the course of 2014.
- Definition of the institutional architecture of the SHIA.
- Once the new SHI Law is approved, steps need to be taken to make the SHIA operational and to absorb the functions of SHI/VSS. This process could take from one to three years.
- Supervision of the SHIA as illustrated in figure 8.4, would be by a SHI Supervisory Committee composed of the MoF, MoH, and a representative of parliament. This will replace VSS in the transition period, although VSS would be represented on the SHI Board.

Recommendations

Recommendation 1 on revision of the SHI Law:

- Define the objective/mandate of SHI as the financial instrument to achieve UC;

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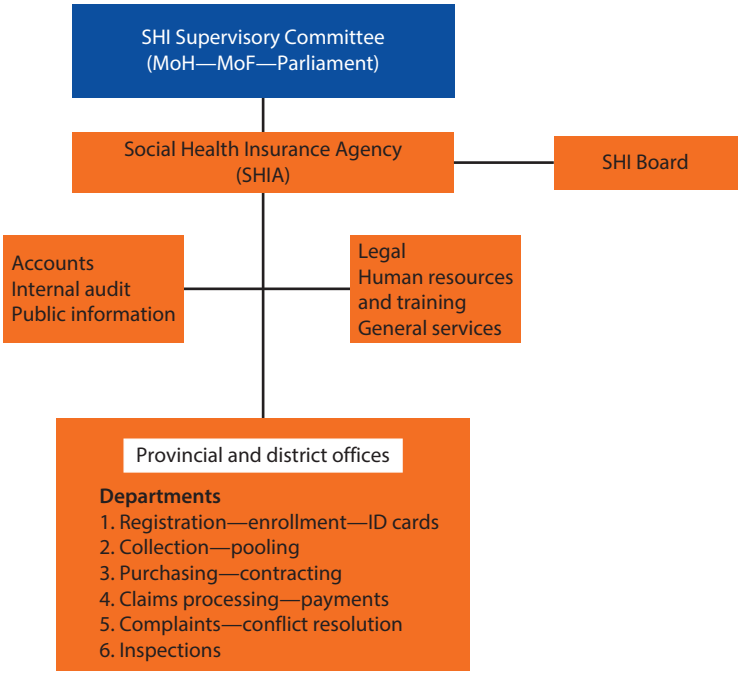
Figure 8.4 Final Supervision Arrangements for the SHIA



- State the objective or mandate for the SHI Fund/Agency (in the interim VSS) "to collect and pool revenues from individuals, employers, and the government (transfers and subsidies) to finance the purchase and payment of predetermined packages of health care goods and services;" and
- Delegate effective regulatory and monitoring powers to VSS within the overall SHI supervision by the MoH.

The purpose of this recommendation is to have a clear understanding of the role and mandate of the VSS as an effective implementer of SHI and its relationship with the MoH. It is critical for the state entities, national assembly, VSS in managing SHI, providers and suppliers, beneficiaries, and the population at large to clearly understand the roles and mandates of VSS and MoH in SHI.

Recommendation 2: Revise and define the roles and mandates, responsibilities, and authorities of key agencies (MoH, VSS) in SHI to reduce institutional fragmentation and dual mandates.

The purpose of this recommendation is to ensure VSS is an effective implementer of SHI. To achieve this, it needs defined health financing/insurance functions (beneficiaries' enrollment and registration, collection, pooling, purchasing, and payment of providers and suppliers) and implementing powers. The idea is to strengthen VSS and to consolidate functions and expertise within VSS to

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manage SHI as a special and specialized type of insurance that requires specific technical and administrative skills. The MoH retains its overall policy and regulatory role, regulation of providers and suppliers, public health, and supervision to minimize conflicts of interest.

Recommendation 3 on SHI organization:

- Provide for VSS to manage SHI with a specialized SHI Division until an SHIA is established; and
- Provide for an SHI director to be appointed by the government to manage the VSS/SHI unit or department. Alternatively legislate for the VSS Management Council to appoint the SHI director.

The purpose of this recommendation is to give SHI an institutional identity within VSS. It will provide for the unity of the SHI system under VSS until the SHIA is established with its central office and local branches, and require VSS to have an organizational structure based on the health financing/insurance functions.

Recommendation 4 on SHI management:

- Provide for the VSS/SHI Division to have an SHI Board as the SHI decision-making and supervisory body, with proper representation. Alternatively, have the VSS Management Council establish an SHI Management Committee as the managing council for SHI; and
- Provide for the director of SHI to report to the SHI Managing Committee and perform as its ex officio secretary (or by reason of the position) and participate in the Board with voice and no vote.

The purpose of this recommendation is to institutionalize a dedicated governance structure for SHI implementation, performance, guidance, and supervisory functions.

Recommendation 5 on SHI governance:

- Require VSS to have separate accounts for SHI to avoid cross-subsidizing from pensions and social assistance;
- Establish within VSS an SHI conflict resolution system for managing complaints by providers, suppliers, and beneficiaries;
- Require VSS to include information on complaints and conflict resolution in Annual Reports; and
- Define clearly the situations that merit penalties, the level of penalties, and the authority to impose and enforce penalties (should be VSS).

The purpose of this recommendation is to clearly stipulate and require the establishment of systems that assure government, providers, suppliers, and beneficiaries that SHI is managed fairly, openly, and responsibly.

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Recommendation 6 on SHI accountability:

- Require that state and external auditors audit VSS/SHI accounts annually; and
- Require SHI/VSS to prepare and publicize annual reports on SHI funding, coverage (including enrollment and services financed and provided), and other matters to be determined by the Management Council/SHI Board.

The purpose of this recommendation is to ensure clear, objective, and accountable management of SHI financing responsibilities to the government, providers and suppliers, and to beneficiaries.

Notes

1. Until 2002, the Vietnam Health Insurance Agency was attached to, and under the responsibility of, MoH. Thereafter it was merged into the VSS Agency (SS, the national agency responsible for implementing pension insurance, health insurance, and other short-term allowance schemes (sickness, maternity allowances). The rationale for this move was to reduce the number of government agencies that undertake similar tasks to reduce duplication and to improve administrative efficiency. The government's Organization Committee (today Ministry of Internal Affairs) considered that health insurance and pension insurance have very similar work. The prime minister decided to merge the Vietnam Health Insurance Agency into the Vietnam Social Insurance Agency (WHO 2013).
2. Discussed in chapter 4.
3. By way of comparison, in Chile (population 17.4 million) the National Health Fund has 239 budgeted staff and 1,175 staff under services contracts; and in Montenegro (population 630,000) the Health Insurance Fund has 114 staff.
4. Since the SHI Law establishes that MoH manages SHI, here the broader term "administer" is used to refer to the role of VSS regarding SHI and to avoid confusion. This role will be complemented later under Management and Governance sections of this chapter.
5. MoLISA: Ministry of Labour—Invalids and Social Affairs.
6. The SHI Law partially addresses the many issues regarding the operation of the key health financing functions: (a) *Revenues*. The SHI Law defines the contribution rates and subsidies for the various subjects/beneficiaries of mandatory and voluntary health insurance, and their affiliation or enrollment into the health insurance system (Articles 12–15); (b) *Pooling*. The SHI Law states that contributions and subsidies are paid/transferred to the Health Insurance Fund; and (c) *Purchasing*. The SHI Law refers to agreements or contracts between the implementing agency and providers, but does not elaborate on the main issues of the purchasing function such as strategic purchasing and selective contracting.
7. Building the proper legal contractual framework requires (a) a thorough revision of the existing public sector purchasing/procurement legal framework to introduce amendments to existing public sector legislation. For example, if the purchaser is a state agency that has to abide by the public sector procurement norms without the flexibility of contracting under private civil and commercial codes, the contracting process has serious inherent limitations; and (b) an assessment of how the current contracting is taking place: how autonomous contracting is from political interference,

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how transparent, how accountable, and how effective it is in terms of value for money and in the quality of the services contracted and delivered.

8. In the Republic of Korea, the SHI Board of Directors has 18 members, in Estonia, 15, and in Montenegro, 13.
9. In Chile all laws (especially on health, pensions, and labor) are regularly updated and inexpensively published and sold in kiosks at subsidized prices for all the population to have access and be properly informed.
10. In this sense, social health insurance is similar to private prepaid insurance that is also a special form of health insurance.
11. The title VSS SHI Directorate or SHI Department should be decided by the government. In this document it is called SHI/VSS as it is assumed that it will have high-level management within VSS.
12. The new SHI Law should be *comprehensive*, meaning that it should refer to SHI in all its aspects, purposes, definitions, Health Insurance Agency, health financing/insurance functions, roles of the MoH, MoF, and regulation and supervision, among others. The same law could even contain a chapter on private health insurance.

References

Fattore G., and F. Tediosi. 2013. "The Importance of Values in Shaping How Health Systems Governance and Management Can Support Universal Health Coverage." *Value Health* 2013 16 (1): Suppl S19023.

OECD (Organisation for Economic Co-operation and Development). 2004. "Principles of Corporate Governance." Paris, France.

Savedoff, W. D., and P. Gottret, eds. 2008. *Governing Mandatory Health Insurance: Learning from Experience*. Washington, DC: World Bank.

WHO (World Health Organization). 2013. "Report on Organization and Governance of Vietnam Health Insurance." Background Paper prepared for *Moving towards Universal Coverage of Social Health Insurance in Vietnam: Assessment and Options*. Unpublished.

http://dx.doi.org/10.1596/978-1-4648-0261-4