Chapter 2

BACKGROUND OF VIETNAM

Health insurance is linked with the health sector and the economy. Thus, an overview of the socio-economic situation and the health sector in Vietnam will be presented below.

2.1 The Socio-Economic Situation of Vietnam

Vietnam with an area of 332,000 square kilometres, is a South-East Asian country. It borders China in the north, Cambodia and Laos in the west and faces the Pacific Ocean on the east and south. The country is divided into 61 provinces, with 597 districts and 10,331 communes. The population was 77 million in 1998 with around 54 minority ethnic groups, 78 percent of the population resides in rural areas. The 2 biggest cities are Ho Chi Minh City with 4.9 million people in the Mekong delta of the South, and Hanoi with 2.5 million in the Red River delta in the north of the country (National Statistics Book of Vietnam,1998).The religion of the population is divided into two main streams: 70 percent are Buddhist, 15 percent are Catholic. The rest of the population is non-religious or follow other religions. In terms of culture, education and ethical behaviour, theVietnamese were influenced by Confucian theory mixed with French style.The majority of Vietnamese are hesitant to go to hospital.

Since 1987, the economic and political climate has been changing rapidly with the move from a centrally planned to a market-based economy. However, reform was accompanied by a fiscal policy calling for a reduction in public expenditure, including cuts in allocations for health care. As a result, the health sector has been increasingly under pressure. Public resources are no longer sufficient to respond to the need to improve the quality of care, especially in the poorest provinces.

In 1989, Vietnam became the world's third-largest exporter of rice. Oil production was expected to reach 7 million tons in the mid-1990s, compared with 1990 production of 2.6 million tons (MOH of Vietnam, 1994). Due to the fact that exports exceeded imports, the trade balance has been positive since 1994 and, as a result, the trend of payment deficit of government has been reduced, and hyper-inflation has been cut down from nearly 40% in 1990 to around 10 % in 1993-1998 (Table 2.1).

Table 2.1 Inflation Rate in Vietnam from 1990 to 1998

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Inflation rate (%)	37.5	31.5	34.2	11.8	8.8	12.7	4.5	3.7	9.2

Source: MOF of Vietnam.

The average real growth rate of the gross domestic product (GDP) was 5.2% between 1986-1991 and 10 % between 1992-1995 and from 9.3% to 5.8% between 1996-1998. In 1989, the per capita gross national product (GNP) at market prices was estimated at USD 175. This index was about USD 300 in 1994-1998.

Despite the overall economic growth and the rise of private sector activity, the level of government taxation has remained low, due to the difficulties in tapping new sources of activity. In 1989, the ratio of taxes to GDP was 11.2 %. In 1994, this tax ratio rose to 21.1%, in part as a result of better tax collection. It is manifest that the overall low level of government taxation hampers the financing of social expenditures, such as those on health services. Now, the situation has improved, the government revenue has increased step by step, from around 10 % of GDP in 1986 to around 20 % of GDP now(MOH,Annual report,1998).

2.2 The Health Care Issues in Vietnam

The health care services in Vietnam provided by government, are mainly public with four levels:

- National,
- Provincial,
- District, and
- Commune

Following the 1998 official statistic indicators from Department of National Statistics of Vietnam, in the whole country, there are 817 public hospitals, 956 polyclinics, 56 maternity homes, 21 rehabilitation centers, and 10,929 community health stations/health stations of other branches. The total number of hospital beds is 166,628 with 10,700 beds available at the national level, 52,003 at the provincial level and 47,447 beds at the district level, 41,183 beds are located in commune health stations, the rest (15,295 beds) belong to other ministries. The number of medical doctors is 34,001; pharmacists: 5,406; assistant doctors: 48,459; and other staff: 125,233.

Table 2.2 Inhabitants per Physician 1995-1997

No	Categories	1995	1996	1997
1	No of habitants per doctor	2,374	2,253	2,256
2	No of habitants per doctor & assistant	946	923	930

Source: Health Statistics Yearbook - Vietnam 1998.

Vietnam has been traditionally committed to the health sector. Since 1954, have been efforts made to extend basic health services to the communal level. 80 % of rural and urban populations now has access to this basic health network. National health movements in the areas of hygiene, nutrition and eradication of vectors of disease accompanied the efforts. In 1990, the number of physicians, medical assistants and nurse-midwives was 24,934, 46,412, and 98,288, respectively. The latter translates into the following ratios of health personnel per 1,000 population, 4.19, 7.2 and 15.0 for physicians, and medical assistant and for nurses or midwives respectively. In 1988-1997 the percentage of one year olds immunised was 95%, the population with access to safe water was 46%, the life expectancy increased from 44.2 in 1960 to 67 in 1998. The general mortality rate was 0.7%, and under-five mortality has dropped from 232 per 1,000 in 1960 to 48.5 per 1,000 in 1997.

However, maternal mortality (MMR) is still 100 per 100,000 live births. The average population growth rate between 1960 and 1990 was 2.2%, and around 1.8 % in 1997.

2.2.1 Health Care Financing

The structure of Health care financing in Vietnam includes four components:

- Government budget,
- Foreign aid,
- Health insurance premium, and
- Hospital fees (User's fees).

Table 2.3 Sources of Health Care Finance 1998

Source	Revenue(Bill VND)	Percentage(%)
Government budget	2,531	61.59
Health Insurance	669	16.28
User fees	370	9.0
Foreign Aids	539	13.11
Total	4,109	100

Table 2.4 Health Expenditure by Categories 1998

Category	Expenditure (Bill. VND)	Percentage(%)
Research	13.8	0.34
Training(central)	80.3	1.95
Construction at central level	332.2	8.08
Curative & Preventive care	3,682.7	89.63
Total	4,109	100

Table 2.5 Vietnam National Health Budget 1991-1998 (Billion VNDong)

	1991	1992	1993	1994	1995	1996	1997	1998
National Budget	12,081	22,815	38,080	48,270	60,200	75,900	77,380	80,770
Health Budget	716	1,020	1,468	2,220	2,817	2,430	2,780	2,531
%	5.9	4.47	3.85	4.6	4.7	3.2	3.59	3.13

Source: Ministry of Planning and Investment, Health Statistical Profile/MOH -Vietnam, 1998

The proportion of the national government budget for current expenditures spent on health increased from 2.76 % in 1986 to 5.9% in 1991 and has remained around 3.5% until the present time (Table 2.5). The amount of health expenditures supported by government increased year by year (except 1996), but proportion decreased. Since the population increased rapidly, treatment and consultation demands also increased, the government budget for the health sector was only 50% of health care expenditures. If Vietnam had not been by the effected Asia economic crisis, government budget would have increased. However, due to the crisis the proportion of health budget has seen a decreasing trend from 1991 to 1998.

It is recognised that, in the face of these problems, the health budget from government is insufficient. The 1994 assessment of the Vietnamese National Assembly stated that it covers about 60 % of total health care need, only enough for normal running costs. This means that a lot of "needs" can not be satisfied, such as purchasing new and modern health machines, constructing and decorating new buildings for hospitals which were built a long time ago, and using new drugs and facilities for treatment and diagnosis.

In 1989, a system of user fees for district, provincial and national level hospitals was established in order to increase resources for health, but as we can see in Table 2.6, it covers only around 5-7% (1990-1995) and has increased to more than 14% (1996-1998) compared with government expenditures for health. Also, improvement of health care financing through user fees has not been forthcoming due to the many exemptions that are granted and the reduction in the attendance at public health care facilities.

Table 2.6 User Fee Compared to Government Expenditure (Billion Dong)

Year	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Gov't exp.	427	716	1,020	1,468	2,220	2,817	2,430	2,780	2,531
User fees	20	45	72	102	110	150	472	500	370
%	4.68	6.28	7.06	6.95	4.95	5.32	19.4	17.9	14.62

Source: MOH – Vietnam, 1998

2.2.2 Health Insurance

As part of the efforts to bring more resources into the health sector, the Health Insurance Program has been advocated for a number of years. The severance scheme has been operating since 1989 but mostly as a pilot program at the provincial or district level. In 1992, the government approved the principle of health insurance at the national level. Civil servants and factory workers were insured on a compulsory basis. Other citizens could join on a voluntary basis. The initial emphasis was also on health insurance coverage of the cost of hospital services. In practice, this law is expected to lead to the gradual implementation of health insurance for most of the population. Indeed, due to different socio-economic conditions, this implementation is likely to be carried out at differing paces in the various regions. Moreover, much will have to be assimilated and improved regarding the functioning and management of health insurance. One has to realise that even though the scheme is now 8 years old, it is still in a very early stage of development.

The feasibility of health insurance should be investigated at all administrative levels, including the commune level. Note, for instance, that the communes are now required to supplement the funds from the government health budget by their own initiatives to raise funds among the commune's population. Hence, health insurance could well be a potential source of funds at the commune level.

Existing health insurance schemes in Vietnam are in the public system, organised and managed by a governmental organisation at the national level, called Vietnamese Health Insurance Department with responsibility for policy making, management guidance and general reserve fund keeper. There is a sub-department of the Health Insurance Department for each province. The sub-department has the right to act autonomously, using independent accounting as well as to manage the district-health-insurance agencies which belong to it. Among total revenue from insurance premiums, a maximum of 8% can be used for administration, and in the case of the compulsory health insurance (CHI) program, 2% must be contributed to the central

department for the general reserve fund, the rest has to be used for paying health care service benefits of insured patients.

Financial Mechanism of Health Insurance in Vietnam

The *main characteristic* of this mechanism is that the health insurance agency is a public, non-profit organisation. Insured persons (see the section *"Members of Health Insurance"*) pay nothing when they use health care services from providers inside the insured scope, while hospital costs are reimbursed by third-party-payment made directly to the hospital after checking by and, under the supervision of health insurance officers. Consumers, providers and insurers get benefit from government subsidies through health budget allocation for public hospitals. The mechanism's actions as a part of the Vietnamese health care financing framework, where providers are district, provincial and central hospitals, consumers are CHI and VHI patients and the health insurance agency is the provincial health insurance sub-department with the district agencies belonging to it.

The Structure of Health Insurance in Vietnam

The context from which the health insurance was formulated. In the late eighties, health care establishments had to cope with new challenges such as increasing demands for health care, but the state budget for the health service could not keep pace with escalating prices and high inflation. These challenges had a significant negative impact on the quality of health care services. In order to find new sources of funds and to relieve the financial burdens of health care establishments, the government allowed public health care establishments to collect a part of the user's fees, and allowed doctors and pharmacists to practice as private services. These solutions partially addressed demands for health care for some groups of people most of them were healthly or had rather high incomes. Meanwhile, the majority of low-income people no longer enjoyed subsidies in health care as they did in the past. Many of them, when they had to go to hospital due to illnesses, could not afford to pay for high-cost services. In such a situation, some local authorities were brave

enough to take a first step in overcoming financial problems to maintain the activities of local hospitals by mobilising the contributions of local people in many forms in order to have more funds for health care.

Organisation and management structures of the health insurance system. By 1993, the number of health insurance offices established all over the country was 59. They included the Vietnam Health Insurance Agency, the Vietnam health insurance branch office in Ho Chi Minh City, 53 city/ provincial health insurance offices, and 4 sectoral health insurance offices. The Vietnam health insurance system was formulated from central to local levels and consisted of:

- The Vietnam Health Insurance Agency, which was under the Ministry of Health,
- City/ provincial health insurance offices, which were put under the responsibility of directors of provincial health services of each locality,
- Sectoral health insurance offices which belonged to their own sector.

  City/ provincial and sectoral health insurance offices, were all put under the Vietnam Health Insurance Agency.

The Vietnam Health Insurance Agency, city/ provincial and sectoral health insurance offices were operated in the form of self-financing. They had their own legal status, stamp and account. The Vietnam Health Insurance Agency was only responsible for providing localities with technical guidance, whilst the local people's committees (their respective health service and financial bureau). The concerned sectors that had sectoral health insurance offices were in charge of monitoring their health insurance units' compliance in terms of state financial regulations.

The above described organisation and management structure created some basic problems existing in such a system, including:

- The rights and benefits of health insurers were not standardised over the whole country. Some cities/ provinces provided their own regulations on ways of payment/ reimbursement for health insurance.

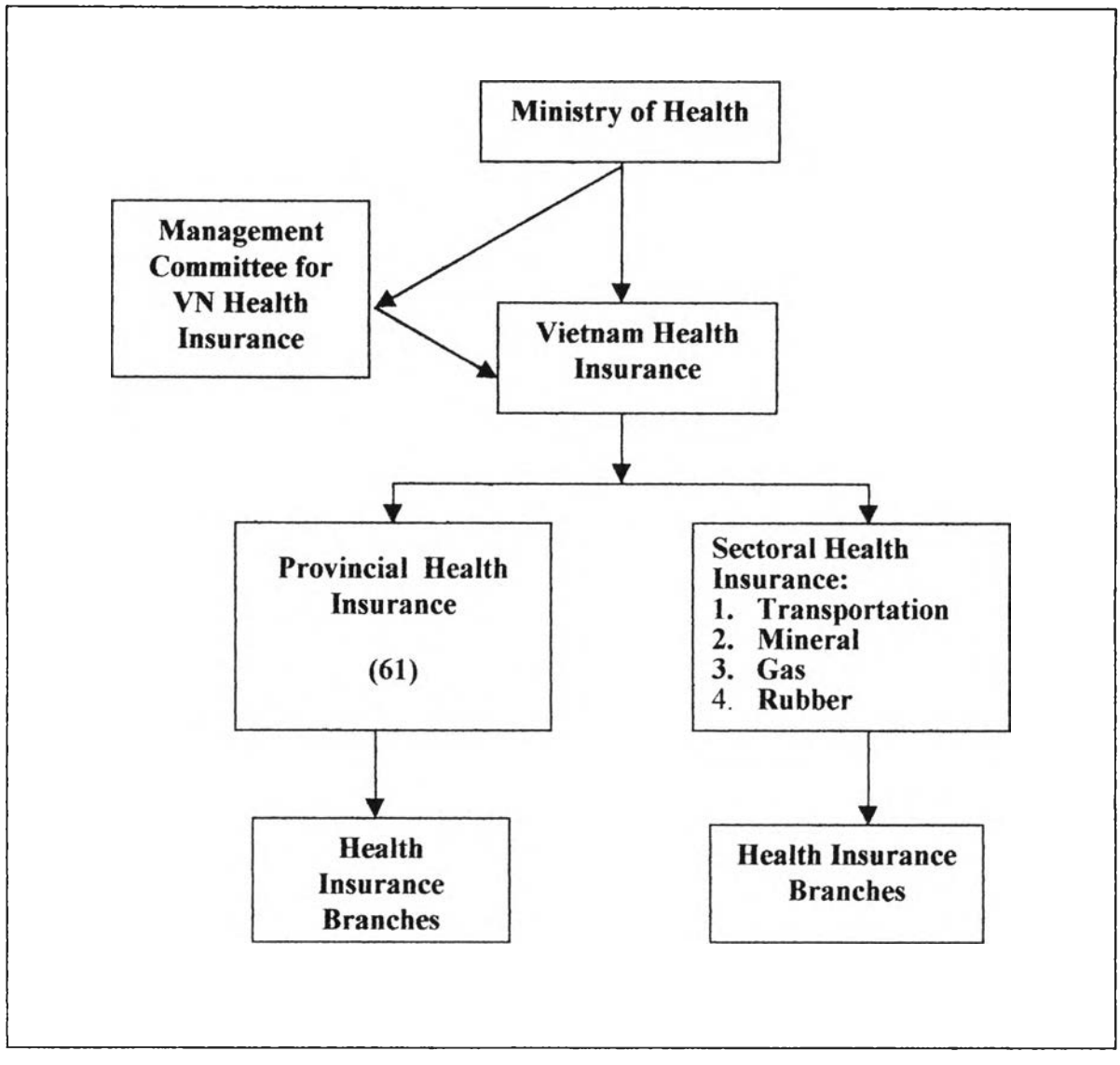
- Some localities had limited health insurance revenues that resulted in restricted payments for health care costs under the health insurance whereas some others could generate more funds and had a surplus. However, there was no mechanism to regulate/ transfer funds from surplus areas to places of shortage.

Basic changes in terms of managements are:

- The Vietnamese health insurance system has been organised and managed in a uniformed system from central to local levels.
- Health insurance funds have been managed in a concentrated and uniformed manner for the whole Vietnamese health insurance system, which are independent in terms of financing with the state budget and under the state auspices.

Therefore, health insurance funds are managed in a concentrated and uniformed manner. This method of management creates favorable conditions to ensure the safety and growth of funds and makes it possible to regulate/ transfer funds when there is an imbalance of funds across localities and regions. The uniformed management and organization of health insurance funds may be a source to ensure fund safety. Up to now, the health insurance system in Vietnam has been exclusively managed from the central level down to peripheral levels with one Central Health Insurance Agency, 61 city/ provincial health insurance offices and four sectoral health insurance offices – namely the health insurance offices of the transportation, mineral, gas and rubber sectors.

Figure 2.1 **ORGANIZATION STRUCTURE OF THE VIETNAM HEALTH INSURANCE SYSTEM**



The objectives of the health insurance policy in Vietnam

The health insurance in Vietnam is a kind of social welfare policy with the aim of implementing health insurance for illness cases. It is actually a type of social insurance scheme comprising health insurance funds formed from insurance fees contributed partly by employers, partly by the health insurance funds partly by employees. The establishment of health insurance funds aims at serving personal needs of health insurance participants in cases where they are ill and need support from the funds. As in other countries, the health insurance system in Vietnam is designed to address the following objectives:

- The first objective is to generate an extra fund to supplement the financing source of the public health care system. Its aim is to mobilise financing sources to form a centralised health insurance fund with the premium shares contributed by employees and their employers. A part of these contributions will be given to public health establishments to cover health care costs for health insurance participants. Revenues from the health insurance, in combination with the state budget allocated at the present for localities, will be used to improve the quality of health care services for health insurers. It is hoped that with these financing sources, health care services will be provided in a smooth and effective manner.
- The second objective is to release the financial burden of high-risk people in cases of serious illnesses and high cost services. A purpose of health insurance is to ensure the reduction of financial burdens by allowing individuals and their families to contribute, in advance, an amount of money in order to reduce financial risks in case of illness.
- The last objective of health insurance is to partially contribute to the implementation of equity in health care and redistribution of income. With the large number of members participating in the health insurance, each member will be given the maximum benefit at a modest contribution of fees. Another point of equity is that the collection of fees is done among people of different social strata. For example, the formulation of health insurance premiums based on the

percentage of incomes allows high-risk and low-income people to be supported by low-risk but high-income people.

The members of the health insurance system

There are two main schemes of health insurance in Vietnam, they are the compulsory and voluntary health insurance schemes.

Compulsory health insurance:

According to the current health insurance regulations (promulgated under Resolution No.58/1998/ND-CP), as well as the former regulations, the compulsory health insurance scheme is applied to the following categories of population:

- State officials, workers working in state administrative agencies, party organisations, social and political associations, mass organisations.These people are put into the same category called a category for state administration.
- Workers working in state enterprises, economic organisations of administrative bureaus. They are classified in a category for state enterprises.
- Workers working in non-state units and economic organisations that have at least 10 employees. They belong to a category for private enterprises.
- Workers working in companies that have shares from foreign investment, processing zones, centralised industrial areas, foreign and international agencies operating in Vietnam. They are gathered under a category of foreign investment.
- Retirees, disabled and those suffering from occupational accidents, rubber workers enjoying monthly health insurance allowances. They fall into a category for retirees.

Voluntary health insurance scheme:

According to the prevailing health insurance regulations, everyone can join the voluntary health insurance scheme at his/ her will. During the last period, the following categories are participating in the voluntary health insurance scheme:

- Pupils and students,
- Urban, and Rural populations (peasants)
- The poor : Income less than 5 USD/person/month (Vietnamese' s economy 1945-1995, Tran Hoang Kim, 1996)
- Workers' relatives.

By the end of 1998, the number of members contributing to the health insurance reached almost 10 million accounting for 12.71% of the population with the 1998's growth pace of 158% compared with that of 1993. This shows that there are everincreasing numbers of people participating in the health insurance system and getting welfare benefit from the health insurance. It illustrates the superiority of the health insurance system in this current phase.

If making a general calculation for all schemes of health insurance, the growth rate of 1998 reached 158%. However, if broken down into specific schemes of health insurance for assessment, it is observed that the number of members to the compulsory health insurance scheme in recent years has been rather stable with a low growth rate. Meanwhile, the number of members to the voluntary health insurance scheme has been increasing rapidly over the years. The number of participants in 1998 reached 1049% compared with the growth rate of the base year of 1993. This figure shows that the expansion of voluntary health insurance coverage has done well.

Table 2.7. Number of Health Insurance Members (CHI&VHI) to the HI System

Indicator	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Total number of health insurance members	3,799,255	4,246,084	7,104,187	8,632,492	9,550,827	9,788,426
% of members per population	5.35	5.86	9.61	11.46	12.62	12.71
% of growth rate in comparison with 1993	-	16	87	127	151	158
Number of compulsory members	3,473,386	3,720,151	4,870,009	5,559,415	5,734,560	6,046,299
% of growth rate in comparison with 1993	-	7	40	60	65	74
Number of Voluntary members	325,569	543,933	2,234,178	3,073,077	3,816.267	3,742,127
% of growth rate in comparison with 1993	-	67	585	843	1071	1049

Source: Vietnam Health Insurance, 1998

2.2.3 Hospital fee collection Policy in Vietnam

The introduction of user fees was introduced in public hospitals in Vietnam in 1989. The shortage of government funds for hospitals during the inflation period of the late 1980's pushed the government to introduce fees collection in public health facilities. Public health services were recognized as being unable respond to health needs. Various policies were developed for social mobilization, for diversification of health care services, and for decentralization of responsibilities. Consequently, private practice of the medical and pharmaceutical professions was legalized, and compulsory health insurance was established. The new stage of stable development requires a more stable health system which is more professionally, socially, economically and culturally suitable. The policy of cost recovery was approved as the right choice. The new policy of the Communist Party to shift from a planned, subsidised, centralised, bureaucratic mechanism to a market-oriented mechanism under the state socialist-oriented control has brought Vietnam out of economic crisis, stabilised the politics, and at the same time create positive impacts to health care activities. Big changes in health care policy of the government as follows:

- Socialising of health care services: hospital fee collection, health insurance.
- Diversifying the forms of hospital and health care service: encouraging private health care services.

These policies have created favourable conditions for the development of the health care system in Vietnam in line with orientations of the people, by the people and for the people, as well as ensuring equity in health care in general and health care services in particular. Hospital fees and health insurance policies has been in existence for almost 10 years now but it is a sensitive policy for every member in the society. Therefore, the government always shows concern and modifies them in order to fit them with the social situation. This was reflected in the process of formulating and developing hospital fee policy in Vietnam.

Table 2.8. **FORMULATION AND DEVELOPMENT OF THE HOSPITAL FEE - HEALTH INSURANCE POLICY IN VIETNAM.**

	Decision 45/HDBT - Interministerial Circular 14/LB	**Decree 95/CP - Interministerial Circular 20/TTLB**	**Decree 33/CP - Interministerial Circular 14/TTLB**
Forms of collection	Out-patient: -None HI cardholder: paid by number of consultation and technical services. - HI card holder: paid as above but apply for only about 13 - 45% of total health insurance fee from registered cards.		
	In-patient: - Paid by number of bed-occupied days. - Net fee of drug, X-ray operation, tests... - HI cardholder: paid by average No. of bed-occupied days.	In-patient: - Paid by average No. of bed-occupied days. -No other payments. -Using the collection form for both hospital fee and health insurance	In-patient: - Paid by average No. of bed-occupied days. -Net fee of drug, X ray, operation,test -Free operation - Using the collection form for both hospital fee and health insurance
Frame of the price	- Consultation. - No. of bed-occupied days. - Technical services -Test - Body function tests - Imaging diagnosis. - The price frame of hospital fee and health insurance are not included in in-patient treatment fee.	- The average of in-patient days: including technical services, drugs, blood transfusion, and equipment... - Uniform price frame for both hospital fee and health insurance	- No. of bed-occupied days. - Technical services - Imaging diagnosis - Without surgery and operation. - Uniform price frame for both hospital fee and health insurance
Levels of fee	- Based on estimated price of consultation, in-patient day, technical service. - Differences between levels in fee collection are still low.		
Health Care policy for the poor	- No Government budget allocation. Hospitals have to cover with their own budget.	- Some provinces provide: Health insurance for the poor. Health care service card for the poor.	
Utilisation	- 60% cover costs for curative activities. - 35% reward to hospital staffs. - 5% cover administration costs.	- 85% cover costs for curative activities. - 15% reward to hospital staffs.	- 70% cover costs for curative activities - 30% reward to hospital staffs.

Source: Dept. of Finance/MOH of Vietnam, 1998

2.2.4 Relationship between User fees and Health Insurance in Vietnam

Hospital fees and health insurance schemes have supplied the expenditures of health care services. Implementing the collection of user fees and health insurance is done to recover a part or all the cost. Recovering cost by hospital fees and health insurance is a policy that almost every country in the world implemented to socialize in health care services, improving the quality of curative activities.

The amount of money paid for health care costs under the health insurance system has been rapidly increasing in recent years. By 1997, spending from the fund for health care and treatment compared with the budget allocation to hospitals rose from 7% in 1993 to 38% in 1997. In 1994, spending for health care and treatment provided under the health insurance funds exceeded the source of user's fees in health care establishments. In 1997, it reached the rate of 92%. It is estimated that spending from the fund for health care and treatment will continue to increase when user's fees rise.

Table 2.9 Comparison between HI payment with Hospital fees Revenues

	1993	1994	1995	1996	1997
Payments for Health care Insurance (billions Dong)	49	130	250	410	480
Comparison with State's Budget for Hospitals (%)	7	14	24	37	38
Comparison with Hospital Fees (%)	48	118	60	87	92

Source: Vietnam Health Insurance/MOH of Vietnam, 1998

Health care expenditures in the starting years did not exceed 50% of the health insurance revenues. However, by 1997 they approximately reached the rate set aside for the fund for health care and treatment. During 1996 and 1997, many localities overspent their budgets.

Interaction between the two schemes in Vietnam (user fees and health insurance) can be charictarized as follows:

- When fees are included as an factor in a choice model it becomes possible to examine the impact of fee changes on people's choice and to compare the impact of fee changes with the impact of changes in other site factor.
- Increasing user fees, first of all will help the health sector receive more revenue, especially those collected from weathly people. However, it will have a direct impact on the life of laborers. Health care expenditures also take a big share of laborers' total expenditures. At present, in Vietnam, the poor and very poor pay high rates. If there is no exemption mechanism applied for the poor, increases in user fees will have the most direct and greatest impacts on this group because the demand for health care by this group is high. Increase in user fees also affects low

and middle-income people. These afore-mentioned impacts will obviously make a large proportion of the population participate in the health insurance scheme. As such, when the government provides a health insurance scheme, the number of contributors to health insurance will probably increase.

2.2.5 Utilization

The utilization of health services can be seen in terms of the annual number of consultations, the annual number of inpatient admissions as well as the annual number of hospital days/ person.

Table 2.10 Utilization of Health Care Services by Health Insurance Members

Indicator	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Number of OPD visits by HI members (millions time)	2,000	5,300	9,000	10,000	12,800	13,682
Average times of seeing doctor per year of a member	0.53	1.24	1.26	1.16	1.34	1.42
Average times of seeing doctor per year of a citizen	0.67	0.76	0.92	1.17	1.21	-
Number of IPD treatment for HI member (millions time)	200	500	1,000	1,000	1,200	1,309
Average times of IPD treatment per year per 100 members	5.26	11.73	14.08	11.58	12.56	13.37

Source: Vietnam Health Insurance MOH of Vietnam, 1999

The utilization rates of health insurance members has increased over the years and, if comparing the utilization rates of health insurance members with those of the population in general, it is noticed that the awareness of people in general for health care as well as that of health insurers in particular is increasing. However, the higher utilization rates of health insurers compared with the utilization rates of people in general may also be explained by an argument that, because the health insurance covers health care costs for health insurers, they may be inconsiderate in consuming health care services.

2.2.6 Revenues and Expenditures of Health Insurance Scheme

In the year that health insurance in Vietnam was implemented, the health insurance revenue was only VND 111 billion, accounting for 8% of the state budget for the health sector. By 1998, the revenue was almost 669 billion Dong, which was an increase of 503% in compared with the base value of 1993.

Table 2.11 Health Insurance Revenues

Indicator	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
Value of collection (billions Dong)	111	256	400	5200	540	669
Growth rate in comparison with year 1993 (%)	-	201	267	330	321	360
Comparison with Health sector Budget (%)	8	15	20	25	25	25

Source: Vietnam Health Insurance MOH of Vietnam, 1999

By 1998, the revenue reached almost 25% of the state budget. With revenues coming from providing health care services for health insurance participants, the health sector had generated a considerable financial source every year to directly serve health care activities. Health insurance revenues have made a considerable contribution in improving the quality of care and upgrading health care establishments, particularly those at district level.

Revenues from the health insurance are divided into the following funds: a fund for health care and treatment, a fund for health insurance management and a reserve fund for health care and treatment.

Such assumptions are required to make predictions about how various reform policies might influence national health expenditures.