# Health Insurance for PLHIV in Ninh Binh and Dong Thap provinces

## Assessment Results from Ninh Binh and Dong Thap

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# ACRONYMS

| | |
|---|---|
| ART | Antiretroviral Therapy |
| CCRD | Center for Community Health Research and Development |
| GVN | Government of Vietnam |
| HAPSAT | HIV/AIDS Program Sustainability Analysis Tool |
| HI | Health Insurance |
| HID | Health Insurance Department (MOH) |
| IDI | In-depth interview |
| LOS | Length of Stay |
| MOH | Ministry of Health |
| NTP | National Target Program |
| OI | Opportunistic Infection |
| OOP | Out-of-pocket |
| OPC | Outpatient center |
| PAC | Provincial AIDS Center |
| PLHIV | People Living with HIV |
| PPC | Provincial People's Committee |
| PSS | Provincial Social Security |
| SHI | Social Health Insurance |
| TB | Tuberculosis |
| USAID/HPI | US Agency for International Development/Health Policy Initiative |
| VAAC | Vietnam Administration of HIV/AIDS Control |
| VCT | Voluntary Counseling and Testing |
| VND | Vietnam Dong |
| VSS | Vietnamese Social Security agency |
| WTP | Willingness to Pay |

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# Executive Summary

The HIV/AIDS epidemic in Vietnam was first noted in most-at-risk populations 20 years ago. Since then, prevention, care and treatment programs have been largely financed by international donors. In view of the reduction in both bilateral and multilateral funding for HIV/AIDS programs, PEPFAR, USAID and the government of Vietnam (GVN) are actively seeking the most efficient and effective ways to continue the sustainable national funding of programs. Effecting the inclusion of PLHIV into the Vietnamese Social Security (VSS) social health insurance (SHI) program is one of the primary strategies currently being discussed.

In an effort to contribute to the growing body of knowledge, USAID's Health Policy Initiative Project in Vietnam (USAID/HPI) conducted a series of assessments related to the use of SHI by people living with HIV/AIDS (PLHIV) in the provinces of Dong Thap and Ninh Binh in February and March 2013. With the valuable support of the Center for Community Research and Development (CCRD), quantitative and qualitative research was carried out to explore four specific topics:

1- Existing use of SHI by PLHIV
2- Mobility of PLHIV
3- Possible duplication of PLHIV registration for care and treatment
4- Provider perspectives on SHI coverage of HIV/AIDS care and treatment.

Results from the analysis of the data from the quantitative surveys show that the majority of PLHIV already hold SHI cards. People living with HIV/AIDS do use their SHI benefits, although mostly for non-HIV/AIDS related outpatient and inpatient care. This is because outpatient clinics (OPCs) provide ARV treatment free of charge. Many PLHIV SHI cardholders receive subsidized cards because they fall into the poor and near poor economic categories. Despite the current subsidies for ARV treatment, out of pocket expenditures amount to more than 7% of a poor PLHIV's annual income.

Regarding the mobility of PLHIV, the data shows that PLHIV are not particularly mobile with only 6.4% having relocated after they learned of their status. Of those who relocated, 25.8% did so because they changed their place of work and 22.5% moved to try to escape discrimination. No duplication of registration at treatment centers was found.

Data from the qualitative survey conducted through in depth interviews with providers and other stakeholders show unequivocal support for the idea of making HIV/AIDS treatment available as one of the SHI benefits. Points of view on how to do so did vary among stakeholders. The clearest difference of opinion was between those who believed that PLHIV should be allowed to bypass registration at the commune level (and instead register at the district or provincial level) and those who believe that the current SHI regulation mandating registration at the commune level be maintained.

Both the quantitative and qualitative aspects of this study provided important insights into how PLHIV access care and treatment in Ninh Binh and Dong Thap provinces. Survey results also show that increasing the effective inclusion of PLHIV and their treatment into the SHI benefit package is generally considered feasible although further discussion is required to reach a consensus on how to overcome the remaining obstacles.

# Research Methodology

## 1.1. Background

The HIV/AIDS prevention and control program in Vietnam is 20 years old and as of December 31, 2011, there were 210,703 People Living with HIV (PLHIV) of whom 61,669 have developed AIDS. A total of 63,372 people have died of this disease since the beginning of the epidemic. According to epidemiological estimations and forecasts from the Ministry of Health (MOH), the number of PLHIV in Vietnam was approximately 250,000 people in 2012 and is expected to reach 263,500 by 2015.

Results of the HAPSAT (HIV/AIDS Program Sustainability Analysis Tool) survey conducted in 2010 by the Health Systems 20/20 Project with the support of USAID/Health Policy Initiative Vietnam (USAID/HPI) indicated that the out-of-pocket expenditure (OOP) per capita per year for the care and treatment for PLHIV was approximately VND 4,169,800. This is about 25% of the average annual per capita income in Vietnam in 2010 (VND 16,700,000) *(Source: Household Living Standards Survey 2010)*. Currently most treatment, including ART, is provided free of charge to PLHIV thanks to significant support from PEPFAR and other international sources. Since the majority of PLHIV in Vietnam are from poor or near poor households, it is likely that if donors reduce their support, the cost of care and treatment will become a significant economic burden to PLHIV.

In view of this situation, the MOH has developed and is submitting the Financial Security Plan for HIV/AIDS Prevention to the Government of Vietnam (GVN) for ratification. Health Insurance has been identified as one means to mobilize resources for this program. Also, MOH is supervising and collaborating with the Vietnamese Social Security (VSS) agency and other government stakeholders to initiate a process to increase the effective coverage of the Social Health Insurance (SHI) Fund for HIV/AIDS care and treatment.

In order to assist the GVN in developing a sustainable financing model for HIV/AIDS care and treatment, PEPFAR has supported the Vietnam Administration of HIV/AIDS Control (VAAC) and MOH to implement research activities related to the funding transition. One of these activities was financed by USAID through the USAID/HPI project implemented by Abt Associates Inc., who conducted the research with the support of the Center for Community Research and Development (CCRD). Four topics related to the access and use of SHI among PLHIV in Ninh Binh and Dong Thap were studied in March and April 2013. The study sites were specifically selected to represent provinces that were receiving minimal international donor support for HIV/AIDS care and treatment, this care and treatment being largely financed through the National Target Program (NTP). These two provinces represent differences in the organization of HIV/AIDS prevention and control programs, including the care and treatment system. The results from the assessments were used to inform the design of a health insurance pilot model for PLHIV which covers HIV testing services, treatment of HIV-related opportunistic infections (OIs) and ARV treatment in outpatient clinics (OPC).

## 1.2. Objectives

Specifically, the assessments targeted four topics:

- Characteristics of PLHIV in Ninh Binh and Dong Thap, including the demographic characteristics, social and economic situation, and migration of PLHIV;

- The possibility of duplication of HIV treatment registration;
- Access and use of SHI for health care services by PLHIV and type of subscription (poor/near poor, voluntary);
- Provider perspectives on the inclusion of PLHIV care at treatment centers as an integral part of SHI.

### 1.3. Research Methods

Quantitative methods were principally used, supported by qualitative analysis in combination with secondary data analysis, including:

- Literature review and secondary analysis;
- Surveys based on questionnaires administered to PLHIV registered at OPCs;
- In-depth interviews (IDI) with program management staff from local provincial health departments, provincial level social insurance agencies, Provincial AIDS Centers (PAC), service providers and PLHIV;
- Organized technical advisor meetings with experts, management staff of the Ministry of Health (the Insurance Department, VAAC and the Treatment Department), Vietnam Social Security (VSS), USAID, PEPFAR partners and implementing partners.

Research instruments were developed based on the indicators and information matrix referencing materials, and on questionnaires from other research conducted on expenditure and health insurance for PLHIV, especially the 2010 HAPSAT study. Within the scope of this study, the research team looked only at information related to SHI administered by VSS. Therefore, all of the analysis, as well as the research results which mention health insurance, refer to the SHI of VSS, not private health insurance. Due to the sensitive nature of the subject and the risk to human subjects, Institutional Review Board approval (both US and Vietnamese) was sought and obtained. An advisory board including a range of stakeholders met at key intervals during the research to provide input and enhance buy in.

Research instruments were tested and revised by the senior researchers of CCRD with support from USAID/HPI experts before training of the data collection team began. The research team selected Hanoi and Ha Nam as the locations to test the data collection tools to allow a comparison between an area with internationally funded projects (Hanoi) and an area that receives minimal donor funding (Ha Nam). After the pretests, comments were summarized and reviewed to provide input for finalization of research instruments.

**Quantitative research**

Quantitative research was largely based on surveys of PLHIV currently registered at OPCs, along with data from annual reports of PAC and SHI agencies, and was to collect the following information:

- General information about the study groups, including demographic characteristics, health status and economic conditions;
- Information on SHI coverage and the use of SHI cards for HIV care and treatment;
- Information on the registration, treatment and payments of PLHIV at OPCs;
- Information on health care costs for both inpatient and outpatient treatment in medical establishments other than OPCs, along with prevention and self-treatment, which were used to calculate the OOP expenses of PLHIV.

The target population groups for the quantitative research were PLHIV currently registered at OPCs in the two provinces of Dong Thap and Ninh Binh. Quantitative research tools were designed based on what key information was to be collected, and included a structured questionnaire for PLHIV and an information collection table from the provincial social insurance department.

To calculate sample size for the quantitative study, the research team applied the sample size formula commonly used in the simple random sampling method. The sampling frame was based on the list of PLHIV currently being treated at the OPCs. The WHO Sample Size of 2.0 was used to calculate the sample size for each province. Ten percent of the total sample was added to the original number to compensate for respondents that may not be accessed. The ultimate sample size from which data was collected was 484 PLHIV (240 PLHIV in Ninh Binh and 244 PLHIV in Dong Thap). The final sample size for each province is presented in the table below.

| Province | Percent PLHIV using SHI[1] | No. of PLHIV at OPC[2] | Formula-based sample size | Adjusted sample size |
|---|---|---|---|---|
| Ninh Binh | 37.5% | 501 | 210 | 231 |
| Dong Thap | 28.7% | 576 | 204 | 224 |
| **Total** | | 1,077 | 414 | **455** |

*Sources: HAPSAT survey (Question 7.1) [2], Treatment Division of VAAC*

Systematic random sampling was applied to select PLHIVs who were receiving services at the HIV treatment facilities included in the survey. This method ensured random selection of candidates from among the lists of PLHIV receiving treatment at the OPCs.

**Qualitative Research**

Information was collected from program managers, staff providing medical services for HIV/AIDS patients, and social insurance and health insurance agency managers, with the intention of complementing the quantitative research. The research team also interviewed PLHIV to support and illustrate the results of the quantitative research.

A total of 38 in-depth interviews (IDIs) with representatives from VAAC, VSS, MOH (departments of Medical Examination & Treatment and Health Insurance Department), PACs, Provincial Health Departments, Provincial Social Security (PSS), HIV-related service providers (OPC, VCT, district/provincial hospitals) and PLHIV were conducted at the central, provincial and district levels.

The qualitative data collection tool kit included specific IDI guidelines for different groups. Separate interview guidelines were developed for:

- VAAC, the Health Insurance Department(HID)/MOH and PAC;
- Central and Provincial Social Security Departments;
- HIV care and treatment service providers;
- PLHIV.

### 1.4. Data collection

**Selection and training of supervisors and interviewers**

CCRD researchers were organized into two research teams, one working in each province. Each team consisted of a team leader and 2-3 researchers. The team leaders were senior researchers holding a Master's Degree in public health or sociology with at least 10 years experience in research and program management in the area of community health and HIV/AIDS. These team leaders had previous experience in HIV/AIDS and HAPSAT surveys as well as similar surveys done on a national and regional scale.

In each province, the research team selected three field supervisors and ten field data collectors who were provided by the PACs and who had experience working with PLHIV in a research setting. Each data collection group included a field supervisor who held at least a bachelor's degree and had five years experience working in field supervision doing research. Field supervisors were responsible for reviewing data and ensuring quality in the field, and checking for complete and logical information on completed questionnaires before their submission to CCRD's research team leaders.

Prior to data collection, the survey supervisors in each province underwent a four-day training session. After hands-on practical sessions, senior researchers and trainees discussed what they had learned and experienced before beginning field data collection at the survey sites.

**Quality collection and assurance**

Upon completion of the training workshop, the surveyors in the field collected data applying the methodology in which they were trained using a timetable provided by the study team. Two senior researchers monitored data collection in each province. Each survey team had a designated supervisor who was responsible for daily review and quality control to ensure that all questionnaires were filled out and met the quality requirements as per instructions provided in the training workshop.

All IDIs were conducted by team leaders and senior researchers with previous experience in qualitative research and excellent interview skills.

### 1.5. Data analysis and processing

**Quantitative data**

Epi Data 3.2 software was used for data entry. Two independent groups conducted double entry to ensure the accuracy of the data entry process. Data cleaning was done using a comparative software package before data processing and analysis. Data analysis was conducted using SPSS 18.0 and Stata 10.0 software. Descriptive methods with appropriate significance tests were used for data analysis and presented in the report.

Of the PLHIV chosen for this sample, some were tuberculosis (TB) patients with high treatment costs incurred by long-term inpatient treatment at central level hospitals, who did not use SHI. These cases were not considered representative of all PLHIV who receive TB treatment. To avoid skewing treatment costs as well as the data on PLHIV OOP spending, these cases were removed from the analysis related to healthcare costs.

**Qualitative data**

All interviews were recorded and taped as transcripts in Vietnamese and double-checked to ensure the accuracy of the taping transcript process. In addition to the analysis software, the report writing team carefully reviewed all transcriptions of interviews to ensure that all information is reflected in the report. NVIVO 7.0 software was used to support the data analysis process following the encoding system for report writing.

### 1.6. Strengths and limitations of this research

**Strengths**

This research benefited greatly from the enthusiastic and effective support of the PACs in Ninh Binh and Dong Thap. It is notable that local leaders were aware of the importance and significance of this research, which is to contribute to the formation of a proposed sustainable support model for PLHIV care and treatment. Their support and understanding contributed positively to the whole process from data collection to information testing to survey follow-up.

Furthermore, the participation of the advisory board consisting of representatives from MOH, VAAC, PEPFAR agencies, USAID and other implementation partners facilitated a buy-in from the central level. This buy-in should in turn ensure that the information generated from these assessments will be used to develop strategies to implement a sustainable funding model.

This study benefited from the extensive experience of the CCRD research team in surveying PLHIV, in part gained from participation in the HAPSAT 2010 exercise sponsored by USAID and the Health System's 20/20 flagship program. The careful selection of field researchers in charge of data collection under stringent criteria helped ensure the quality of the field survey, data analysis and the report.

**Limitations**

The most important limitation of this survey was the selection of participants. A large number of PLHIV are not managed by OPCs but this research targeted only those PLHIV who were registered at an OPC. Therefore, the findings represent the group of PLHIV who were registered for treatment. This group is not intended to be a proxy for all PLHIV in the community. Accessing PLHIV was challenging as many are busy at work or visit OPCs only to have their prescriptions filled. Unfortunately, many people who were to be reachable at their registered phone number were not reachable. This factor affected data collection and also necessitated an alteration regarding some PLHIV who were taking part in the research.

Furthermore, the data collection was constrained by the limited ability of some PLHIV to recall their spending on 'expenses and treatment costs' over the past year. This hindered the estimations and may have lead to some large confidence intervals in the numbers calculated.

The team also encountered difficulties getting data on SHI reimbursements for PLHIV care and treatment because the insurance agency has no system to track or export this data.

Time constraints were a significant challenge to this research. Due to the impending closure of the USAID/HPI project, all of the consensus building, data collection, entry and analysis, as well as report writing and dissemination had to be done in five months. While the work was completed within the time limitations, more in depth analyses, review and discussion with stakeholders would have been possible in a longer timeframe.

# RESEARCH FINDINGS

## 2.1. Description of research sites

### Current HIV epidemic in Ninh Binh and Dong Thap

As of December 31, 2012, the number of people living with HIV (PLHIV) in Dong Thap was 4,663, including 2,265 AIDS patients. In Ninh Binh, the number of PLHIV was 2,301, including 818 AIDS patients.

The number of patients registered at OPCs in Dong Thap and Ninh Binh at the time of this study was 690 and 579 respectively. This indicates that only 14.8% of PLHIV in Dong Thap and 25% in Ninh Binh are being followed and managed by OPCs. As for AIDS patients, only about 30% and 70% of AIDS patients (respectively) in the two provinces are being treated at OPCs. These rates are rather low compared to the actual needs.

***Table 1:*** Current situation of HIV epidemic and OPCs in Ninh Binh and Dong Thap

| | **Ninh Binh** | **Dong Thap** |
|---|---|---|
| **Information on situation of PLHIV** | | |
| Number of PLHIV as of December 31, 2012 | 2,301 people | 4,663 people |
| Number of AIDS patients | 818 people | 2,265 people |
| **Information on OPCs** | | |
| Total number of OPCs | 2 OPCs, part of the "preventive" system (one OPC at PAC and one OPC at the Medical Center in Kim Son District) | 3 OPCs, part of the "treatment" system (one OPC at the provincial General Hospital, one OPC at Hong Ngu General Hospital and one OPC at Sa Dec General Hospital) |
| Total number of patients currently receiving treatment | 1. OPC at PAC: 476 patients<br>2. OPC at the medical center of Kim Son District: 103 patients<br><br>**Total: 579 patients** | 1. OPC at provincial General Hospital: 416 patients<br>2. OPC at Hong Ngu General Hospital: 185 patients<br>3. OPC at Sa Dec General Hospital: 89 patients<br><br>**Total: 690 patients** |

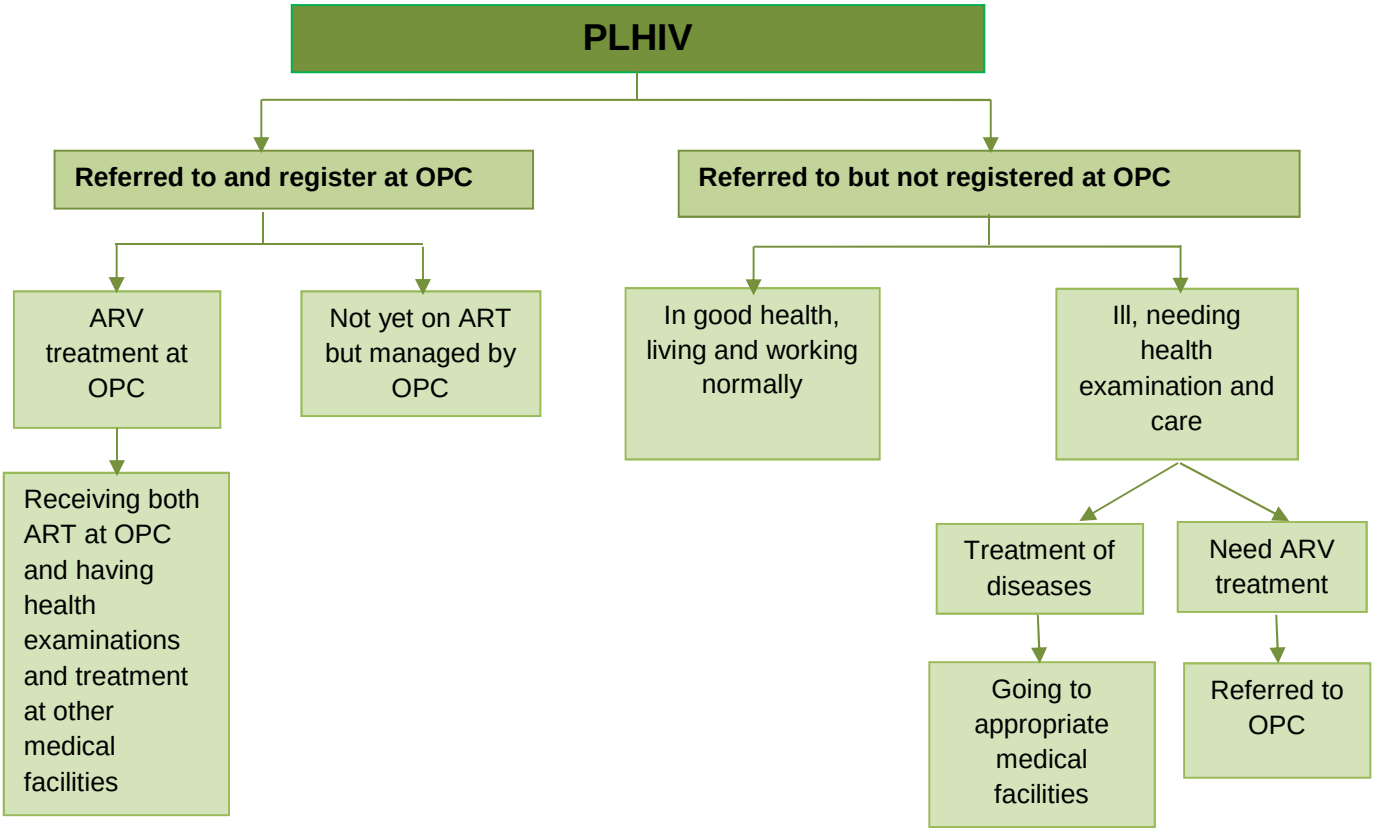
According to reports from Dong Thap and Ninh Binh PACs, male PLHIV represent the majority of cases. However, based on a comparison of data collected annually, the rate of female PLHIV seems to be increasing with many being infected via unsafe sexual relations with their HIV-infected spouse/partner. In addition, there is a notable difference in the means of HIV transmission between the two provinces. In Dong Thap, unsafe sexual intercourse accounts for 92.4% of infections while in Ninh Binh 70.2% of PLHIV were infected via injection. The survey results indicate the existence of the same trend among patients who are being treated at OPCs in the two provinces.

**PLHIV management model in Ninh Binh and Dong Thap**

Both provinces adhere to VAAC regulations in the management and treatment of PLHIV. When clients receive a positive HIV test result they are referred by the medical staff to OPC where they are to register for examination and treatment. One of the three following scenarios may occur:

- The PLHIV effectively registers at an OPC for examination and outpatient treatment. The patient receives both a clinical examination and a CD4 test to identify appropriate therapeutic prescriptions. If he/she qualifies for ART, ARV medicines are provided free of charge and the patient is monitored and has regular appointments with a physician at which time they are to pick up their medication. If the patient does not qualify for ARV treatment, he/she will be put on the list of patients who are periodically monitored and tested for CD4 count as well as liver and kidney functions.
- PLHIV does not register at an OPC. In the case of other morbidity, a PLHIV is treated the same as anyone in the general population. If a PLHIV has a serious OI disease or TB, the medical facility will refer them to an OPC for ARV treatment.
- PLHIV registers to use medical services at an OPC but he/she goes to other medical establishments for examinations and treatment.

***Diagram of PLHIV management***



**HIV care and treatment system, and PLHIV payment for services**

There are two OPCs in Ninh Binh and three OPCs in Dong Thap. However, there is a clear difference between the models for HIV/AIDS care and treatment in the two provinces:

In Ninh Binh, both OPCs are part of the 'preventive' system. One OPC is located at the provincial PAC and the other OPC is located at the Medical Center in Kim Son District. In Ninh Binh, the SHI fund will not reimburse for services provided at either OPC because OPCs which are part of the preventive system are not eligible to obtain reimbursement for SHI medical services.

In Dong Thap, all three OPCs are part of the 'treatment' system within public hospitals and are located at Dong Thap General Hospital, Hong Ngu General Hospital and Sa Dec General Hospital. Because these OPCs are part of the treatment system, SHI cardholding PLHIV residing in Dong Thap have insurance coverage for basic tests performed at the OPCs as per existing SHI guidelines.

There are other similarities between the two provinces in terms of HIV care and treatment system. For example, neither of the two provinces have a specific policy on SHI support for PLHIV. However, in both provinces PLHIV registered at an OPC are eligible to receive free ARV medicine and CD4 testing and SHI cardholding PLHIV do have HI coverage for medical services performed at authorized medical facilities (other than OPC) and for inpatient treatment.

***Table 2:*** OPC funding sources

| | **Ninh Binh (OPC in 'preventive' system)** | **Dong Thap (OPC in 'treatment' system)** |
|---|---|---|
| CD4 tests (regular test) | Blood sample taken from patients for CD4 test at PAC Ninh Binh and Kim Son. Blood samples then sent to PAC Nam Dinh for CD4 tests paid by Global Fund. | Patients receive free CD4 test at PAC, in which:<br>1. Biological: paid for by VAAC<br>2. Incentive: paid for by NTP |
| ARV | Paid for by Global Fund | 1. Provincial General Hospital and Hong Ngu OPC: paid for by Global Fund<br>2. Sa Dec OPC: paid for by NTP |
| OI prevention drugs (Cotrimoxazole) | Paid for by Global Fund | 1. Provincial General Hospital and Hong Ngu OPC: paid for by Global Fund<br>2. Sa Dec OPC: paid for by patients OOP |
| OI treatment drugs | Paid for by patients OOP | Paid for by patients OOP |
| Other routine tests | Paid for by patients OOP | 1. Patients with SHI card: covered in accordance with health insurance regulation<br>2. Uninsured patients: paid for by patients OOP |
| **Source of funds for other expenses** | | |
| Salary, consumable supplies, utilities, etc. | State and local budget allocation (regular revenue) | State and local budget allocation(regular revenue) |
| Incentives | Global Fund | Global Fund |
| Other non recurrent expenses | NTP or regular revenue | NTP or regular revenue |

## 2.2. Characteristics of PLHIV participating in the survey

This section provides an overview of the survey population groups and includes information related to demographic characteristics (age, gender, marital status and residence) and socioeconomic characteristics (living standard, education, occupation). This essential information is used to analyze and process data related to factors affecting PLHIV's health, their healthcare habits and their manner of seeking healthcare services.

### Demographic characteristics

The survey results show that 99% of the PLHIV participating in the survey are of the Kinh ethnicity and 1% are of other ethnic groups such as Han Chinese, Kho Me, Muong and Tay. The gender split among PLHIV in the total sample is 53.7% male and 46.3% female (a report from OPC showed 63.2% male and 36.8% female). The average age of the participants in the survey is 35.4 years and 93.2% are between 25–49 years old.

Most PLHIV surveyed live in rural areas. This is especially true of Ninh Binh where the rate is over 80%. The average family size of PLHIV in both provinces is 4.3 people.

***Table 3:*** Demographic characteristics of PLHIV

| | Ninh Binh (n=240) | Dong Thap (n=244) | Total (n=484) |
|---|---|---|---|
| **Gender** | | | |
| Male | 60.8% | 46.7% | 53.7% |
| Female | 39.2% | 53.3% | 46.3% |
| **Ethnic group** | | | |
| Kinh | 98.8% | 99.2% | 99.0% |
| Other | 1.2% | 0.8% | 1.0% |
| **Age group** | | | |
| 18 – 24 | 1.3% | 4.9% | 3.1% |
| 25 – 34 | 52.1% | 42.2% | 47.1% |
| 35 – 49 | 44.2% | 48.0% | 46.1% |
| Over 49 | 2.5% | 4.9% | 3.7% |
| **Average age (years)** | 35.2 | 35.7 | 35.4 |
| **Marital status** | | | |
| Never married | 7.9% | 7.8% | 7.9% |
| Married | 69.6% | 66.0% | 67.8% |
| Widowed, divorced, separated | 22.5% | 25.0% | 23.8% |
| Living together | 0.0% | 1.2% | 0.6% |
| **Average number of years residing in current residential area** | **30.3** | **30.2** | **30.3** |
| **Urban/Rural** | | | |
| Urban | 16.3% | 33.2% | 24.8% |
| Rural | 83.8% | 66.8% | 75.2% |
| **Income group** | | | |
| Poor, near poor | 57.5% | 34.4% | 45.9% |
| Non-poor | 42.5% | 65.6% | 54.1% |

Regarding marital status, 67.8% of the survey participants are married. It is interesting to note that based on gender analysis, 12% of male PLHIV are widowers, divorced or separated while 41.5% of female PLHIV are widows, divorced or separated

The survey results show little difference in PLHIV marital status between the two surveyed provinces. However, the divorce rate of PLHIV in Dong Thap is three times that of PLHIV in Ninh Binh.

***Table 4:*** Marital status of PLHIV

| | Married | Widowed | Divorced | Separated | Living together |
|---|---|---|---|---|---|
| **Province** | | | | | |
| Ninh Binh (n=221) | 75.6% | 19.5% | 1.8% | 3.2% | 0.0% |
| Dong Thap (n=225) | 71.6% | 20.4% | 5.3% | 1.3% | 1.3% |
| **Gender** | | | | | |
| Male (n=224) | 88.4% | 3.6% | 5.4% | 2.2% | 0.4% |
| Female (n=222) | 58.6% | 36.5% | 1.8% | 2.3% | 0.9% |
| **Urban/Rural** | | | | | |
| Urban (n=106) | 71.7% | 18.9% | 4.7% | 3.8% | 0.9% |
| Rural (n=340) | 74.1% | 20.3% | 3.2% | 1.8% | 0.6% |
| **Age group** | | | | | |
| 18 – 24 (n=12) | 91.7% | 0.0% | 8.3% | 0.0% | 0.0% |
| 25 – 34 (n=203) | 73.4% | 22.2% | 1.5% | 1.5% | 1.5% |
| 35 – 49 (n=213) | 72.8% | 18.8% | 5.2% | 3.3% | 0.0% |
| Over 49 (n=18) | 72.2% | 22.2% | 5.6% | 0.0% | 0.0% |
| **Income group** | | | | | |
| Poor, near poor (n=216) | 67.1% | 27.3% | 2.8% | 2.3% | 0.5% |
| Non-poor (n=230) | 79.6% | 13.0% | 4.3% | 2.2% | 0.9% |
| **Total (n=446)** | 73.5% | 20.0% | 3.6% | 2.2% | 0.7% |

**Education and occupation**

Half of the survey participants completed secondary school (49.8%) while 28.5% completed primary school. It is astonishing to note that illiteracy among PLHIV in Dong Thap is six times that of PLHIV in Ninh Binh.

Analysis shows a clear difference in education between urban and rural areas, between poor and non-poor groups and between men and women. Urban, non-poor men are better educated. The illiteracy rate among the rural poor is twice that of the urban non-poor. Female illiteracy is 1.5 times the male illiteracy rate.

***Table 5:*** Educational level of PLHIV

| | Primary school | Secondary school | High school | Vocational school | University/ College | Illiterate |
|---|---|---|---|---|---|---|
| **Province** | | | | | | |
| Ninh Binh (n=240) | 20.0% | 56.7% | 17.1% | 4.2% | 1.3% | 0.8% |
| Dong Thap (n=244) | 36.9% | 43.0% | 13.9% | 0.0% | 1.6% | 4.5% |
| **Gender** | | | | | | |
| Male (n=260) | 24.2% | 50.4% | 18.1% | 2.7% | 2.3% | 2.3% |
| Female (n=224) | 33.5% | 49.1% | 12.5% | 1.3% | 0.4% | 3.1% |
| **Urban/rural** | | | | | | |
| Urban (n=120) | 25.8% | 47.5% | 20.0% | 3.3% | 1.7% | 1.7% |
| Rural (n=364) | 29.4% | 50.5% | 14.0% | 1.6% | 1.4% | 3.0% |
| **Age group** | | | | | | |
| 18 – 24 (n=15) | 6.7% | 46.7% | 33.3% | 0.0% | 6.7% | 6.7% |
| 25 – 34 (n=228) | 24.1% | 51.8% | 15.8% | 3.9% | 2.2% | 2.2% |
| 35 – 49 (n=223) | 33.2% | 48.9% | 14.8% | 0.4% | 0.4% | 2.2% |
| Over 49 (n=18) | 44.4% | 38.9% | 5.6% | 0.0% | 0.0% | 11.1% |
| **Income group** | | | | | | |
| Poor, near poor (n=222) | 36.0% | 48.2% | 10.4% | 1.4% | 0.5% | 3.6% |
| Non-poor (n=262) | 22.1% | 51.1% | 19.8% | 2.7% | 2.3% | 1.9% |
| **Total (n=484)** | **28.5%** | **49.8%** | **15.5%** | **2.1%** | **1.4%** | **2.7%** |

Although most survey participants are of working age, the employment status for PLHIV in the two provinces shows that both those in both urban and rural areas have unstable incomes. Specifically, unemployed PLHIV or PLHIV working in the informal sector account for 33.7% of the study population with 36.7% living in urban areas and 32.7% living in rural areas. In the general population, the rural unemployment rate in both provinces is 5.0% while urban unemployment is at 9.2%.

Comparing occupation structure by gender, there is a clear difference between men and women except for those working in agriculture/forestry/fishing and laborers. Most male PLHIVs are either unemployed or are working in the informal sector (43.1%) while most female PLHIVs work in services and trading (20.5%) and handicrafts (4.5%). The unemployment rate for PLHIV women is twice that of men and 7.6% of the PLHIV females are housewives without an income.

The occupation structure also differs among the poor/near poor and non-poor groups and reflects the income instability mentioned above. In both income groups the percent who work in agriculture/forestry/ fishing is high as is that of those who are unemployed laborers.

***Table 6:*** Occupations of PLHIV

| | Un-employed | Agriculture/ Forestry/ Fishing | Laborer | Services / trading | Handi-craft | Un-employed laborer | House-wife |
|---|---|---|---|---|---|---|---|
| **Urban/Rural** | | | | | | | |
| Urban (n=120) | 9.2% | 8.3% | 5.8% | 27.5% | 7.5% | 36.7% | 5.0% |
| Rural (n=364) | 3.6% | 41.8% | 3.3% | 12.1% | 1.6% | 32.7% | 5.0% |
| **Gender** | | | | | | | |
| Male (n=260) | 3.8% | 33.8% | 3.1% | 11.9% | 1.9% | 43.1% | 2.3% |
| Female (n=224) | 6.3% | 33.0% | 4.9% | 20.5% | 4.5% | 22.8% | 8.0% |
| **Income Group** | | | | | | | |
| Poor, near poor (n=222) | 5.4% | 42.8% | 3.2% | 7.7% | 1.8% | 35.6% | 3.7% |
| Non-poor (n=262) | 4.6% | 25.6% | 4.6% | 22.9% | 4.2% | 32.1% | 6.1% |
| Total (n=484) | 5.0% | 33.5% | 3.9% | 15.9% | 3.1% | 33.7% | 4.9% |

**Living standards**

Regarding the living standards of the survey participants, 45.9% are poor/near poor households and 54.1% are non-poor households. At least one durable item is owned by 93.9% of PLHIV households. Television ownership is most common at 90.5% followed by video/DVD/VCD player ownership at 46.9%.

Ninety percent of PLHIV households have at least one mobile phone and in this there is no difference between the poor/near poor and non-poor. There is however a difference in ownership of means of transportation between the two income categories. Eighty two percent of non-poor households own motorbikes while 70.7% of poor/near poor households rely largely on bicycles for their transportation.

***Table 7:*** Ownership of valuable/durable property by income

| | **Ninh Binh** | | | **Dong Thap** | | | **Total** | | |
|---|---|---|---|---|---|---|---|---|---|
| | Poor, near poor (n=138) | Non-poor (n=102) | Total (n=240) | Poor, near poor (n=84) | Non-poor (n=160) | Total (n=244) | Poor, near poor (n=222) | Non-poor (n=262) | Total (n=484) |
| Television | 84.1% | 91.2% | 87.1% | 95.2% | 93.1% | 93.9% | 88.3% | 92.4% | 90.5% |
| Mobile phone | 92.0% | 94.1% | 92.9% | 76.2% | 94.4% | 88.1% | 86.0% | 94.3% | 90.5% |

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Poor, near poor (n=138) | Non-poor (n=102) | Total (n=240) | Poor, near poor (n=84) | Non-poor (n=160) | Total (n=244) | Poor, near poor (n=222) | Non-poor (n=262) | Total (n=484) |
| Motorbike | 58.7% | 80.4% | 67.9% | 47.6% | 83.1% | 70.9% | 54.5% | 82.1% | 69.4% |
| Bicycle/Electric bicycle | 73.9% | 51.0% | 64.2% | 65.5% | 35.0% | 45.5% | 70.7% | 41.2% | 54.8% |
| Video/DVD/ CD player | 19.6% | 48.0% | 31.7% | 47.6% | 69.4% | 61.9% | 30.2% | 61.1% | 46.9% |
| Telephone | 8.7% | 20.6% | 13.8% | 13.1% | 20.0% | 17.6% | 10.4% | 20.2% | 15.7% |
| Computer | 0.7% | 9.8% | 4.6% | 1.2% | 15.0% | 10.2% | 0.9% | 13.0% | 7.4% |
| Radio/ cassette player | 5.1% | 4.9% | 5.0% | 4.8% | 8.8% | 7.4% | 5.0% | 7.3% | 6.2% |
| Internet connection | 0.7% | 2.9% | 1.7% | 0.0% | 8.1% | 5.3% | 0.5% | 6.1% | 3.5% |
| Other | 2.9% | 10.8% | 6.3% | 1.2% | 3.8% | 2.9% | 2.3% | 6.5% | 4.5% |

**Migration**

When comparing the average number of years that PLHIV in the two provinces have resided in their current living area, little difference was found. Approximately 94% of PLHIV are registered permanent residents at their current address and only 1% had not registered at all. This implies lower mobility than expected among the survey participants. There is no difference between men and women regarding residence registration.

Only 6.4% of PLHIV changed their place of residence after they learned that they were HIV infected and they changed their place of residency and average of two times. The main reasons given for changing their place of residence were discrimination (22.5%) and change of workplace (25.8%).

***Table 8:*** PLHIV residential status by province

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Male (n=146) | Female (n=94) | Total (n=240) | Male (n=114) | Female (n=130) | Total (n=244) | Male (n=260) | Female (n=224) | Total (n=484) |
| **Residential status of PLHIV** | | | | | | | | | |
| Registered permanent residence | 95.9% | 93.6% | 95.0% | 93.9% | 93.1% | 93.4% | 95.0% | 93.3% | 94.2% |
| Registered temporary residence | 2.7% | 4.3% | 3.3% | 4.4% | 6.2% | 5.3% | 3.5% | 5.4% | 4.3% |
| Not registered/ waiting | 1.4% | 2.1% | 1.6% | 1.8% | 0.8% | 1.2% | 1.5% | 1.3% | 1.4% |
| **Change of residence after HIV infection detection** | | | | | | | | | |
| Yes | 6.8% | 9.6% | 7.9% | 5.3% | 4.6% | 4.9% | 6.2% | 6.7% | 6.4% |
| No | 93.2% | 90.4% | 92.1% | 94.7% | 95.4% | 95.1% | 93.8% | 93.3% | 93.6% |

Based on the information gained during the IDIs, it is clear that PLHIV continue to suffer from discrimination, some feel isolated from their communities and some are very concerned about earning a living. These are the reasons they gave for changing their place of residence.

*Q: Are there many PLHIV in your group who have changed their place of residence?*

*A: Yes. For example, in my village, if you know that I am a PLHIV and then you tell others, they don't understand and they then become distant from me and talk negatively about me. For this reason, PLHIV might have to leave home and find another place to live. Here, if they know that I am a PLHIV, they will not hire me and then I wouldn't make any money. This is why PLHIV might have to move. If they move someplace where no one knows that they are PLHIV, they might get hired and do OK.*

(IDI with PLHIV – SHI card holder, Dong Thap)

*A: I got married a short time before the Tet holidays. After Tet I got a health examination and discovered that I am PLHIV. At first I did not believe the result so I went to Hanoi to have another test done..When the second test verified that I am PLHIV I had to believe it. Soon after I was discriminated against in my village so I moved to Kim Trung. In 2006, after I lived in Kim Trung for more than a year, I returned to my village and I have been living here ever since. People here now have a better understanding of PLHIV so it's easier to for me to live here.*

(IDI with PLHIV – SHI card holder, Ninh Binh)

***Table 9:*** Number of residences and reasons for change of residence

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Male (n=10) | Female (n=9) | Total (n=19) | Male (n=6) | Female (n=6) | Total (n=12) | Male (n=16) | Female (n=15) | Total (n=31) |
| Number of living places after PLHIV learns of HIV infection | 1.9 | 2.1 | 2.0 | 2.0 | 1.8 | 1.9 | 1.9 | 2.0 | 2.0 |
| **Reasons for change of residence after learning of HIV infection** | | | | | | | | | |
| Change house/ go to live near relatives | 50.0% | 33.3% | 42.1% | 50.0% | 33.3% | 41.7% | 50.0% | 33.3% | 41.9% |
| Change workplace | 30.0% | 11.1% | 21.1% | 50.0% | 16.7% | 33.3% | 37.5% | 13.3% | 25.8% |
| Fear of discrimination | 20.0% | 0.0% | 10.5% | 16.7% | 66.7% | 41.7% | 18.8% | 26.7% | 22.6% |
| Got married | 10.0% | 33.3% | 21.1% | 0.0% | 0.0% | 0.0% | 6.3% | 20.0% | 12.9% |
| Other (commit a crime, go to 06 center) | 10.0% | 22.2% | 15.8% | 0.0% | 0.0% | 0.0% | 6.3% | 13.3% | 9.7% |

### 2.3. Social Health Insurance and use of healthcare services by PLHIV

This study specifically focused on the Vietnamese national health insurance program, Social Health Insurance (SHI), which is managed by VSS. All results and discussion related health insurance (coverage, health insurance subscription types) in this document refer to the VSS-SHI program.

**SHI coverage for PLHIV in Ninh Binh and Dong Thap provinces**

Only 54% of PLHIV have SHI in the two provinces compared to 70% among the general population. However, the percent of PLHIV who participate in the SHI scheme in Ninh Binh is much greater than in Dong Thap, 69.2% compared to 38.9%, respectively. The main reasons stated by respondents for not participating in the SHI scheme were lack of money to buy the SHI card subscription (62.3%), believing SHI is not necessary (18.4%) and fear of discrimination (13.0%).

When looking at gender, it is seen that more women than men have SHI coverage in both provinces. It is interesting to note that survey results show that one-third of those in the non-poor group have SHI cards while 83.3% of those in the near poor group have SHI cards. This could be due to the effective implementation of subsidies for poor and near poor groups to enhance their access to the SHI scheme. A discrepancy does still exist between Ninh Binh and Dong Thap. In Ninh Binh 94.2% of poor PLHIV have a SHI card while in Dong Thap only 75% of poor PLHIV have coverage.

***Table 10:*** Proportion of PLHIV with SHI cards by income and gender

| | Ninh Binh (n=240) | | Dong Thap (n=244) | | Total (n=484) | |
|---|---|---|---|---|---|---|
| | With SHI cards | Without SHI cards | With SHI cards | Without SHI cards | With SHI cards | Without SHI cards |
| **Income** | | | | | | |
| Poor, near poor | 93.5% | 6.5% | 66.7% | 33.3% | 83.3% | 16.7% |
| Non-poor | 36.3% | 63.7% | 24.4% | 75.6% | 29.0% | 71.0% |
| **Gender** | | | | | | |
| Male | 61.6% | 38.4% | 35.1% | 64.9% | 50.0% | 50.0% |
| Female | 80.9% | 19.1% | 42.3% | 57.7% | 58.5% | 41.5% |
| **Total** | 69.2% | 30.8% | 38.9% | 61.1% | 53.9% | 46.1% |

Chart 1 below represents types of SHI cards currently held by PLHIV. The majority of SHI cards held by PLHIV are subsidized cards for the poor. It should be stressed that even though ARV treatment is currently provided free of charge, nearly 25% of PLHIV have voluntarily purchased SHI cards (35.8% in Dong Thap and 15.7% in Ninh Binh), which shows a willingness to pay (WTP). Surveyed PLHIV also stated their intention to participate in the SHI scheme and these two pieces of information are an indication that SHI coverage among PLHIV could be expanded.

***Chart 1:*** Types of SHI cards currently held by PLHIV by province

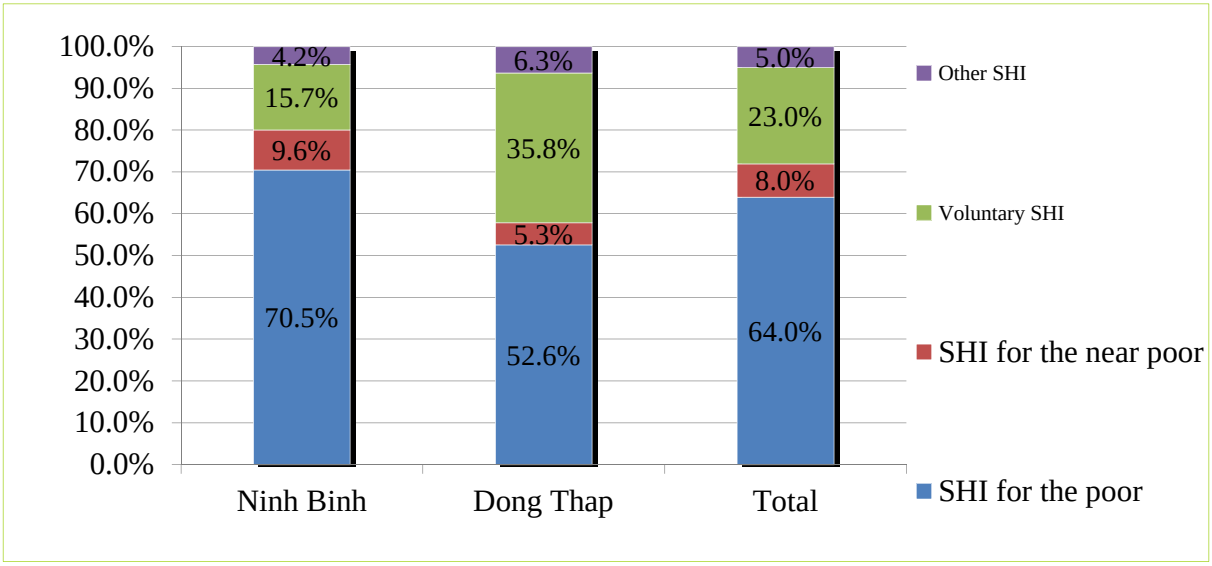



Table 11 below shows the registration of PLHIV with SHI cards at primary healthcare facilities in the two provinces. Most PLHIV register to receive primary healthcare at a commune healthcare station, although this is more common in Ninh Binh (78%) than it is in Dong Thap (62%). An explanation for this is that most PLHIV that have an SHI card have a subsidized SHI card which is available to the poor. Every cardholding PLHIV, and everyone else in the population that has a card, registers by default at their commune healthcare station. When classifying the study

population by income or type of SHI card, the place of registration stands out as a markedl difference between the poor and non-poor groups. Approximately one-third of PLHIV who do not have subsidized SHI cards (i.e. those in the non-poor group), 41% in Ninh Binh and 31% in Dong Thap, have registered at the commune level. Over 80% of subsidized card holders (those in the poor group) registered at the commune level. Ninety percent of poor/near poor PLHIV with SHI cards chose their commune healthcare stations as their registered primary healthcare facility. Of those PLHIV who were participating in SHI voluntarily (i.e. those who purchased unsubsidized cards), only 28% chose to register their commune healthcare station as their primary healthcare facility. More than 60% of those who purchased an non-subsidized SHI card chose to register at a hospital at the district level or higher making that their primary healthcare facility.

***Table 11:*** PLHIV registering SHI cards at primary health facilities by income and type of subscription

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Commune healthcare stations | District hospitals | Provincial hospital | Commune healthcare stations | District hospitals | Provincial hospital | Commune healthcare stations | District hospitals | Provincial hospital |
| **Income group** | | | | | | | | | |
| Poor/ near poor | 88.4% | 8.5% | 0.0% | 83.9% | 14.3% | 0.0% | 87.0% | 10.3% | 0.0% |
| Non-poor | 40.5% | 40.5% | 5.4% | 30.8% | 38.5% | 25.6% | 35.5% | 39.5% | 15.8% |
| **Types of SHI cards currently held by PLHIV** | | | | | | | | | |
| SHI for the poor, near poor | 91.0% | 6.8% | 0.0% | 85.5% | 12.7% | 0.0% | 89.4% | 8.5% | 0.0% |
| Voluntary SHI | 23.1% | 53.8% | 3.8% | 32.4% | 41.2% | 33.3% | 28.3% | 46.7% | 13.3% |
| Other SHI | 28.6% | 42.9% | 14.3% | 16.7% | 33.3% | 50.0% | 23.1% | 38.5% | 30.8% |
| **Total** | 77.7% | 15.7% | 1.2% | 62.1% | 24.2% | 10.5% | 72.0% | 18.8% | 4.6% |

These numbers do not reflect PLHIVs' preference for place of registration. Although most PLHIV who hold SHI cards register their primary healthcare facility as the commune healthcare station, when asked where they would prefer to receive primary care, only 24% of PLHIV answered that they preferred the commune healthcare stations. About 60% of them said that they'd rather designate a healthcare facility at the district or provincial level as their primary healthcare facility. This was corroborated by survey interviews with PLHIV.

*Q: Which place would you like to designate as your primary healthcare facility? The provincial hospital, the district hospital or the commune healthcare station?*

*A: The General Hospital of Cao Lanh Province*

(IDI with PLHIV who had no SHI, Dong Thap)

*Q: If you participated in SHI, which place would you register as your primary health facility?*

*A: In the future, if I can, I want to go to the medical establishment that is nearest to my home, and I live three km from the district hospital. To go there would be convenient for me and, if someone was seriously ill, it would be convenient for my family members to go there and care for the sick person.*

(IDI with PLHIV who had no SHI, Ninh Binh)

**PLHIVs plans to participate in the SHI scheme**

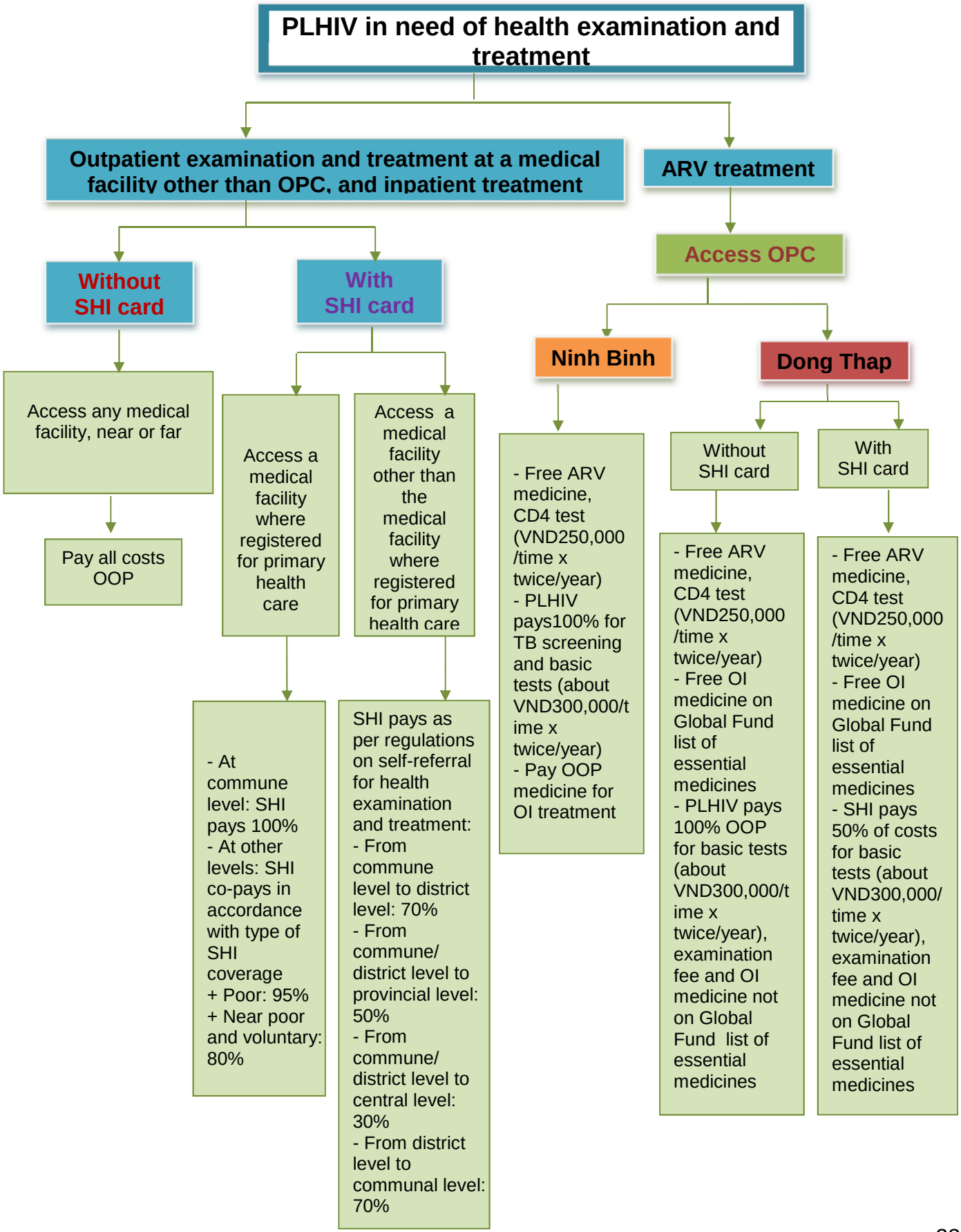
Most PLHIV (86% in both provinces) of all groups, the poor, near poor and non-poor, plan to participate in the SHI scheme in the future. However, many said that only if the SHI card was half its current cost would it be affordable. Differences between income groups were noted in WTP and payment capacity across the income groups. It was interesting to see that the poor group showed a greater WTP than the near poor group should they have to buy their own SHI cards. It is logical that PLHIV who intend to participate in the SHI scheme are more WTP than those who say that they have no intention to participate in the SHI scheme in the future.

***Table 12:*** Willingness to pay and affordability of SHI premiums

| | Ninh Binh | | | | Dong Thap | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Poor (n=120) | Near poor (n=18) | Non-poor (n=102) | Total (n=240) | Poor (n=64) | Near poor (n=20) | Non-poor (n=160) | Total (n=244) | Poor (n=184) | Near poor (n=38) | Non-poor (n=262) | Total (n=484) |
| **Intend to participate in SHI scheme** | | | | | | | | | | | | |
| Yes | 88.3% | 77.8% | 81.4% | 84.6% | 85.9% | 85.0% | 88.1% | 87.3% | 87.5% | 81.6% | 85.5% | 86.0% |
| No | 10.0% | 16.7% | 13.7% | 12.1% | 4.7% | 10.0% | 6.9% | 6.6% | 8.2% | 13.2% | 9.5% | 9.3% |
| N/A | 1.7% | 5.6% | 4.9% | 3.3% | 9.4% | 5.0% | 5.0% | 6.1% | 4.3% | 5.3% | 5.0% | 4.8% |
| **Desired level of SHI premium (thousand VND)** | | | | | | | | | | | | |
| Intend to participate | 279 (±145) | 257 (± 128) | 350 (± 154) | 306 (± 152) | 224 (± 101) | 230 (± 135) | 274 (± 123) | 258 (± 120) | 260 (± 134) | 242 (± 131) | 302 (± 140) | 281 (± 139) |
| Not intend to participate | 175 (±127) | 167 (±115) | 239 (±155) | 205 (±140) | 167 (±115) | 50 (±70) | 150 (±87) | 141 (±92) | 173 (±121) | 120 (±109) | 200 (±135) | 182 (±128) |
| **Choice of primary healthcare facility** | | | | | | | | | | | | |
| Commune health station | 28.3% | 27.8% | 10.8% | 20.8% | 50.0% | 20.0% | 17.5% | 26.2% | 35.9% | 23.7% | 14.9% | 23.6% |
| District hospital | 40.8% | 16.7% | 21.6% | 30.8% | 12.5% | 10.0% | 21.9% | 18.4% | 31.0% | 13.2% | 21.8% | 24.6% |
| Provincial hospital | 18.3% | 11.1% | 30.4% | 22.9% | 37.5% | 55.0% | 51.3% | 48.0% | 25.0% | 34.2% | 43.1% | 35.5% |
| PAC | 10.0% | 27.8% | 20.6% | 15.8% | 0.0% | 0.0% | 0.0% | 0.0% | 6.5% | 13.2% | 8.0% | 7.9% |
| OPC | 1.7% | 16.7% | 15.7% | 8.8% | 0.0% | 15.0% | 7.5% | 6.1% | 1.1% | 15.8% | 10.7% | 7.4% |
| National hospital | 0.8% | 0.0% | 0.0% | 0.4% | 0.0% | 0.0% | 0.6% | 0.4% | 0.5% | 0.0% | 0.4% | 0.4% |

**Use of SHI cards and access to healthcare services**

***Diagram 1:*** *Model of PLHIV method of payment for medical services*



**Access and use of SHI for HIV care and treatment services**

The survey data from the two provinces show that there is no duplication of registration or use of HIV healthcare and treatment services in the group of PLHIV who are using services at OPCs. Not one survey respondent said that he/she is currently registered to receive or has received HIV treatment at two different OPCs at the same time. About 18% of PLHIV have changed their place of registration for HIV treatment sometime in the past to a treatment facility in the same or different provinces than their current place of residence. The main reason respondents cited for changing their treatment facility was to be able to go to a treatment facility that was closer to their home.

Most PLHIV who register for HIV treatment at OPCs are currently receiving ARV treatment (93.4%). Most visit their OPC once a month to receive ARVs. Treatment facilities also provide CD4 testing, clinical examination and assessments.

There is a distinct difference in SHI card use at OPCs and for ARV treatment between the two provinces. In Ninh Binh, SHI use has not been applied at any of the three OPCs because the OPCs are classified under the "prevention" system. In Dong Thap, because OPCs are located in hospitals and are classified under the "treatment" system, PLHIV can use their SHI cards to access benefits related to basic tests and OI treatment when it is prescribed by OPC doctors. However, less than 30% of PLHIV use SHI cards at Dong Thap OPCs or for ARV treatment. PLHIV in Dong Thap stated that they do not use their SHI cards for ARV medicine because it is provided free of charge, and they don't use their SHI cards for a desired service that is not covered by SHI. Fear of discrimination also discourages them from using the card.

*Q: In the HIV treatment department, do you use HI?*
*A: No*
*Q: Really? Why?*
*A: Because the medicine (ARV) is provided free of charge there.*

(IDI with PLHIV - SHI card holder, Dong Thap)

It should be noted that the SHI reimbursement for regular tests provided to PLHIV at OPCs in Dong Thap is not consistent and therefore not predictable. Many difficulties were noted which are due to a lack of implementation guidelines and support documents.

**Medical care at health facilities other than OPCs, including outpatient, inpatient and self-treatment**

On average, 30% of PLHIV accessed medical facilities other than OPCs to receive non-HIV/ARV treatment three times in the past 12 months. About 14% of PLHIV received inpatient treatment in the past 12 months an average of 1.3 times with an average length of stay (LOS) of 13 days per episode. Social Health Insurance cardholding PLHIV use outpatient services at medical facilities other than OPCs more often than PLHIV without SHI cards (38.6% compared to 28.9% for outpatient examination and treatment at other medical facilities; 17.9% compared to 10.0% for inpatient treatment). PLHIV with SHI cards do tend to use these services more regularly than PLHIV without SHI cards. Regarding over the counter drug purchases, over 60% of PLHIV buy medicine for self-treatment. There was no notable difference between PLHIV with and those without SHI cards regarding their purchase of medicine for self-treatment.

***Table 13:*** Average number of outpatient and inpatients visits, and at-home care and self-examination/ treatments by PLHIV in the past 12 months

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | With SHI (n=157) | Without SHI (n=72) | Total (n=229) | With SHI (n=94) | Without SHI (n=147) | Total (n=241) | With SHI (n=261) | Without SHI (n=223) | Total (n=484) |
| Outpatient examination/ treatment | 48.4% | 19.4% | 39.3% | 22.3% | 17.0% | 19.1% | 38.6% | 17.8% | 28.9% |
| Average number of outpatient episodes | 4.0 (±3.8) | 2.7 (±2.0) | 3.8 (±3.6) | 1.2 (±0.7) | 2.1 (±2.5) | 1.7 (±1.9) | 3.4 (±3.6) | 2.3 (±2.3) | 3.1 (±3.3) |
| Inpatient treatment | 20.4% | 11.1% | 17.5% | 13.8% | 9.5% | 11.2% | 17.9% | 10.0% | 14.3% |
| Average number of inpatient episodes | 1.2 (±0.5) | 1.1 (±0.4) | 1.2 (±0.5) | 1.8 (±1.7) | 1.1 (±0.3) | 1.4 (±1.2) | 1.4 (±1.0) | 1.1 (±0.3) | 1.3 (±0.9) |
| Average LOS for each inpatient episode | 17.2 (±17.2) | 12.1 (±6.4) | 16.2 (±15.8) | 10.2 (±7.7) | 9.6 (±7.8) | 9.9 (±7.6) | 15.2 (±15.4) | 10.5 (±7.3) | 13.7 (±13.5) |
| Home-based care | 45.2% | 23.6% | 38.4% | 5.3% | 2.7% | 3.7% | 30.3% | 9.6% | 20.6% |
| Average number of times receiving home care | 5.9 (±5.7) | 8.5 (±8.1) | 6.4 (±6.2) | 2.8 (±1.9) | 2.0 (±2.0) | 2.4 (±1.4) | 5.7 (±5.6) | 7.2 (±7.6) | 6.0 (±8.0) |
| Self-treatment | 72.6% | 65.3% | 70.3% | 55.3% | 57.1% | 56.4% | 66.1% | 59.8% | 63.2% |

Eighty percent of PLHIV SHI cardholders stated that they use their cards for outpatient examinations and inpatient treatment at medical facilities other than the OPC. Seventy five percent used their SHI cards for ALL outpatient examination and inpatient treatment at other medical facilities. This confirms that VSS sponsored SHI already provides coverage to PLHIV for general services and also that PLHIV are used to using their cards and know how to navigate the process when they access healthcare facilities.

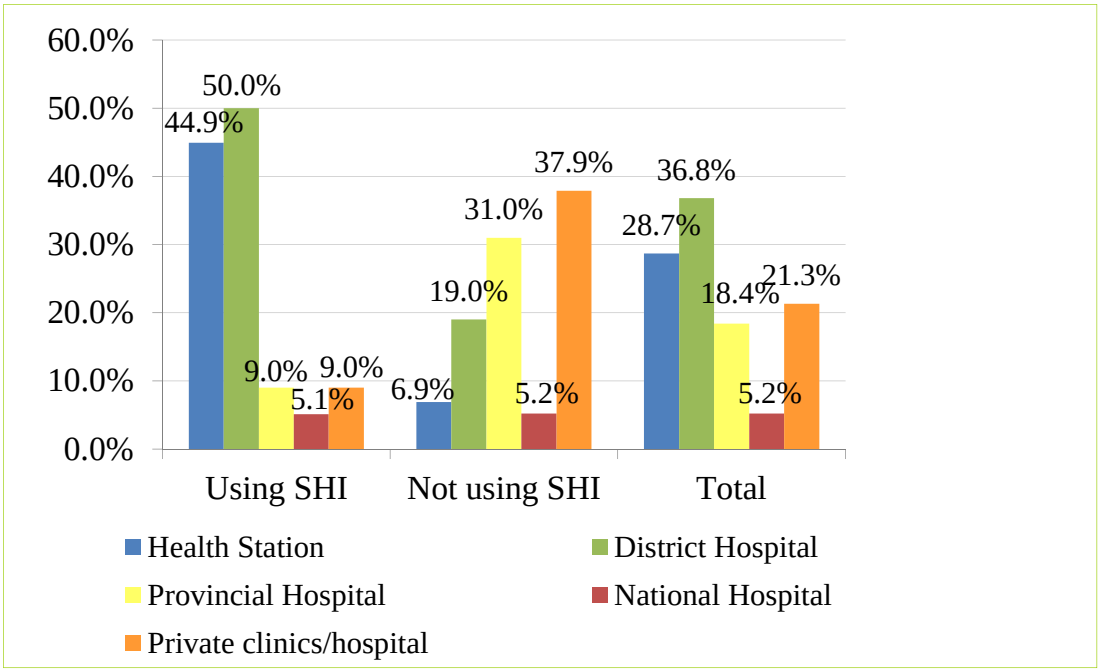
There is no big difference between PLHIV men and women in terms of rate of using HI for health examination and treatment. However, when analyzed by province, it was seen that more PLHIV in Ninh Binh use their cards for outpatient treatment at medical facilities other than OPCs than do PLHIV in Dong Thap.

***Table 14:*** Rate of SHI use by PLHIV for in and outpatient treatment at medical establishments other than OPCs

| | Ninh Binh | | | Dong Thap | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total | Male | Female | Total |
| **Outpatient treatment at medical establishments other than OPC** | | | | | | | | | |
| Using SHI for all episodes | 88.6% | 82.9% | 85.5% | 50.0% | 27.3% | 38.1% | 80.0% | 71.2% | 75.3% |
| Using SHI for some episodes | 2.9% | 4.9% | 3.9% | 0.0% | 0.0% | 0.0% | 2.2% | 3.8% | 3.1% |
| Not using SHI | 8.6% | 12.2% | 10.5% | 50.0% | 72.7% | 61.9% | 17.8% | 25.0% | 21.6% |
| | *$Chi^2$=0.501; df=2; p=0.778* | | | *$Chi^2$=1.147; df=1; p=0.284* | | | *$Chi^2$=1.038; df=2; p=0.595* | | |
| **Inpatient treatment** | | | | | | | | | |
| Using SHI for all episodes | 70.6% | 80.0% | 75.0% | 80.0% | 75.0% | 76.9% | 72.7% | 78.3% | 75.6% |
| Using SHI for some episodes | 0.0% | 6.7% | 3.1% | 0.0% | 0.0% | 0.0% | 0.0% | 4.3% | 2.2% |
| Not using SHI | 29.4% | 13.3% | 21.9% | 20.0% | 25.0% | 23.1% | 27.3% | 17.4% | 22.2% |
| | *Chi2=2.169; df=2; p=0.338* | | | *Chi2=0.043; df=1; p=0.835* | | | *Chi2=1.496; df=2; p=0.473* | | |

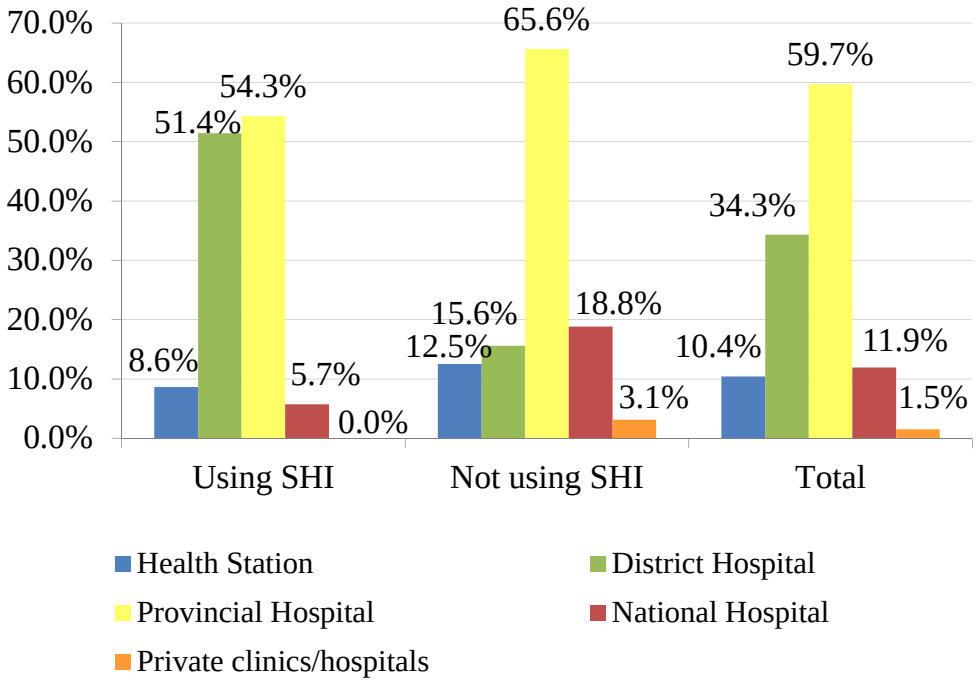
The survey showed the types of medical facilities (other than OPCs) that were accessed for outpatient services and inpatient treatment by PLHIV using SHI and those not using SHI. Most PLHIV with SHI cards access medical facilities other than OPCs at the commune and district levels while PLHIV without SHI cards access private clinics and provincial hospitals.

***Chart 2:*** Non-OPC examination and treatment providers for PLHIV by SHI card use



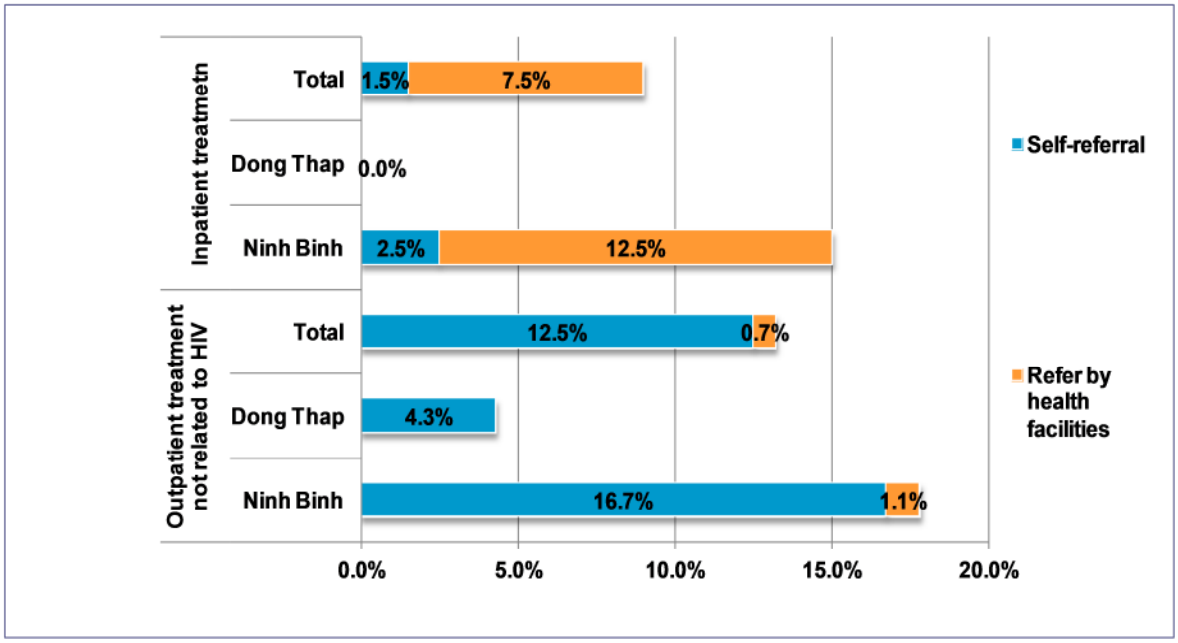
Regarding inpatient treatment, PLHIV with SHI were just as likely to stay at a provincial hospital as at a district hospital for inpatient treatment.. Most PLHIV who are without SHI get treatment at their provincial hospital.

***Chart 3:*** Inpatient treatment providers for PLHIV by SHI use




About 13% of PLHIV were referred during their outpatient treatment at medical facilities (other than OPCs) and 9% of PLHIV were referred during their inpatient treatment. However, for those receiving outpatient treatment, this was mainly a self-referral, while for those receiving inpatient care it was a referral by their doctor. When analyzed by province, there is a notable difference in referrals. The overall referral rates in Ninh Binh (both medical and self-referral) were higher than in Dong Thap for both inpatient and outpatient treatment in medical facilities other than OPCs.

***Chart 4:*** PLHIV referrals in Ninh Binh and Dong Thap




## 2.4. PLHIV healthcare expenses

This section describes and analyzes OOP expenses incurred by PLHIV which include a) direct costs such as examination and treatment, hospitalization, medicine and tests; and b) indirect costs such as travel, accommodations for patient and family, gifts to healthcare workers and other costs.

Overall costs and OOP expenses in particular are critical factors that determine a patient's health service options and medical facility choices. Healthcare expenditure can also affect a person's living standard, especially for PLHIV who generally have low household incomes. The cost of care is the main thing which limits access to healthcare by low-income people, especially PLHIV. Large OOP expenses can plunge vulnerable people (like PLHIV) into poverty.

### Estimated annual healthcare expenditures of PLHIV

This section provides estimates of PLHIVs' total annual expenditure on healthcare for the 12 months prior to this survey. This information was compared with their total spending and total income during the same period. The findings show that the average annual medical expenses of a PLHIV (including the cost of services at OPC, ARV treatment, outpatient examinations, treatment at medical facilities other than OPC, inpatient treatment and medicine) was 2.4 million VND, accounting for 20% of their total expenses and about 17% of their total income. Table 14 shows that, on average, healthcare expenditures for one PLHIV during the 12 months preceding the survey were VND2.8 million in Ninh Binh and VND2.0 million in Dong Thap. Total spending on healthcare by a PLHIV in Ninh Binh is equal to 21.8% of their yearly income. In Dong Thap, the expenditure is only 11.4% of their yearly income.

***Table 15:*** *Annual PLHIV healthcare expenditures*

| | Ninh Binh | | Dong Thap | | Total | |
|---|---|---|---|---|---|---|
| | **Mean** | **SD** | **Mean** | **SD** | **Mean** | **SD** |
| Health and Health care (thousand VND) | 2,894 | ± 4,861 | 2,002 | ± 2,620 | 2,436 | ± 3,900 |
| Annual healthcare expenses as a percent of income | 21.8% | | 11.4% | | 16.5% | |
| Annual healthcare expenses as % of total household spending | 20.3% | | 20.2% | | 20.3% | |

**Out-of-Pocket expenses for examination and treatment at OPCs**

Outpatient clinic services include examinations and ARV treatment. Total annual average OOP expenses incurred by an individual PLHIV in the 12 months prior to the survey were VND 1.1 million, of which ARV treatment accounted for VND 926,000. There was no difference in OOP expenses for ARV treatment between poor/near poor and non-poor PLHIV. Average expenses for ARV treatment during this period was VND 890,000 for a poor/near and poor PLHIV, while the average expense for a non-poor PLHIV was about VND one million.

A detailed spending analysis shows that indirect costs like travel and accommodation (for both patients and caregivers) account for 56% of total expenses. This is explained by the fact that most direct costs for OPC treatments (cost of ARV drugs) are covered by either the government or project funding. Despite direct costs being covered, indirect costs are quite a burden for many PLHIV whose daily income may be only enough for food.

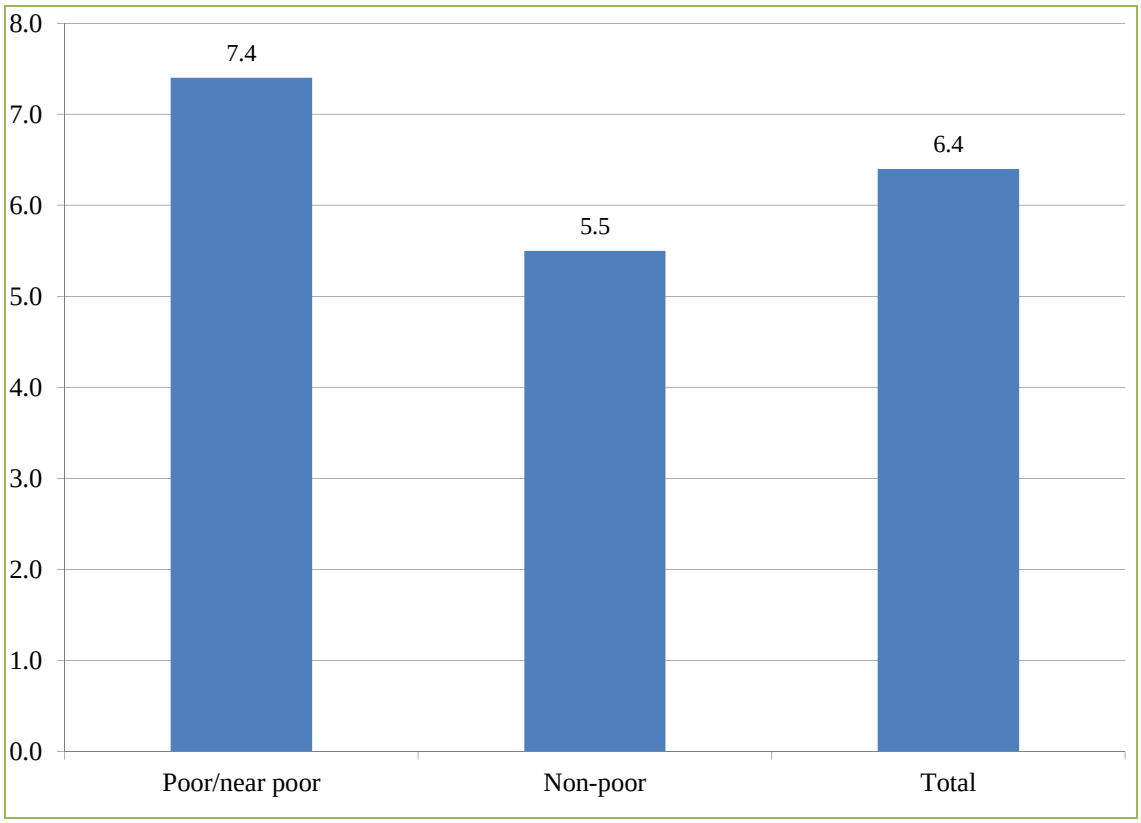
***Table 16:*** **PLHIV** OOP spending at OPC by income category

*Currency unit: One Thousand VND*

| Cost category | Expenses at OPC | | | Expense of ARV treatment | | |
|---|---|---|---|---|---|---|
| | Poor/Near poor | Non poor | Total | Poor/Near poor | Non poor | Total |
| Average expenses for health care | 110 (± 140) | 148 (± 167) | 131 (± 156) | 94 (± 131) | 136 (±125) | 116 (± 129) |
| | 10.7% | 12.8% | 11.9% | 10.5% | 14.2% | 12.5% |
| Medicine, testing, misc. items | 315 (± 1,022) | 399 (± 1,132) | 360 (± 1,083) | 329 (± 1,051) | 354 (± 1,068) | 342 (± 1,037) |
| | 30.8% | 34.4% | 32.8% | 36.9% | 37.0% | 36.9% |
| Travel, vehicle maintenance | 454 (± 462) | 465 (± 418) | 460 (± 438) | 468 (± 574) | 468 (± 455) | 468 (± 514) |
| | 44.3% | 40.1% | 41.9% | 52.5% | 48.9% | 50.5% |
| Accommodations (patient and caregiver) | 144 (± 410) | 155 (± 289) | 150 (± 349) | -- | -- | -- |
| | 14.1% | 13.4% | 13.7% | -- | -- | -- |
| **Total** | 1,024 (± 1,284) | 1,159 (± 1,287) | 1,097 (± 1,286) | 891 (± 1,222) | 958 (± 1,232) | 926 (± 1,173) |

Chart 5 below compares PLHIV OOP expenses for services at OPC to income level and average spending (excluding food) per capita per year. The survey data show that this expense in terms of total yearly income of the non-poor group and the poor group was 5.5% and 7.4%, respectively,

***Chart 5:*** Ratio of PLHIV OOP expenses at OPCs to total income




The analysis shows that the OOP healthcare expense of PLHIV who obtained healthcare services at OPCs in Dong Thap and Ninh Binh was VND 1.15 million and VND 1.05 million, respectively. There is a difference in cost structure at OPCs between the two provinces. In Ninh Binh, the cost of medicine and additional testing done outside the OPC accounted for the greatest proportion of total expenses (50.8%). In Dong Thap, travel costs accounted for 51.1%.

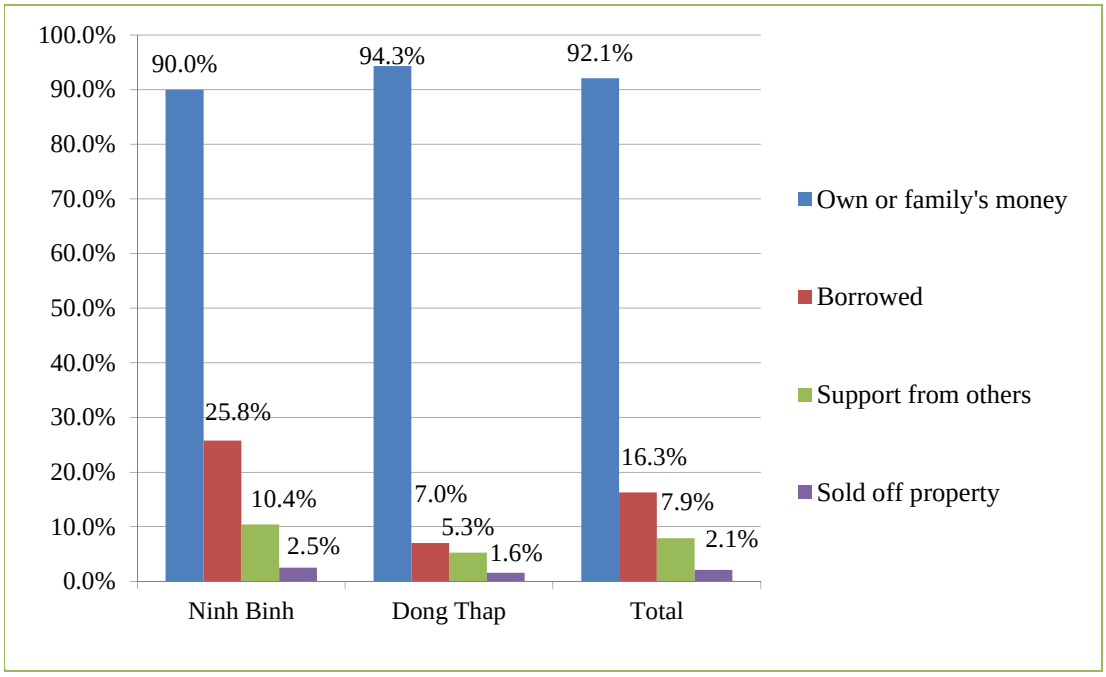
***Table 17:*** Cost structure of OOP incurred by PLHIV at OPCs by province

*Currency unit: One Thousand VND*

| | Ninh Binh | | Dong Thap | |
|---|---|---|---|---|
| | Expenses at OPC | Payment for ARV treatment | Expenses at OPC | Payment for ARV treatment |
| Average expenses for healthcare | 145 (± 180) | 119 (± 175) | 117 (± 127) | 113 (± 38) |
| | 13.8% | 12.8% | 10.3% | 12.3% |
| Medicine, tests, misc. items | 535 (± 1.453) | 474 (±1.371 ) | 195 (± 478) | 195 (± 374) |
| | 50.8% | 50.9% | 17.2% | 21.2% |
| Travel, vehicle maintenance | 333 (± 293) | 339 (± 470) | 581 (± 513) | 611 (± 524) |
| | 31.6% | 36.4% | 51.1% | 66.5% |
| Accommodations (patient and caregiver) | 41 (± 130) | -- | 253 (± 448) | -- |
| | 3.9% | -- | 22.3% | -- |
| **Totals** | 1,054 (± 1560) | 932 (± 1.488) | 1,137 (± 956) | 919 (± 668) |

An analysis of PLHIV sources of cash to pay for examinations and treatment at the OPC, provided in Chart 6 below, shows that about 19% of PLHIV must borrow money or sell items of value (their own or their family's) to cover their OOP at OPC. In Ninh Binh the ratio is remarkable at 26%.

***Chart 6:*** OOP funding sources for PLHIV examination and treatment at OPCs



**OOP expenses for outpatient examination/treatment incurred by PLHIV at healthcare facilities other than the OPC**

Outpatient examination and treatment at health facilities other than OPC includes outpatient examination and treatment at other medical facilities (excluding examination at OPC, ARV treatment, methadone and/or TB treatment). During the 12 months preceding the survey, average OOP expense of a PLHIV using outpatient examination and treatment services at health facilities other than OPC was VND 920,000 and each period of outpatient examination and treatment cost them VND 486,000 on average. When the use of SHI cards was stratified, the results show that the average OOP expenses during 12 months for outpatient examinations and treatments at health facilities other than OPC for the non-SHI card holding PLHIV group was three times higher than the group which did have SHI cards (VND 1.4 million versus VND 577,000).

The analysis of outpatient OOP expenses incurred by PLHIV for outpatient examination/treatment at healthcare facilities other than OPC shows that outpatient examination and treatment expenses which were the largest expense were medicine, testing and miscellaneous items (VND 397,000, accounting for 43.2%). The next highest category is the direct expense for other medical facilities (VND 297,000, accounting for 32.3%), followed by travel and accommodation costs of patients and their caregivers.

***Table 18:*** Average PLHIV OOP spending for outpatient services categorized by SHI cardholders and non-SHI cardholders

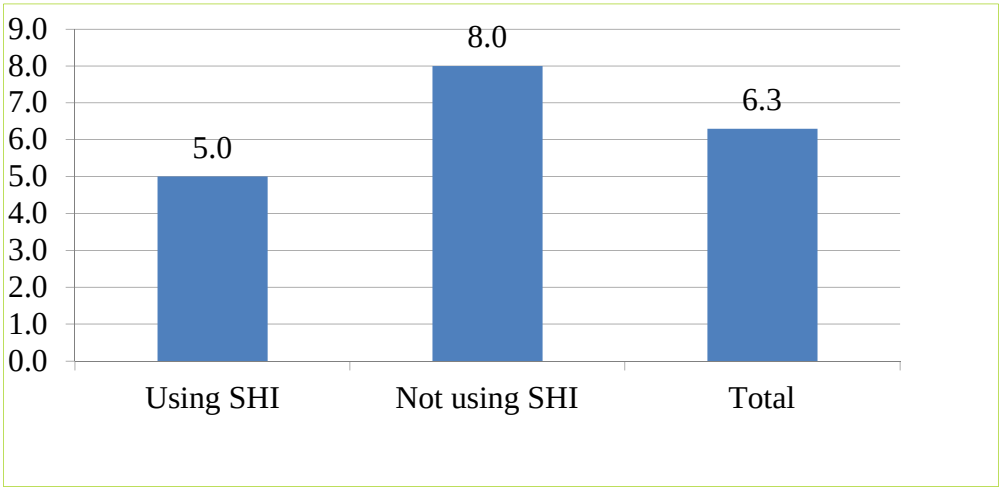
*Currency unit: thousand VND*

| | Using SHI cards (n=78) | Not using SHI cards (n=58) | Total (n=136) |
|---|---|---|---|
| Average expenses for healthcare | 166 (± 429) | 472 (±670) | 297 (± 563) |
| | 28.8% | 34.2% | 32.3% |
| Medicine, testing, misc. items | 290 (± 1,011) | 541 (± 920) | 397 (± 976) |
| | 50.3% | 39.2% | 43.2% |
| Travel, vehicle maintenance | 97 (± 152) | 280 (± 821) | 175 (± 553) |
| | 16.8% | 20.3% | 19.0% |
| Accommodations (patient and caregiver) | 24 (± 86) | 89 (± 220) | 52 (± 160) |
| | 4.2% | 6.4% | 5.7% |
| **Total expenses** | 577 (± 1,266) | 1.381 (± 1,819) | 920 (± 1,572) |

Comparing the expense of outpatient examination/treatment at healthcare facilities other than OPC with PLHIV's annual income and per capita spending (excluding food), the survey data show that for a PLHIV who used a SHI card, the ratio to total annual income is 5.0% and to

total annual spending it is 6.4%. For those PLHIV who did not use a SHI card, the ratio reached up to 8.0% of annual income and 16.0% of total annual spending on non-food items.

***Chart 7:*** Ratio of OOP expenses incurred by PLHIV for outpatient examination and treatment at non-OPC facilities to total income




Data by province show that a PLHIV in Dong Thap spends an average of VND 1.2 million per year on outpatient examination and treatment compared to the VND 780,000 that PLHIV spend in Ninh Binh. Comparing the expense structure of the two provinces shows that the travel and accommodation expense to total expenses ratio of PLHIV in Dong Thap is a lot higher than that in Ninh Binh (35.6% in Dong Thap compared with 16% in Ninh Binh). The ratio of direct spending on expenses for medical care in Ninh Binh is higher than that in Dong Thap.

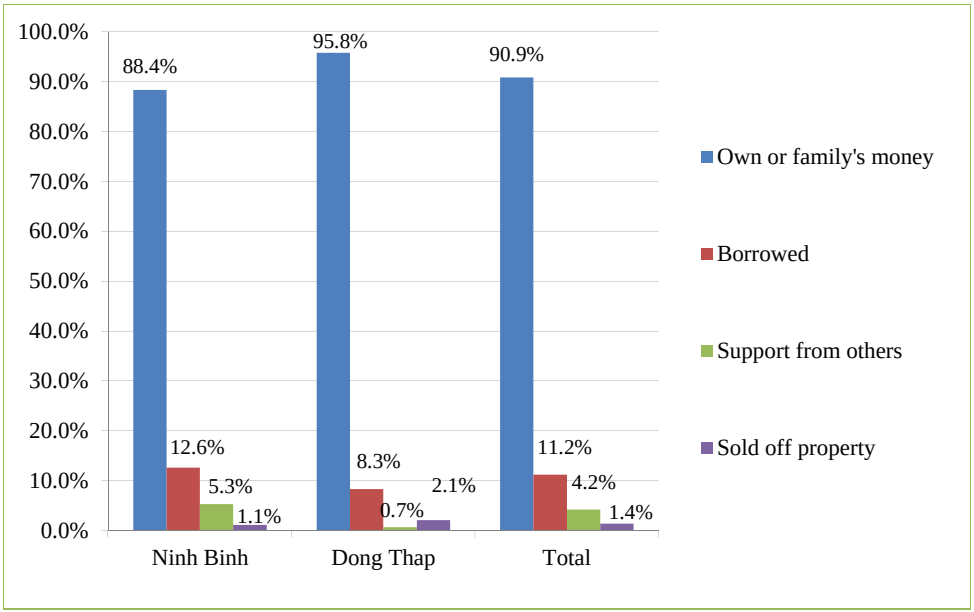
***Table 19:*** PLHIV OOP spending for outpatient services by province

*Currency unit: thousand VND*

| | **Ninh Binh** | | | **Dong Thap** | | |
|---|---|---|---|---|---|---|
| | Using SHI (n=69) | Not using SHI (n=21) | Total (n=90) | Using SHI (n=9) | Not using SHI (n=37) | Total (n=46) |
| Average expenses for healthcare | 160 (± 443) | 792 (± 927) | 307 (± 645) | 214 (± 309) | 291 (± 374) | 276 (± 360) |
| | 30.1% | 49.9% | 39.5% | 22.9% | 23.0% | 23.0% |
| Medicine, testing, misc. items | 282 (± 1,052) | 554 (± 955) | 346 (± 1,032) | 349 (± 645) | 533 (± 912) | 497 (± 863) |
| | 53.1% | 34.9% | 44.5% | 37.4% | 42.1% | 41.4% |
| Travel, vehicle maintenance | 77 (± 133) | 213 (± 367) | 109 (± 217) | 247 (± 208) | 318 (± 994) | 304 (± 894) |
| | 14.5% | 13.4% | 14.0% | 26.4% | 25.1% | 25.3% |
| Accommodations (patient and caregiver) | 11 (± 29) | 29 (± 70) | 15 (± 43) | 124 (± 227) | 122 (± 266) | 123 (± 256) |
| | 2.1% | 1.8% | 1.9% | 13.3% | 9.6% | 10.3% |
| **Total expenses** | 531 (± 1,262) | 1.587 (± 1,819) | 777 (± 1,471) | 934 (± 1,310) | 1.265 (± 1,834) | 1.200 (± 1,736) |

Chart 8 below shows the analysis of OOP funding sources for outpatient examination and treatment expenses at healthcare facilities other than OPC. Thirteen percent of PLHIV in Ninh Binh and 10% in Dong Thap must borrow money or sell property to pay for outpatient examination and treatment.

***Chart 8:*** OOP funding sources for PLHIV outpatient healthcare at non-OPC facilities




**OOP expenses of PLHIV for inpatient treatment**

Hospitalization expenses can be an economic burden for PLHIV and tip their families into poverty, especially when patients are the primary wage earner. The Social Health Insurance program can only be considered an effective part of the financing strategy for HIV/AIDS if it contributes to reducing the economic burden on PLHIV, especially for the poor/near poor group.

Table 20 shows the average OOP expenses for inpatient treatment over 12 months for PLHIV who SHI and PLHIV who do not use SHI. Inpatient OOP expenses for a PLHIV are on average VND 5.4 million per capita per year. Study results also show that the average OOP expenses incurred by the non-SHI group for inpatient treatment were 1.5 higher than for those using a SHI card. The reason for the difference is that those using SHI cards have much lower direct expenses than those who are not using SHI cards. Other costs were similar when comparing the two groups.

Survey results show that that average annual per capita income of PLHIV is VND 20 million and average spending for non-food items per capita per year is VND 8.6 million. Hospitalization expenses when not using a SHI card were VND 6.8 million, accounting for 28.3% of total income. The expenses for inpatient treatment was only VND 4 million for those using a SHI card, accounting for 24.6% of their total income.

Table 20 shows the expense structure related to inpatient treatment services. Analysis indicates that direct expenses for care and treatment at medical facilities was the largest proportion of total OOP expenses for inpatient treatment services (48.6%), followed by costs for medicine and additional testing outside the OPC (19.2%). In addition to the expenses for healthcare services,

the indirect costs (including travel and accommodation) are significant financial barriers for PLHIV when accessing inpatient treatment services. The indirect annual OOP spending of PLHIV for inpatient treatment was VND 1.7 million, which represents 32% of their total income. The above figures show that although PLHIV can benefit from the use of SHI, hospitalization is still a significant financial burden for them, mainly due to indirect costs like travel and accommodations.

***Table 20:*** Average PLHIV OOP spending for inpatient treatment categorized by SHI cardholders and non-SHI cardholders

*Currency unit: Thousand VND*

| | Using SHI (n=35) | Not using SHI (n=32) | Total (n=67) |
|---|---|---|---|
| Average expenses for health care | 1,624 (± 3,081) | 3,733 (± 4,563) | 2,631 (± 3,975) |
| | 39.0% | 55.0% | 48.6% |
| Medicine, testing, misc. items | 1,040 (± 2,216) | 1,044 (± 1,822) | 1,042 (± 2,022) |
| | 25.0% | 15.4% | 19.2% |
| Travel, vehicle maintenance | 454 (± 960) | 490 (± 605) | 471 (± 804) |
| | 10.9% | 7.2% | 8.7% |
| Accommodations (patient and caregiver) | 869 (± 1,067) | 1,415 (± 1,613) | 1,130 (± 1,373) |
| | 20.9% | 20.8% | 20.9% |
| Tips/gifts for medical workers | 160 (± 667) | 97 (± 322) | 130 (± 528) |
| | 3.8% | 1.4% | 2.4% |
| Other (buying domestic utensils, buckets, water) | 15 (± 55) | 13 (± 42) | 14 (± 49) |
| | 0.4% | 0.2% | 0.3% |
| **Total expenses** | 4,161 (± 5,247) | 6,792 (± 5,641) | 5,418 (± 5,557) |

The results of an analysis by province show that OOP expenses incurred by a PLHIV for inpatient treatment in Dong Thap were VND 4.4 million on average, whereas the expenses of PLHIV in Ninh Binh were VND 6.1 million, 1.5 times higher than for those in Dong Thap. The major difference is the indirect expenses, including the cost of travel and accommodations for the patient and caregivers.

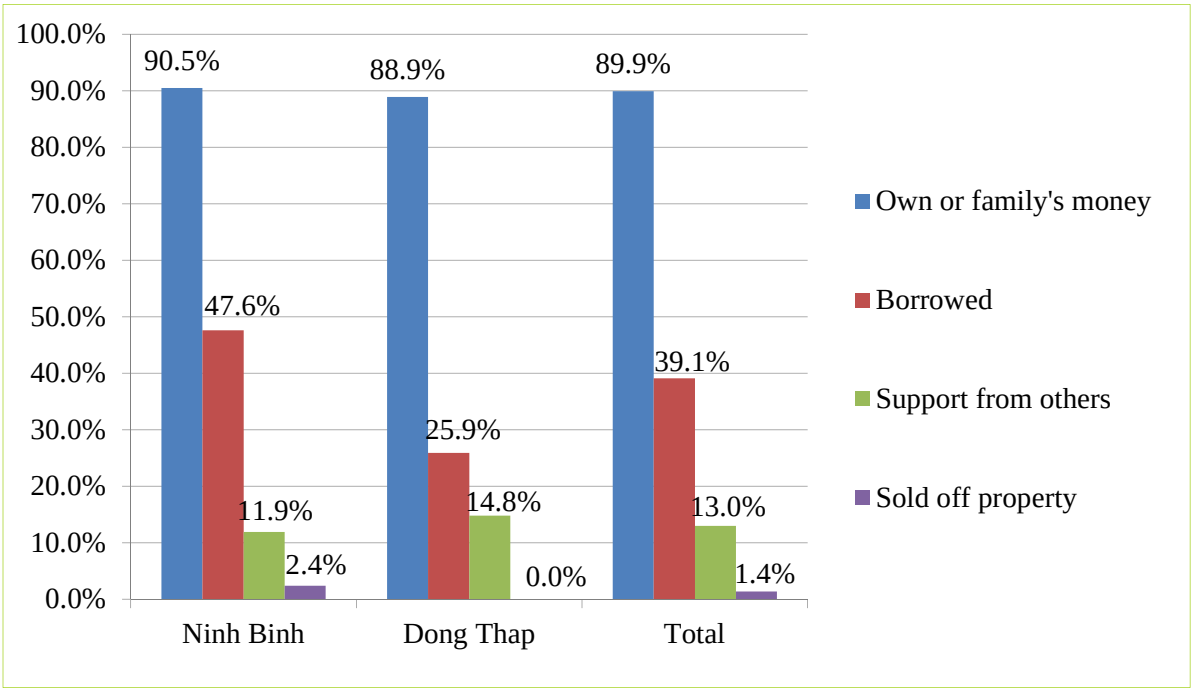
***Table 21:*** PLHIV OOP spending for inpatient treatment by province

*Currency unit: Thousand VND*

| | Ninh Binh | | | Dong Thap | | |
|---|---|---|---|---|---|---|
| | Using SHI (n=25) | Not using SHI (n=15) | Total (n=40) | Using SHI (n=10) | Not using SHI (n=17) | Total (n=27) |
| Average expenses for health care | 1,731 (± 3,303) | 4,588 (± 3,582) | 2,803 (± 3,644) | 1,355 (± 1,354) | 2,978 (± 5,275) | 2,377 (± 4,479) |
| Medicine, testing, misc. items | 1,080 (± 2,501) | 1,105 (± 2,329) | 1,089 (± 2,408) | 940 (± 1,363) | 991 (± 1,297) | 972 (± 1,296) |
| Travel, vehicle maintenance | 510 (± 1,118) | 424 (± 502) | 478 (± 928) | 316 (± 343) | 547 (± 694) | 461 (± 592) |
| Accommodations (patient and caregiver) | 1,028 (± 1,216) | 2,232 (± 2,046) | 1,480 (± 1,662) | 470 (± 342) | 695 (± 447) | 612 (± 419) |
| Tips/gifts for medical workers | 224 (± 784) | 207 (± 453) | 218 (± 672) | 0 | 0 | 0 |
| Other (buying domestic utensils, buckets, water) | 21 (± 64) | 13 (± 35) | 18 (± 55) | 0 | 12 (± 48) | 7 (± 38) |
| **Total expenses** | 4,594 (± 6,030) | 8,569 (± 5,583) | 6,085 (± 6,113) | 3,080 (± 2,283) | 5,223 (± 5,367) | 4,429 (± 4,543) |

Results of the analysis on sources of cash for OOP expenses of PLHIV receiving inpatient treatment show that about 40% of PLHIV had to borrow money or sell property in order to pay for their inpatient treatment. The proportion was nearly 50% in Ninh Binh and approximately 26% in Dong Thap.

***Chart 9:*** OOP funding sources for PLHIV inpatient healthcare



**Expenditures for over-the-counter medicines**

During the 12 months preceding the survey, the mean expense for a PLHIV buying self-treatment medicines, with no examination or treatment at a medical center, was VND 425,000. To self-medicate, a PLHIV in Ninh Binh had pay three times more for over-the-counter medicine than a PLHIV in Dong Thap (VND 610,000 and 199,000, respectively). Analyzing the mean expense of over-the-counter medicine by gender, it's seen that women spend more on self-treatment than men (VND 465,000 and 358,000, respectively).

***Table 22:*** PLHIV spending on over-the-counter medicine

*Currency unit: thousand VND*

| | Ninh Binh | | Dong Thap | | Total | |
|---|---|---|---|---|---|---|
| | **Mean** | **SD** | **Mean** | **SD** | **Mean** | **SD** |
| **Gender** | | | | | | |
| Male | 503 | ± 1,024 | 194 | ± 188 | 385 | ± 813 |
| Female | 746 | ± 2,718 | 202 | ± 208 | 465 | ± 1,909 |
| **Poverty level** | | | | | | |
| Poor/near poor | 519 | ± 1,340 | 208 | ± 195 | 410 | ± 1,083 |
| Non-poor | 737 | ± 2,628 | 193 | ± 202 | 440 | ± 1,779 |
| **Total** | **610** | ± 1,978 | **199** | ± **199** | **425** | ± 1,474 |

## 2.5. Attitudes and opinions of leaders and HIV/AIDS related service providers towards SHI for PLHIV

In this section, we analyze the viewpoints of leaders and HIV service providers regarding the inclusion of PLHIV into the national SHI program managed by VSS.

**Viewpoints of leaders and HIV service providers at the central level**

The research group investigated the opinions and viewpoints of representatives from the VAAC, the HID and the Department of Medical Examination and Treatment Management/MOH. This was done through a series of technical consulting group discussions on the topic of establishing and implementing SHI as part of the financing model for the care and treatment of PLHIV.

Overall, the opinions expressed in the group discussions were in agreement that it is necessary and feasible to set up and implement SHI for care and treatment of PLHIV. It is generally felt that any PLHIV SHI card holder who requests examination and treatment (including HIV treatment) should have coverage from the SHI scheme at any medical facility which is competent to provide those services.

In the opinions of representatives from the Department of Medical Examination and Treatment Management and HID, OPCs in the preventive system are currently eligible to participate as providers in the SHI scheme if they are qualified. These OPCs can therefore sign on with VSS be a SHI examination and treatment establishment.

Respondents agree that PLHIV should initially register their SHI cards at a medical facility which is competent to provide HIV service, and a medical facility at the district level is recommended. However, PLHIV should be able to register at a commune healthcare station if they prefer. The use of SHI cards for examination and treatment, and the reimbursement of providers should follow the same procedure as for any other medical service, as defined in existing regulations.

A representative from HID expressed the need for a roadmap that would lead to a comprehensive Health Insurance payment model for PLHIV in the future. Until 2015, ARVs will be financed by the State and programs which are in part financed by international donors. For this reason SHI should only cover other related services. PLHIV are to have access to comprehensive SHI coverage once the policy/mechanism is in place.

Central level representatives indicated that the MOH has already been planning and building a road-map to effectively implement SHI for PLHIV. In Hai Phong and Thai Binh, the HID is implementing a pilot model that will include expense calculation and management of PLHIV when using SHI. Furthermore, the MOH has established a Design Board that is to provide "Instruction for Health Insurance examination and treatment payment for PLHIV and people using HIV/AIDS related medical services."

**Viewpoints of leaders and HIV service providers at the provincial level in Ninh Binh and Dong Thap**

In this section, we look at the viewpoints of leaders and HIV service providers in Ninh Binh and Dong Thap. The topics covered (1) The perceived need and practical feasibility of a SHI model for PLHIV, (2) A proposed SHI model and support mechanism for PLHIV, (3) Opinions on a comprehensive SHI payment model that will include ARV, and partial payment, (4) Essential conditions and requests for the support that will be necessary to implement the SHI model for PLHIV, (5) The roles of ministries and offices in establishing and implementing the SHI model for PLHIV.

### 2.6. The need for, and feasibility of, an SHI model for PLHIV

**Perceived need**

It is the viewpoint of government leaders on HIV/AIDS prevention & control and service providers in the two surveyed provinces that the extension of SHI to PLHIV is essential because it would reduce the burden for HIV prevention and treatment expense for PLHIV. This is important because most PLHIV are poor and have irregular incomes. Moreover, SHI will improve access to comprehensive prevention and care services.

> *"As I see it, PLHIV are usually poor, and the rich are rarely infected with HIV. It would be best if PLHIV had SHI, it is the best solution, because SHI helps cover other services. When a PLHIV has scabies, he/she can not receive*

*dermatological treatment if he/she is without money. The same is true for liver diseases. If PLHIV have SHI coverage, they can get treatment for all kinds of diseases and use different services. SHI is the best solution and SHI services will help PLHIV throughout their examination and treatment process."*

(IDI with PAC, Dong Thap)

*"When the existing sources of funding end in the future, the provision of medical services via the SHI system is the best option for PLHIV. SHI supports PLHIV and full SHI coverage of HIV-related services, including prevention, care & treatment, is very necessary. Also, there is now the expectation that PLHIV will live longer before the onslaught of full-blown AIDS and death. SHI will help limit the risk of HIV transmission."*

(IDI with the Medical Technique Division, Dong Thap Health Department)

In addition, SHI will help PLHIV access different medical services that can identify and provide early treatment of related diseases. This will reduce the cost burden for the patients in particular and the healthcare sector in general.

*"I personally see it as highly necessary. If the SHI scheme is made available to PLHIV, it will help do away with the situation where PLHIV do not seek treatment prior to it becoming full-blown AIDS. PLHIV will go in for a medical examination early and that will help identify other diseases. If they go to a hospital, they will then be referred to our OPC and gain access to medical services sooner. If PLHIV who do not have SHI or money are referred to a hospital, they just go home. Thus the SHI scheme will help in both the prevention and treatment processes. SHI coverage will help greatly if it is implemented."*

(IDI with OPC, Kim Sơn, Ninh Binh)

**Feasibility**

When asked about the feasibility of including PLHIV in the SHI program, leaders of the provincial Health Departments of both provinces agreed that the implementation of SHI for PLHIV is feasible and not difficult because HIV is a disease like other diseases. They also said that PLHIV will take part in the SHI scheme if it is implemented.

*"I think SHI for PLHIV is feasible because, as a matter of fact, HIV is a disease like other usual diseases. If it is included in the list of diseases to be treated, SHI payments for HIV will be based on the conventional procedures and laws on HI. That will not be difficult."*

(IDI with the Medical Technique Division, Ninh Binh Health Department)

*"Currently, care for PLHIV is funded by projects for HIV treatment medicine, testing and OI treatment, and they are not concerned about taking part in an SHI scheme. When such funding is no longer available, or support for them is based on the SHI scheme, PLHIV will want to buy SHI cards and pay the premiums. At present, HIV treatment is provided separately, thus PLHIV are still not aware of benefits of the SHI scheme. If HIV treatment provision is taken on by hospitals, and PLHIV can be treated not only for the usual diseases but also for HIV, they will accept taking part in SHI scheme"*

(IDI with Medical Technique Division, Dong Thap Health Department)

While many thought that implementation of the model is feasible and there are no problems with the model, staff member at OPC expressed concerns about the feasibility of implementing the model. They fear that the SHI Fund will be inadequate because treatment costs for PLHIV are quite high.

> *"…I am afraid that while SHI would certainly good for PLHIV, I doubt if the SHI Fund would be capable of covering SHI payments for PLHIV. But, it will be no problem for service providers. PLHIV with SHI will be our clients and we will be dedicated to providing services for them. The more patients we have, the better our service will be."*
>
> (IDI with Ninh Binh, VCT)

While there were concerns about the financial capacity of the SHI Fund, some respondents were optimistic. They argued that because the SHI Fund is now capable of paying for the expensive treatments required to treat chronic diseases such as diabetes and renal failure, it will be capable of covering the cost of HIV/AIDS care and treatment.

> *"We consider PLHIV to be similar to those infected with chronic diseases like hypertension and diabetes that require long-term treatment. Medicines for such diseases are not very expensive. In the future, when ARVs are produced domestically, ARV treatment will cost less, perhaps several hundred thousand dong per month. OI medicine does not cost much, either. If someone says that SHI claims for PLHIV would force the SHI Fund to go bankrupt, then HIV-related treatment costs should be compared to that for patients with diabetes or who are on dialysis. Treatment for such patients is also expensive because those diseases are chronic, lasting 7, 8, 10, 15 years."*
>
> (IDI with Ninh Binh, PAC)

> *"I estimate that diabetes treatment costs about VND 1 million per month or VND12 million per year. As for hemodialysis done at Military Hospital No. 5, the cost is around VND20 million a quarter, or nearly VND7 million a month."*
>
> (IDI with Ninh Binh, Social Insurance)

Based on the viewpoint of VSS, there will be no problem regarding SHI payments because the SHI scheme is based on the idea of maximizing the participation of subscribers whose premiums will cover costs incurred by the smaller number of actual beneficiaries. Universal health insurance will cover the payments for SHI incurred by PLHIV.

> *"I think this is not difficult. As a matter of fact, there should be no concern about SHI coverage for PLHIV and SHI coverage should be made universal. If SHI premiums paid by PLHIV are not sufficient to cover their life-long treatment, the universal health insurance plan will help. We are striving for universal SHI that will cover PLHIV."*
>
> (IDI with Ninh Binh, Social Insurance)

In addition to the concerns about the payment capacity of the SHI Fund, there was the concern about human resources and the ability of healthcare workers to meet the needs for care and treatment of PLHIV:

*"It is necessary, but not feasible. ARV treatment lasts throughout the life of a PLHIV. That's why doctors that treat and care for PLHIV need training and certification. Also, it will be a big challenge to deploy a full system of treatment. It will be challenging to implement SHI for PLHIV at the hospital level. If it is implemented to provide ARV like other common treatments for usual diseases at every establishment, it will be very difficult for SHI."*

(IDI with OPC, Ninh Binh PAC)

So, most leaders and service providers agreed that SHI coverage for PLHIV is very necessary and is quite feasible. However, some respondents expressing concerns related to the financial capacity of the SHI Fund, as well as human resource issues like the ability of healthcare staff to meet the demand for PLHIV care and treatment which will necessarily increase with the effective inclusion of PLHIV into the SHI scheme.

### 2.7. Viewpoints on a SHI pilot model and support for PLHIV

**Social Health Insurance pilot model**

In order to have a fuller picture of the proposed initiative to include PLHIV into SHI and implement a pilot model, the study team consulted the leaders and HIV service providers in the two provinces on fundamental issues such as choice of primary health facility, pattern of coverage, providers of SHI coverage for PLHIV, and types of SHI subscriptions.

Leaders and service providers in the two provinces had different viewpoints on the selection of the primary health facility for PLHIV when they take part in the SHI scheme. Some respondents felt that the commune-level health care facility should be selected as the primary health facility while others felt that the OPC or district hospital should be the primary health facility.

In Ninh Binh, service providers (OPC and VCT) proposed that OPCs should be considered primary healthcare facilities because they currently provide care, monitoring and ARV treatment for PLHIV. Respondents were concerned that if ARV treatment is transferred to the commune level, it will cause difficulties in treatment monitoring and ARV provision for patients.

*"We expect that access to SHI will be provided for PLHIV. However, where to place the primary health care facility is a hard-to-resolve problem. Will people be given SHI cards when they are first identified as HIV+ or will another method be implemented? The primary health facility must be PAC. It is responsible for examination, monitoring and treatment. If it is a communal medical establishment, it will be difficult for these medical establishments to perform their tasks because of the lengthy illness of patients and the lengthy side effects of ARV medicine, which regularly happens, and it is beyond the capacity of doctors at the commune level to monitor and resolve problems properly."*

(IDI with OPC at provincial PAC)

*"I do not know what happens in other provinces but in Ninh Binh almost every HIV patient wants to register to make the PAC their primary healthcare facility. If PACs are able to provide examination, subclinical diagnosis and treatment, HIV*

*patients should register their SHI cards with PAC. That is best and it's most convenient. First, they do not have to explain their status; second, the status of their health has been monitored over several years and the development of their disease has been well tracked. PACs are aware of their disease. Third, the services here are very good. If the PAC in our province of Ninh Binh is equipped with an X-ray machine, I think it will possible for the PAC to be a primary health facility to service HIV/AIDS patients."*

(IDI with Ninh Binh, VCT)

In contrast, PAC managers and members of the Medical Technique Division in Ninh Binh held the view that PLHIV should continue registering the commune level healthcare station as their primary health facility. Patients requiring ARV treatment should be referred to OPCs which should be able to receive SHI reimbursements. If OPCs were the primary healthcare facility, it would mean reduced access because of the increased travel time.

*"In my opinion, the SHI policy that is adopted should provide the most convenience for participants in SHI scheme, including the location of primary healthcare facility. For example, if a person resides 50 kms away from their primary healthcare facility, for each examination he'd have to go to the establishment of Mr. Phuong (the OPC in the local PAC) in Ninh Binh, so far away. That is irrational. We should encourage PLHIVs to choose as their primary healthcare facilities a facility at lower, local level. Suppose that the Health Department assigns Mr. Phuong's establishment to take on the duty of treatment. Will it be possible that upon referral, Mr. Phuong's establishment will admit any patient from a lower level or any patient with some other disease? Mr Phuong's establishment is regarded as a provincial HIV treatment establishment. I want the primary healthcare facility to be placed at the commune level, this is our primary concern."*

(IDI with Medical Technique Department,
Ninh Binh, Provincial Health Department)

*"In our opinion, patients with a local primary healthcare facility in different places and districts do get served at PACs. For the sake of patient convenience, I think we should not let PACs become primary care providers. Rather, patients should register at their local medical establishments. Those establishments will refer patients to PACs so that SHI coverage is applied for them. That way is more convenient for patients who are 50-60km from here, some coming here to have primary healthcare. Therefore, I think that if OPC departments organize to provide examination and treatment to patients within the SHI scheme, OPC should not be the primary healthcare facility."*

(IDI with Ninh Binh, PAC)

In Dong Thap, leaders held differing viewpoints regarding primary healthcare facility. Representatives of the Medical Technique Divisions of local Health Departments said that a primary healthcare facility for PLHIV should be the district level hospitals because that would make OI disease treatment more convenient for PLHIV. However, representatives from the provincial SHI Fund and PAC held the view that primary healthcare facilities for PLHIV should be at the commune level.

*"The best primary healthcare facility for PLHIV is the district hospital. First, the district hospital is near patients' place of residence and is convenient for patients who want an examination and treatment of OI diseases. For HIV treatment, the provincial department of health may allow district hospitals to apply ARV medicine for PLHIV. This ARV medicine is not in the list of medicines distributed at the commune level. OPCs and AIDS prevention & control centers are far from the residing place of patients and its difficulties for them to go there for an examination and to receive medicine. In Dong Thap, there are only two places where they can get an examination and treatment, Dong Thap Hospital and Hong Ngu General Hospital. It is very difficult to go to these two establishments. In addition, OPCs or PACs are not eligible to sign SHI agreements because they do not provide adequate tests and thus they are not eligible to treat OI diseases. Therefore, it is the best to let district hospitals become the primary healthcare facility."*

(IDI with Medical Technique Department,
Dong Thap. Provincial Health Department)

*"In my opinion, the primary healthcare facility should be at the commune level because every commune has been trained for this. Medical staff members at the commune level have been trained in AIDS prevention. I found that the training is comprehensive and at present all medical stations in Dong Thap have SHI and the rate of patient visits to these medical establishments is rather high. Registering the primary healthcare facility at the district level is best, but it would be difficult for patients to get there. For example, if one is registered for treatment at the district level, one would have to travel far to receive little medicine. The travel cost would be higher than the cost of the medicine, which is covered by SHI."*

(IDI with Dong Thap, Social Insurance)

Regarding the SHI subscriptions for PLHIV, according to service providers, access to SHI for PLHIV should be the same as it is for civil servants. Civil servants subscribe once a year and OPCs could make a list of participants to be sent to the local Social Insurance fund and then OPCs could receive SHI cards that it could distribute to PLHIV:

*"SHI provision should be the same as for civil servants on the basis of one-time payment per year. If OPC management of patients was on yearly basis, a list of SHI participants could be renewed yearly to be sent to Social Insurance and SHI to get SHI cards. Patients' SHI cards must be replaced/renewed yearly."*

(IDI with OPC, Ninh Binh PAC)

There was a suggestion that SHI subscriptions could be sold to PLHIV through a system of health insurance agents. These agents would need to be trained and certified in order to do this:

*"We (PSS) could sign a contract with two or three agents, people recommended by the communes. He/she should be trained and certified in order to be contracted by us. He/she would collect money and send us, and they would receive a commission to cover their expenses".*

(IDI with Dong Thap, Social Insurance)

Service providers expressed the view that health insurance reimbursements for eligible services provided to PLHIV should follow the same mechanism used for other subscriber groups:

*Q: In your opinion, how should health insurance reimbursement be paid?*
*A: SHI reimbursement should be done like its currently being done..*

(IDI with OPC, Ninh Binh PAC)

**Subsidizing SHI**

Respondents mentioned that support should be provided to PLHIV for SHI premiums in the same way as for the poor/near poor. Most PLHIV qualify to be included in this group and have financial constraints:

*" As far as I know, at present, PLHIV are not subsidized so they can still get SHI cards,, but they should be supported as a poor group or a near poor group, or HIV should be categorized as a chronic disease."*

(IDI with Dong Thap, PAC)

When implementing communication activities, VSS/VAAC should advocate that the entire locality should participate in the SHI and no differentiation should be made between PLHIV and non-PLHIV:

*"Communications should mobilize all people to participate, people with diseases and without diseases. This applies the principle that premiums paid by the large number of (healthy) subscribers can cover costs incurred by the small number of sick beneficiaries. We cannot sort out which SHI subscribers are infected with HIV and which are not."*

(IDI with Dong Thap, Health Insurance)

**Opinions on a model of comprehensive SHI coverage (including ARV) and partial coverage**

According to opinions voiced by leaders and service providers in both provinces, all hope for a comprehensive SHI package as long as the necessary conditions exist. However, if conditions are not favorable, and the model of partial coverage has to be applied, the leaders in Ninh Binh suggested that a roadmap be developed to gradually include ARV reimbursement. Service providers were firm about prioritizing ARV medicine in SHI coverage:

*"This is a macro-level issue and thus it should be considered by the MoH and VSS. If we cover ARV in SHI benefits, this should be implemented step by step. In the immediate future, we should include only medicine for OI diseases, basic tests and patient beds in SHI coverage. Because we are still in the pilot stage, it will be a chaos if the fund goes into default at this stage. Therefore, I say we should implement it step by step."*

(IDI with Ninh Binh, PAC)

*"ARV is the most important expense that must ultimately be paid by the SHI fund. Other service coverage will help only partially."*

(IDI with provincial VCT)

Other viewpoints were also expressed. For example, that comprehensive SHI coverage should be applied for ARV and tests but that the GVN or provinces should reimburse VSS for the payments made by SHI for ARV medicine:

> *"…the SHI fund will cover full treatment costs and that way everybody will see that it is reasonable to extend SHI to PLHIV. However, SHI will not easily accept this. I propose two solutions: First, ARV treatment costs should be financed by the state or refunded to SHI. Second, the local SHI Fund or medical facilities should request that the provincial authority finance ARV treatment. The SHI fund would not be financing ARV treatment but would pay for other types of treatment. Medical facilities would request use of the Provincial People's Committee (PPC) fund for ARV treatment, upfront, or the healthcare facilities might bear the ARV costs and then request reimbursement from the PPC. That is the only way. This would mean that PLHIV would be participating in an SHI scheme where they would be paying for their subscription, but ARV treatment would be funded by the PPC or social organizations, either via the SHI Fund or by national budget financing. This is the only solution.*
>
> (IDI with Medical Technique Department, Dong Thap, Provincial Health Department)

> *"If it is possible, the SHI Fund should pay all the costs. If it is not able to cover all costs, ARV can be separated out from the expenses to be covered by the SHI Fund. ARV can be funded by the state or some other source of funding might be found. Regular tests can be covered by SHI. That is not a problem. But it would be convenient if there was a single source of funding, such as the SHI Fund, to cover all types of costs incurred by PLHIV inclusion."*
>
> (IDI with Medical Technique Department, Ninh Binh, Provincial Health Department)

**Views on Preconditions and needs for support to implement a SHI pilot model for PLHIV**

Respondents thought that one of the most important points for implementing this type of model is to have a consensus between authorities that would include the MoH, VSS and the VAAC. Modifications need to be made to some of the stipulations in existing laws and regulations. According to the views of a representative of the Ninh Binh Health Department, this SHI model can be implemented but it is important to have the permission and cooperation of the competent authorities and the legal documents that would guide the implementation:

> *"I think, regarding this issue, the most important point is that there should be guiding documents and permission from the competent authorities as to how to implement the SHI scheme for PLHIV. That's a fundamental issue…the matter of SHI-covered healthcare expenses being just a governance issue.*
>
> (IDI with Medical Technique Division, Ninh Binh Health Department)

Views were also expressed regarding safeguards against stigma and discrimination from healthcare workers in the regulations on SHI payments. More importantly, the settlement mechanism should be improved with simplified procedures of insurance coverage to attract the participation of PLHIV.

*"As a matter of fact, every PLHIV wants to buy a SHI premium and have SHI. But they are concerned about their SHI benefits. First, when a PLHIV can afford to have SHI, the person experiences stigma/discrimination when he/she goes to use it. That's why medical staff involved in SHI implementation for PLHIV should extend fair treatment to PLHIV with SHI to make them feel safe. This is a precondition. If PLHIV believe that it will not harm them, they will be willing to take part in the SHI scheme. SHI is obviously needed by PLHIV."*

(IDI with PAC, Dong Thap)

*"The insurance system should be clear and have simplified administrative procedures for people. It is unacceptable to cite unfounded reasons to apply regulatory documents at the health providers' discretion. It is unreasonable to refuse SHI coverage to PLHIV and not take into account the causes of their HIV infection. It is not a crime to be infected with HIV from drug injection, sex relations or being a sex worker. HIV is a disease. Because it is a disease, discrimination is not allowed anywhere, including in SHI coverage."*

(IDI with PAC, Dong Thap)

According to the head of HIV/AIDS Prevention and Control, for this SHI model to be implemented, an agreement among SHI, local agencies and associations needs to be reached, especially regarding the inclusion of PLHIV:

*"There must be an agreement among three parties, not just two parties. First is the consent of the SHI fund. Second is the consent of local associations. For example, the youth union and the women's union need to understand this issue. Third, in order to implementation this, the PLHIV have to want to do it. If PLHIV are made to feel inferior, they will not want to participate at all."*

(IDI with Dong Thap, PAC)

As this is about designing a new program and model, in order to attract the participation of the client group, implementation should include campaigns via the media, especially propaganda for PLHIV and their family members, to help them understand the benefit of SHI so that they will voluntarily participate in SHI. Other respondents suggest that this kind of SHI marketing should be included in counseling during OPC treatment:

*"At first, we have to propagandize PLHIV family members so that they understand the benefits of SHI to PLHIV and their family members so that they find will feel positive about SHI. If they participate in SHI, they will receive more benefits and have better conditions for treatment considering the fact that they do not have the money to buy medicine for treatment and they will not get medicine for treatment if they do not participate in SHI. And, if they participate in SHI, they have an opportunity to be treated for all their life. Once they understanding this, they will participate."*

(IDI with Ninh Bình, Social Insurance)

*"Regarding PACs, when they implement this program, they should tell PLHIV about the SHI scheme from the beginning. I think it would be the best for the patients to hear about the SHI scheme when they're getting treated at OPCs.*

*When they a medical person talks to them about treatment, they will also tell them about the SHI scheme."*

(IDI with Dong Thap, PAC)

The two OPCs in Ninh Binh are currently a part of the 'prevention' system and they have therefore not signed a contract with VSS which would allow reimbursement for health service costs by the SHI scheme. In order to implement a pilot SHI scheme for PLHIV, leaders and service providers said that exisiting OPCs will have to recruit more staff members and upgrade their equipment before they qualify for a contract with VSS:

*"If these patients can be reimbursed by SHI because our center is allowed to apply SHI payment, that would be very convenient for the patients. However, before it can do so, the centers must have medical instructions from doctors and the rooms must meet the requirements for performing basic medical tests."*

(IDI with Ninh Binh, PAC)

*"To implement a SHI scheme in clinics, additional staff must be recruited and rooms and medical equipment must be upgraded.."*

(IDI with OPC at Ninh Binh, PAC)

In Dong Thap, OPCs are placed within the 'treatment' system. One is located at the provincial general hospital, another is located at the General Hospital of Hong Ngu District and the third is at the General Hospital in Sa Dec District. These OPCs are considered to be hospital departments and they are entitled to SHI reimbursement since the hospitals have signed agreements with VSS. In the OPC, if PLHIV have SHI cards, their tests are covered as regulated by SHI. The placing of the OPCs in the treatment system of the provincial health section in Dong Thap makes current and future SHI reimbursements to the health facilities possible. Despite this positive aspect, service providers are of the opinion that it is necessary to improve the equipment in the existing facilities, recruit more staff members and strengthen the financial capacity of the OPCs:

*"Rooms should be upgraded. Although they are currently spacious, they should be put in good repaired because the number of patients to be served will increase. The next issue is personnel. We must have more staff members. Third, we need to be better financed."*

(IDI with Tam Nong, VCT)

**The role of government authorities and different sectors in the development and implementation of a SHI pilot for PLHIV**

To implement a pilot SHI scheme for PLHIV, all stakeholders have to reach a consensus, and this must include the Provincial Department of Health, PSS and PAC. The Provincial Department of Health plays a very important role since approval is required before a medical establishment is designated as eligible for SHI reimbursement. After the provincial Department of Health approves a medical establishment, VSS can sign a contract with that healthcare facility. The Department of Health also regulates referrals to higher levels of care and can modify regulations so that they comply with SHI requirements.

*"Specifically, the provincial Health Department conducts a survey and gives its approval such that SHI medical services are then eligible for reimbursement. At*

*that point the two parties (the healthcare facility and the SHI Fund) can sign a contract for SHI-based medical services."*

(IDI with Ninh Binh, Social Insurance)

*"By regulation, the approval for medical examination and treatment, with referral of patients within that area of the province, is something which is issued by the provincial Department of Health."*

(IDI with Ninh Binh, Social Insurance)

If a SHI pilot were implemented in Ninh Binh, the PAC would play the role of organizer and coordinator.

*"PAC plays the role of both organizer and coordinator in charge of consulting with the leaders of the provincial Department of Health. We will coordinate with general hospitals and medical centers to operate medical establishments that provide SHI-based healthcare services."*

(IDI with Ninh Binh, PAC)

# CONCLUSIONS

The findings of the assessments in Ninh Binh and Dong Thap have provided pertinent information which shows the diverse situation that exist in the provision of care and treatment of HIV/AIDS patients in those two provinces. We now have a better picture of migration and duplication issues and can better understand how current PLHIV SHI card holders participate in the SHI scheme. Finally, the qualitative research and interviews with service providers has provided insight into their perspectives on effectively including HIV/AIDS care and treatment in the existing national health insurance scheme.

There are both similarities and differences in the healthcare models for PLHIV in the two provinces. In both provinces PLHIV enrolled at OPCs receive ARV medicine and CD4 tests free of charge. Neither province has a dedicated policy on SHI support for PLHIV, or ARV treatment. When a PLHIV is a SHI card holder, they receive coverage from the SHI scheme as would anyone in the general population who uses services which are not HIV/AIDS specific. This is where the similarities end.

The most important distinction between the two provinces in relation to developing effective coverage of SHI for PLHIV is that OPCs in Ninh Binh are all categorized under the 'preventive' system, while OPCs in Dong Thap are categorized under the 'treatment' system. This situation prevents the OPCs in Ninh Binh from signing with PSS to be eligible for SHI reimbursement for cardholding clients. In effect, SHI cardholding PLHIV who get the usual tests and OI treatment at an OPC in Ninh Binh are not covered by SHI. PLHIV SHI cardholders in Dong Thap are eligible to receive benefits from the SHI Fund as does any other SHI cardholding member of the general population.

This research also looked into the migration of PLHIV and possible duplication for HIV/AIDS treatment enrollment since these could be complicating factors in an eventual roll out of SHI for PLHIV. The study found that there is much less mobility than expected among PLHIV, at least among the study population in these two provinces. When PLHIV do change their place of residence they often cite stigma as the key reason leading to their relocation. No duplication of enrollments in HIV treatment facilities was found, although about 20% of PLHIV had changed their enrolled HIV treatment facility since their diagnosis.

With regards to the use of SHI by PLHIV, the study found that the proportion of PLHIV with SHI was similar to the average national coverage rate. The majority of the survey respondents, who did hold SHI cards, fell into the categories of poor, near poor and voluntary insurance. Card holding PLHIV do use their SHI coverage benefits when they seek outpatient treatment at healthcare facilities other than OPC or when they use inpatient healthcare. In general, PLHIV, including the poor, want to participate in the SHI scheme and demonstrated some willingness to pay for the service. They would, however, prefer to register as their primary healthcare provider a district or provincial level hospital.

Total healthcare costs of PLHIV represent a large portion of their income with the bulk of direct costs of medical services coming largely from inpatient treatment received. Indirect costs (including the cost of travel, food and accommodations) account for a large portion of the total medical costs incurred by PLHIV. With regards to outpatient healthcare at medical facilities (non-OPC), OOP payments incurred by PLHIV without SHI are triple those incurred by PLHIV with SHI. This difference in OOP is also true for inpatient treatment, but to a lesser extent.

The success of integrating care and treatment for HIV/AIDS effectively into the existing SHI scheme is also predicated on the support of the service providers. The qualitative research component of this study shows that, on the whole, relevant authorities and service providers are very supportive of this idea. Most respondents expressed the view that health insurance coverage for PLHIV is essential and feasible. However, there are concerns about financial feasibility and the payment capacity of the SHI Fund. Concern was also expressed regarding human resource capacity and the availability of necessary equipment and quality facilities.

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