



International  
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► **Coordination mechanisms between social protection and occupational health services in Viet Nam**



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# Introduction

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Human health is determined by physiological factors and by the conditions in which people are born, grow, live, work, play and age and the systems and forces that shape these – in other words, social, environmental, behavioural and political factors (Marmot 2001). At the individual level, the different determinants of health are not experienced in silo and therefore should ideally be tackled and addressed by employing a coordinated and holistic set of policies and institutional frameworks. Social protection and occupational safety and health systems both aim to address some of the social and environmental determinants of health for the working population and beyond, and in particular, occupational health services (OHS) and social protection schemes covering healthcare and employment injury and occupational diseases. They share a common public health objective of promoting good health, preventing (work-related) injuries and diseases, supporting access to health care without hardship, guaranteeing income security throughout sickness and injury and facilitating rehabilitation. In this respect, both policies directly support the achievement of SDG targets 1.3 and 8.8, respectively, and jointly contribute to the achievement of SDG 3 on health and wellbeing for all.

In support of coordinated and holistic approaches, a research project consisting of a scoping review and three country case studies was undertaken as part of the ILO-France Project “Universal Access to Social Protection and Health and Safety at Work” to generate an understanding of existing linkages and coordination mechanisms between national social protection systems and occupational health services, while also highlighting the current gaps in knowledge that need to be filled. This country case study brings together the findings of the research in Viet Nam, with the aim of providing an overview of the existing coordination mechanisms between Viet Nam’s national social protection system and the national occupational health services system, while also highlighting the current gaps that need to be addressed. By examining current practices and identifying areas for improvement, the report aims to facilitate the coordination of OHS services and the national social protection system, ultimately ensuring enhanced protection and well-being for all workers in the country.

The remainder of the introduction provides some definitions of the terms used in the report, and background for

## Social protection

Social protection is defined as a set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle (ILO 2024). The term encompasses a broad variety of policy instruments, including social insurance and social assistance, with most social protection systems adopting a combination of instruments to achieve their objectives. As outlined in the Social Protection Floors Recommendation 2012 (No. 202), it encompasses, at a minimum, access to healthcare without hardship, which includes maternity care, and income security throughout the life cycle (ILO 2019b).

Social health protection (SHP), as defined by the ILO, refers to measures that ensure effective access to health care without financial hardship and income security in case of sickness or maternity (ILO 2020). These guarantees are anchored in several international social security standards, including the Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Social Protection Floors Recommendation, 2012 (No. 202). Convention No. 102 also acknowledges the need to guarantee income security during maternity and sickness, thereby contributing to the achievement of health objectives. In addition, access to health care without financial hardship is a right recognized for persons affected by employment injury or occupational disease, in line with the minimum standards set out in Conventions No. 102 and No. 121. These instruments do not prescribe a specific model for the administration of benefits, leaving room for the integration of these guarantees within diverse institutional arrangements.

## Occupational health services

The ILO’s normative framework on occupational safety and health (OSH) numbers over 40 instruments, including two fundamental Conventions. The Convention on the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) calls for the promotion of continuous improvement of occupational safety and health through the development of a national OSH framework composed of a national OSH policy, a system and a programme. The Convention stipulates that a national OSH system – that is, the infrastructure through which OSH policies and programmes are implemented - itself should be composed of, among other components, a national tripartite advisory body on OSH, training, information and advisory

ry services, occupational health services and provisions for collaboration with insurance or social security schemes covering occupational injuries and diseases.

Occupational health services are defined by the Occupational Health Services Conventions, 1985 (No. 161) as those services entrusted with essentially preventive functions, which are required to advise employers, workers and their representatives concerning the requisite means for establishing and maintaining safe and healthy working environments so as to promote optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers in consideration of their physical and mental health. Convention No. 161 and the Occupational Health Services Recommendation, 1985 (No. 171) call on States to progressively develop occupational health services (OHS) for all workers. Additionally, Convention No. 161 specifies the scope of functions of occupational health services as are adequate and appropriate to the occupational risks of the undertaking.

### Potential for synergies

In their respective objectives and complementary missions, there exist several opportunities for collaboration and coordination between occupational health services (OHS) and social protection, in particular, social health protection (SHP) and employment injury insurance (EII). Firstly, both systems have similar objectives with regard to the maintenance and restoration of health, whether at the workplace, in the case of OHS, and both within and beyond the workplace in the case of social protection systems.

The potential for such synergies is identified in relation to the responsibilities and functions outlined in the normative frameworks for social security and occupational health services. Convention No. 130 recognizes that the benefits covered by SHP include preventive care, wherein opportunities for institutional coordination with respect to the primarily preventive function of OHS might be identified. Moreover, Recommendation No. 171 provides for occupational health services to “engage in other health activities, including curative medical care for workers and their families, as authorized by the competent authority” depending on the national context and distance of the workplace to health facilities; while the list of medical benefits to be provided in case of employment injury or occupational disease under Convention No. 121 includes emergency and follow-up treatment at the place of work, where synergies can potentially be identified. Finally, the engagement of both OHS and employment injury insurance in vocational rehabilitation (as per Recommendation No. 171, Convention No. 102 and Convention No. 130) presents opportunities for coordination.

Further, recommendations on the governance and administration of OHS and social protection offer opportunities not just for collaboration but also for the deployment of greater synergies. International social security standards offer clear guidance on this point, outlining the primary responsibility of the state in guaranteeing the right to social protection. The standards are non prescriptive when it comes to the administrative and institutional arrangements for publicly-led schemes, as Article 7.2 of Convention No. 161 provides for a plurality of organisation modalities, including by social security institutions. This opens up the potential for synergies to be operationalized, or even the integration of some, if not all of the OHS functions.

It was against this background that the research endeavoured to identify the types of linkages that exist between OHS and social protection systems – and in particular, SHP and employment injury insurance (EII). Notably, the research aimed to identify what the nature of linkages between OHS and social protection might be and those countries where they are reported. In this report, linkages are defined as direct and regularized relations between two or more institutions, that is, any policy, operative process or programme that formally or informally links social protection systems and occupational health services. An institution was considered to be any government agency, semi-private or private organization that is tasked with overseeing and administering specific functions of OHS or government-led social protection schemes.

## Methodology

This study is based on a **desk review**<sup>1</sup>, which was carried out to understand current policies, regulations, organisational arrangements and implementation of occupational health services, health insurance scheme, and the Occupational Accident and Disease Insurance Fund in Viet Nam, and the linkages between these (ILO 2024b). This desk review was complemented by **Key Informant Interviews conducted in** October and November 2023 with state actors to collect data which were not available in the public domain. Informants from the following institutions were interviewed:

- ▶ Ministry of Health, Viet Nam Health Environment Management Agency (VIHEMA)
- ▶ Ministry of Labour, War Invalids and Social Affairs (MOLISA) Safe Work Department
- ▶ MOLISA Social Protection Department
- ▶ Viet Nam National Institute of Environmental and Occupational Health (VNNIEOH)
- ▶ Viet Nam Social Security (VSS) – Social Insurance Policy Branch
- ▶ VSS – Health Insurance Implementation Department

The report begins by presenting some background to the context in Viet Nam, including in relation to the occupational safety and health (OSH) and social protection systems. The second section examines and analyses the linkages that exist between the systems and their potential implications, as well as the existing opportunities for strengthened coordination between OHS and social protection, before concluding with some reflections on the implications of the findings for the wider research project.



<sup>1</sup> See Bibliography



# Background

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Both health and social protection are rights enshrined in the Constitution of Viet Nam, with a range of strategies and plans in place that aim to ensure and enhance access, quality and adequacy of services and schemes. Similarly, several plans and programmes have been adopted in recent years to promote workers' health and improve occupational safety and health. However, the high prevalence of employment in the informal economy (which represented 67.5 per cent of employment amongst employed persons aged 15 and over in 2019 (ILO 2021b)) results in relatively low coverage of contributory social protection schemes guaranteeing income security and limits access to occupational health services. Thus, according to the Occupational Health and Safety report of 2022 published by the Viet Nam Health and Environment Management Agency (VIHEMA), medical facilities recorded in 2022 some 994,397 cases of work-related injuries, 9,378 of which resulted in fatalities (VIHEMA 2022). However, this data is considered to be a significant underestimate of the prevalence of work injuries and occupational diseases, which largely go under-reported.

## ► Socio-economic context

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### Demographic and economic profile

Viet Nam is Southeast Asia's fastest growing economy and Asia's 2nd with a forecasted GDP growth of 6.3 per cent in 2023 (Asian Development Bank 2022). The impressive economic growth seen in the past three decades follows the introduction of the Đổi Mới economic reforms in 1986, which significantly transformed Viet Nam's labour market. The policy of industrialization and modernization shifted the distribution of employment away from agriculture, forestry and fishery towards manufacturing and services: thus, between 2000 and 2020, employment in the sector of agriculture fell from 62.2 per cent to 34.5 per cent while employment in the industry and construction sectors grew from 13 per cent to 30.5 per cent, and from 24.8 per cent to 36 per cent for the service sector (Ministry of Planning and Investment of Viet Nam 2020; 2019).

Viet Nam's total population is estimated at over 100 million inhabitants in 2023, with a median age of 32.4 years old (United Nations, Department of Economic and Social Affairs, Population Division 2024). Despite its young population, Viet Nam is amongst one of the fastest ageing countries in the world, with the old-age dependency ratio having risen from 9.5 in 2000 to 12.7 in 2023 (United Nations, Department of Economic and Social Affairs, Population Division 2024).

In total, some 66 million of people in Viet Nam are of working age (15-64)<sup>2</sup>, while the labour force participation rate stands at 78.3 per cent, which is significantly higher than the average of 60.9 per cent for the Asia Pacific region (ILO 2024a). Informality remains prevalent in Viet Nam, with 67.5 per cent of the employed aged 15 and over engaged in the informal economy in 2019 (ILO 2021b). The prevalence of informal employment varies greatly between economic sectors: almost all agricultural employment in Viet Nam is informal, while 90 per cent and 70 per cent of employment in the construction and services sectors is informal, respectively (ILO 2021b). Workers in the informal economy are at heightened risk of work injury or an occupational disease, and of becoming vulnerable as a result. Indeed, informal workers typically lack access to OSH measures and training, and are seldom reached by labour and OSH inspectors. Workers in the informal economy also have limited access to essential occupational health services and social protection measures, including work injury insurance and social health protection. In addition, occupational accidents and diseases remain generally underreported, and particularly in the informal economy. As a result, their health and well-being at work remain inadequately safeguarded.

### Occupational disease burden

The rapid economic growth brought by industrialization in Viet Nam since the 1990s was accompanied by a significant reduction in communicable diseases, substituted by an increase in non-communicable diseases. These now dominate the disease burden in Viet Nam, accounting for 75 per cent of morbidity and mortality as expressed in DALYs in 2019, compared to roughly 49 per cent per cent in 1990

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<sup>2</sup> ILOSTAT.

(Institute for Health Metrics and Evaluation 2019).

DALYS attributable to occupational risks ranked in 9th position in 2019 (ibid), and more than 21 000 deaths in the country were also estimated to be attributable to occupational health risk factors in 2016 by ILO-WHO joint estimates (WHO and ILO 2021). According to VHEMA's Occupational Health and Safety report of 2022, some 994,397 cases of work-related injuries were recorded at medical facilities in 2022, including 9,378 of which resulted in fatalities (VIHEMA 2022). The most common work-related disease was acute chronic respiratory tract inflammation, while the three occupational diseases for which employees received the highest cumulative number of social insurance benefits in 2022 were occupational silicosis (21,407 cases), occupational coal workers' pneumoconiosis (734 cases) and noise-induced hearing loss (5249 cases)<sup>3</sup>. The occupational health burden profile of the country calls for additional investments in occupational health services and social health protection (WHO and ILO 2021).

## ► Overview of social protection and OSH systems

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### Social protection system, including public health insurance

Social protection, the right to which is entrenched in the Constitution, is one of key priorities of the Government of Viet Nam. The objectives in relation to the extension of coverage and the improvement of benefit adequacy are outlined in a range of sectoral and multisectoral policies and strategies. Viet Nam's social protection system is comprised of both contributory and non-contributory schemes covering all nine life contingencies. Despite its comprehensiveness, the system primarily covers the country's minority formal sector, leaving the majority of persons in informal employment with little to no social protection coverage.

The **health insurance fund** is administered by the Viet Nam Social Security (VSS). Coverage is compulsory for all and offers a unique package of benefits. The population is categorized into six broad groups, with different contribution rates, subsidy levels and co-payment levels depending on group and category and relying on a mix of contributions and public funding (see Table 1).

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<sup>3</sup> Morbidity and occupational diseases among the working population data disaggregated by sector was not available, however.

► **Table 1: Summary of key design features of the health insurance scheme: coverage, benefit and service provision**

Population groups and membership categories	Contribution rate	Funding source	Member co-payment level
<b>Group 1:</b> Formal workers, civil servants, public officials at commune level	4.5% of insurable or base salary depending on the category	Employers contribute 3%; employees contribute 1.5%	20% of eligible treatment charges
<b>Group 2:</b> Pensioners and recipients of social insurance benefits	4.5% of pension or base salary, or allowance depending on the specific group	VSS pays full amount	5% of eligible treatment charges for pensioners and those on disability benefit. 20% of eligible treatment charges for the rest
<b>Group 3:</b> Active-duty military or police forces, students of military or police training institutions, persons of merit, social assistance recipients, members of poor households, ethnic minorities, children under age 6, elected representatives at national level, organ donors, foreign students, commune-level officials on a pension, People who exhausted their disability benefits but receive monthly payments from the state budget	4.5% of insurable or base salary depending on the category	State budget (or that of MoLISA and DOLISA) pays full amount depending on category	Between 0% and 20% depending on the category
<b>Group 4:</b> Individuals living in near poor households, pupils and students, agricultural households	4.5% of base salary	State budget pays full amount or pays 30% of contributions depending on the category	Between 5% and 20% depending on the category
<b>Group 5:</b> Individuals not covered in any other category, largely informal	1st household member: 4.5% of base salary. Additional household members contribute a decreasing share of the 1st member's contribution rate.	Household pays full amount	20% of eligible treatment charges
<b>Group 6:</b> Dependents of military, police personnel (parents, spouse, biological and adopted children)	4.5% of base salary	Employer of military, police personnel pays (state budget, service delivery unit or enterprise)	20% of eligible treatment charges

The scheme has achieved high coverage, reaching 93.35 percent of the population (VSS 2024), with the ambitious target of achieving a coverage of 95 per cent by 2025 as set out in the new Social Security 5-year plan 2021–2025 (Bales, Phe Goursat, and Phuong 2021). However, out-of-pocket health spending continues to increase, with persistent inequities and coverage gaps among near-poor groups and workers in the informal economy (Bales et al. 2021). But despite the high coverage, out-of-pocket (OOP) health spending continues to increase, with persistent inequities and coverage gaps among near-poor groups and workers in the informal economy (*ibid*).

In addition, **social insurance** covering old-age, survivorship, unemployment, sickness, maternity and employment injury is also administered by the VSS. Some 38 per cent of the labour force were covered in 2022 (VSS 2023). The administration of all social security benefits under a single institution allows for linkages across schemes to be established, which facilitates continuity of coverage and contributes to administrative cost efficiency.

In addition, several **social assistance** programmes exist, catering for specific groups of the population

(including orphans, single parents and persons living with HIV) which are narrowly defined, cover a limited scope of benefits and achieve low coverage, although several policies are in place, supporting a more comprehensive and inclusive system that will offer wider coverage (James and McClanahan 2019).

## OSH profile

The Law on Occupational Safety and Hygiene of 2015 (No. 84/2015/QH13) defines the preventative actions to be made available to workers, and outlines the legal duties of the state, workers, employers and other relevant stakeholders with regards to safeguarding workers' health.

However, the Law does not clearly define the organizational model for the provision of OHS (for example, in-house services, external services, state-led services etc), nor does it identify the main entity responsible for organizing and providing OHS. Thus, the responsibility for the provision of OHS is shared among various actors (Matsuda 1996; Diep 2020), namely:

- ▶ **Ministry of Labour**, responsible for conducting safety inspections via labour inspectorates which have been established at all levels to survey compliance of employers and to investigate labour complaints, as well as reported occupational diseases and accidents (Diep 2020; Matsuda 1996) and;
- ▶ **Ministry of Health**, responsible for the provision of basic OHS to workers via a network of occupational health centres and health stations (Matsuda 1996; Diep 2020; Pham 2019). The Viet Nam Health and Environment Management Agency (VHEMA) is subordinate to the MoH and supports the implementation of occupational health regulations.
- ▶ **Industry-related ministries**, playing a key role in the organisation and management of occupational health services, as well as working environment monitoring, health check-ups, occupational disease examination, OSH training for employers and employees and first aid training and also the surveillance and reporting occupational accidents and diseases (Diep 2020).
- ▶ **Employers**, responsible for the provision of training and guidance on OSH regulations, provision of occupational equipment, of health care, and of medical examination for detection of occupational diseases, the investigation, reporting and surveillance of occupational accidents and diseases through report writing, and the creation of diseases and injuries inventories.
- ▶ **The Viet Nam Fatherland and Front<sup>4</sup> and its member organizations (state)**, collaborate with relevant agencies to organize education and training in OSH and in the development of OHS.
- ▶ **Trade unions**, responsible for collaborating with employers to develop and supervise the implementation of OSH plans, investigate occupational accidents as requested as well as inspect and supervise OSH activities including the adequate provision of workers' compensation and vocational training for affected employees. They are also engaged in the organizing educational campaigns on OSH and advocacy activities.

OHS centres are financed by the state budget through the Ministry of Health, although the budget allocation for occupational health services is still considered limited in all provinces. It is estimated that only workers in formal employment, who accounted for 32.3 per cent of the workforce in 2023 (General Statistics Office of Vietnam 2023), have effective access to these services.

## National health system overview

The right to health for all citizens is enshrined in the Constitution. To give effect to these rights the Government of Viet Nam has adopted several national policies and strategies outlining objectives pertaining to the development of the sector and the health workforce. This includes the five-year **National Strategy for protection, care and improvement of the people's health through 2030 adopted in 2024<sup>5</sup>** and the

<sup>4</sup> According to Law on Vietnam Fatherland Front 2015, the VFF is the political base of people's power, representing and protecting lawful rights and the interests of the people.

<sup>5</sup> Created by Decision No. 89/QĐ-TTg dated 23 January 2023.

Scheme for the Development of Healthcare Workforce for the 2023-2030 Period, with a Vision to 2050<sup>6</sup>.

The Ministry of Health (MOH) is the main steward of the system and responsible for developing health policies, technical guidelines, and monitoring policy implementation. Local authorities are also responsible for managing health-related activities in their administrative regions (Oanh, Phuong, and Tuan 2021). Indeed, Viet Nam's healthcare system is decentralized and divided into four administrative levels (central, provincial, district, and commune) which correspond to the state administrative management system. At the basic level, communes and district have mandate over the provision of basic medical care and preventative services. Provincial facilities serve as the primary care centres for their respective regions while central administrative regions are entrusted with the management of secondary, tertiary and quaternary levels of care as well as health education programs with central oversight.

Since 1989, Viet Nam's health care system has transformed from a fully publicly financed system to a mixed public-private provider system. Composed of both public and private healthcare facilities, the latter is growing in number and becoming increasingly popular among the citizens as they are perceived to offer higher quality care (Ministry of Health 2022). However, according to the latest estimates the majority of healthcare workers still remains employed in the public sector (M. P. Nguyen and Wilson 2017).

As of 2018, Viet Nam had an estimated total of 3.66 skilled health workers per 1,000 people (0.86 physicians, 1.14 nurses, and 0.29 pharmaceutical personnel) falling just a little short of the WHO threshold required to achieve Universal Health Coverage (4.1 skilled health workers per 1,000) (Viet Nam Ministry of Health 2018). Despite progress in the availability of health workers, distribution of personnel across regions remains uneven, with clear disparities in the density and quality of qualified health workers across the country (WHO 2016).



<sup>6</sup> Created by Decision No. 869/QĐ-BYT dated 8 April 2024.

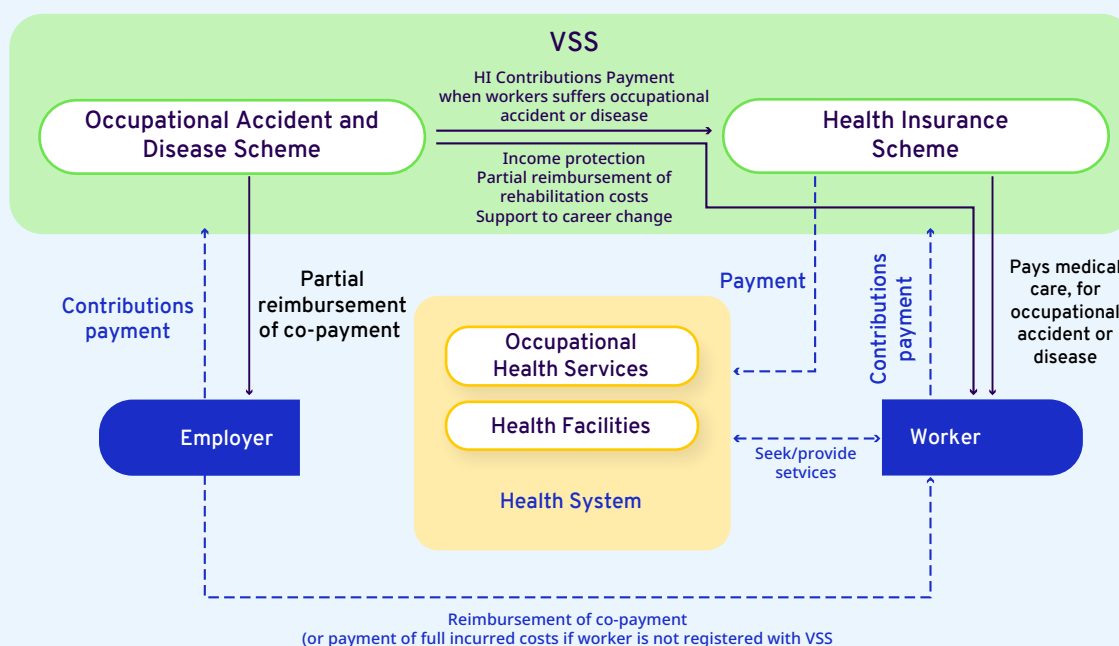


# Linkages between social protection and occupational health services

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This chapter outlines the identified linkages between the OHS on the one hand, and the social protection – and especially employment injury insurance and social health protection – on the other. Figure 1 summarises the linkages that exist.

► Figure 1. Illustration of the linkages between OHS and social protection in Vietnam



## ► Linkages between employment injury insurance and health insurance within VSS

The design and operation of the EII (known locally as the Occupational Accident and Disease Insurance Fund), the pension scheme and the health insurance fund are interlinked to provide financial protection for workers affected by diseases or accidents, whether occupational or otherwise. In practice, responsibilities for contribution payment, payments of benefits to workers and health facilities' settlement claims are interwoven among the three schemes.

### Payment of health insurance contributions by the Occupational Accident and Disease Insurance Fund

Firstly, a worker receiving periodical payment for occupational diseases or accidents has her/his health insurance contribution automatically paid by VSS Occupational Accident and Disease Insurance Fund to the health insurance fund<sup>7</sup>. This arrangement is also made for workers in receipt of a pension, a maternity allowance, a long-term sickness allowance, and unemployment benefits, which facilitates the continuity of health insurance coverage when a person is injured, sick, retired, on maternity leave, etc...

VSS internal financial transfers to the health insurance scheme from other schemes concerned 4 percent of the total health insurance members. Among those, only 6,800 workers on average every month (or

<sup>7</sup> As per clause 8, article 42 of the Law on Occupational Safety and Health of 2015 and Paragraph c, clause 1 of article 13 Law on Health Insurance of 2008 as amended in 2014.

0.008 percent of total health insurance members) benefited from this transfer from the occupational accident and disease scheme to the health insurance scheme. While the VSS transferred revenues represent 8.7 percent of the health insurance annual revenues in 2020, the transfer for the occupational scheme only represents a very small fraction of the HI total revenues (0.006 percent)<sup>8</sup>.

The payment of contributions by one social security branch to another on behalf of their rightsholders is not exclusive to the case of Viet Nam. In Germany, the agencies administering unemployment benefits (both contributory and non-contributory) pay and remit contributions for the statutory health insurance scheme (Gesetzliche Krankenversicherung or GKV) on behalf of unemployment benefit recipients. Both in Germany and Viet Nam, health insurance coverage is mandatory, and such mechanisms contribute to ensuring that recipients remain affiliated, whilst also ensuring the value of the benefits received are not eroded and remain adequate.

In Viet Nam, this approach is also important because it is the health insurance fund that covers the medical costs of workers for employment injuries or occupational diseases, as further elaborated in the next section.

### Coverage of benefits for employment injuries and occupational diseases by health insurance and the pension branch

In Viet Nam, benefits for the survivors of workers who die as a result of a WIOD are covered under the pension scheme according to the Law on Occupational Safety and Health, while medical examinations and treatment in cases of WIOD are implicitly included in the list of eligible services covered by the health insurance fund. Coverage of medical costs in the event of an occupational disease and employment injury have not been included in the past two laws on social insurance but were, instead, an employer's liability. These services were also excluded from coverage under the Law on Health Insurance of 2008, wherein "*Medical examination, treatment and function rehabilitation in case of occupational diseases, labour accidents or disasters*" were not included in the health insurance benefit package. However, the amendments introduced in the Health Insurance Law of 2014 removed such services from the list of exclusions, with the clause now reading that only "*Medical care and function rehabilitation in case of disasters*" were excluded. As such, such medical examinations, treatment and functional rehabilitation in the event of a work injury or occupational disease are now implicitly included in the list of eligible services covered by the health insurance. As far as the research could ascertain, the health insurance fund is not reimbursed by the employment injury scheme.

If an employer does not pay contributions for employees subject to compulsory social insurance or if a worker is not covered by the health insurance fund, the employer is liable to cover the benefits to which covered workers would be entitled under each scheme<sup>9</sup>.

Income protection as well as other costs resulting from work injury or occupational disease is covered by the Occupational Accident and Disease Insurance Fund. The manner in which the benefits in the event of a work injury or occupational disease are covered in the social insurance system are summarized in the below table (see Table 2).

<sup>8</sup> This information comes from unpublished VSS internal data shared with the ILO in 2021.

<sup>9</sup> Art. 38 of the Law on Occupational Safety and Health of 2015

► **Table 2: Entitlements for workers affected by work injury or occupational diseases and their survivors by social protection scheme and employer liability in Viet Nam**

Benefits covered	
<b>Occupational Accident and Disease Fund</b>	<ul style="list-style-type: none"> <li>• Costs relating to medical assessment</li> <li>• Lump-sum, monthly and service allowances</li> <li>• Assistive and orthopaedic devices</li> <li>• Expenses for convalescence and part of expenses for health rehabilitation</li> <li>• Reskilling</li> <li>• Health insurance contribution</li> <li>• Reimbursement to employers of part of co-payments incurred (see below)</li> </ul>
<b>Health Insurance Scheme</b>	Medical care in the event of occupational disease or accident is not excluded from the benefit package
<b>Survivorship Allowance Regime</b>	<ul style="list-style-type: none"> <li>• Monthly survivorship allowance</li> <li>• Funeral allowance</li> </ul>
<b>Employer liability</b>	<ul style="list-style-type: none"> <li>• <u>For workers not covered by above-mentioned schemes:</u> all above-mentioned entitlements</li> <li>• <u>For workers covered by above-mentioned schemes:</u> reimbursement of co-payments and expenses that are not covered by health insurance (themselves partly reimbursed by the Occupational Accident and Disease Fund – see above)</li> </ul>

**Source:** Law on Occupational Safety and Health of 2015, Law on Health Insurance 2008 (amended in 2014), Law on Social Insurance of 2024

Viet Nam is not the only country in which medical costs resulting from a work injury or occupational disease are not covered by the employment injury insurance scheme. In some countries, such insurance schemes simply do not exist, and employers are liable to cover medical costs and provide financial compensation – as was the case prior to the legal reforms in Viet Nam. In other countries, the social protection system does not include a specific employment injury branch, but instead income support is provided under the Sickness and Maternity branch (in the case of temporary benefits) or the pension branch (in the case of long-term benefits), while medical costs are covered and administered through the health insurance, as is the case in Estonia for example (ISSA, n.d.).

## Potential implications

There are several potential implications to such arrangements in Viet Nam, which warrant further investigation.

Firstly, the implicit inclusion of medical care for persons victims of occupational disease or injury in the benefit package of the health insurance fund is expected to ensure that financial protection in accessing such services achieves wide **coverage**. Indeed, while the health insurance achieves almost universal coverage, the employment injury schemes covers less than a third of the labour force, where the self-employed are legally excluded and workers in informal employment face challenges to access. The different scopes of coverage of different contingencies and coverage modalities are outlined in Table 3.

► Table 3: Legal and effective coverage of OSH and social security contingencies

	OSH; employer liability mechanisms	Health insurance	Survivorship Allowance Regime	Occupational Accident and Disease Fund
<b>Effective coverage</b>	32.5 per cent of the labour force (e.g. formal)	93.35 per cent of the total population	31.5 per cent of the labour force are active contributors	29.6 per cent of the labour force

Source: Data available under the ILO social security inquiry, (VSS 2024; General Statistics Office of Vietnam 2023)

Inclusion of such benefits in the health insurance also presents the potential for improved **effective access** to services, as compared to arrangements where these are an employer’s liability or covered by the social insurance scheme, for two core reasons. Firstly, while the Law on Occupational Safety and Health of 2015 provides for the provision of benefits by employers in cases where workers are not covered by health insurance, employer liability mechanisms are typically ineffective in ensuring access to benefits, whether because of a lack of awareness among employers of their responsibilities or a lack of compliance (ILO 2024d). Secondly, where medical costs incurred in the event of employment injury and occupational disease are covered by employment injury schemes, the procedures necessary to submit claims, prove the work-related nature of a disease or injury and be reimbursed by the scheme may be overly complicated, representing a disincentive to submit a claim or a barrier to effective access, as evidenced in Taiwan for example (Cheng, Chung, and Cheng 2019).

From an **administrative perspective**, the “non-exclusion” of medical treatment in the event of a work injury or occupational disease from the health insurance benefit package may remove a layer of bureaucratic complexity within the administration of both the health system and the Occupational Accident and Disease Insurance fund. This arrangement facilitates the payment of claims submitted by health care providers, based as it is on the experience and expertise of the health insurance fund in provider management and payment. Given that both employment injury insurance and the health insurance fund are administered by the same institution (VSS), it also makes administrative sense to deliver and cover medical benefits in the event of a work injury or occupational disease through the health insurance scheme, thus avoiding potential duplication of certain functions, for example: contracting with healthcare facilities, negotiating fees and processing and paying claims.

Yet, this arrangement creates a **separation in the administration of income security and financial protection of medical care** in the event of a work injury or occupational disease between two separate schemes. Financial protection against the costs of accessing healthcare services and income security in the event of a temporary or permanent disability resulting from an employment injury or occupational disease are complementary and tightly intertwined: without the one, the effectiveness of the other in preventing poverty and maintaining, restoring or improving the health of the affected worker may be undermined. The separate administration of the two benefits in Viet Nam, with different levels of coverage, results in a situation where a large share of the workforce (largely in the informal economy) only have access to financial protection against the costs of healthcare, without income security. It is important to ensure that the complementary objectives and outcomes of financial protection and income security are achieved through better alignment in coverage of both schemes.

On the other hand, the amendment to the Law on Health Insurance was not accompanied by other necessary adjustments to take account of the financial implications, particularly as no mechanisms for the reimbursement of the health insurance fund by the Occupational Accident and Disease Insurance fund was identified. Indeed, it is not clear whether the adoption of this amendment was informed by an actuarial assessment or estimation of the cost of this inclusion and hence, the additional expenses to be borne by the health insurance fund. In turn, it is unclear whether the share of expenses incurred by the health insurance fund as a result of the delivery of services in such events is monitored, which hinders any analysis of these financial implications.

Additionally, the provisions in the respective laws and regulations create complex reimbursement mechanisms for co-payments which could usefully be rationalized.

Finally, it will also be important to assess the extent to which this arrangement aligns with international

social security standards, and in particular provisions outlined in Convention 102 on Social Security (Minimum Standards)<sup>10</sup> and Convention 121 on Employment Injury Benefits. Elements of particular focus include:

- ▶ How this arrangement distributes **contribution** responsibilities between employers and workers (in the case of employees) for benefits in the event of a work injury or occupational disease – whether medical, income-security, or other in-kind benefits.
- ▶ Whether the **waiting period** of 30-day applied for specific categories of members (namely the near-poor, students and members under group 5 (which include workers in informal employment)) is in line with international standards which outlines that waiting periods should not be applied for coverage under employment injury schemes (Para. 8 of Recommendation No. 121).
- ▶ Finally, reimbursement mechanisms for **co-payments** are complex and could usefully be rationalized. International social security standards call for workers affected by work injuries or occupational diseases to bear no costs relating to health services accessed in such events, while in Viet Nam, co-payment levels vary from 0 to 20 percent of eligible treatment charges, depending on the membership group and category outlined above, with complicated reimbursement arrangements. Indeed, the legal framework attempts to limit the financial burden employers and workers would have to bear in such cases, through the following measures:
  - **Employers are required to compensate workers for incurred co-payments**, as per paragraph a, clause 2 of article 38 of the Law on Occupational Safety and Health of 2015 which requires employers to cover “co-payment expenses and expenses which are not covered by health insurance for employees with health insurance”. This provides a higher financial protection to the worker, but reliance on employer liability for the reimbursement of co-payments for occupational diseases puts the worker in a situation of vulnerability: the worker may not dare to ask for reimbursement for fear of retaliation, and may not be properly equipped to make an appeal.
  - **Employers can claim for reimbursement from VSS for part of those costs.** Employers covered by the Occupational Accident and Disease Insurance Fund are eligible for reimbursement of the co-payments they reimbursed to workers as above. Indeed, the Law on Occupational Safety and Health of 2015 outlines provisions for the fund to finance “prevention and risk sharing activities”, the latter of which includes “health check-up and medical treatment of occupational diseases”. Employers covering the costs of examinations or copayments for medical treatments of an occupational disease are eligible to be reimbursed up to 50 percent of those costs - after the health insurance has paid out in the case of the latter - up to a maximum of 800’000 VDN and 15 million VDN per person respectively<sup>11</sup>. This measure provides protection for employers, which is particularly useful for SMEs that may not have the financial capacity to support such costs. The Law and Decree do not mention such risk-sharing arrangements in the event of work injuries, however. In turn, partial reimbursement to employers only apply for “employee [who] has paid occupational accident and disease insurance [contributions] for at least 12 months and is still participating in such insurance up to the month immediately preceding the month of request for financial assistance”. This may limit the coverage of these cost sharing arrangements.
  - **Employees can claim partial reimbursement of rehabilitation costs:** in case a worker covered by the Occupational Accident and Disease Insurance Fund is recommended to attend occupational rehabilitation by a health facility, and he/she suffers from a “whole person impairment” of at least 31% as a result of the occupational accident or occupational disease, the worker is entitled to the reimbursement of 50 percent of the costs incurred by rehabilitation services after health insurance payout, to the limit of VND 3,000,000 per person per time, with a limit of two times a year. Employers are not liable

<sup>10</sup> Viet Nam has not ratified Convention 102 on Social Security (Minimum Standards) of 1952.

<sup>11</sup> Decree 88/2020/ND-CP Elaborating some articles of the Law on Occupational Safety and Health on Compulsory Insurance for Occupational Accidents and Occupational Diseases

to cover co-payments relating to rehabilitation services, part of which is therefore borne by the injured worker.

Given the complexity introduced by such provisions (e.g. part of the costs being borne by the health insurance, part of the costs borne by the employer who may then claim reimbursement from the Occupational Accident and Disease Insurance Fund), there may be room to rationalise the modalities for co-payments. For example, in Kazakhstan, provisions are made by the health insurance scheme to waive co-payments under specific conditions including health services provided in the event of occupational injuries or accidents, which are covered under the scheme (ILO 2024c).

## ► Linkages between occupational health services and employment injury insurance

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### Occupational Accident and Disease Insurance Fund parameters stipulated in OSH law

As referred to above, there are important linkages between the legal frameworks of the OSH and social insurance systems. Indeed, the recently adopted Law on Social Insurance of 2024 does not include provisions on the qualifying conditions for, nature and level of entitlements under, and use of funds of, the Occupational Accident and Disease Insurance, as administered by the VSS, as these are defined in the Law on Occupational Safety and Health of 2015. It would be important to assess the impact that this legislative arrangement has on compliance considering that, to be able to understand their responsibilities with regards to compensation in the event of an employment injury, employers would be required to consult the Law on Health Insurance, the Law on Social Insurance, and the Law on Occupational Safety and Health.

### Financing of prevention activities by the Occupational Accident and Disease Insurance Fund

Another important linkage, as outlined in the Law on Occupational Safety and Health of 2015, is the use of resources of the Occupational Accident and Disease Insurance branch to finance prevention and rehabilitation activities. According to Clause 1 of Article 56, the Occupational Accident and Disease Insurance branch must reserve a maximum of 10 percent of its revenue to support the “prevention and sharing of risks” of occupational accidents and diseases, activities of which include:

1. Health check-up and medical treatment of occupational diseases (as mentioned above).
2. Working function rehabilitation – namely the reimbursement of rehabilitation costs to workers as outlined above.
3. Investigation of occupational accidents and diseases at the request of the social insurance agency. Here, 100 percent of the costs relating to the re-examination are paid.
4. Occupational safety and health training for specific categories of workers<sup>12</sup> covered by the occupational accident and disease insurance. Here, 70 percent of the costs of training are reimbursed to employers by the Fund, with maximums dependent on the position of the trainee. In order to access the reimbursement, employers must submit an application for funding, including reports on implemented activities and the real cost to the Department of Labour, War Invalids and Social Affairs (DOLISA). Upon approval from DOLISA, provincial VSS disburses the funds directly to the employers.

<sup>12</sup> Occupational safety and health managers, occupational safety and health officers, health workers and occupational safety and health workers at production and business establishments shall participate in occupational safety and health training and may obtain a certificate from the occupational safety and health training institution after passing an examination. In turn, employers must organize training for employees performing jobs subject to strict requirements for occupational safety and health and provide them with safety cards before assigning them to such jobs.

Such resources cannot cover the costs of activities covered by the Health Insurance Fund, or expenses paid by employers for workers affected by occupational accidents and diseases. In addition, clause 6 of Article 42 of the Law on Occupational Safety and Health of 2015 also stipulates that the Occupational Accident and Disease Insurance funds can be used for the “payment of expenses for victims of occupational accidents and diseases to change their occupations or jobs when they return to work”, eligibility conditions for which are outlined in Decree 88/2020/ND-CP. The resources are allocated based on financial assistance plans prepared by the DOLISA at provincial level or central-affiliated city and relevant agencies, as per Decree 88/2020/ND-CP.

Thus, in 2020, some 200 billion VDN were imputed to the fund to support prevention and risk sharing, while 300 billion VDN were imputed to support career changes. According to an actuarial valuation of the scheme conducted by the ILO in 2021, this expenditure represented 0.07 per cent of total insured earnings in 2020 (ILO 2021a). Interestingly, this combined allocation is equivalent to 90 percent of the expenditure of the fund on periodic benefits in 2019 (551 billion VDN). However, no information was provided to indicate whether such expenditures would be recurrent.

The allocation of resources from a social security system to preventive or rehabilitative activities to prevent occupational diseases or employment injuries is a practice that is also adopted in other contexts, including in Russia and Poland for example (Alshits and Kulkova 2018; Rydlewska-Liszkowska 2002). From the perspective of the social protection system, allocating resources to prevention and rehabilitation can be cost-effective, with the potential to reduce the number of claims made under the scheme (Salim 2014) in order to face the under-reporting of occupational accidents and diseases, has introduced new methods of identifying them. In addition to the Employment Accident Notification (CAT. International evidence has already been able to ascertain the potential savings made by social security institutions based on such investments. Such effects have not been measured in the case of Viet Nam, however. From the perspective of OHS, the allocation of resources from the social security system can represent an important addition to the available resources to organize OHS, which are generally underfunded, including in Viet Nam. However, owing to the fact that the resources are allocated to reimburse employers for the activities they undertake, these consequently do not contribute towards the funding of public occupational health service institutions. This stands in the way of opportunities for such resources to finance activities or functions that could otherwise reach workers uncovered by the Occupational Accident and Disease Insurance. In turn, as only specific categories of workers are eligible for such funding, the potential reach of activities is reduced, and excludes, in particular, workers in informal employment and workers without labour contracts.

The practical application of these provisions – and in particular, the extent to which financed activities are effectively coordinated with or implemented through existing OSH structures – is unclear, which poses a challenge, particularly for understanding whether such activities are implemented in an effective and efficient manner (an issue highlighted in the global literature on such approaches (Meffert, Mittag, and Jäckel 2013)). The quality of activities financed and organised through social security schemes, and their effect on existing structures, may be undermined if they are uncoordinated, as evidenced elsewhere (Lecomte-Ménahès 2022).

## ► Coordination between occupational health services, health insurance and employment injury insurance

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In addition to the elements highlighted above, there also exist provisions, programmes and resolutions that provide opportunities for coordination between occupational safety and health, the health insurance fund, and the Occupational Accident and Disease Insurance.

### **Governance, legislative and regulatory instruments guiding coordination**

Firstly, the VSS participates as a member of the drafting committee for regulations guiding the implementation of the Law on Occupational Safety and Health, particularly with respect to provisions concerning the

Occupational Accident and Disease Insurance. This follows on from the fact that the provisions concerning the scheme are set out in this Law and not in the Law on Social Insurance.

Secondly, Article 91 of the Law on Occupational Safety and Health specifies the mechanisms for coordination in the area of occupational safety and health, setting out the primary responsibility for the implementation of activities coordinated with other ministries, ministerial level agencies, local government and relevant agencies. The types of activities to be coordinated include:

- ▶ The formulation of occupational safety and health policies, laws, standards and technical regulations;
- ▶ The formulation of national occupational safety and health programs and records;
- ▶ The investigation of occupational accidents; accidents and technical incidents endangering occupational safety and health; and policies and regimes for victims of occupational accidents and diseases;
- ▶ Occupational safety and health information, communication, education, training, statistical work and reporting; inspection of machinery, equipment and supplies subject to strict requirements for occupational safety and health;
- ▶ Occupational safety and health inspection, examination and supervision; and handling of violations of the occupational safety and health law;
- ▶ Commendation and reward related to occupational safety and health and;
- ▶ Research and application of occupational safety and health science and technology.

However, further Government guidance to provide detail to article 91 of the law is expected, and in practice there is limited reported coordination between OSH and social protection actors for now.

## **Programmes to promote and coordinate resources for worker's health and safety and the prevention of occupational diseases**

In addition to the above, two separate programmes, implemented by the Ministry of Health and the Ministry of Labour, War Invalids and Social Affairs (MOLISA), also call for the improvement of coordination among all stakeholders, as well as the pooling of resources in support of workers' health.

Approved by Decision 659/QĐ-TTg dated 20 May 2020, as requested by the Ministry of Health, the Programme on Care and Improvement of Workers' Health and Prevention of Occupational Diseases in the period 2020–2030 aims to provide a coordinated framework for the protection, care and improvement of workers' health, the promotion of healthy lifestyles and nutrition; the prevention of occupational accidents and diseases; and the safeguarding of workers' lives. The programme applies to all industries and sectors nationwide and calls on the coordination of a wide range of actors to promote greater coordination<sup>13</sup>. The resolution outlines 15 "projects" to be implemented to achieve stated objectives, including strengthening capacities, establishing databases for monitoring, and strengthening advocacy and communication, among others.

While the VSS is not specifically identified as a collaborating agency in the resolution or any of the projects, the Resolution identifies opportunities for the pooling of resources by the health insurance fund and the Occupational Injuries and Diseases Insurance Fund to expand available resources for the programme. Firstly, the resolution calls for the elaboration of guidelines to use the budget from the Occupational Injuries and Diseases Insurance Fund for the prevention of occupational diseases to support in "strengthening medical professional service delivery systems and computerization". In turn, the resolution calls for coordinating and integrating the programme resources "with existing resources", including of the Health

<sup>13</sup> These are the Ministry of Health, Ministry of Labour, War Invalids and Social Affairs, Ministry of Finance, Ministry of Planning and Investment, Provincial people's committees, Viet Nam General Confederation of Labour, Viet Nam Chamber of Commerce and Industry and Viet Nam Cooperative Alliance, Viet Nam Farmer's Union, The Viet Nam National Institute of Occupational Safety and Health, The Viet Nam Association of Small and Medium Enterprises, The Viet Nam Occupational Health Association as well as the Viet Nam Association of Science and Technology for OSH.

Insurance Fund, and the Occupational Injuries and Diseases Insurance Fund.

However, some Ministries – including MoLISA – did not submit documentation for reporting to the Ministry of Health on the 1st three-year implementation of the Decision, representing an obstacle to identifying whether indeed coordination or integration of resources from the two funds under the VSS was effectively achieved<sup>14</sup>.

The National Program for Occupational Safety and Health 2021-2025, promulgated by [Resolution No 19/NQ-CP](#) issued on February 16th 2022 at the request of MoLISA, also calls for strengthened coordination among a wide range of actors<sup>15</sup> to achieve improvements in working conditions of workers, the prevention of occupational accidents and diseases and the safeguarding of workers' lives. Similar language is used in the resolution calling for the cooperation and combination of programme resources (primarily from the state and local budgets) with other available sources, including from the health insurance fund and the Occupational Injuries and Diseases Insurance Fund. The research was unable to ascertain the extent to which such coordination in funding was achieved.

Despite legal and regulatory documentation calling for collaboration, some lack of clarity persists as to the actual level of collaboration in the implementation of activities, with limited available information in this area. The involvement of stakeholders in annual meetings and joint initiatives on OSH dissemination might facilitate the garnering of lessons and eliciting of recommendations for improved collaboration, whether at the central, provincial, district or communal level.

## ► Opportunities for coordination

The case study has also identified additional opportunities for coordination besides those identified and discussed above and all within the ambit of the legislative and regulatory frameworks. These include in relation to monitoring and reporting, and

### Monitoring and reporting

Currently, both the Ministry of Health and MOLISA hold responsibilities in relation to the monitoring and reporting of different aspects of occupational health and safety and WIOD. The regulatory framework<sup>16</sup> states that MOLISA and VSS have oversight on annual reporting to the Government on the implementation of the Occupational Accident and Disease Insurance and its accounting work and the gathering of associated statistics. MOLISA further collates data on occupational accidents, which is informed by data to be provided by the Ministry of Health on workers affected by work injuries undergoing medical examinations and treatment. Articles 36 and 37 of the Law on Occupational Safety and Health further sets out how the Ministry of Health is also in charge of preparing statistics and developing a database on occupational diseases, as well as monitoring, aggregating and disseminating information on OHS. Conversely, VIHEMA monitors working environments to confirm whether there is evidence of occupational hazards, which is the essential criterion for classifying any disease diagnosis as being occupationally related. Thus, while reporting on occupational health may be fragmented, it is nevertheless a shared process.

Notwithstanding the importance of this fact, there is apparently limited reported coordination between the Ministry of Health and the VSS with regard to the collection and collation of data relating to persons with work injuries and occupational diseases and their receipt of benefits from Occupational Injuries and Diseases Insurance Fund. Accordingly, the health insurance fund, despite covering the costs of services accessed in such events, is not mandated in any regulation to contribute to these monitoring and report-

<sup>14</sup> MOH, No 560/BC-BYT dated 27 Apr 2023

<sup>15</sup> Including between MOLISA, MOH, MOF, The Ministry of Planning and Investment, Viet Nam General Confederation of Labour, Viet Nam Chamber of Commerce and Industry and Viet Nam Cooperative Alliance, Viet Nam Farmer's Union, The Viet Nam National Institute of Occupational Safety and Health, The Viet Nam Association of Small and Medium Enterprises as well as Provincial people's committees.

<sup>16</sup> As per article 40 of Decree 88/2020/ND\_CP dated 28 July 2020.

ing efforts. And indeed, it is unclear to what extent the scheme collates information on this topic, as there is no public information available thereon. Therefore, there is scope for better coordination of surveillance and reporting with the social protection system.

### **Opportunities for referrals to extend access and coverage**

The institutional arrangements also create opportunities for improving access to occupational health services in the informal economy and expanding the coverage of social protection schemes. Firstly, OHS are integrated in the network of public health facilities through the Centres for Disease Control (Diep 2020). Such services are delivered both to formal and informal economy workers as indeed, under Decision 659/QĐ-TTg of 2020, the Ministry of Health is responsible for implementing “basic occupational health service packages for small and medium-sized enterprises, craft villages and for workers without labour contracts”. The delivery of OHS services through public facilities represents an opportunity to expand access thereto, particularly to vulnerable workers and those in the informal economy. This arrangement may also represent an opportunity to share information about social protection rights and entitlements or to make referrals of affected workers by the health facilities to the health insurance or the Occupational Injuries and Diseases Insurance Fund, the income protection from which is complementary to the preventive and curative services delivered by the public health facilities.

In turn, the health insurance fund and the Occupational Injuries and Diseases Insurance Fund are both administered by the VSS. This institutional arrangement may present opportunities for greater coordination and potential referrals between the schemes. For example, workers accessing medical services due to work injuries or occupational diseases who are not affiliated to the Occupational Injuries and Diseases Insurance Fund could be referred thereto by the health insurance, in order to access income protection. This would, however, require the health insurance to record the occupational or work-related nature of an injury or disease.

# Conclusion

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The research identified a range of linkages of different types, and between OSH and different social security contingencies. While not the focus of the research, this also identified linkages between different contingencies of the social security system that may have important implications for coverage and access.

While several of the linkages mirror those identified in other contexts, the experience of Viet Nam also provides rich complements to the categories of linkages that were identified at the global level under the research project for which this case study was conducted. In particular:

- ▶ It is also not uncommon for provisions relating to social protection schemes to be spread across several **legislative** instruments, although it is less frequent for these to be outlined in laws pertaining specifically to OSH, although in some contexts, provisions for OSH and some social protection contingencies are legislated together (Flores, Giménez Caballero, and Peralta 2017). Both in Viet Nam and in such contexts, this may illustrate the ambition from the legislator to consider these two areas together in an integrated fashion.
- ▶ Several linkages of a **financial** nature exist in Viet Nam. The investments made by the employment injury branch into prevention activities is not uncommon (ILO 2013), and the modality adopted in Viet Nam of reimbursements to employers for trainings they organize is also seen elsewhere (Alshits and Kulkova 2018). It would, however, be important to understand whether such an approach promotes or provides greater incentives for coordination with OHS actors. On the other hand, the calls for the *pooling of resources* between social protection contingencies and other sources to contribute towards the financing of programmes on worker's health promotion and prevention activities were not approaches that were identified in other contexts under the framework of the research. Further research on the factors (or actors) driving such calls, the challenges and opportunities to implementation of such financing modalities, and the effects of such pooled financing, would be valuable to draw lessons from this experience.
- ▶ The non-exclusion of the costs of medical benefits in the event of a work injury or occupational disease from the benefit package the health insurance fund – and the absence of identified reimbursement measures by the Occupational Injuries and Diseases Insurance Fund – means these **costs are covered and administered by the health insurance fund**. This arrangement is also adopted in other contexts (ILO 2024b), presenting the potential for certain administrative efficiencies while also potentially supporting the achievement of wider coverage and improved access for workers. Further research would be needed, however, to assess whether these benefits are achieved under such arrangements, as well as the financial implications thereof, and the extent to which these align with international social security standards.
- ▶ The existence of programmes for the promotion of worker's health and prevention of work injuries and occupational disease that **call for coordination** between all relevant stakeholders is also an interesting and important first step to translate linkages into coordination. Fostering coordination through individual programmes was a mechanism adopted in Spain around the surveillance of workers exposed to asbestos, through which multiple levels of coordination and exchange were achieved (García Gómez et al. 2006). However, the absence of reporting on the same in Viet Nam represents a challenge in terms of identifying the relative success of the endeavours, and the opportunities and challenges to coordination.

Thus, there was limited evidence pointing to concrete policies, initiatives, or activities implemented in a *coordinated* fashion between OHS and social protection actors, this despite the strong regulatory basis for doing so and the number of linkages identified between the systems - several of which themselves offer incentives and opportunities for further coordination, some of which have been outlined in the previous chapter.

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# Annex 1: National health system overview

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## Background

Health has been recognised as a national priority by the Government of Viet Nam since the country's foundation and therefore represents an integral objective of social development and economic growth. Indeed, the country's constitution recognizes the right to health care for all citizens. Since 1989, Viet Nam's health care system has transformed from a fully publicly financed system to a mixed public-private provider system. In addition, user-fees were introduced at point of care, representing a potential financial barrier for groups with limited financial means. Since then, the country has committed to achieving universal health coverage (UHC), including through the social health insurance first introduced in the early 1990s (see Annex 2).

## Vision and national health strategies

The Government of Viet Nam places great emphasis on the role of healthcare in achieving social progress and equality, enhancing the quality of life for its citizens, and meeting the demands of industrialization and modernization. In this regard, the government views investment in healthcare as a crucial component of sustainable development, recognizing its significant impact on the overall well-being of the country. To support its commitment towards ensuring the right to health for all its citizens, the Government of Viet Nam has developed several national policies and strategies. A few are presented below.

- ▶ **Five-Year Health Sector Development Plan (also known as Viet Nam's Plan for People's Health Protection, Care and Promotion)**<sup>17</sup>. The country's master plan and strategy document for the health sector highlighting the State's priorities and intentions for developments in the health care sector with a focus on the implementation of universal health coverage.
- ▶ **Viet Nam's Master Plan for Health Workforce Development 2012-2020**<sup>18</sup>. The country's master plan for the strengthening of health workforce with a vision towards 2030.
- ▶ **The Healthy Viet Nam Programme**. The country's main health promotion programme approved by the Prime Minister in 2018 to promote positive health behaviours and raise awareness of healthcare services accessible to citizens.

None of three above documents includes occupational health services as an essential component of UHC.

## Health system governance

Viet Nam's healthcare system is decentralized and divided into four administrative levels, which correspond to the state administrative management system. These levels include central, provincial, district, and commune (D.-C. Le et al. 2010). The categorization of the healthcare system into these levels helps to ensure that healthcare services are efficiently delivered and managed at the local level.

The Ministry of Health (MOH) is the main steward of the system and responsible for developing health policies, technical guidelines, and monitoring policy implementation. It is also responsible for the management of national referral and teaching hospitals as well as for the planning and implementation of medical education (Oanh, Phuong, and Tuan 2021). On the other hand, local authorities are responsible for managing health-related activities in their administrative regions (Oanh, Phuong, and Tuan 2021).

<sup>17</sup> Created by Decision No.139 /KH-BYT dated 1 March 2016.

<sup>18</sup> Created by Decision No. 816/QĐ-BYT dated 16 March 2012.

## Overview of service provision

Service provision follows the decentralized structure of the system. At the basic level, communes and district have mandate over the provision of basic medical care and preventative services. Provincial facilities serve as the primary care centres for their respective regions while central administrative regions are entrusted with the management of secondary, tertiary and quaternary levels of care as well as health education programs with central oversight.

### Health care providers

Viet Nam's healthcare system consists of public and private healthcare facilities. The number of private healthcare facilities has grown as these have become increasingly popular among Viet Nameese citizens, perceived as they do to offer higher quality care (Ministry of Health 2022). The significance of the private healthcare sector appears to be more pronounced in outpatient care, as it constituted 28 per cent of all outpatient attendance in 2018, but accounts for only 6 per cent of all inpatient treatments (Viet Nam General Statistics Office 2019). In turn, according to the latest estimates the majority of healthcare workers (84%) still remains employed in the public sector (M. P. Nguyen and Wilson 2017).

### Human resources for health

The health workforce, including doctors, nurses, midwives, and pharmacists, plays a critical role in delivering quality health services, accelerating universal health coverage (UHC), and achieving the health-related Sustainable Development Goals (SDGs). The Viet Nameese government has prioritized the development of the health workforce at the grassroots level to improve the sustainability and resilience of the health system through primary care and disease prevention. To achieve this goal, several policies have been implemented, including special medical training programs, special allowances for health staff in rural/remote areas, fixed-term rotation of health staff at district and commune levels, and task-shifting between professional groups. Viet Nam's Master Plan for Health Workforce Development spanning from 2012-2020, with a vision for 2030, aimed to improve the quality and quantity of the country's healthcare workforce. The plan focused on increasing the number of healthcare workers, improving their distribution across the country, enhancing their skills and knowledge through education and training programs, and building capacity in human resource management. Additionally, the plan aimed to retain staff in rural and disadvantaged areas.

And indeed, Viet Nam has seen a significant increase in the number of health training institutions and graduates in the past 20 years. The number of universities offering doctor training has nearly doubled since 1997, increasing from nine to a current total of 17 (WHO n.d). As of 2018, Viet Nam had an estimated total of 3.66 skilled health workers per 1,000 people (0.86 physicians, 1.14 nurses, and 0.29 pharmaceutical personnel) falling just a little short of the WHO threshold required to achieve UHC (4.1 skilled health workers per 1,000) (Viet Nam Ministry of Health 2018). Despite progress in the availability of health workers, the distribution of personnel across regions remains uneven, with health worker density lowest in the North-west mountainous and Central highlands and highest in the South East region (WHO 2016).

# Annex 2: Social protection system overview

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## Vision, national strategies, and policies

Social protection is one of key priorities of the Government of Viet Nam. The country social protection system comprises primarily of social insurance, health insurance and social assistance programmes covering all nine social security branches namely: old age benefit, invalidity benefit, survivors' benefit, sickness benefit, medical care, maternity benefit, employment injury benefit, unemployment benefit and family benefit.

Different strategy and policy documents set out the country's vision for social protection. The new Constitution recognizes the right to social security for all citizens as well as the State's responsibility in securing this right for all across the life cycle (Art 34, 2013). In addition, all citizens have the right for health protection, health care and equality in using medical services (Art 38, 2013). In 2012, the Government of Viet Nam adopted the Resolution 15 on Social Policies for 2012-2020 to strengthen the role of social protection in Viet Nam's poverty reduction framework through a series of reforms. In it, it laid out the country's vision for social protection which comprises of four mutually reinforcing pillars, namely: 1) labour market policies, 2) social insurance, 3) social welfare/assistance and 4) provision of basic social guarantees such as health care, education, housing and clean water.

A series of recent reforms has been undertaken to increase the scope of coverage and of benefits provided under social assistance and social insurance benefits. In 2017, the Master Plan on Social Assistance was adopted in view of expanding the coverage to the poorest as well as to raise benefits level. In 2018, the Master Plan on Social Insurance Reform was adopted with as key objective, the extension of social insurance to the informal sector. The Government's objectives in relation to social health protection are laid out in Resolution 20 which outlines the objectives of achieving a health coverage of 95 of the population by 2025, and to reduce out-of-pocket expenditure on health to 35 percent and 30 percent by 2025 and 2030 respectively.

Lastly, the country's Socio-economic Development Plan 2021-2025 clearly lays out the Government's social protection goals and targets for the 5-year period. Notably, it calls for the establishment and implementation of a roadmap towards achieving universal health coverage. It also strives to extend other branches of social security via social insurance and with as targets, reaching a social insurance coverage of 45 per cent of all eligible workers and more precisely, reaching an unemployment insurance coverage of 35 per cent of the eligible labour force.

## Main schemes and programmes and scope of population coverage

There are several fragmented non-contributory programmes targeted at specific groups of the population, including orphans, people with disabilities, persons living with HIV, and persons aged over 80 who are not in receipt of a contributory pension.

The Social Insurance regime provides income protection against the risk of old-age, survivorship, unemployment, sickness, maternity and employment injury. The health insurance fund provides financial protection against the costs of healthcare. Income protection schemes cover mainly formal employees, reaching roughly 38 percent of the population, while the health insurance scheme has achieved 93.35 percent of population coverage.

Both the social insurance regime and the health insurance are administered by the Viet Nam Social Security (VSS), a public service agency under the oversight of the Ministry of Labour, War Invalids and Social Affairs (MOLISA) who is responsible for promulgating labour laws and policies and the overseeing of the implementation of labour legislation. The Ministry of Health plays an identical role in relation to the Health

Insurance, while the Ministry of Finance (MOF) provides general oversight on the financial management of the schemes.

## Social health protection

### ► *Legal coverage*

The Health Insurance is the country's main social health protection scheme providing legal coverage to the entire population. It was established in 2008 under the first Health Insurance Law which consolidated previous schemes into one national social health insurance scheme. Under the Law on Health Insurance of 2008 as amended in 2014, health insurance coverage is mandatory for all residents, regardless of employment status or citizenship. The scheme includes six membership categories which define their financial protection levels as well as the source of funding for their contributions (Bales, Phe Goursat, and Phuong 2021).

The six categories are as follows:

- **Group 1: Individuals whose contributions are shared between employers and employees.** This group comprises of formal economy workers, civil servants (excluding active armed forces) and public officials hired at the commune-level on contracts.
- **Group 2: Individuals whose contributions are subsidized by the VSS.** This group comprises of pensioners, and current recipients of social insurance benefits such as persons receiving monthly social insurance pensions due to occupational accidents or diseases, unemployment benefits, disability benefits and paid sick leave.
- **Group 3: Individuals whose contributions are fully tax-financed.** This group comprises primarily of military and police officers (including those in training), veterans, poor households, children under six and social assistance recipients amongst others.
- **Group 4: Individuals whose contributions are partly subsidized by tax.** This group comprises of near-poor individuals, school children and college students and agricultural households.
- **Group 5: Dependents of armed forces personnel.**
- **Group 6: Remaining individuals.** This group comprises of individuals not covered in the above categories including informal economy workers whose contributions are paid on a family basis.

### ► *Sources of financing*

The Health Insurance relies on mixed financing comprised of both contributions and tax financing (Bales, Phe Goursat, and Phuong 2021). Health Insurance funding sources correspond to the six membership categories described above:

- **Group 1:** Employers and employees' contributions in the case of Group 1 correspond to 3 per cent and 1.5 per cent of earnings respectively.
- **Group 2:** VSS Social Insurance funds in the case of Group 2.
- **Group 3:** Taxes in the case of Group 3 and Group 4 individuals living in near-poor households in poor districts.
- **Group 4:** Taxes and household and individual contributions in the case of Group 4 except for the individuals mentioned above.
- **Group 5:** Employers' contributions only in the case of Group 5.
- **Group 6:** Household contributions in the case of Group 6.

### ► *Benefits package*

The HI scheme offers a unique package of benefits to all members, regardless of their membership categories. The package is relatively comprehensive and includes diagnosis and treatment, rehabilitation, antenatal care, delivery care, medicines, radioactive substances, technical medical services, medical devices and consumables, including traditional and modern medicine methods (Bales, Phe Goursat, and Phuong 2021). The current benefit package excludes coverage of health services covered by other funding sources or programmes such as preventative services, contraception, forensic medicine, prosthetic devices, elective services and other services such as optometry, hearing aids and mobility devices (Bales, Phe Goursat, and Phuong 2021). Health promotion services remain excluded from the benefit package as they are covered by state funding at district health centers or commune-level facilities (Bales, Phe Goursat, and Phuong 2021). Similarly, costs associated with the prevention and control of infectious diseases are covered under the state budget (Bales, Phe Goursat, and Phuong 2021).

Interestingly, while medical examination, treatment and functional rehabilitation in case of occupational diseases and work-related accidents were excluded from the benefit package under the Law 2008 (Art. 23), the amended version 2014 removed these from the exclusion list (Art.22).

### ► *Cost coverage/Financial protection levels*

Financial protection levels under SHI depend on a member's SHI membership category. To access SHI benefits, most members are required to make co-payments at the point of care with the exception of certain vulnerable groups (such as children under 6 years of age, the poor, individuals from disadvantaged ethnic minority groups and social assistance recipients), and meritorious groups (revolutionaries, war veterans, active armed forces and family members of certain meritorious groups) (Bales, Phe Goursat, and Phuong 2021). Pensioners, individuals who are living in near-poor households and family members of certain persons of merit are only required pay a 5 per cent co-payment (Bales, Phe Goursat, and Phuong 2021). For members who do not belong to these categories, a co-payment of 20 per cent applies (Bales, Phe Goursat, and Phuong 2021). SHI beneficiaries who bypass the referral system also face higher co-payment levels (Bales, Phe Goursat, and Phuong 2021). Persons receiving monthly social insurance pensions due to occupational accidents or diseases fall under category 2, and pay 20% as co-payment.

### ► *Network of service providers*

VSS contracts with a vast network of public and licensed private providers to provide health care services to its beneficiaries. Registered facilities include primary care facilities (such as commune-level health centres, regional polyclinics, district health centres, workplace clinics and some private clinics), public and private hospitals (Bales, Phe Goursat, and Phuong 2021). While a referral system has been set up to facilitate the integration of preventative medicine and curative care services, the former is often bypassed due to continued underfunding and poor quality of commune-level health care services (ibid). VSS contracts with all public sector hospitals and health centres (ibid). It also automatically covers services provided at the commune health centres without entering into contractual agreements with the facilities (ibid). VSS also contracts with private hospitals and clinics, but the large majority of private outpatient clinics used widely are not under contract by VSS and thus not covered under SHI signaling the existence of a parallel private system (ibid).

### ► *Effective coverage*

By the end of 2021, the Health Insurance has covered 93.35% of the population. The remaining uncovered population is believed to be made up of workers in informal employment and students though no study has been conducted to confirm this (Bales, Phe Goursat, and Phuong 2021). A study looking at incentives for the extension of coverage to the informal economy found that information provision and health insurance subsidies didn't increase coverage among informal workers indicating potential quality and accessibility challenges (Wagstaff et al. 2016).

### ► *Acceptability and quality of benefits*

Despite a comprehensive benefit package, access to effective primary and secondary health services under the SHI has been limited due to perceptions of low quality (N. Le et al. 2018). Insufficient funding and limited capacity among medical staff in primary care facilities has been reported as key contributors to poor quality of services observed at the primary care level (Lieberman and Wagstaff 2009; Somanathan et al. 2014; World Bank 2016). At the secondary care level, overcrowding and long waiting times have been reported as common in provincial and central hospitals (T. K. T. Nguyen and Cheng 2014; Somanathan, Dao, and Tien 2013). This phenomenon can be explained by the presence of self-referral of patients to higher levels of care as a result of perceived poor quality at primary facilities (N. Le et al. 2018). Lack of a referral system also allows tertiary facilities to compete with lower-level facilities. An increasing quality gap between services offered to SHI-beneficiaries and non-beneficiaries within the same facilities has been observed with perceived discrimination against SHI beneficiaries (Dang 2013; Duong 2014; Kim and Vu 2013).

Patient accessibility to health services under SHI is facilitated by a broad network of VSS-contracted facilities and provider choice for patients (N. Le et al. 2018). Village health workers and birth attendants affiliated with commune health stations also facilitate access to health services in remote locations. Despite such efforts, uneven distribution of financial and human resources between rural and urban areas deprives persons living in remote and disadvantage regions of access to quality health care.

## Employment injury and occupational disease protection

### ► *Coverage*

The work injury and occupational disease scheme is the only public compensation scheme in the country. The scope of legal coverage is defined under Viet Nam's labour code, the Law on Occupational Safety and Health and that on Social Insurance to include public- and private-sector employees, including household workers, with at least a one-month contract; employees in agriculture, fishing, and salt production; civil servants; employees of cooperatives and unions; police and military personnel; part-time workers in communes, wards, and townships, and certain groups of foreign citizens legally working in Viet Nam. Self-employed persons are excluded from the scheme, as are part-time staffs in communes, wards and townships.

Latest data indicates that the effective coverage of the scheme is 26.2 per cent (ILO 2020).

### ► *Sources of financing*

The Insurance Fund for Occupational Accidents and Diseases comprises of the following sources of funding:

1. Employers contributions equal to 0.5 per cent of employee's monthly payroll;
2. Profits from investment activities implemented by the Fund;
3. Other lawful revenues.

### ► *Benefits*

The scheme mainly provides compensation to injured and/or workers suffering from an occupation disease in the forms of allowances and access to medical equipment. Compensation is provided only for eligible accidents and occupational diseases, included in the official list of occupational diseases jointly issued by the Ministry of Health and the MoLISA.

The core entitlements available under the scheme are briefly summarized below:

- **Lump Sum allowance** equal to 5 times the worker's basic salary, supplemented with half of the basic salary for each additional 1 per cent of working capacity decrease, for workers suffering a 5% working capacity decrease. It is complemented by an additional allowance calculated based on the number of months/years for which contributions were made.
- **Monthly allowance** equal to 30 per cent of the basic salary, plus 2% of the basic salary for each additional 1% working capacity decrease, for workers suffering a working capacity decrease of

31% and more. It is complemented by an additional allowance calculated based on the number of months/years for which contributions were made.

- ▶ **Medical equipment** including daily-life aid equipment and orthopedic devices.
- ▶ **Attendance allowance** for severely injured workers suffering 81% or more of loss of working capacity.
- ▶ **Death benefit** for relatives of employees who die of a work-related accident or an occupational disease equal to 36 times the basic salary.
- ▶ **Convalescence and rehabilitation leave and allowance** between 5 and 10 days and per diem allowance between 25 and 40% of basic salary

The benefits under the scheme do not include the payment of medical care related to occupational accidents and diseases, which are covered under the health insurance (as mentioned above), while co-payments and treatments not covered in the health insurance benefit package are to be borne by the employer (who may be reimbursed by the social insurance if covered). According to clause 2, art 38 of the Law on Occupational Safety and Health, employers are liable to pay all medical expenses for employees without HI.

Similarly, benefits provided to survivors in the event of an occupational-related death is also currently supported by the general survivor's pension branch, shifting the burden of occupational disease and accident from employers to workers who contribute the scheme.

#### ▶ **Responsiveness to population needs and occupational disease burden**

One major limitation of the scheme lies in its **narrow definition of occupational diseases**. The current list of 35 diseases eligible for compensation under the scheme fails to include work-related musculoskeletal disorders and psychosocial hazards such as workplace stress and anxiety<sup>19</sup>. Although determining causality in work-related illnesses can be challenging, several studies have revealed work-related factors associated to common diseases found among workers such as depression, mental fatigue and musculoskeletal pain. The absence of such diseases from the official list highlights critical gaps in the coverage of workers' occupational health needs.

A survey of nearly 400 female workers in seafood processing factories found that approximately 80% of workers experienced musculoskeletal pain after which were contributed by work conditions and task demands (T. T. T. Tran et al. 2016). Another study of 289 Viet Namese industrial workers found that 38.6% of workers suffered from depression (B. X. Tran et al. 2019). The study also revealed that working long hours and health hazards exposure at work were part of factors contributing to increasing the possibility of having depression. The findings highlight the necessity for a more comprehensive and inclusive approach to workers' compensation policy in Viet Nam that recognizes and addresses a broader range of occupational health issues faced by workers.

Total expenditure of the fund was 808 billion Vietnamese Dong (VND) in 2019 while total revenue, including contributions and investment income, reached 7 433 billion VND, representing more than 9 times the fund's total expenditure (ILO, unpublished 2021). The fund's positive net cash flow also revealed an increase of the fund's reserve from 32 066 billion VND at the end of 2016 to 47 487 billion VND at the end of 2019. The fund's low expenditure levels compared to its revenues (by international standards) suggests that the scheme's benefit package may need to be reviewed, and that the management of the scheme is currently not optimal for reaching all workers who could benefit from the scheme (ILO, unpublished 2021).

Workers in the informal economy continue to face **barriers in accessing** the work injury and disease scheme. Unlike the voluntary enrolment option available for self-employed workers in the old-age pension scheme, the work injury and disease scheme does not provide a similar opportunity for self-employed individuals to participate. A recent study conducted by the ILO examined access to social protection and occupational health services for coffee farm workers. The study found that despite 78 per cent of farm

<sup>19</sup> Circular No. 15/2016/TT-BYT published on May 15, 2016 and amended by Circular No. 02/2023/TT-BYT published on February 9, 2023.

workers self-reporting occupational injuries, no accidents have been reported to MOLISA in agroforestry enterprises, including coffee production, since 2019 (Depouilly and Pham 2022). Several factors contribute to this underreporting: i) only injuries resulting in a specific level of health consequences, such as a day off work, are included in these reports; ii) work-related accidents and injuries suffered by informal workers are categorized as household accidents, which are not reported as occupational health incidents and lastly; iii) in some cases, both employees and employers choose not to report work-related accidents owing to the perceived burden of fulfilling administrative requirements for claiming compensation and the fear of facing fines (Depouilly and Pham 2022).

Yet 78 per cent of the coffee farmers surveyed had identified the work injury and disease scheme as a need, and 42 per cent have shown interest in receiving more information on the scheme (Depouilly and Pham 2022). This signals a pressing need to extend work injury and disease compensation benefits to workers in the informal economy who are at increased risk of injury and illness.

The valuation results also identified **inadequate** benefit levels, attributed in part to the scheme's allowances being based mainly on the "basic salary" rather than the actual salary of the worker (ILO, unpublished 2021). The valuation suggests revising the benefit formula to calculate the entire allowance based on the actual salary of the worker, which would result in higher allowances and increased benefits for affected workers (ILO, unpublished 2021). Expansion of the occupational disease list as well as an increase in the benefits level and scope should also be considered.

# Annex 3: National occupational health services system

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## Legal basis for the provision of OHS

The legal basis for the provision of OHS is the Law on Occupational Safety and Hygiene (No. 84/2015/QH13). It defines the preventative actions to be made available to workers as well as the state, workers, employers and other relevant stakeholders' legal duties with regards to safeguarding workers' health. However, the law does not clearly define and mandate the organizational model for the provision of OHS (for e.g. in-house, external services, social security model, state-led services etc.), nor does it identify the main entity responsible for organizing and providing OHS. The responsibility for the provision of OHS is to be shared amongst the following main stakeholders:

- ▶ **Viet Nam Fatherland and Front and its member organisations (State)** who is notably responsible for collaborating with relevant agencies to organize communication, education and training in OSH as well as developing OHS;
- ▶ **Trade unions** which are responsible to collaborate with employers to develop and supervise the implementation of OSH plans, investigate occupational accidents as requested as well as inspect and supervise OSH activities including the adequate provision of workers' compensation and vocational training for affected employees. They are also mainly engaged in the organizing educational campaigns on OSH and advocacy activities;
- ▶ **Employers** which are responsible for the provision of training and guidance on OSH regulations, provision of occupational equipment, provision of health care and medical examination for detection of occupational diseases as well as the investigation, reporting and surveillance of occupational accidents and diseases through report writing and the creation of diseases and injuries inventories.
- ▶ **Ministry of Labour** who is responsible conduct of safety inspections via labour inspectorates which have been established at all levels to survey compliance of employers and to investigate labour complaints, as well as reported occupational diseases and accidents (Diep 2020; Matsuda 1996) and;
- ▶ **Ministry of Health** who is responsible for the provision of basic OHS to workers via a network of occupational health centres and health stations (Matsuda 1996; Diep 2020; Pham 2019). These are discussed below.

## Organization of occupational health services

As discussed above, the organization of occupational health services in Viet Nam does not follow a strict service delivery model. There are notably no explicit legal obligations for employers to organize in-house or external prevention services though their obligations to provide OHS such as training, preventative medical examinations and surveillance is explicitly stipulated in the Law on Occupational Safety and Health of 2015. The Ministry of Health, industry-related Ministries, employers, and private enterprises are key players in the delivery of basic OHS. While MOLISA is primarily responsible for the implementation and management of occupational safety regulations and programmes, MOH is responsible for all occupational health and hygiene-related matters (Matsuda 1996; Diep 2020). The provision of occupational health services is divided into the following levels.

### ► *Central Level*

At the Central Level, the Viet Nam Health and Environment Management Agency (VHEMA) — which sits under the MOH — supports the Ministry in implementing occupational health regulations and manages a total of 5 national institutions engaged in preventative medicine, notably the provision of basic OHS, training on OSH and the implementation of national occupational health programs (Diep 2020). These include:

1. The Institute of Occupational and Environmental Health;
2. The Institute of Public Health of Ho Chi Minh City;
3. Tay Nguyen Institute of Hygiene and Epidemiology;
4. Nha Trang Pasteur Institute;
5. The Institute of Marine Medicine.

Universities providing medical and pharmacy training involved in the delivery of OSH training and basic OHS are also under the management of VIHEMA (Diep 2020).

### ► *Industrial sectors/Ministry Level*

Industry-related ministries and 7 industrial sectors are involved in the provision of OHS. These include the Ministry of Trade and Industry, Ministry of Agriculture and Rural Development, Ministry of Construction, Ministry of Transportation, Ministry of Public Security and the Ministry of Defense as well as the Rail Way, Aviation, Coal Mine and Mineral, Textile, Rubber, Petroleum, Post and Telecommunications sectors (Diep 2020; Matsuda 1996). OHS are organized and managed by the respective industries/Ministries and delivered via one or a combination of industry hospitals and industry-specific occupational disease clinics (in-house or external) (Diep 2020; Matsuda 1996).

Services provided typically include working environment monitoring, health check-up, occupational disease examination, OSH training for employers and employees and first aid training as well as the surveillance and reporting occupational accidents and diseases (Diep 2020).

### ► *Provincial Level*

The Department of Health (DOH), which sits under the Ministry of Health is responsible for management of all occupational health-related activities within a given province (Diep 2020). Following the reform of Viet Nam's health system in 2017<sup>20</sup>, the provision of preventative care has been implemented through Centres for Disease Control of "CDCs", previously known as Provincial Preventive Medicine Centres. CDCs provide a variety of general preventative services including OHS (Diep 2020). The latter are delivered via occupational health clinics which are managed by the Departments of Occupational Health of a given province (Diep 2020). It is important to note that not all provinces have such department which means the provision of OHS remains limited to only those which have an OH department and its associated clinic.

Occupational health services provided typically include work environment monitoring, health check-up, occupational disease examination, OSH training for employers and employees and first aid training (Diep 2020). While most CDCs include an OD clinic, their capacity in delivering OHS remains weak. At the provincial level, the majority of facilities did not have the capacity to provide adequate surveillance of occupational health conditions and adequate occupational health diagnostic tests (Diep 2020).

According to a VIHEMA report and data published on the Ministry of Health webpage, a total of 106 occupational disease clinics were established in 2022. In addition, 243 working environment monitoring units (which are attached to public or private hospitals but separate from the occupational disease clinics) were approved by the sectoral Ministries and the Department of health.

<sup>20</sup> Introduced by Circular No. 26/2017/TT-BYT dated June 26, 2017 of the Ministry of Health on providing guidance on the functions, tasks, powers and organizational structure of Centers for Disease Control of provinces or centrally run cities.

### ► *District Level*

At District level, District Health Centres provide a variety of curative and preventative services to the entire population. The provision of OHS is done via the Public Health Section of District Health Centres (Diep 2020). Occupational health services provided typically include work environment monitoring (which all enterprises must undergo), health check-up (including pre-employment and periodic) and first aid training (Diep 2020).

According to the guidance from MOH, the working environment monitoring must show occupational hazards to diagnose an occupational disease. Providers meeting eligible criteria for working environment monitoring would be disseminated on the website of VIHEMA or Department of Health. However, no district health units have licences from Department of Health to conduct working environment monitoring or conduct investigation and diagnosis of occupational diseases (VIHEMA, 2023). In turn, the supervision of the results of working environment monitoring is limited. Thus, all KII from health sector recommended that an external agency is needed for validation the results of working environment monitoring.

Annually, VIHEMA holds a review meeting with 1) results of periodic health examination (five levels of health classification by MOH guidance); 2) common diseases in workers; 3) results of examination and assessment of 34 occupational diseases (annex 1.2). Work Environment Monitoring Results were reported by Circular 19/2016/TT-BYT from district to province then submit to central level (VIHEMA).

### ► *Commune Level*

The commune level is responsible for the delivery of primary health care for people, and is notably accessed by agricultural and informal sector workers (Diep 2020). Commune health stations (CHSs)/Commune health centres (CHCs) provide a variety of basic health services such as mother and children health care, family planning, treatment for acute respiratory infections, immunization and treatment of common ailments (Diep 2020). With regards to OHS, services provided typically include periodic health check-up for workers, first aid training and first aid service for local enterprises (Diep 2020).

### ► *Enterprise level:*

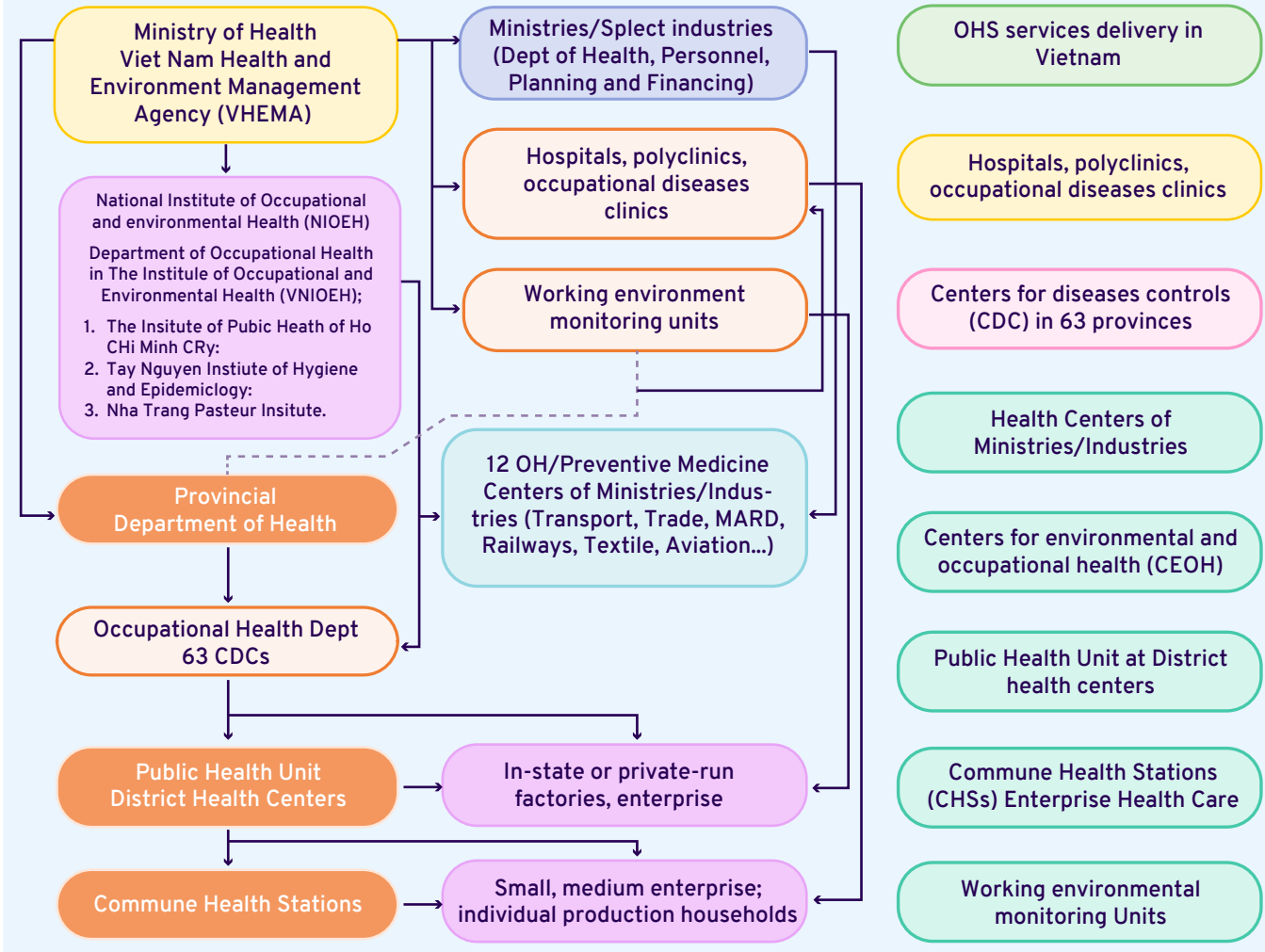
According to the OSH Law, to ensure occupational safety and health in production and business establishment, OHS unit (art 72), Health Unit (Art 73), OSH representative (Art 74), and OSH councils (Art 75) are mandatory established at enterprise level, depending on the “size and characteristics of work, risks of occupational accidents and diseases, and working conditions”. It is common for factories to have in-house health stations where occupational medical services are available to workers, including pre-employment and periodical health check-ups, general consultations as well as first aid services (Matsuda 1996; Diep 2020, 202). Suspected cases of occupational diseases diagnosed in these stations are then referred to the Division of Occupational Medicine in district or provincial hospitals (Matsuda 1996). According to a survey by VHEMA of 57 provinces out of 63 in 2016, 11.7 per cent of enterprises had in-house medical personnel, 5.4 per cent had health centres, 0.05 per cent had privately-run hospitals, 0.2 per cent had privately-ran clinics and 3.5 per cent contracted with other health care facilities (Diep 2020).

In addition, pursuant to Article 38 of the Law on Occupational Safety and Hygiene (No. 84/2015/QH13), the employer has the following obligations:

- Coverage of co-payments as well as expenses for medical care which is not included in the benefits package of the national health insurance scheme, and payment of medical care for workers not covered by health insurance.
- Organize timely first aid and emergency care, cover and advance their costs.
- Organize and pay for the health check-ups of workers at least once a year and at least once every six months for workers performing heavy, toxic, hazardous work/occupations, for workers with disabilities, minor workers and elderly workers. Health check-ups must be provided at health facilities that meet national technical requirements and standards.

Figure 2 below summarizes the organization of occupational health services in Viet Nam.

► Figure 2. Organization of occupational health services in Viet Nam



Orange boxes represent the public health system, which includes but is not limited to occupational health services (OHS), also covering environmental health and disease control. The second column shows vertically organized structures by industry. The two central orange boxes are cross-cutting but specialized in OHS. The 12 Preventive Medicine Centers operate at the same level as the Occupational Health Departments but are affiliated with sectoral ministries; only selected industries currently have such centers.



International  
Labour  
Organization

# Coordination mechanisms between social protection and occupational health services in Viet Nam

**International Labour Organization**  
**Governance Department - Occupational Safety and Health and Working Environment Branch**  
**Universal Social Protection Department**  
Route des Morillons 4  
CH-1211 Geneva 22  
Switzerland

**T: +41 22 799 7239**  
**E: [socpro@ilo.org](mailto:socpro@ilo.org)**  
**W: [www.ilo.org](http://www.ilo.org)**  
**[www.social-protection.org](http://www.social-protection.org)**