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VIEWPOINT

Universal health insurance program for people living with HIV in Vietnam: an ambitious approach

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Abstract

International funding for HIV treatment and prevention drastically decreased when Vietnam transitioned from a low-income to a lower-middle-income country in 2010. Vietnam has attempted to fill the funding gap from both public and private sources to cover antiretroviral therapy (ART) treatment. However, policies that enable social health insurance to pay for ART treatment-related costs often exclude people living with HIV (PLHIV) without appropriate government documents from accessing the health insurance-funded ART program. The Vietnamese Ministry of Health might consider alternative approaches, such as implementing a universal health insurance program among PLHIV regardless of residency or documentation status, to expand coverage of ART treatment to achieve the UNAIDS 95–95–95 targets by 2030. This expanded universal care will increase the uptake of ART treatment among uninsured PLHIV as well as increase coverage of health insurance-funded ART among insured PLHIV. Most importantly, the proposed insurance scheme could significantly improve population health by reducing HIV new infections and providing economic benefits of ART treatment through increased productivity and decreased healthcare costs.

Keywords Universal health insurance · Sliding-scale treatment · Uninsured · People living with HIV · ART treatment · Vietnam

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Key messages

- Existing health insurance policies are reducing treatment access for people living with HIV by placing a considerable financial burden on insured and precluding uninsured from eligibility for ART programs.
- Vietnam's Ministry of Health might implement a universal health insurance program among vulnerable populations to increase the uptake of ART treatment to reduce premature mortality and infections.
- The proposed universal insurance program has the potential to improve population health by decreasing new HIV infections and generating economic benefits of ART treatment through productivity gains and lower healthcare costs.

Introduction

International funding for HIV/AIDS prevention and treatment programs in low- and middle-income countries (LMICs) has failed to keep pace with the pandemic. The number of people living with HIV (PLHIV) in LMICs grew by 25% between 2009 and 2019, but international funding remained unchanged compared to a decade ago [1]. The funding from the United States (U.S.), the largest contributor to the global HIV response, dropped by 8% over the two years 2018–2019 [2] while the United Kingdom (U.K.) reduced its UNAIDS annual funding by 80%,s from $19.3 million in 2020 to $3.2 million in 2021 [3].

Future funding from donor governments for HIV/AIDS programming remains uncertain due to the economic impacts of COVID-19 [1]. Donor nation contributions are especially consequential for Vietnam where international donors supported 90% of total AIDS funding in 2006. This support increased antiretroviral therapy (ART) treatment coverage from 4.6% in 2006 to 62.5% in 2018 [4]. Based on national data in 2012, it is estimated that 94.1% of Vietnamese PLHIV who had access to free ART would have been unable to continue receiving it without international funding [5–7]. International funding for HIV declined drastically declined from 73.4% in 2010 to 53.0% in 2020 [8] as Vietnam transitioned from a low-income to a lower-middle-income country. In 2015, domestic resources supported 30% of Vietnam's HIV response, increasing by approximately 3.5% per year until it reached 49% in 2022 [8, 9].

Although Vietnam has made steady progress in contributing to total AIDS funding, the central government must fill the funding gap to sustain effective HIV care and treatment programs. Notably, Vietnam was the first country in Asia to commit to the UNAIDS 90–90–90 goals by 2020, which means to diagnose 90% of all HIV-positive individuals, provide ART for 90% of those diagnosed and achieve viral suppression for 90% of those treated. Although considerable gains were made, progress was uneven with 89% of PLHIV aware of their HIV status, 76% on ART, and 96% of all patients receiving ART have achieved viral

suppression [10]. Cambodia, like Vietnam, is a Southeast Asian nation with a one-party dominant state government. Its HIV programs heavily rely on international donor funding. Despite a substantial decline in international funding from 46.5% in 2014, when Cambodia became a lower-middle-income country, to 26.1% in 2017, the country was still able to successfully achieve the 90–90–90 target through remarkable efforts. This success was attributed to prioritizing ART treatments as a crucial investment in both saving lives and preventing further HIV transmission [11]. To reach the new UNAIDS 95–95–95 targets by 2030, the Vietnamese Ministry of Health should consider implementing similar innovative policies to increase ART treatment uptake, which can contribute to lowering the incidence of HIV infections, reducing the number of patients in need of treatment and yielding economic benefits by enhancing productivity and reducing healthcare-related expenses.

History of health insurance and its impacts on PLHIV

From 1989 to 1992, several Vietnamese provinces piloted a national insurance program that targeted formal workers and pensioners (Fig. 1). In 2009, Vietnam scaled up the program and began the implementation of universal health insurance for all residents of Vietnam but began by focusing on the poor and near-poor, and informal sectors [12]. As of 2020, government-sponsored health insurance covered 91% of Vietnamese [13]. The universal health insurance program provides free health insurance to prioritized groups such as the poor, ethnic minorities, children under 6, and the elderly over 80 years of age. Students or those in the category 'near-poor' pay about 30–70% of health insurance premiums while employed individuals have their health insurance premiums deducted directly from their salaries by their employers. Other workers (such as freelancers) pay full out-of-pocket costs for health insurance.

In response to the reduction of international HIV funding, Vietnam attempted to diversify its funding sources by ensuring that national health insurance included PLHIV. In 2013, the Prime Minister issued Decision No. 1899/QD-TT to ensure financing for HIV/AIDS prevention and control. According to this decision, by 2015, 80% of PLHIV would have health insurance cards and by 2020, coverage would reach 100% [14]. In 2016, the Prime Minister issued a supplemental

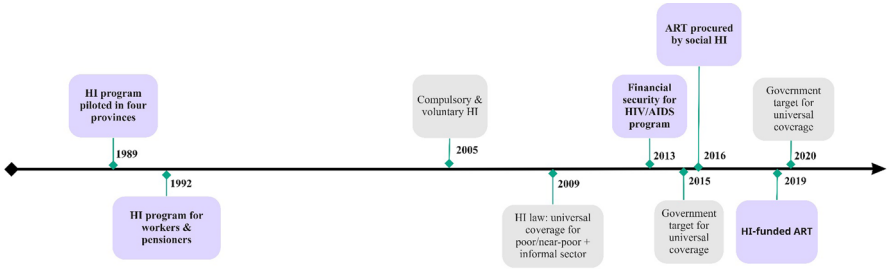

Fig. 1 Road map of health insurance (HI) reforms

authorization, Decision No. 2188/QD-TTG, stipulating that ART payment would be covered by social health insurance [15]. After years of advocacy by the Vietnam Authority of AIDS Control—which is responsible for coordinating the national HIV/AIDS prevention and control strategy, Vietnam's Ministry of Health approved the policy of using social health insurance to pay for medical services dedicated to HIV, and insured PLHIV have received free ART since January 2019 [8].

Before the national ART policy began, insurance covered only 30–50% of PLHIV across the country's provinces in 2016 [16], and this figure rose to 90% in 2021 [17]. Insured PLHIV can access free services including (1) HIV examination and treatment (ART, opportunistic infection, and CD4 count test) and (2) first-line ART regimens [8]. However, Vietnamese PLHIV experience higher rates of poverty and unemployment compared to the uninfected population [18]. It is unclear how the current policy will meet expanding demand for ART coverage across the population given the financial burden it places in insured PLHIV. In addition, uninsured PLHIV cannot assess the ART program which may contribute to other medical costs, infections, and to continuing transmission. Therefore, expanding the coverage of ART treatment and ensuring sustained treatment continuation among these vulnerable groups could significantly boost the economy by improving productivity and reducing healthcare expenses. Currently, Vietnam has no official system to record and evaluate HIV infection among international migrants who account for a small percentage of the population. Therefore, this paper exclusively focuses on all categories of Vietnamese citizens, but excludes migrants.

The mechanism for registering health insurance among PLHIV

In Vietnam, HIV occurs mostly among men who have sex with men, female sex workers, and people who inject drugs [4], many of whom may be mobile and unstably employed. In 2022, the Vietnam Ministry of Health made an official statement that sexual orientation and gender identity are not considered illnesses. However, same-sex marriages remain neither legalized nor protected under the law. Additionally, drug use and commercial sex are illegal in the country, and people who inject drugs may be subjected to mandatory treatment centers. This may result in detention and incarceration of people who inject drugs and commercial sex workers, further exacerbating their already vulnerable economic situation. PLHIV are also susceptible to the impacts of societal and internalized stigma. Importantly, Vietnamese PLHIV cannot access health insurance if they lack residency status within a province or lack identity documents that prove eligibility. For instance, "highly mobile" female sex workers and newly released prisoners who lost their identity documents for any reason are ineligible to participate in health insurance.

This means that PLHIV may be precluded from accessing health insurance-funded ART. Health insurance premiums are waived only if PLHIV are classified as "poor, ethnic minorities, children under 6, the elderly above 80," and have the appropriate government documents. Otherwise, PLHIV who are students or considered near-poor are expected to pay 30–70% of health insurance premiums while "wealthier" groups pay 100% out-of-pocket. Paying the full cost of health insurance

premiums could place a financial hardship on vulnerable populations. During the COVID-19 pandemic, PLHIV who obtained required health insurance from their employers or schools also faced the potential of ART treatment interruption due to loss of employment or completion of school through graduation [19].

Co-payment and paper documentation as barriers to access HIV treatment among insured

Publicly funded health insurance coverage includes ART, opportunistic infection treatment, and CD4 count tests. As several other essential services are required for treatment, PLHIV may confront additional service co-payments and personal expenditures. Particularly, publicly insured PLHIV must provide a co-payment of up to 20% of healthcare-related costs per visit if they use services, such as viral load testing, not covered by social health insurance [20]. This co-payment may limit HIV treatment and reduce prevention opportunities that accumulate from maintaining PLHIV at undetectable levels. This, in turn, could have negative consequences for the population's health, as the risk of HIV transmission would remain high, and the overall health of PLHIV would be compromised. A previous study showed that 10.5% of PLHIV were unable to pay for personal expenditures related to accessing ART treatment (such as travel expenses) and another 16.2% of PLHIV were able to pay for these expenses only partially [5]. As suggested above, outpatient clinics and assigned clinics within province provide HIV treatment services. If a PLHIV is registered for public health insurance in their birthplace, as frequently happens, but currently lives elsewhere, that person must obtain a referral letter from an outpatient clinic in their hometown to the new temporary living place for health insurance-funded ART. This requirement necessitates travel, expense, and disclosure of HIV status to administrative personnel in the hometown (Fig. 2).

Alternative solutions for current health insurance policy

Universal health insurance program for PLHIV regardless of residency status or priority groups, or both

As an alternative to the provision of free health insurance for prioritized populations, the Vietnamese Ministry of Health in collaboration with the Vietnam Authority of AIDS Control could implement a universal treatment program for PLHIV regardless of residency status or other qualifying factors. For example, health insurance premiums could be waived for anyone after an HIV diagnosis regardless of residency status but under a certain income threshold (such as a minimum monthly salary of less than $200 among paid workers and employees in 2022). This would increase the likelihood of participation in countrywide coverage of ART treatment. Importantly, the main barrier to this universal health insurance program is that the government lacks the funds to sustain the program. Currently, government covers all health insurance costs for only four prioritized groups including the elderly. The

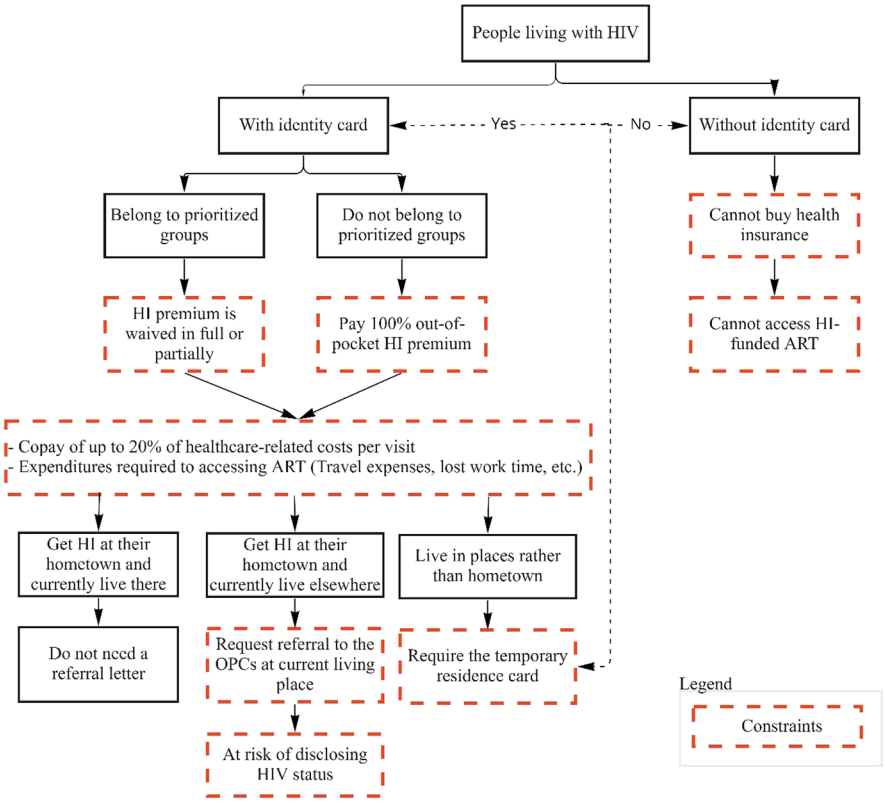

Fig. 2 Health insurance procedures among people living with HIV. * Prioritized groups: health insurance premiums are waived in full (e.g., among the poor, ethnic minorities, children under 6, and the elderly over 80 years of age) or partially (e.g., for students or near-poor); HI: Health insurance

population of Vietnam is one of the most rapidly aging in the world, the proportion of elderly, aged 65 and older, is projected to account for approximately 20% of the total population by 2049. Associated health care costs are rising [21] and hence, more revenue will be needed to extend universal health insurance to an additional 25,000 uninsured PLHIV (with an annual expected increase of 6000 new cases per year) [4].

An international not-for-profit organization, Unitaid, pioneered a potential pathway to raise funds. Its airline program has raised 1.9 billion in the 2007–2012 period for HIV/AIDS, malaria, and tuberculosis in low-income countries. This program generates almost two thirds of its funding through a mandatory tax, known as the "air ticket levy"—a contribution a passenger makes when purchasing an airline ticket [22]. Vietnam has five main local carriers including Vietnam Airlines, Vietjet Air, Bamboo Airways, Vietravel airway, and Pacific Airlines. The government might replicate this program by adding a minimum tax levy on tickets for these air carriers for all passengers on all flights originating from Vietnam. Many industries faced challenges during

COVID-19. Vietnam lost $782.6 million from transportation operations and declining revenue of $4.35 billion in 2020 compared to the previous year [23]. Thus, success of approaches susceptible to global economic trends may give rise to need for multiple options.

Another successful fundraising program is Debt2Health Initiative. Under an agreement facilitated by the Global Fund, creditors forgo repayment of a portion of their loans to low-income countries on the condition that that country invests an agreed amount in health. As of September 2021, the Global Fund secured $232 million to support health programs for 10 implementing countries [24]. Currently, Vietnam is receiving official development assistance from three major creditors: Japan, World Bank, and the Asian Development Bank. If the government could convert debt payments into life-saving investments in health, Vietnam will have more money to expand successful HIV programs.

Implementation of sliding scale fee treatment at all points of ART dispensing

A second alternative is to initiate sliding scale pricing at patient check-in (at facilities such as outpatient clinics licensed clinics for HIV treatment plus community health stations) for PLHIV who are not covered by insurance or whose insurance is not accepted by health facilities. This would address ART coverage gaps among Vietnamese PLHIV and remove barriers to HIV care for those who do not have the appropriate local identification papers. This pay-what-you-can strategy would allow PLHIV to choose any clinic, make services more affordable, and the avoid stigma of having to return to their birth villages to disclose their HIV status to secure needed documentation. Before scaling up sliding scale fee treatment, it is necessary to evaluate its impact of sliding scale fee treatment on the economic status and health outcomes of PLHIV, as well as the magnitude of potential contributions.

Given its centralized government structure, Vietnam could deploy top-down policies like sliding scale treatment without having to negotiate provincial laws. To make sliding scale treatment fees accessible for low-income PLHIV and self-payers, our suggestion is to limit the minimum fee to be much lower than the out-of-pocket fee for ART treatment per year (ranging from $261 to $565). If, as we think likely, a majority of PLHIV can afford to pay only the minimum fee, what cost differential might need to be absorbed by the government? To sustain such an approach, Vietnam would need to mobilize sufficient funds using creative fundraising mechanisms such as those mentioned above. To maximize the effect of sliding scale treatment, it would be necessary to scale up the sliding scale fee at all community health stations and outpatient clinics. The healthcare system includes approximately 11,100 community health stations that provide primary health care to 63 provinces/cities. If the proposal is adopted, it could create more than 11,500 points of ART dispensing.

Valuing the outcomes of a universal health insurance program

If the Vietnamese Ministry of Health initiates a universal health insurance program for PLHIV, it is likely that nearly 100% of PLHIV will participate in the ART program, far more than the uptake of 68% in 2020. This will help Vietnam narrow the gap to reach the UNAIDS 95–95–95 targets by 2030 and help to curb the rising infection rate. Additionally, health policymakers might assess other indicators after initiating the universal health insurance program such as the percentage of adherence and late presenters after 1 year of implementation among those who have been diagnosed with a CD4 cell count $< 350/mm^3$ or an AIDS-defining condition. In the long run, Vietnam could evaluate the incurred insurance costs against projected medical costs for those not virally suppressed as well as analyze potential economic benefits and population health of implementing universal health insurance. These indicators could be stratified by economic groups to deeper evaluate costs and needs among PLHIV with different socio-demographic statuses.

Conclusion

Given the ongoing impacts of COVID-19 and the tapering of international funding, the implementation of a universal health insurance program for PLHIV would add a considerable national expense; however, innovative, targeted fundraising strategies could narrow the funding gap. Expanded universal care remains the best option to increase uptake of ART treatment in uninsured PLHIV as well as remaining accessible to lifelong health insurance-funded ART among insured PLHIV. Of greater significance, the proposed universal insurance program could have a significant impact on population health by promoting wider availability of ART treatment and reducing the transmission of new HIV infections, which could potentially generate economic benefits.

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Declarations

Conflict of interest The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this commentary.

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