

# State of UHC: Vietnam

This snapshot summarises the key points raised in a focus group discussion held on 1 July, 2021, with 36 representatives of different vulnerable and marginalised communities in Vietnam.

## What needs to be done?

1. Simplify the paperwork and document requirements to reduce administrative barriers to accessing care, particularly for those with limited documentation.
2. Address stigma and discrimination against marginalised and vulnerable communities.
3. Improve outreach to ethnic minorities and provide interpretation services.
4. Invest in long-term care for the elderly, including mental health services.
5. Cover the cost of care for addiction treatment, sexual and reproductive health products and services, including contraception and abortion.
6. Review hospital policy to ensure access to health care for people who can not afford cash deposits and co-payments.
7. Create a support mechanism for prisoners and former prisoners to access health care.
8. Provide services specific to the needs of transgender people.
9. Work with civil society to improve mechanisms to encourage long-term treatment adherence.
10. Involve the community in the rollout and monitoring of new health initiatives to ensure acceptability and effectiveness.



## UHC context

1. The Government of Vietnam is committed to universal social health insurance. Social health insurance covers certain procedures and medications, however most people need to co-pay.
2. Coverage is complemented by special programs, such as drug rehabilitation or prison health, and social health insurance plays an increasingly important role in securing health care coverage for vulnerable people as health care costs keep rising. Groups including children under six, elderly over 80, certified poor households, people with disabilities, and ethnic minorities in impoverished areas are given a free social insurance card.

## Challenges facing those who risk being left behind

1. Many migrants lack the identity documents needed to access services.
2. Ethnic minorities can face information and linguistic barriers to accessing care, in addition to socio-cultural and geographic barriers.
3. The elderly can face difficulties accessing health centres, particularly when they are dependent on caregivers, or require mental health assistance.
4. The homeless, and out-of-school children face additional barriers to accessing care due to administrative obstacles.
5. Limited services are available for transgender, intersex or agender people, particularly when their identity documents do not match their appearance.
6. Poor people may abandon long-term treatment (e.g. for tuberculosis or ARV for HIV) due to the lack of ongoing support and assistance.
7. Stigma and discrimination deter PLHIV from accessing/receiving quality care.
8. As hospitals are expected to be financially autonomous, co-payment and cash deposit become a barrier.



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Discussions included representatives from marginalised and vulnerable communities including migrants, elderly, youth, urban poor, people with disabilities, women and girls, sex workers, people who use drugs, LGBTQI+, and ethnic minorities.



## What's working



1. In theory, the poor and near poor, as well as children up to six years of age are completely covered by assistance.
2. Civil society is invited to participate in planning, budgeting, and monitoring and evaluation meetings.
3. Hotlines exist to report problems, allowing people to provide feedback and participate in monitoring.
4. During COVID-19, people living with HIV with good adherence records were allowed to take home two months of ARV instead of one, which reduced the travel burden.

## The impact of COVID-19



1. Medical staff were reassigned to COVID prevention and treatment centres, causing shortages in other facilities.
2. Non-emergency medical issues were delayed for follow up.
3. Some programs, e.g. methadone, were suspended.
4. Services became more complicated or longer to access due to the need for COVID-19 screening.
5. The economic impact of COVID-19 made it difficult for people to pay medical bills, sometimes resulting in food or other essentials being sacrificed.
6. Some people who were quarantined could not access their usual treatment, e.g. for HIV or TB.

## What needs to be improved



1. Approval procedures require a lot of documentation and are not user-friendly, creating a barrier to access.
2. Some medication is not covered and can be expensive for the patient, excluding some people from the care they need.
3. Some additional services and support are not available in the country, meaning that assistance is inaccessible for many.
4. Health services need to be more disability-friendly.
5. While the poor and near poor can be covered by insurance, including 80% of their healthcare costs, many who need this support do not have this status and need to buy their own card and cover 20% of the costs, which they are unable to.
6. Children without birth certificates are unable to access the benefits available to children up to the age of six.
7. Staff at the district and commune levels do not always have access to updated policies and treatment guidelines, resulting in some incorrect or outdated practices.
8. Many primary health care units lack basic equipment and medicines, or only those of low quality. Some conditions, including HIV, can therefore only be treated at the provincial level, which can be inaccessible for some.
9. The community is excluded from local planning and budgeting.
10. There have been reports of discrimination received against women, girls, PLHIV, people who use drugs, and LGBTQI+.