CHAPTER II

ESSAY

LOW COVERAGE OF SCHOOL HEALTH INSURANCE IN VIETNAM

2.1 – **Introduction:**

2.1.1 – **Health Insurance of the World:**

The Health Insurance idea originated in the Middle Ages of Europe, even before capitalism, when manufacturing was principally by small independent craftsmen organized into guilds. It was the guilds that made use of insurance. In the sixteenth and seventeenth centuries, the guilds of carpenters, masons, and so on would collect their member funds to help a colleague in distress or the widows of deceased guild members.

In the eighteenth century and more rapidly in the nineteenth century, with the transition from agricultural into industrial countries, saving funds could not be relied on any more. Many sickness insurance schemes based on the regular contribution of the members were formulated to help the sick and members whose wages were suddenly terminated, and this idea spread rapidly throughout the working population in Europe. An especially large number of *Kranken Kassen* or sickness insurance societies were developed in Germany.

In 1881, Bismarck, Chancellor of the German Empire, under Emperor William I, introduced a bill in the Reichstag (parliament) that would have established a central national sickness insurance fund. After extended debate, the idea of a large central insurance fund was rejected, but in June 1883 a law was passed that marked the beginning of national social insurance for financing in Germany. The social insurance idea soon spread to other European countries – first to Austro-Hungarian Empire and eventually to every country on the continent.

After the World War I (1914-1918) the idea of health insurance for industrial workers began to spread outside of Europe. Japan was the first country outside of Europe to enact such law in 1922. After Japan, a number of countries in Latin America and in the Western Pacific passed laws to cover industrial workers with health insurance such as Chile (1924), Brazil (1931), Peru (1936) and New Zealand (1939).

After the World War II, the health insurance concept as an approach to improving the accessibility of medical care spread to all continents. And by the beginning years of 1990', 70 countries, with a majority of the world's population, provided social security, or equivalent health care protection for all or some portion of their national population. The coverage is universal or nearly so in 34 countries, all but a few of which are industrialized. Coverage is only partial in 36 countries, all of which are economically developing, except the United States. In these countries coverage is gradually broadening, although in many it still constitutes only a small fraction of the population (Milton I. Roemer, 1993).

During the long development history of health insurance in the world, a lot of successful as well as failed experiences have been introduced. The development experiences of social health insurance in the world in the last century are a valuable lesson for health insurance development in Vietnam.

2.1.2 – **Social Health Insurance Development in Vietnam**:

Since 1987, the economic and financial climate in Vietnam has been changing rapidly with the move from a centrally planned to a market economy. However, reform was accompanied by a fiscal policy calling for reduction in public expenditure, including cuts in allocation 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.

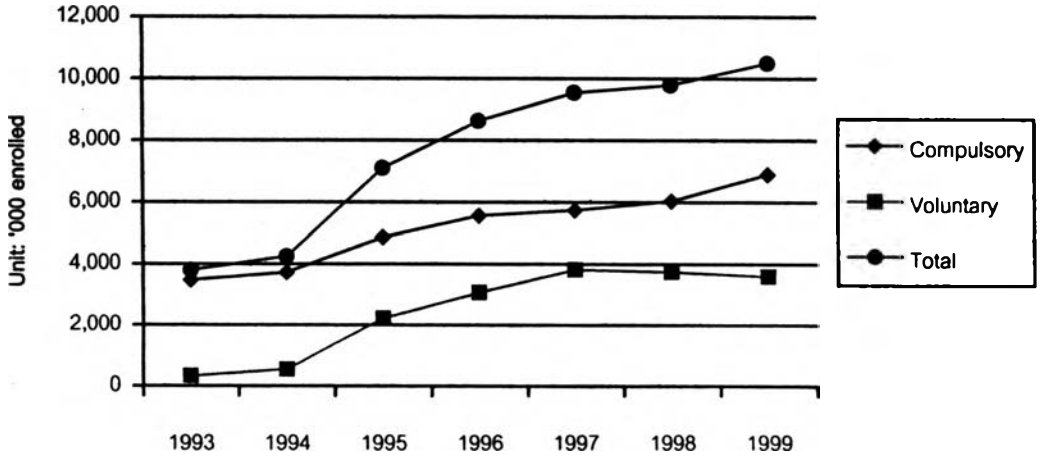
Accordingly, the Government of Vietnam recognized the need for cost sharing with the population as a viable alternative and, in August 1992, issued a National Health Insurance Decree calling for compulsory health insurance for salaried workers in public and private sectors, for retired persons, civil servants, and for special groups of the population, who need social support, such as war invalids, veterans, etc., (Ministerial Decree No. 229 / HDBT). Voluntary membership in the scheme was made available from the start, in an attempt to improve access to health care for the rural population. This Decree was immediately followed by the implementation of Vietnam Health Insurance (WHO, 1993).

Vietnam Health Insurance (VHI) was established as an operation unit within the Ministry of Health to implement both compulsory and voluntary health insurance schemes throughout the country, through a series of decrees related to contribution levels, collection, benefits, the use of contribution revenues and providers payment.

At present time, VHI offices have been set up in all 61 cities (under direct management of the central government) and provinces, most with branch offices in some or all of their districts. VHI has two central offices in the north and in the south of the country. The Hanoi central VHI office serves as the national directorate.

By the end of 1999, the number of participants in the health insurance program almost reached 10.5 million people accounting for 13.77 % of the total population with the growth rate of 177% in comparison with that of 1993 (see detail in Chart 1).

Chart 1: **Health Insurance Participation from 1993 – 1999**



Source: *MOH, Vietnam.*

The data from Chart 1 shows that there is an increasing number of people participating in the health insurance system and getting welfare benefit from the health insurance system (MOH, 1999). However, when breaking down specific schemes of health insurance, it is observed that the number of participants in the compulsory health insurance scheme in recent years is rather stable with a low growth rate but it covered 87.6% (6.9 mil / 7.87 mil.) of the eligible population (MOH – ADB, 1999). Whereas the voluntary scheme has barely made a dent into the eligible population for which it was established. This means that the growth of health insurance in Vietnam in the future must focus on the population of the voluntary scheme, recognizing the need to involve these populations in the scheme. New approaches will need to be introduced to pupils and students, the rural population (peasants), the poor, the urban population, worker's relatives and people who are targets of the social policy (social humanitarian).

Together with the rural population and the poor, school pupils and university students are priority target groups of numerous social policies in general and of health insurance expansion in particular. The point of view from the Government is that the children today are the important resource of the country in the future; therefore, school's pupils and students should be given comprehensive education and care, including virtue, knowledge, physical and mental health. As School Health Insurance (SHI) is a means to implement socialization of education and health care activities, therefore, how to expand the coverage of SHI is not only a great concern of the Government with its representative bodies, namely the Ministry of Health and

Ministry of Education and Training (MOET) etc., but also an interesting issue to study.

2.2 – **School Health Insurance in Vietnam**

2.2.1 – **Current Status of School Health Insurance**

2.2.1.1 – **Initial steps:**

One basic policy issue was whether VHI should move to health insurance on a family basis, ensuring insurance coverage of dependents via membership and contribution of the household heads. This would be the usual practice in social health insurance. Separate health insurance programs for distinct population groups' leads, among others, to adverse selection and excessive administrative costs. However, the Government was keen to respond rapidly to two main worries of Vietnamese parents: first, to cushion family budgets against the major expenses of hospitalization of children and second, to create conditions in schools under which children stay healthy. Therefore, a policy decision was taken in 1995 to introduce national SHI as a component of VHI. A new Interministerial Circular NO. 40/1998/TTLT-BGDDT-BYT enacted on 18 July 1998 officially endorsed SHI. It was signed by the Vice-Minister of both the MOH and MOE&T (WHO, 1999).

Selected components of the Circular:

(i) Eligibility: All children, from primary schools upward, are eligible to joint SHI.

(ii) Coverage:

1. Basic health care at the school health clinic, consisting of:
   - Personal hygiene, nutrition and environmental hygiene, prevention
   - First aid for accidents and sudden illness, as well as food safety at school;
2. Hospital care:
   - Outpatient care as a result of emergencies and accidents;
   - Inpatient care;
3. Cash benefit in the case of death from illness and accidents.

The insurance coverage is quite comprehensive and offers significant attention to prevention and promotion. However, there are a number of exclusions that correspond to those diseases whose treatment is, in principle, subsidized by the Government.

(iii) Health insurance contribution:

For primary and lower secondary schools (PS / LSS), the contributions are defined from 15,000 VND to 25,000 VND per pupil per year (equivalent to USD 1.1 – 1.8). For upper secondary schools (USS) and higher, the

contributions would be between 30,000 VND and 40,000 VND (equivalent to USD 2.1 to 2.8). It is left to Provincial and Municipal governments to decide which level of contribution is suitable in view of their local socio-economic circumstances. Health insurance contributions are collected once or twice a year, depending upon provincial or municipal regulation. Schools and universities are responsible for collection, usually through the teachers.

(iv) Allocation of School Health Insurance revenues:

- 65% is allocated to the Provincial or Municipal Health Insurance fund to be spent as follows:
  - 60% for health care services and funeral grants.
  - 4% as an administration fee to the Provincial/Municipal Health Insurance.
  - 1% to the central VHI office, of which
  + 0.8% is put in reserve fund
  + 0.2% is an administration fee for the central VHI office.
- 35% is allocated to school health services and programs, to be spent as follows:
  - 30% for school health workers' allowances for the purchase of medicine, simple medical equipment for first aid and basic health care at the school or university health clinics.
  - 5% for those individuals who take part in the marketing of SHI and in the collection of health insurance contributions.

In addition, it is specified that if there is a surplus in the health insurance fund for health care services, 80% of this will be put in a special reserve and 20% will be used to purchase health insurance cards for disadvantaged schoolchildren.

(v) Implementation:

The implementation of SHI is a joint responsibility of several government ministries and not only of VHI. This intersector approach is meant to be more effective than if only one ministry or only VHI were responsible for its implementation.

2.2.1.2 – **Current status:**

In school year 1994-1995, 650,000 children were insured via VHI. In school years 1997-1998 and 1999-2000, this number increased to 3,460,540 and 3,396,400 respectively. To the end of 1999, SHI has covered about 20% of the eligible group (Tran Van Tien, 2000). The results of SHI implementation from school years 1994-1995 to 1999-2000 are shown in Table 1.

Table 1: **Result of SHI implementation from school years 1994-1995 to 1998-1999**

School Year	Number of Insured	Revenue (Mil. Dong)	Revenue located for school clinics (Mil. Dong)	Revenue spent for health care services (Mil. Dong)
1994-1995	650,000	8,330	2,915	4,998
1995-1996	2,264,643	24,241	8,484	14,545
1996-1997	3,335,142	50,737	17,757	30,442
1997-1998	3,460,540	47,963	16,787	28,778
1998-1999	3,396,400	58,993	20,626	35,360

Sources: *VHI report*

2.2.1.3 – **Problem statement:**

"In Vietnam, SHI represents an important opportunity to improve schoolchildren's health via health promotion and prevention activities" is the remark of WHO's health insurance experts (WHO 1999, School health insurance as a vehicle for Health-Promoting Schools, P.3).

In Vietnam, SHI has been implemented for just 5 years. To the end of 1999, there are 3.396 million school pupils and university students who participated in the SHI scheme, covering around 20% of total pupils and students of the whole country. SHI has contributed its part in ensuring the quality of primary health care activities for

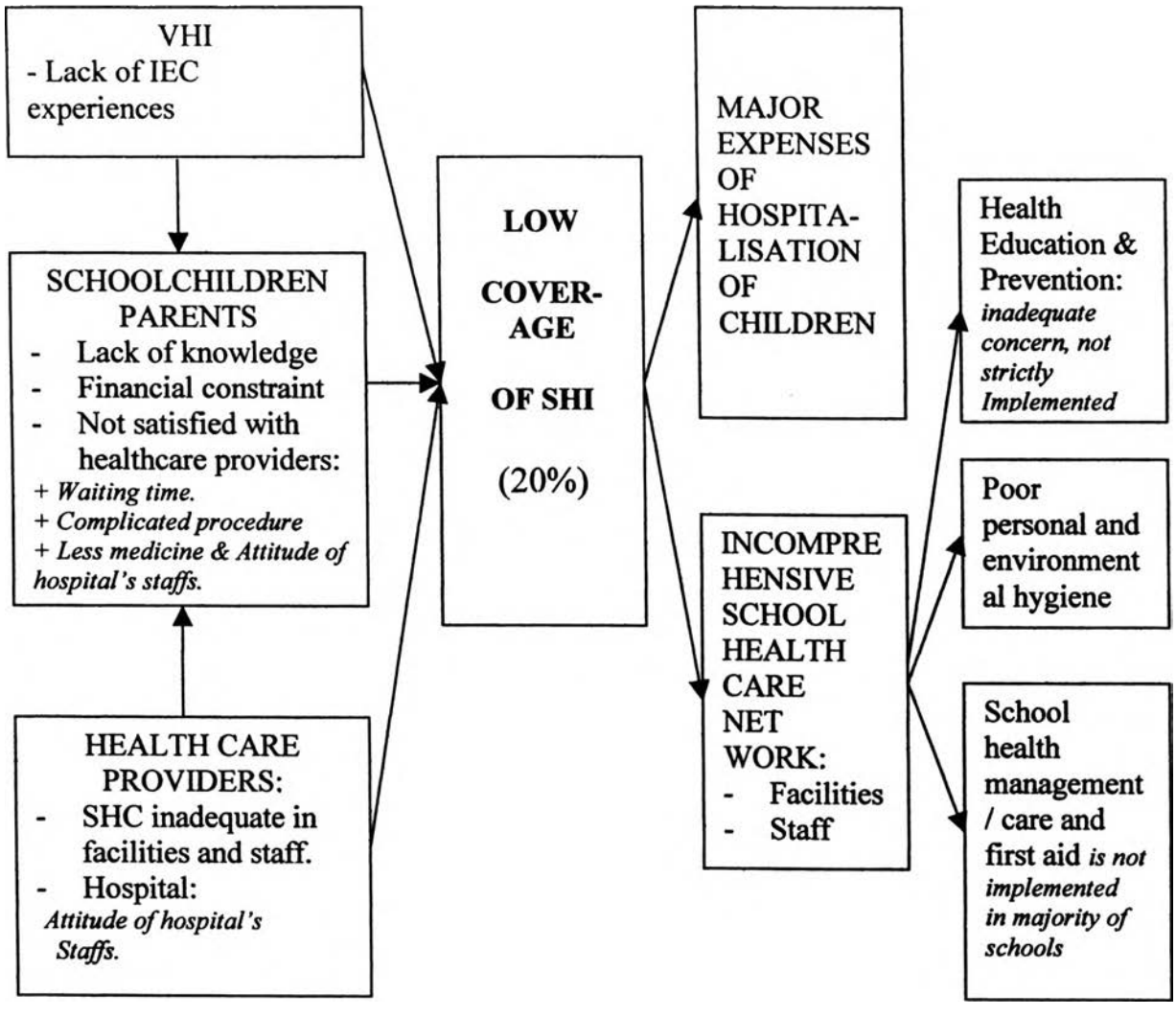
pupils and students at the schools through the development of a school health care network. SHI has supported programs of drug addict control, HIV/AIDS control, tobacco control, environmental hygiene and safe water supply in the schools. SHI has provided first aid for sudden illness and accident at the school, carried out periodic health examination to manage health status and early detection of the diseases for the pupils to be treated in time. There were pupils paid several ten of millions dong for one treatment course, specifically, there was pupil who has been paid up to more than 200 million dong for his hospital expenditure. Beside the above-mentioned initial results, SHI is also facing some problems and challenges in which the low number of insured is the main problem. The coverage is just 20% of the total pupils and students in the whole country. The coverage should be 40 – 50% of the total eligible group to ensure sufficient subsidy for those who get sick (Le Ngoc Trong, 2000).

Thus, why is the coverage rate of SHI is still so low? What factors affected the participation of school pupils and students? What is the consequence of low SHI coverage on children? How can the coverage of SHI be expanded? These questions became the initial issue that caused great concern of not only the related ministries and departments but also of the researchers.

2.2.2 – **The Causes and Consequences of low coverage of SHI in Vietnam**

The following web can illustrate the causes and consequences of low coverage of SHI in Vietnam.

Chart 2: Causes and Consequences Web:



2.2.2.1 – **Causes leading to low coverage of school health insurance:**

The causes leading to low coverage status of SHI in Vietnam may be due to many reasons, but the followings are the three main causes:

(1) – Vietnam Health Insurance:

Since the early days of VHI establishment, the lack of information, education and communication experiences is one of the biggest weaknesses of VHI as noted by WHO. The lack of experience hampers development of appropriate promotion and public relations material and methods (WHO, 1993). Regarding health financing and insurance in Vietnam, the technical experts group of ADB wrote: "Marketing has been identified as a key constraint to the further development of VHI. Most provincials, district and local staffs are unclear about how to market health insurance within the voluntary program. Little time is taken to market to communities and communes" (MOH/ADB, Rural Health Project, TA. No. 3077-VIE, 1999, P.17).

Marketing activities of VHI now a day mainly is done via mass media means. Although the mass media channels communicate with large numbers of people, the fact that the message is sent via a medium (such as radio or TV) makes it difficult to obtain immediate feedback and modify the communication to be responsive to the needs and characteristics of the audience. Many research studies have now shown that the direct persuasive power of mass media is very limited (Ewles & Simnett, 1996). The content of information is mainly to motivate but not to inform or build skills. No information, education, communication program has been discussed which will inform those who obtain the cards of the benefits and how to use them appropriately and to which facilities they may be able to go for care.

Interministerial Circular no. 40/1998/TTLT-BGDDT-BYT, dated July 18, 1998. of the MOET and MOH on 'Guideline for SHI Implementation', has regulated the marketing of SHI activity as the responsibility of the Provincial and Municipal HI offices in cooperation with the Department of Education and Training of the local governments. But many offices did not properly provide information on the role and benefits of SHI for the children, their parents and teachers resulting in limited motivation to participate. That is the explanation of Dr. Tran Van Tien, Director General of VHI in his speech at the "SHI 5 Year Review Meeting" that was held in Hanoi on 30 August 2000. This weakness was reconfirmed by Prof. Dr. Le Ngoc Trong, Vice Minister of Health, Vietnam, in H.E's speech at the meeting.

(2) – Schoolchildren's parents:

The causes of schoolchildren's parents not buying health insurance cards for their children include the following among the main reasons:

(i) – Inadequate information on SHI:

In general, Vietnamese have lived under subsidized economic mechanisms for more than 20 years since the liberation of the North 1954 to the later years of the 1980's. The people received education and medical care totally free of charge. Health insurance was just introduced in Vietnam in 1992, in the period of transition from subsidized economic mechanisms to government oriented market economic mechanisms; therefore, people are not so familiar with living with health insurance.

Especially, SHI was just implemented 5 years ago, so in general the ratio of schoolchildren's parents in Vietnam who know about SHI is high, but their understanding of SHI is inadequate. In other words, the number of parents who know about SHI by term is high but by the meaning is low. They do not have enough information on the objectives of SHI, the benefits of SHI, how to use SHI card etc.,. A survey of the factors affecting buying SHI cards in Primary Schools of Gia Lam district, Hanoi, in the school year 1999 – 2000, is part of the evidence. The result of the survey is showed that 93.2% of schoolchildren's parents have heard about SHI. The sources from which they obtained information are as follows:

Table 2: **The sources from which the schoolchildren's parents received information on SHI:**

Information sources	n	%
Radio and TV	73	23.3
Communal speakers	0	0
Books and newspapers	15	4.8
Leaflets	5	1.6
Schoolchildren's parents meeting	298	95.2
From their children	43	13.7
From health personnel	8	2.6
From health insurance staffs	3	1

Source: *The Survey in Gia lam district, 2000.*

The data in the Table 2 showed that the information on SHI which the schoolchildren's parents (SCP) received via meeting of SCP with the schoolteachers is rather high (95.2%), from mass media such as national radio and TV is only 23.3% and from the communal speaker system is none. However, the content on SHI that should be taught to the parents in the meeting is rather low (Table 3).

Table 3, **SHI information disseminated in parents meeting:**

Content of the meeting	n	%
- Disseminated information on SHI	156	46.6
- SHI information is only mentioned as one of many items that SCP should pay for	179	**53.4**

Source: *The Survey in Gia lam district, 2000.*

Thus, the information on SHI is disseminated in the schoolchildren's parents meeting is rather low: 53.4% of schoolchildren's parents answered that they heard about SHI as one of many items that they should pay for in the beginning of school year (Le Ngoc Chau, 2000).

(ii) – Financial constraint:

In the world, several health insurance schemes for people outside formal sector employment (refers to a number of distinct groups, including those working in the informal labor market, persons engaged in small-scale agricultural production and

certain vulnerable population groups such as widows, orphans, the landless and unsupported elderly), that had examined the issue of affordability acknowledge that it could be a problem. For moderate to large, low-income households in Nkorazan district, Ghana, the estimated cost of premiums amounted to 5-10% of the annual household budget, which may well be a financial barrier to membership (Somkang et al., 1994). In Muyinga, Burundi, 27% of the respondents of a household survey stated that financial inability to purchase a card was one of the main reasons for not participating in the scheme (Arhin, 1994). And in Mexico, about 20% of those enrolled in the prenatal prepayment scheme dropped out. This was attributed mainly to financial inability to keep up payments (Ensor, 1995).

Vietnam is still in the group of low-income developing countries. GDP per capita of Vietnam in 1999 was 5,239.80 thousands dong, equivalent to USD 374 per capita per year (Health Statistic Yearbook 1999). In Ba Vi district, where Hanoi Medical College in collaboration with Karonlinska Institute has been setting up an epidemiology field lab for research students of both Vietnam and Sweden to study, the average income was 290 kg of rice per person per year (about 600,000 VND, 1996). Meanwhile in Vietnam, there are families which have 3 – 4 children going to school, and whether to purchase a SHI card is still under consideration of the parents (Le Ngoc Trong, 2000). Especially, since SHI cards are sold at the beginning of school year when the SCP have to contribute for many items such as school fees, school housing and facility maintenance, text books, uniforms, electrical and water supply etc.,. In the survey of parents of schoolchildren attending primary schools in Gia lam district, Hanoi, 44.4% of respondents stated that due to the beginning of the school

year, they have to contribute for many items leading to some financial constraint; therefore, they have not purchased SHI cards for their children yet (Le Ngoc Chau, 2000).

(iii) – Not satisfied with health care facilities and providers:

The third reason is that a number of the parents are not satisfied with health care facilities and health care providers. Mainly, they are not satisfied due to the long distance from the health facilities, long waiting times and complicated procedures to get the services, less medicine received and attitude of health care staff.

- With reference to selected experiences of social health insurance development in low-income developing countries from Africa and Asia, the facts showed that one of four main reasons for discontinuing membership of Ugandan schemes is long distance from the health facilities (Guy Carrin, Martinus Desmet and Robert Basaza, 2000). In the Vietnamese survey of SCP of primary schools in Gia Lam district, Hanoi, conducted in the year 2000, 17,1% of respondents stated that they are not satisfied because of long distance from the health facility (Le Ngoc Chau, 2000).

- Long waiting time and complicated procedure to receive services is another reason leading to dissatisfaction of schoolchildren. In the same survey in Gia Lam district, 53.8% of respondents stated that long waiting time dissatisfied them.

- Those students who were enrolled received less medicine when hospitalized and the poor attitude of health care staff in the hospital were also reasons that SCP were dissatisfied. This issue will be presented in more details in the item (3): Health care providers:

(3) – Health care providers:

Regarding to health care providers in SHI scheme, both school health clinics and hospitals (mainly focusing on negative behavior of hospital staff) should be touched upon, as school health clinic has a very close relationship with SHI.

- It is observed in areas, where school health clinics are well developed there are more schoolchildren participating in SHI and conversely. In reality the school health clinics network is not equally developed in all cities and provinces. Many local areas still cannot set up school health clinics because of a lack of health personnel (Tran Van Tien, 2000). This is also one of the obstacles to participating in SHI. In many schools, the ratio of schoolchildren who participated in SHI is low; as a result, the budget located for these schools from SHI was not enough to cover health care activities and to pay wages and allowances for health personnel of the school. To interpret this relationship, it should be kindly acknowledged that the Interministerial Circular no. 03/2000/TTLT-BYT-BGD&DT, dated March 1, 2000 of the MOH and MOE&T, on guideline of school health care activities, confirmed that: "***The fund for school health activities is mainly taken from the revenue that school health insurance fund allocated for school***".

- With the hospital staff, during the beginning years of 1990', in some areas, it was even reported that insured persons would deny having membership cards when seeking care. This was due to some negative behavior of hospital staff as they perceived that insured patients would not want to give them any additional or direct payment, in cash or in kind, as was the practice in some places (WHO, 1993). Now a days the service attitude and behavior of hospital staff has been improved a lot as the active changes brought by the Campaign of Learning and Working which follow the 12 Medical Ethical Elements initiated in 1996 by HE. Minister of Health. In addition, now a day the hospital staff is familiar with the service for the insurance patients.

However, beside the health care network in the school there is a shortage of health personnel. Service behavior and attitude of the staff of health care sector, sometimes and in some places, still dissatisfies SCP (Le Ngoc Trong, 2000).

All of the above-mentioned causes, in different levels, more or less have lead to low rate of SHI enrollment in the last 5 years of its operation. As a result, of course, schoolchildren who are not insured may suffer from financial risk at any time because of unpredicted hospitalization; school health clinics can not be developed to ensure good management and taking care of the schoolchildren. These consequences will be discussed in coming part 2.2.2.2.

2.2.2.2 – **Consequences of low coverage of school health insurance**:

(1) – Major expenses of hospitalization of children:

Up to present time, there is no study on the financial risk of schoolchildren who have not enrolled in SHI. However, the figure from the survey of primary school children in Gia Lam district showed the rate of sudden illness and accidence during the schoolchildren were learning at school as follows:

Table 4: **The rate of sudden illness and accidence at school in Gia Lam**

Sudden illness and accidents	n	%
Yes	68	20.5%
No	263	79.5

Source: The survey in GiaLam district, Hanoi.

In late 1998, another survey was organized among primary school children in 11 out of the 336 primary schools in Ho Chi Minh city (HCMC). The schools were chosen at random: 4 schools are from inner city, 3 are from suburban HCMC and 4 are from the outskirts. Each Vietnamese primary school has 5 grades, and each grade chose 1 class for the survey. There are therefore 55 classes studied, with approximately 40 schoolchildren in each class; in other words approximately 2,200 children were surveyed (Nguyen Thi Kim Thuy, 1998). The ratio of schoolchildren

who were hospitalized at least over one night and up and had to see the doctors at the hospital as outpatient during one year is as follows:

Table 5, **The ratio of schoolchildren admitted and visited hospital**

Type of hospital care	Inner city	Suburban	Outskirts
- Admitted to hospital at least over one night	32.42%	37%	21.81%
- Outpatient care	47.14%	46.1%	40.64%

Source: VHI HCMC,

From the facts of two surveys in primary school children in Gia Lam district, Hanoi and in 11 primary schools in HCMC, it was revealed that the demand of health care for schoolchildren exists.

More than that, the data available at the VHI office showed that during the last few years there were 14 pupils and students who have been paid by VHI with amounts ranged from 23,224,619 VND (*Le Thi My Huyen, pupil of the Sa Dec town USS, Dong Thap province, who suffered diminished respiration due to complication from tuberculosis as lowest*) to 205,000,000 VND (*Nguyen Minh Tuan, pupil of Bui Thi Xuan USS, Ho Chi Minh city as highest one*) respectively for one treatment course. This means that the children who are either insured or uninsured may suffer from financial risk at any time during their schooling years.

(2) – Incomplete school health care network:

Previously, the school health care network had been set up within the school system over the whole country with health professional staffs. The activity of the school health care network was really effective and brought essential benefits to many areas for schools and pupils. It created a favorable condition for managing and taking care of the health of pupils, for carrying out first aid, for guidance and education on disease prevention and self-care for schoolchildren. The activity of the school health care network had been a considerable contribution in improving environmental hygiene in school as well as in families. But due to many reasons, the years at the beginning of 1990s, the school health care network no longer existed (Tran Xuan Nhi, 1997). Now a day, the fund for school health activities is mainly taken from the revenue that SHI fund allocated for school. As the consequence, where the rate of schoolchildren participating in the SHI is low, the rate of the schools having school health clinics and health personnel is low too. The result of a survey conducted by the Department of Preventive Medicine, MOH, in 19 cities and provinces countrywide is in the Table 6 as evidence.

Table 6: **The quantity of school health facilities**

No.	Cities and provinces	Number of schools	Total number of school children	Percentage of insured school Children (%)	Percentage of schools having health care facilities (%)
1	Hanoi	428	352,240	40.9	58.9
2	Ninh Binh	368	231,783	54.0	100.0
3	Hoa Binh	348	198,061	7.5	6.6
4	Thai Binh	609	383,628	31.46	100.0
5	Son La	304	209,459	8.45	3.3
6	Lang Son	297	186,694	14.5	1.3
7	Cao Bang	181	86,274	0.2	0.0
8	Thai Nguyen	343	243,093	46.3	36.2
9	Bac Giang	517	359,343	5.5	0.0
10	Thua Thien Hue	402	239,097	55.3	81.3
11	Da Nang	134	143,082	50.5	100.0
12	Binh Dinh	359	333,464	47.5	99.7
13	Quang Tri	259	99,302	1.8	0.0
14	Ho Chi Minh City	856	567,021	58.1	97.2
15	Can Tho	476	397,349	6.5	5.9
16	Dong Nai	423	466,192	4.8	0.0
17	Gia Lai	256	239,597	8.6	7.0
18	Tay Ninh	380	209,617	1.7	3.4
19	Ninh Thuan	150	109,913	53.7	100.0

Source: Department of Preventive Medicine, 2000.

Regarding health personnel in the school system, there are only some provinces where there are favorable conditions in terms of economic and active support from the local government. Health personnel working in the school system were placed from government staff, such as Ninh Binh (273 persons), Dong Thap (67 persons). The rest are contracted personnel or plurality staff (teachers who are appointed to be responsible for school health activities) with the salary and allowances mainly taken from the budget allocated for the school from SHI funds (Tran Van Tien, 2000). In areas, where the rate of schoolchildren participating in the SHI scheme is

low, there will not be enough budget to recruit health professionals to work in the schools. As the result, the school health system is inadequately developed and lacks of health professionals in the schools. This may lead to:

(i) – Health education and school age disease prevention is characterized by inadequate paid an concern and is not strictly implemented:

In the last decade, health education and school age disease were not properly done in many schools leading to some school age disease; most observed is that short-sightedness and tooth decay tend to be increased. Now a day, the rate of schoolchildren who suffer from shortsightedness is more than what it was in the previous time. It was the time when a warning on school age diseases should be done (Huynh Cong Minh, 2000). In the letter sent to Prof. Dr. Do Nguyen Phuong, Minister of Health on 4th August 1999, HE. Ms. Nguyen Thi Binh, Vice Chairperson of the SR of Vietnam informed that now a day she saw that too many children who suffered from shortsightedness. There is class in which two thirds of the children are shortsightedness. Her Excellency's two grant children were shortsighted, too. She suggested that Prof. Dr. Do Nguyen Phuong should ask the ophthalmology institutions to carry out some investigation on its situation and causes and disseminates prevention guidelines for schoolchildren via mass media and the school health system (Health and Life's New Paper, 2nd September 2000). In Da Nang City only, the statistical data revealed that the rate of schoolchildren having decayed teeth ranges from 82% to 86%, and gums inflamed is more than 50%. The causes of this disease are many, but

one of the main reasons is due to schoolchildren lacking education on dental care and prevention (Tran Sy Tan, 2000).

(ii) – Poor personal and environmental hygiene:

In the economic circumstance of a low-income developing country, and where the school health system is incompletely developed, with a lack of health professionals working in schools, poor personal hygiene in schoolchildren and poor environmental hygiene in schools is a consequence of course. These lead to some preventable diseases continuing to exist. The data from the HCMC schoolchildren survey showed many of the diseases, which affect schoolchildren in Vietnam, are due to a lack of clean water supply and sanitation and accompanying poor hygiene at school (Wimblad and Dudley, 1997). These diseases include diarrhea disease, scabies and intestinal helminthes infections.

(iii) – School health management and care including first aid is not implemented in a majority of schools:

School health management is to help detect early diseases in children and treat them in time, to help schoolteachers organize learning work and physical exercise and other social activities suitable with the health status of children, to give information for macro-level managers to formulate national policies. Although, it is so important and meaningful, during the last ten years, including school year 1999-2000, school based health management for schoolchildren was not implemented in a majority of

schools (The review report of MOE&T and MOH on school health activity, school year 1999-2000). The reasons are many; but one of the reasons is an underdeveloped school health network. And as a consequence, first aid is not paid adequate concern. When the first aid is needed in schools where there are no health professionals, the teachers have to leave the class to provide first aid for specific children. But more important, they were not trained for offering first aid activities. If they didn't know how to perform appropriate first aid, it may lead to more harm for the children and even lead to unexpected permanent injuries or bad complications (Le Thi Thuan, 2000).

With all of the above-mentioned causes and consequences of the problem of low enrollment rate of SHI, devising proper solutions to problems and expanding the coverage in SHI is a priority of many related departments and researchers.

2.2.3 – **Solution to expand the coverage rate:**

To solve the low coverage rate problem in SHI, the related Ministries and VHI should have a comprehensive solution. The solution should deal with all causes including the cause from VHI, the causes from the SCP as well as from health facilities and health care providers. The following are alternative solutions for related agencies to take into consideration.

2.2.3.1 - **Alternative solutions:**

- First, improving IEC to bring more information on health insurance to the people, especially in Vietnam where the people are not yet familiar with insurance. Creating the condition for the SCP and teachers in the school to communicate with VHI for improving the operation of the scheme.

- Second, enhancing the collaborative relationship between VHI and the Education Sector in SHI implementation.

- Thirdly, an improving and regulating SHI scheme in the following areas will attract the participation of schoolchildren, their teachers and their parents:

- Revised premium levels and twice a year collection methods:
- Benefits packet including the rate of revenue allocated for schools should be adequate for health care service at school to be covered and a drug list for the insured.
- An incentive or can be offered (premium insurance) for the insured that have not used their insurance card for a long period of time (example three or five years), due to good health, and not needing to use the card.

- Fourth, improving the quality of health care services, strengthening education on service behavior and attitude in health service, and bringing the health services

facilities closer to the living location of schoolchildren to attract their participation and create the conditions for their participation.

- Fifth, mobilizing financial support from existing sources (health insurance, education services, health services, donor agencies, parents and others) to develop and strengthen the school health system, to conduct school health professional training, and to create favorable conditions for SHI expansion and development.

The alternative solutions may be numerous, but all do not have to be done in one day and cannot be done by one sector or one department; therefore, each department and office in different levels should select for itself an appropriate solution.

2.2.3.2 – **Solution chosen:**

Some of the above-mentioned alternatives can only be done at the ministry level such as re-regulating SHI scheme, and even at the ministry level the regulations to be reformulated should be in line with a comprehensive socio–economic development policy of the country. Some others can be done by the offices at certain levels. In the specific capability of the researcher, the most appropriate alternative solution that can be chosen as an experimental study is improving IEC via community organization approach to bring more information on health insurance to the SCP, especially in Vietnam where the people are not familiar with insurance and creating

the condition for the SCP and teachers in the school to communicate with VHI office to improved their knowledge on health insurance in general and SHI in particular.

2.2.3.3 – **Solution strategies and techniques:**

(1) – Strategies:

An Education Strategy via Schoolchildren's Parents Association (SCPA) approach adopted from Models of Community Organization of Rothman (Rothman and Tropman, 1987) is utilized for mobilizing the participation of SCP in the SHI scheme.

SCPA approach is applied because in theory "community organization" is important in health education in part as it reflects one of the field's most fundamental principles, that of "starting where the people are" (Meredith Minkler & Nina Wallerstein, 1997). The purpose of the community organization approach is to stimulate cities and provinces to use their own social structures and resources to accomplish health goals that are consistent with local values (Bracht & Kingsbury, 1990). In Vietnam, SCPA exists in all schools with its sub-associations in each class. SCPA holds meetings at least twice a year to discuss all issues related to their children studying and practicing in the school. In practice, much of what Hai Phong (Vietnam) is doing, in expanding the rural health insurance scheme via Communal People Council and Collective Farmers Association, could be considered as a good model of a community organization adopting SHI (MOH/ADB, 1999).

(2) – Techniques:

In practice of Vietnam, in each SCPA, the Head of the Association and Head of Sub-Association play a very important role in all activities of the association. They stimulate other members to think critically and to identify problems and new solutions. Therefore, it is necessary to gain the understanding and support from the head of SCPA and sub-association. To do it and to train them to be the facilitators later in group interaction, a workshop should be organized and some important principles of community organization model and face-to-face education (two-way communication) would be borrowed and integrated in workshop procedure.

However, with the SCPA as a whole, the concepts and methods to be applied, which is "Community Organization and Community Building" by group interaction method with each sub-association, will be done in one group through the dialogue. The dialogue in each sub-association will be led by the Heads of Sub-Association trained as facilitators and under the support of research team. Through the dialogue, the SCP will discuss the school health situation, the need of improving the school health system, the health status of their children, the sudden illness and accidents that their children may suffer from at any time. They will also discuss the existing SHI scheme with its role, premium, benefits packets and related issues. And the last, but not the least, they will discuss how they can collaborate with schools and SHI to create a healthy environment for the children to study and stay in the school; how their families can avoid financial risk due to unexpected hospitalization of their children or

in other words, how their children will be living with SHI. From the discussion, the SCP may make active choices for their children.

2.3 - **Conclusion**

SHI is not a new concept, but the use of its premium to strengthen a school health program is an innovation (WHO, 1999). But due to many reasons, not all SCP in Vietnam are aware about it. Although SHI has been implemented in Vietnam for 5 years, SHI just covered about 20% of the eligible population. To have enough funding to ensure the subsidy of the healthier for the sicker, more for less (risk pooling as basic principal of a social health insurance scheme) on one hand, and to be able to strengthen the school health program on other hand, Vietnam SHI should expand its coverage to at least 40 – 50% of eligible pupils and students. To meet this target, there are several alternative solutions, but an education strategy via SCPA is the most effective and most feasible way. An experimental intervention project would be done in Ba Vi district with the hope that it would provide some active changes for VHI and related authorities to consider in expanding SHI process in coming years.

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