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Reducing health inequalities in Vietnam: Implications for health in all policy

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Abstract:

Vietnam is currently undertaking various measures to reduce health inequalities among specific populations, especially ethnic minorities. The government is re-designing the healthcare system to ensure its resilience and inclusiveness by enhancing equal access to health services specifically in the context of COVID-19. The goal is to reduce gaps in service that have great influence on citizen's health outcomes particularly across ethnic groups. To address these gaps, the Government may consider the following suggestions: (1) Increase the efficiency, effectiveness, and sustainability of health insurance; (2) Build partnerships across sectors; and (3) Integrate health in all policies. A combination of both building partnerships across sectors and integrating health in all policies should be promoted. In this article, the authors make policy recommendations to effectively address the complex and multi-faceted issues of health inequalities in Vietnam.

Keywords: **ethnic minorities, health in all policy, health inequalities, social inclusion.**

Classification number: *7*

Introduction

Health inequalities are unjust and avoidable differences in the health of citizens across the population and between specific population groups. Health inequalities go against the principles of social justice because they can be preventable. The existence of health inequalities means that the right of an individual to access the highest attainable standard of physical and mental health is not being experienced equally across the population and between specific social groups. Health inequalities refer to differences in health care among specific population groups. These inequalities are driven by structural factors and determined by circumstances beyond an individual's control. Today's income disparity and the existing COVID-19 pandemic are major factors widening inequalities in health. These circumstances limit a citizen's opportunities to live longer and healthier. Different determinant factors can make it difficult for vulnerable groups to access and utilize health services. These include class, race, ethnicity, gender, income, education, residence, disability, all of which can affect an individual's ability to achieve good health.

Health inequalities in Vietnam

For many decades, Vietnam has achieved good results in terms of health outcomes for its citizens, providing an example of a relatively low-income country that has succeeded in its public health efforts despite the lack of resources [1, 2]. However, during the first decades of the 21st century, ethnic groups and those living in mountainous areas in Vietnam have suffered from health inequality due to differences in socioeconomic and environmental factors. It is no surprise that the poor and ethnic minorities have limited access to resources and receive less health care [3, 4].

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Indeed, health inequalities persist in Vietnam among the poor, ethnic minorities, and disadvantaged people. To identify this problem, it is necessary to examine the uninsured population in the current healthcare system. Over the past decade, according to the Ministry of Health (2021) [5], the extent of health insurance coverage in Vietnam has been increasing over time (65% in 2012, 75% in 2015, and 91% in 2021). Despite these efforts, many people still rely on out-of-pocket payments. T.D. Nguyen and A. Wilson (2016) [6] indicated that only one-fifth of the near-poor population (20.3%) were covered by health insurance. They found that there was a significant link between enrolment in health insurance and poor health status. Vulnerable groups are likely to forgo adequate access to health-boosting resources, which leads to health inequalities among specific populations. The poor also have less frequent visits to the hospital and spend less on healthcare than the rich in Vietnam (Fig. 1).

over time. Ethnic minorities belong to the lowest income quintile while the Kinh/Hoa group is of a much higher quintile. At present, 35% of ethnic minorities are still living in poverty. This means reducing extreme poverty is more of an inclusion agenda to help ethnic minorities have more share in the growth process [5]. People in poorer areas are not able to obtain all the healthcare services they need. Meanwhile, the rich have four times greater access to healthcare services as compared to the poor. In addition, poorer citizens in residing in mountainous areas have six times less access to health services than the rich in lowland areas.

Although Vietnam's child mortality rate is generally very low compared to current national income levels, it remains quite high among ethnic minorities. The rate of undernutrition among children under 5 years of age has only slightly improved while the infant mortality rate is four times higher than that of the Kinh and Hoa

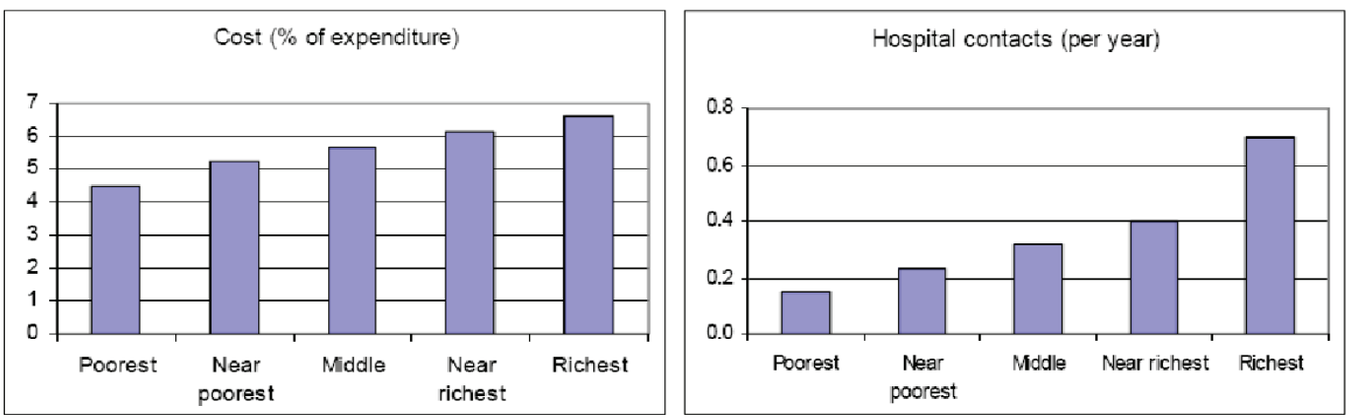

Fig. 1. Widening health inequalities in Vietnam [7].

There are numerous factors influencing health inequalities. The income gap between ethnic minority groups and the majority group of Kinh/Hoa[1] is a strong determinant of health inequality, which is significant and has been increasing

groups [9]. As reported by the Ministry of Health (2021) [5], poverty, lack of education, as well as unemployment are barriers that the poor and ethnic minorities must overcome to gain access to health services despite the fact that they are provided with free health insurance. M. Målqvist, et al. (2013) [2] found that geographic separation affects the ability of ethnic minority groups to access healthcare services. Generally, these citizens tend to isolate

[1]In Vietnam, Kinh and Hoa ethnic groups both lived in the relatively developed regions characterized by highest level of income. They accounted for over 86% of the total population in 2019 [8].

themselves in mountainous and remote regions. A number of programs such as the "Socio-Economic Development Program for the Communes Facing the Greatest Hardships in Ethnic Minority and Mountainous 15 Areas" (Program 135) have been established to build infrastructure and improve public services in mountainous and remote areas. However, health services and infrastructure remain unavailable, and citizens in highland areas have less access to health services than those in lowland areas. The poor mainly visit commune health stations, which are poorly equipped and understaffed. Because of geographical difficulties, patients visit health facilities only when they are in serious condition.

The frequency of access to maternal health care services of the richest group was three times higher than that of the poorest group. About 25% of the poorest get access to health care services as compared with 67% of the richest. Citizens that have completed secondary school had a three times greater chance of accessing maternal healthcare services than those who are illiterate. Maternal mortality rates in the poorest 62 districts in Vietnam are five times higher than the national average, and ethnic minority children have a four-fold higher level of infant mortality. Although the population has seen a decrease in infant and under-five mortality rates, these rates have increased among ethnic minorities [10].

According to a survey undertaken by the Hanoi University of Public Health and the World Health Organization (2015) [11], catastrophic health expenditures have already pushed many households into poverty, leading to lower income that negatively affects their health status (Fig. 2). Most of these citizens are forced to pay out of pocket for health treatments and expenses that exceed their financial capability by at least 40%.

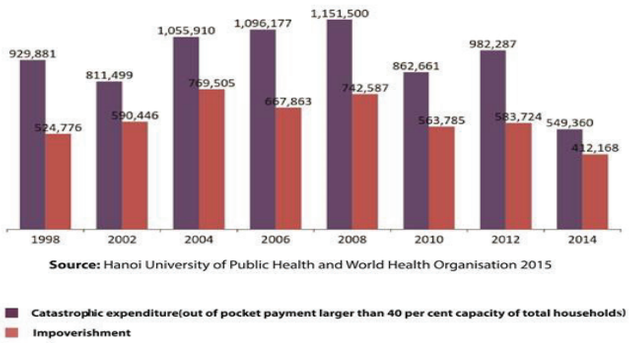

Fig. 2. Households with catastrophic expenditure and impoverishment [11].

In addition to income, poverty, and residential location, language barriers are also cited as a major factor influencing health inequality. Q.T. Tran (2015) [12] showed that ethnic minorities in the Northwestern region went to the hospital for examination but could not speak the Kinh language. As a result, this created an invisible barrier in communication between doctors and patients. The study reported ethnic patients found it difficult to navigate the health system as well as urban facilities such as bus transport when they had to seek medical services.

Health inequalities in the COVID-19 outbreak

Since 2020, Vietnam has experienced an unexpected infection surge with coronavirus outbreaks (COVID-19). The pandemic has imparted negative impacts of rising poverty, livelihood, and widening income inequalities. All areas across sectors such as food security, travelling, livelihood, unemployment, health, education, and culture have been largely affected. Ethnic minorities and low-income citizens living in mountainous regions were hit the hardest. In addition, the COVID-19 pandemic also caused serious psychological and mental health damage. Individuals across the globe have been experiencing anxiety, insecurity, and stress due to job loss, reduced income, lockdown, testing, infection, pains, and hospitalization.

According to United Nations Development Fund for Women (UNIFEM) and United Nations Development Programme (UNDP) (2020) [13], the impact of COVID-19 exacerbated stark disparities between low-income ethnic minorities and those living in big cities, reversing the government's efforts of narrowing down inequalities. The study revealed a greater loss in income for ethnic minorities than for Kinh households in the same area. Regarding the share of total household income, ethnic minority households (70.3%) suffered a reduction of 4.8 percent points higher than Kinh households (65.5%).

The health and lives of children in ethnic minority areas were found seriously affected by their limited access to healthcare services. As a result of social distancing during the COVID-19 pandemic, many ethnic minority families faced a greater difficulty accessing health services. As reported by Institute of Labour and Social Affairs (ILSSA), Arish Aid, and UNWomen (2021) [14], about 88% of commune health stations had to temporarily stop providing vaccination services during social distancing. At the same time, advocacy and guidance on child healthcare as well as the regular monitoring of child development of children under 5 years old were also temporarily suspended. The same study revealed that the nutrition levels of ethnic minority children have been significantly affected during the COVID-19 pandemic, especially those living in poor households. However, emergency support policies have not provided prompt support to meet the demands of affected groups of children.

Therefore it is necessary to immediately formulate relevant health policies to remedy the negative impacts of COVID-19 on health equity and to protect vulnerable groups, especially ethnic minorities, from health crises. Indeed, such negative impacts are long lasting and not easy to overcome. This problem is challenging not only because national reserves are heavily strained by public spending to mitigate pandemic impacts, but also due to inequality issues.

To ensure that ethnic minority households benefit from the government's support of people affected by the COVID-19 pandemic, mainstreaming health equity into policies for recovery and development post-COVID-19 must be safeguarded. Local citizens and healthcare workers require more information and basic resources for disease control. More importantly, they need effective access to healthcare services and knowledge about COVID-19 prevention methods such as wearing masks, washing hands, sanitizing their homes, practicing 5K[2], and ensuring personal hygiene daily. In this regard, research assessment and communication are necessary to inform authorities in a timely manner and provide them with evidence for making decisions.

Conclusions and policy suggestions

Inequalities in healthcare are critical issues and reaching disadvantaged groups is necessary to close the current gap. In many areas of the country, especially in the ethnic and remote regions of Vietnam, a citizen's access to social services and use of health resources are limited. There are structural factors creating health inequality gaps, one of which is poverty in ethnic groups. Addressing this requires policy and program interventions to overcome key challenges imposed by geography constraining the integration of ethnic minorities and citizens living in lagging areas who are not yet fully engaged in the more dynamic parts of Vietnam's economy.

So far, Vietnam has taken steps to build an environment favourable for the protection and improvement of their citizen's health. Resolution No. 20-NQ/TW dated 10/25/2017

[2]The Ministry of Health has officially announced a message featuring 5K (in Vietnamese): Khau trang (facemask) - Khu khuan (disinfection) - Khoang cach (distance) - Khong tu tap (no gathering) - Khai bao y te (health declaration) in order to help citizens get used to living safely with COVID-19 in "new normal" period.

focuses on the targeted groups including ethnic minorities, households, and enterprises in ethnic and mountainous areas. During the 1990s, the government initiated the Health Fund program to cover basic health services for the poor. In 2010, Vietnam adopted universal health coverage as part of its national agenda for health development and has implemented a series of policies and reforms to achieve such goals.

The Law on Health Examination and Treatment, considered one of the most crucial reforms undertaken by the government, was amended in 2017 in order to ensure affordable medical services at all levels and has proved to be an important legal base for reducing health inequalities. However, health inequalities cannot be solved or eliminated by merely one single policy, which can be deteriorated in large-scale crises such as the COVID-19 pandemic. Placing citizen health and life first is a humane approach in pandemic prevention efforts in Vietnam. In particular, taking care of mental health, especially when living together with a pandemic, is very necessary along with efforts to treat and save patients while reducing the number of deaths from COVID-19. Conducting timely diagnoses and treatments of mental health are important to protect citizens from the negative, long term, and dangerous impacts of the COVID-19 pandemic [8].

Therefore, the government should combine a variety of strategies from multiple angles and mobilize not only internal but also external resources to address this issue. Fostering strong cooperation is essential for creating a collective impact for changes that meet the needs of citizens. The Ministry of Health can play a bridging role associated with various stakeholders such as experts, advocates, practitioners, and the business and private sectors. Further, it can function as a facilitator to open channels for collaboration across sectors so that all stakeholders are engaged in the design and implementation of policies to address health inequalities. Once harmony is found and responsibilities are assigned to go beyond one-time collaboration, health equity policy will become the most effective at advancing its primary goals.

To continually improve health equity, it is necessary to pursue social inclusion in healthcare and support. Therefore, the government should commit to:

1. The promotion of healthcare and medical treatment to all citizens towards equity, efficiency, and inclusion so that the health system is developed to meet the needs of all social segments and approaches international standards.

2. The improvement of public policies to ensure citizens are protected, cared for, and that their health quality is enhanced toward an inclusive "new normal" during the period of socio-economic recovery from COVID-19.

3. The guarantee for citizens of all backgrounds to be able to access to appropriate health services culturally and linguistically and digital technologies that can improve the delivery of health care and social protection services.

4. The mobilization of effective collaboration with other agents, private health providers, community-based organizations, residents, and other partners.

Indeed, there are three strategic alternatives that can be considered to achieve health equity. They also facilitate collaboration among stakeholders in their efforts to reduce health inequalities, namely:

Increase the efficiency, effectiveness, and sustainability of health insurance

The system of health insurance has been institutionalized in pursuit of universal healthcare in Vietnam. The implementation of the health insurance policy for the poor and near-poor has not only taken an important step forward in the fight against poverty but has also provided vulnerable citizens with effective protection. The Ministry of Health has developed a plan to improve the efficiency health insurance use among citizens of ethnic minority, in mountainous areas, and from poor households. Concurrently, the government should revise the level of co-payment for medical examination and treatment costs for the near-poor to overcome their difficulties seeking long-term treatment of chronic diseases (e.g., haemodialysis, cancer, diabetes, etc.), which involves high costs and long-term payments.

Build partnerships across sectors

It is essential to build partnerships across sectors by engaging the private sector to advance coalition-led efforts that improve the healthcare system. The Ministry of Health needs to engage with other stakeholders to leverage resources and existing funding as well as foster collective action. Reaching out to citizens experiencing the greatest health disparities and engaging with them toward participation is considered one of the best strategic plans to address health inequalities. This approach requires a multi- and cross- sector collaboration that relies on effective engagement and strong support from different sectors to work toward a common good.

Integrate health in all policies

The health in all policies approach can help sustainable and consistent access to healthcare. It requires close cooperation and collaboration among stakeholders, who best understand the community context to incorporate health in decision-making and monitoring processes. To be successful, this approach entails strong commitments from policymakers and health service providers, which contribute to the development of trust and an allocation of responsibilities assumed by various stakeholders.

COMPETING INTERESTS

The authors declare that there is no conflict of interest regarding the publication of this article.

REFERENCES

[1] A. Gabriele (2006), "Social services policies in a developing market economy oriented towards socialism: The case of health system reforms in Vietnam", *Review of International Political Economy*, **13(2)**, pp.258-289.

[2] M. Målqvist, et al. (2013), "Ethnic minority health in Vietnam: A review exposing horizontal inequity", *Global Health Action*, **6(1)**, DOI: 10.3402/gha.v6i0.19803.

[3] A. Sepehri, R. Chernomas, A.H.A. Lodhi (2003), "If they get sick, they are in trouble: Health care restructuring, user charges, and equity in Vietnam", *International Journal of Health Services*, **33(1)**, pp.137-161.

[4] The World Bank (2021), "Shared Gains: How high growth and anti-poverty programs reduced poverty in Vietnam", http://documents.worldbank.org/curated/en/282401615960140813/Shared-Gains-How-High-Growth-and-Anti-Poverty-Programs-Reduced-Poverty-in-Vietnam-Vietnam-Poverty-and-Shared-Prosperity-Update-Report.

[5] https://baohiemxahoi.gov.vn/chidaodieuhanh/Pages/thong-tin-baochi.aspx?CateID=0&ItemID=17842&OtItem=date.

[6] T.D. Nguyen, A. Wilson (2016), "Coverage of health insurance among the near-poor in rural Vietnam and associated factors", *International Journal of Public Health*, **62**, DOI: 10.1007/s00038-016-0911-z.

[7] M. Rama (2007), "Social protection and labor markets in Vietnam", Presentation at Commission on Growth and Development: Labor Markets and Growth, October 15, 2007, Washington D. C: World Bank.

[8] General Statistical Office (2020), *Completed results of the 2019 Vietnam Population and Housing Census*, Statistical Publishing House, Hanoi, 842pp (in Vietnamese).

[9] N.A. Dang (2021), "Influences of COVID-19 pandemic on mental health", *Southern Social Sciences Review*, **10(278)**, pp.8-19.

[10] United Nations Population Fund and the Ministry of Heath (2017), "Exploring barriers to accessing maternal health and family planning services in ethnic minority communities in Vietnam", https://vietnam.unfpa.org/en/publications/exploring-barriers-accessing-maternal-health-and-family-planning-services-ethnic.

[11] https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/.

[12] Q.T. Tran (2015), "Income sources and inequalities among ethnic minorities in the Northwest region, Vietnam", *Environment Development and Sustainability*, DOI: 10.1007/s10668-015-9700-8.

[13] https://www.undp.org/vietnam/publications/COVID-19-socio-economic-impact-vulnerable-households-and-enterprises-gender-sensitive-assessment.

[14] https://asiapacific.unwomen.org/sites/default/files/Field%20Office%20ESEAsia/Docs/Publications/2021/11/vn-DTTS-ENG.pdf.