ACCESS TO HEALTH INSURANCE AND HEALTH CARE SERVICES FOR ETHNIC MINORITIES IN VIET NAM

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Astract:

Access to health care/health insurance services has major implications for the health of vulnerable populations, especially ethnic minorities. Sociocultural and gender characteristics shape the use and access to health care services by ethnic minorities worldwide. One such vulnerable ethnic minority is ethnic minority women and children in Viet Nam. As women, they are marginalized in their communities, where women do not have adequate equity and they face many barriers to health care services.The main objective of this study is to provide a nuanced, experiential, description of health insurance and healthcare accessissues for ethnic minority women and children in Viet Nam. Identifying barriers they facein accessing health insurance andhealth care services can help healthcare policymakers make changes based on and tailored to the needs of ethnic minority women and children in Viet Nam.The study was conducted with 18 ethnic Muong people in Vietnam. The interview included demographic questions,open-ended questions about participants' perceptions of their experiences withhealth insurance and health care services,including factorsthat support andhinder them from accessing these services, and questions regarding suggestions to improve accessibility. of health care services based on identified needs. The collected data was analyzed using thematic analysis. The reliability of the study is ensured by the use of audits, reflections and interviews with colleagues. This study explored how language, cultural and gender barriers intersect with other disadvantages that are ingrained in social norms, values and beliefs and influence the access of a group of Muong ethnic minority women in Viet Nam to health care services.

Keywords: Health insurance, health care, Muong ethnic group, Vietnam

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1. Introduction

Equitable and effective people's health care is the goal and policy of the Party and State of Vietnam, which is the thought throughout the process of building and developing Vietnam, especially since the renovation was carried out. Year by year, the work of protecting and caring for people's health in our country has achieved many important achievements. The health network is increasing, especially the system of medical facilities in each hospital is invested in the best possible way, many dangerous epidemics are controlled and repelled, health services are increasingly diversified, many new technology industries are researched and invested to use in the field of technology,People across the country mostly have access to health services, and since then the health index in our country over the years has increased significantly. However, somewhere there is still an ethnic group and groups with different socioeconomic conditions in terms of health status and health service use. Vietnam is a multi-ethnic country with the language, lifestyle, livelihood and culture of each ethnic group. Ethnic minorities account for nearly 15% of the total population. Compared to the Kinh ethnic group, the lack of opportunities to access social services such as infrastructure, education, especially health is very large. With that fact, it has made it even more complicated to ensure human security in ethnic minority communities. Disparities in health indicators are directly related to the levels of access to health services of different regions, ethnic groups and socioeconomic groups.

Ethnic and mountainous areas in Vietnam, currently inhabited by ethnic minorities, are still the most disadvantaged areas in the country. Although the number of people in these regions is not high (about 15%), the proportion of poor people accounts for 50% of the poor of the country. Since 1986, a number of health care policies for ethnic minorities have been promulgated and implemented and some achievements have been made in reducing the gap in health care among ethnic minorities compared to national indicators in general. However, the situation still shows that there is a need for a study with a comprehensive and comprehensive approach to summarize the assessment of the results, effectiveness and impact of policies, identify and forecast urgent basic issues in the health care of ethnic minorities in different regions; on that basis, offer solutions and propose overall recommendations on policies to 2030.

2. Literature review

2.1. Health insurance

The concept of health insurance Born in the late nineteenth century, health insurance is one of the most effective measures to help people when facing health risks to partially equip the cost of medical examination and treatment to help stabilize their lives, contributing to ensuring social safety. Health insurance is one of the 9 contents of social

insurance specified in Convention 102 dated 28/6/1952 of the International Labor Organization (ILO) on minimum standards for social insurance benefits. The concept of health insurance, according to the Vietnam Encyclopedia published in 1995, "is a type of insurance organized and managed by the State to mobilize the contributions of individuals, collectives and social communities to take care of health, medical examination and treatment for the people". According to the Law on Health Insurance No. 25/2008/QH12 passed by the National Assembly on 14/11/2008: Health insurance is a form of insurance applied in the field of health care, not for profit purposes, organized by the State and responsible subjects participating in accordance with this Law.

According to the Law amending and supplementing a number of articles of the Law on Health Insurance No. 46/2014/QH13 passed by the National Assembly on 13/6/2014: Health insurance is a form of compulsory insurance applied to subjects prescribed by this Law for health care, not for profit purposes organized by the State. Thus, health insurance is a form of mobilizing financial resources of the community, under the organization and protection of the State, implementing the principle of risk sharing, taking finance from the contributions of the majority of healthy people, compensating and helping to pay hospital fees for the unfortunate few participants at risk of illness,go to the doctor. Health insurance is both social in nature because it is a type of insurance for the purpose of social security, showing state support and community reciprocity. But health insurance also has economic factors, in the category of economy – health. Health insurance is necessary for everyone, it is a tool to ensure the basic social security rights of people, is the sharing of risks of everyone in the community, creates fairness in medical examination and treatment, increases the quality of medical examination and treatment and medical management, contributes to reducing the burden on the State budget and on families.

2.2. Access to health care

Over the years, there have been many definitions and concepts of health care access (HA). In the early 1990s, it was described as the degree of adjustment between the characteristics of health care resources and the characteristics of the population seeking and receiving care . This definition has been expanded to include the actual use of services and their dependence and efficiency. Evaluating access today involves a clear emphasis on the characteristics of both users and services. While the definition of access to health care may vary, it usually includes the following aspects: acceptability (i.e., health beliefs, psychological, racial, cultural, and ethnic factors that determine the likelihood that a patient will accept the service),affordability (i.e., socioeconomic status, monetary costs, solvency), availability, geographic

accessibility, and accommodation of services (i.e., appointment systems, hours of operation, walk-in facilities). So far, several studies have looked at barriers to health care (HS) services worldwide. Key barriers for students include financial barriers such as the cost of medicines and insurance, geographical barriers such as lack of public transport and distance traveled, and gender barriers. Access to HS was found to vary from country to country due to differences between health systems in those countries. However, studies have shown that a lack of HS leads to delays or abandonment of essential health care and can negatively affect an individual's health. Gaps in HS access occur due to socioeconomic status, gender, ethnicity and more. Vulnerable populations and minority groups are at higher risk of being affected by HA deficiency. More recent attention has focused on HS outreach among disadvantaged populations such as elderly women and ethnic minority groups.

A number of studies have been carried out on access to health services for ethnic minorities, namely: Research on "Assessing the ability and opportunities to access social services of poor and vulnerable groups, especially in remote areas,remote areas, ethnic minority areas" by Nguyen Ba Ngoc et al. (2011,2012) pointed out that: Policies on improving basic social services are already in place, but organizations providing basic social services are still inadequate, the system of providing basic social services in ethnic minority areas is lacking in quantity,weak in quality. Ethnic minorities have little access to social services from poverty reduction policies and programs, and access to basic social service systems of ethnic minorities in mountainous areas is still very limited. Regarding basic health services: free health insurance and medical examination and treatment policies covering 100% of poor people in ethnic minority areas, investment in the health service system as well as a source of staff are also prioritized. However, infrastructure, health workers in remote and communal areas are still weak, health care such as vaccination, epidemic prevention, child nutrition ... have been concerned but there are many gaps, a part of ethnic minorities still have many outdated customs including those related to health and healing, when they believe that if they are sick, they only need to pick tobacco leaves in the forest to drink and drink,Even childbirth does not require hospitalization, just delivery at home. It is these subjective thoughts that put many lives of ethnic minority children at risk.

Another study on "Current situation of health service use of some population groups and barriers to accessing health services" by Vuong Lan Mai, Tran Thi Oanh (2013) showed that there are a number of barriers affecting the access and use of health services of ethnic minorities including:(i) geographical location barriers, (ii) financial barriers related to economic conditions, (iii) socio-cultural barriers, (iv) barriers on the part of service providers. A 2017 study on "Barriers to

accessing health care and family planning services of ethnic minorities in Viet Nam by UNFPA and the Ministry of Health in 2017 conducted in 6 provinces of the Central Highlands, Central and Northern Mountains revealed strengths such as issues that need to be improved. of the current health system and behaviors related to the access and use of health care services by ethnic minorities. The study provides useful information for policy makers, program managers, professionals as well as researchers, and funders in developing and implementing effective health care programs to achieve the goals of the "International Conference on Population and Development of Sustainable Development Goals". in Vietnam.

2.3. People's awareness of health insurance policies

Along with the development of health insurance policies, the participation of all levels and sectors, the quality of communication work has been increasingly improved, which has also helped a part of the people have a proper awareness of the superiority of the health insurance policy, thereby voluntarily participating,at the same time, mobilize relatives and families to participate in health insurance. With many changes in health insurance policies, people have paid more attention to medical examination and treatment. However, from the point of interest in accepting to buy money to enjoy benefits when going to the doctor, there are still many issues to pay attention to. Studying the reality in many places, it can be seen that a common feature is quite common: people are interested but lack trust to decide to spend money to participate in health insurance. They also realize that buying health insurance is necessary, in case of illness and illness. But there are also many concerns about the procedure for registering to buy health insurance is still difficult to implement, do not know the quality of medical examination and treatment? it takes a long time to wait, and many people think that the medicine of health insurance is not good ... Such problems lead to a lack of trust of people with the health insurance policy.

In order for the health insurance policy to really enter the hearts of the people, the immediate problem is to change people's perceptions, so that they see that participating in health insurance is their own benefit, not an obligation. Functional sectors need to strengthen propaganda and advocacy among the people, helping them understand the purpose and meaning of participating in health insurance; promote public and transparent inspection and inspection to ensure the best interests of health insurance participants in time to detect and strictly handle cases of abusing the health insurance policy for the benefit of individuals and units, in order to gradually build trust among the people.

3. Method

A qualitative approach was used to gain an understanding of Bedouin women's

perceptions of their HS accessibility. This approach seeks to study the patient's experience and helps identify potentially modifiable factors to improve health care.Our research includes face-to-face, in-depth, semi-structured interviewswith 18 ethnic Muong women in Vietnam. To ensure maximum variant sampling, we interviewed Muong ethnic women with diverse demographic characteristics. Eligible participants are ethnic Muong over the age of 18, who live in northern Vietnam and have used one of the health services available in this area at least once in the past 5 years. Eighteenwomen were recruited with the help of students, educators and nurses from the villages. None of the participants had any prior familiarity with the interviewer before they participated in the study and they signed a informed consent form. Participation is voluntary and participants can withdraw from the interview at any time if they choose to do so.

The data was collected from June to October 2022. Interviews take place in locations convenient for each participant, mainly in women's homes, based on the participants' own preferences. The interviews lasted 92 minutes and were conducted in Vietnamese-English dialectsby the first author. An interview guide to identify barriers and people supporting access to health care and mapping muong people's perceptions of their healthcare experiences was developed. The interview guide allows flexibility on the order in which questions are asked, and what clarifying questions and questions are asked when necessary, providing a rich understanding of the thoughts and opinions of the participants.

Each interview begins with general demographic questions (i.e., gender, age, marital status, number of children, education level, form of settlement, socioeconomic status)to get to know the participants and build relationships with them. We then asked open-ended questions on topics related to participants' perceptions and experiences with HS, including factors that helped and hindered them from accessing these services. The final part of the interview asked interviewees about their suggestions on improving HS supplies and accessibility based on their own identified needs. We took notes in interviews. Data collection continues until thematic saturation is reached.

Data encryption and analysis occur simultaneously with data collection. We read and reread the interviews several times to familiarize ourselves with the data. The idea of repetition was identified in this initial stage. Peer-to-peer interviews were held after each interview by the research team to analyze the data, following the principles of thematic analysis.The original code was created and a thematic map covering the codes and themes was developed. Then we looked at the topics and named them. In addition, we met to discuss and review the findings on an ongoing basis and engaged in reflective analysis. To ensure the anonymity of the participants, we

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replaced their names with numbers and omitted any identifying details

4. Result

4.1. Current situation of health insurance implementation and access to health care for ethnic minorities

Working with ethnic minorities requires staff to be "dedicated" but working conditions are still difficult, lacking "specific support". Ethnic minorities despite many positive changes in awareness and cooperation in programs; However, there are still many difficulties because there exist groups of people who are "lazy, lazy to work". Therefore, it requires the staff to persevere, persevere, enthusiasm and responsibility in working with ethnic minorities. However, the attractive mechanisms and specific incentives are not suitable and attractive enough for staff working at the facility to be "enthusiastic" and assured of work:

Over the past years, along with increasing investment in the grassroots health system in remote areas, the State has issued health insurance cards and allocated funds for free medical examination and treatment for ethnic minorities. Objective factors such as economic conditions, distance from home to medical facilities, difficult roads, people's perception... has significantly affected the access to health services of people in ethnic minority and mountainous areas.

According to a report of the Vietnam Social Insurance, as of 11/2020, the country had 86.4 million people participating in health insurance, accounting for more than 89.2% of the population participating in health insurance. According to the survey data on the situation of socio-economic development of 53 ethnic minorities in 2019, the proportion of ethnic minorities in ethnic minority and mountainous areas with health insurance cards is 93.5% (in 2016 reached 91%; in 2017 reached 92.05%; in 2018 reached 93.68%). One of the reasons for achieving the above results comes from the effectiveness of propaganda and advocacy to implement the voluntary social insurance model, household health insurance, as well as issuing free health insurance cards to ethnic minorities, poor households and near-poor households. This is always a top priority task, which is of interest to ministries, local authorities and especially the social insurance industry.

Statistics of the Ministry of Health show that by 2020, about 78.8% of commune health stations will be eligible for health insurance examination and treatment; at least 80% of the technical service portfolio of the commune line can be implemented. However, health insurance still has many difficulties and problems. The ratio of doctors per 10,000 people is still low, there is a shortage of medical staff with deep expertise, local health workers, medical facilities in ethnic minority and mountainous areas are lacking and not synchronous. Although the results of issuing free health insurance cards are high, the number of medical examiners and the quality of

medical examination and treatment with health insurance cards at the establishment is still low. The proportion of ethnic minorities using health insurance cards when examining and treating health insurance in 2019 reached 43.7% (Survey results of 53 ethnic minorities in 2019).

Overcoming difficulties in socio-economic conditions, many provinces/cities have actively improved health care for people, especially those under the policy, with health insurance cards. Since the State raised the level of health insurance support for ethnic minorities, the poor and newly out of poverty to 100% of the cost of medical examination and treatment. This is the right policy, contributing to better health care for people in disadvantaged areas, strengthening the trust of ethnic minorities in the Party and the State. Having health insurance cards, people have been more proactive in health care for themselves, no longer afraid to go to medical centers to be examined and checked periodically. When there is a health insurance card, patients come to the doctor more, the quality of health at the grassroots level is also significantly improved; ethnic minorities have been able to receive inpatient treatment in a thoughtful way.

The project to implement the roadmap to universal health insurance with the goal that by 2020 more than 80% of the population will participate in health insurance approved by the Prime Minister is a practical, effective and life-saving universal health care policy. Thanks to many suitable solutions, especially through propaganda, directly to each household, helping people raise awareness and understand the benefits when participating in social insurance and household health insurance. Many localities have almost reached the finish line, completing the task of covering universal health insurance.

The State has prioritized the allocation of budgets for the implementation of targeted programs and projects to invest, build and upgrade the development of medical examination and treatment facilities, equipment and medical facilities, especially investment in district hospitals and commune health stations. At the same time, creating conditions for people to receive medical examination and treatment on medical facilities, health insurance pays 100% to beneficiaries. Therefore, the percentage of people with health insurance cards has always reached a high rate over the years. At the same time, the level and capacity of the medical team for patients is always improved. Human resources for medical examination and treatment for ethnic minorities are increasingly guaranteed in quantity and quality. Currently, the country has more than 400 medical stations and military clinics in remote communes performing medical examination and treatment for people. The work of propagating and mobilizing people to build cultural villages, implementing environmental hygiene lifestyles, eliminating customs, propagating HIV/AIDS prevention... valued. Implementation of the

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population-family planning program, allowances for village health workers, village midwives have also been effectively implemented in many localities.

The Ethnic Minority Committee also promulgated a plan to propagate, disseminate and educate the law for ethnic minority workers and ethnic minorities. In particular, there are contents of integrating, propagating and disseminating policies and laws on medical examination and treatment, voluntary social insurance, household health insurance ... Focusing on the role, meaning, human and ethical values of social insurance policies and participants' rights; contributing to the development of socio-economic development, ensuring social security, political security, social order and safety in ethnic minority and mountainous areas.

4.2. Barriers to accessing health insurance and health care from the perspective of ethnic Muong people in Vietnam

Socio-demographic characteristics of the participants.The ages of the participants ranged from 18 to 50 years and the average age was 32. 8 ± 11 years old. Most of the participants lived in recognized villages and reported incomes typical of low socioeconomic status in the country.The interview results are divided into the following topics:

Firstly, barriers of distance and geography

Barriers in distance, geographical location The study results noted positive changes in convenient transportation due to investment in electricity and roads as well as more diverse means of transportation, including "service taxis" that help ethnic minorities access health facilities (CSYT) easily. However, there are still difficulties that are separate geographically and seasonally. "It is very difficult for people here to move from the lake bed to here (PV1).

About a quarter of ethnic minorities who use health services have to borrow money, sell household items or stop using them because of lack of payment. The distance from home to health facilities has also been mentioned by many reports as a barrier to access to maternal services in mountainous areas.

For example, the average Chinese and Kinh takes 21 minutes, ethnic minorities take 36 minutes to reach the nearest district hospital In addition, CSSKBM service is not suitable for local customs and culture, does not meet the requirements according to gender, as well as the specific needs of people. The information that ethnic minority women receive (through speech or writing) is general, lacks specificity, and is not suitable for the circumstances of service users.

In terms of sanitation, three-quarters of households (75.9%) in 60 communes have clean water. However, there are 4 communes of Lai Chau province that currently do not have clean water in all 100% of households including Pa Wei Su and Ta General (Muong Tè, Lai Chau), Nam Cha (Nam Shrugged, Lai Chau), Tủa Sam Chai (Sìn Ho, Lai Chau). Besides, there are 3 communes of Gia Lai province with a

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clean water rate of less than 30%, Albá and HBông (Chu Se, Gia Lai) and Dak Pơ Pho (Kong Chro, Gia Lai). The proportion of households with hygienic water sources is much lower than the national rate in 2021 (97.4%).

Barriers to customs and conceptions

The results also explain the reason for the low health care and access to health insurance because ethnic minorities mainly take care of health through customs, and the concept of worshipping gods rather than using scientific and technological advances:

> *"If your family has a disease, you will go to the forest to ask the forest god for blessing and eat leaves and grass, you will be fine right away" (PV8)*

> *"They have the ancient practice of hiding from outsiders, not even inviting medical staff but people in the clan, in their surnames to support themselves ..." (PV18).*

> *"..., they are also very shy, the way of birth of the Kinh people they find is not suitable for them" (PV9).*

Information barriers

The reason explains the limited access to information related to health care services.

> *"They have not been fully educated and have such self-inquiry and sex" (PV5).*

> *"The propaganda work in the village has not been deep, the lecture teachers are in general, so their knowledge is not good, we do not understand what health care and health insurance are" (PV11).*

Economic barriers

Economic barriers with the fact that only a small percentage are free due to having insurance due to poor households, the rest do not use health insurance and health care services because they do not have economic conditions.

> *"Because of the conditions, the remaining 10% is free, but collecting money, people do not want to go, even if it is free, sometimes they do not want to go" (PV17).*

Availability of grassroots health services is limited

The results of the study show that the situation does not correspond to the availability of manpower, equipment, drugs as well as current written mechanisms. The shortage of people, lack of supplies, lack of medicines is also an existential problem reflected in in-depth interviews with health workers at both commune, district and provincial levels in mountainous areas for ethnic minorities.

"At one time there is a shortage of people, at other times there is a shortage of supplies" (PV13).

5. Conclusions

In order to effectively implement the health insurance policy for ethnic minorities, the Ethnic Minority Committee proposes ministries, branches and localities to allocate funds, carry out activities of communication, dissemination, legal education, rights and benefits of medical examination and treatment for ethnic minorities and mountainous areas. At the same time, it is proposed to amend and supplement regulations on medical examination and treatment in the direction of: clearly stipulating the State's responsibilities according to ensuring funds, facilities, medical equipment, medical examination and treatment services for ethnic minorities so that people can fully enjoy the right to medical examination and treatment and policies in accordance with the Law on Health Insurance. Continue to strengthen doctors working at district hospitals, commune health stations in ethnic minority and mountainous areas, especially difficult areas. Pay attention to training and fostering to improve professional qualifications for ethnic minority doctors, to contribute to improving the quality of medical examination and treatment for people...

In Resolution No. 88/2019/QH14 of the National Assembly approving the Master Plan for socio-economic development in ethnic minority and mountainous areas in the period of 2021-2030, it stated the target to 2025: "... 98% of ethnic minorities participate in health insurance...". Therefore, the national target program on socio-economic development in ethnic minority and mountainous areas in the period of 2021-2025, Project 7: Taking care of people's health, improving the physical condition and stature of ethnic minorities; prevention of child malnutrition.

This project aims to strengthen grassroots health work so that ethnic minorities can access modern health care services, contributing to increasing the rate of having health insurance cards and using health insurance cards in medical examination and treatment of ethnic minorities; strive to meet and exceed the targets assigned by the National Assembly. Continue to control and eliminate epidemics in ethnic minority and mountainous areas. In particular, there are some key activities such as:

- Building and developing grassroots health facilities in ethnic minority and mountainous areas: Investing in new construction, renovation of facilities and procurement of essential equipment for commune health stations and district health centers; Training medical human resources for poor and near-poor districts in disadvantaged areas; Supporting technical transfer to commune health stations; Supporting allowances for village midwives; Off-station vaccination site support; Supporting ethnic minorities and mountainous people to participate in health insurance, it is expected to support part of the face value (the rest is paid by the local budget) to buy health insurance cards for ethnic minorities if they are not eligible for support under the Health Insurance Law.

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- Improve the quality of population in ethnic minority and mountainous areas by 2030: Universalize counseling and health examination services before marriage; screening, diagnosis and treatment of a number of prenatal and neonatal diseases; Meeting the needs of caring for and improving the health of the elderly in response to rapid population aging; Stabilize and develop the population of ethnic minorities in ethnic minority and mountainous areas and border areas; Improve population management capacity in ethnic minority and mountainous areas; Prevention of thalassemia in ethnic minority and mountainous areas.

Health care, maternal and child nutrition to reduce maternal mortality, child mortality, improve the stature and physical strength of ethnic minorities: Nutritional care in the first 1,000 days of life for mothers and children, integrated in pre-, during and postpartum care to improve stature,ethnic minority strength; Health care, reducing maternal and child deaths; Advocacy and communication to change behavior on health care, maternal and child nutrition.

In social security policy, two important pillars are social insurance policy and health insurance policy. The good implementation of the health insurance policy will contribute to the achievement of the goal of equity in people's health care, help reduce the burden of health costs, and ensure social security. In order to ensure the implementation of economic development goals associated with progress and social justice, the Committee for Ethnic Minorities, the Ministry of Health, Social Insurance of Vietnam, functional sectors, and local authorities joined together, helping to accelerate the progress of health insurance coverage, ensuring benefits for people in ethnic minority and mountainous areas,contributing to the good implementation of the goals of hunger eradication, poverty reduction, socio-economic development.

To our knowledge, this is one of the few qualitative studies related to the access to health insurance and healthcare of ethnic minorities - Muong people in Vietnam. We include both sexes to get a holistic view of health care barriers from both perspectives. To reduce distances and improve access, health care services should be culturally sensitive and tailored to the specific needs of minority groups such as Muong ethnic women in Viet Nam.

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