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“Health is gold”:

Institutional structures and the realities of health access in the Mekong Delta, Vietnam

Panagiota Kotsila

Abstract

Vietnam has dealt historically with health as a valuable asset, a resource that was distributed in an equal manner to all citizens through the development of a wide and inclusive grassroots health network during the 1970s. Since then, the health system has developed – in parallel to the country's economy and shifts in policy – from a free-for-all service of a rather low quality, to a system that is now better regulated and has overall better quality, but is conditioned to user fees. Following the liberalization and decentralization policy directions of the Vietnamese state that initiated in the late 1980s, health is now open to private sector activity and competitiveness while still under the general control and power of the state. The impacts of these changes have been felt more and more recently as a result of widening socio-economic gaps among the population, which reflect on the way health services are being offered and accessed.

This paper reviews the literature and delineates the structure and organization of the health care and health prevention delivery systems in Vietnam. Information is triangulated and enriched with findings from the field, obtained through qualitative interviews with health officials, doctors and citizens in rural and urban localities within the Mekong Delta. While examining the function of health institutions, deficiencies are highlighted: (i) the state is not consistent in monitoring and ensuring the regulatory compliance of public or private health service providers, (ii) financial autonomy in the health sector, combined with the withdrawal of central support away from local health units, are creating inequalities in access while not bettering the quality of offered services, (iii) rurality and poverty are closely connected to each other and to restricted health access, either due to limited existing specialized care facilities or the inability to pay for them. Based on secondary data, the paper also presents the latest statuses of the main health indicators, which not only illustrate the general improvements achieved, but also indicate the yet unreached goal of effective preventive medicine that could sustainably control many prominent diseases and could further build better understanding around health in general.

Keywords: health institutions, health care, Vietnam, economic liberalization, equity, poverty

List of figures

Abbreviations

CDD	Control of Diarrhoea Disease
GDP	Gross Domestic Product
MOF	Ministry of Finance
MoH	Ministry of Health
MOIT	Ministry of Industry and Trade
PC	People's Committee
PHC	Preventive Health Centre
UNICEF	United Nations International Children Fund
VHLSS	Vietnam Household Living Standard Survey
WHO	World Health Organization
WSS	Water Supply and Sanitation

1 Introduction

1.1 Health systems at the epicentre

Health problems are as versatile and prone to change as human populations, cultures and natural environments. At the same time, certain patterns and risks concerning human health have been pinpointed, studied and tackled through the focused efforts of science, policy and society contributing to the general betterment of human health, longer life expectancies and the successful control of many sicknesses around the world. Despite these achievements, existing inequalities still do not allow for universal access to health as described by the Declaration of Human Rights:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."
>
> (United Nations, 2007: 6)

Vicious cycles of poverty and bad health around the world are threatening people's well-being, especially in the context of developing countries (Bloom & Canning, 2003; Harriss and Salway, 2009). However, these cycles can be potentially broken if the principles of equity and justice manage to guide change and policy in the wider health sector (Bloom & Canning, 2003; Braveman & Gruskin, 2003).

During the last UN Summit in September 2010, some of the world's leaders and international organizations, together with civil society and research representatives, committed once more to maintain and fortify their efforts in achieving eight Millennium Development Goals, which include reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases (United Nations, 2010). In the latest World Health Statistics publication by The World Health Organization (WHO, 2012e) some 10 focus areas of health are listed, indicators of which can draw a picture of a place's health situation when looked at together: (1) life expectancy and mortality, (2) cause-specific mortality and morbidity, (3) selected infectious diseases, (4) health service coverage, (5) risk factors, (6) health workforce, infrastructure and essential medicines, (7) health expenditure (8) health inequities (9) demographic and socioeconomic statistics and (10) health information systems and data availability. A distinction can be made between indicators that express wider living conditions (5, 9), health outcomes (1, 2 and 3) and the majority of them that are related to health institutions (4, 6, 7, 8 and 10). While recognizing the interdependency of all the above factors, underlining this distinction shows how the function of existing institutional health structures – in the form of health care, prevention and patterns of health management and governance – has a tremendous role to play in shaping the health status of a country. The WHO (2000), in a report dedicated to health systems, notes:

> "Health systems consist of all the people and actions whose primary purpose is to improve health... They have contributed enormously to better health, but their contribution could be greater still, especially for the poor. Failure to achieve that potential is due more to systemic failings than to technical limitations. It is therefore urgent to assess current performance and to judge how health systems can reach their potential."
>
> (WHO, 2000:2)

1.2 Vietnam: New economic dynamics and health linkages

The regional focus of the present paper is the Mekong Delta in Vietnam, a country that has recently experienced economic upheaval following the opening of its market to global economies in 1986. Combined with the maintained socialist system of state organization, Vietnam offers an interesting combination of structures and dynamics reflecting on the lives of the population and the function of its institutions. The Vietnamese health system has been an appealing subject of study for scholars, due to its transitioning nature: from its socialist past of expanded basic health provision reflected in improved health indicators during the 1960s (Bryant, 1998), it has moved to its current market-guided character, paralleled to wider economic and policy changes in the country, during the last 20 years. The main changes taking place during the renovation era affecting the health sector are mainly the official allowance of private investment in health, starting in 1987, the autonomy of health units with the consequent introduction of fees in 1989, and the compulsory character of health insurance for the working population, apart from farmers and self-employed people, in 1991 (Minh Nguyen Thang & Popkin, 2003; Nghiem Tran Dung, 2010). This transition has brought with it various achievements as well as challenges in the health sector (Axelson et al., 2009; Bloom, 1998; Nguyen Thang et al., 2006:9; Vian et al., 2012:10), which will be discussed in following parts of this paper.

Initially, the gradual shift in focus (and funding) from primary health care and more towards higher-level curative units during the 1990s negatively affected the quality of rural health services (Fritzen, 2007). Basic health still improved continually throughout this period, but this can also be partly explained by the general economic growth that followed the opening of markets, which was translated into better life standards for most of the population (Gainsborough, 2010:265). Poverty since then has certainly been reduced, but not eradicated, as 60 districts in the country have more than 50% of their population living in poverty (Government of Vietnam, 2008b). In a similar manner, health care and health status have not improved equally for all. Access inequality across regions and social groups is increasing, with rural areas or marginalized groups suffering a lack of access to good health services (MoH, 2010:6). Vietnam's Statistical Service reports on how people in urban and rural areas have access to different types of medical facilities (better equipped and staffed tertiary-level hospitals versus local clinics with restricted resources), while this access is also a matter of household income (GSO, 2008). Nowadays, there are 137 private hospitals in the country (Kieu Linh, 2012), a number that has risen quickly but remains relatively small compared to more than 1,000 existing public ones (GSO, 2011; Nghiem Tran Dung, 2010). Most of these private hospitals are situated in urbanized areas and further expansion is hampered, partially because of legislation-related obstacles, but also due to the low demand for highly-priced health care in the country's poorer rural areas (Kieu Linh, 2012).

Problems of equity in the health sector are highlighted in one of the World Bank's (2010) assessment reports (for the Mekong Regional Health Support project) and include out-of-pocket spending among the poor as well as the existing knowledge of health insurance benefits. Such indicators were previously ignored, but were found to be extremely important when defining health access (World Bank, 2010) and started to be appreciated in the country, as is reflected in recent policy documents. However, up to today, catastrophic health expenditures are forcing 3 million people to live below the poverty line yearly (Vian et al., 2012: 3), a problem that new (more inclusive and obligatory) health insurance policy is trying to tackle. At the same time though, efforts to purge the health care delivery system and to protect citizens are being hindered by corruption, which has infiltrated multiple layers of the Vietnamese health sector (Ibid., 2012 :5-8), thus putting overall governance quality and the trustworthiness of the system at stake.

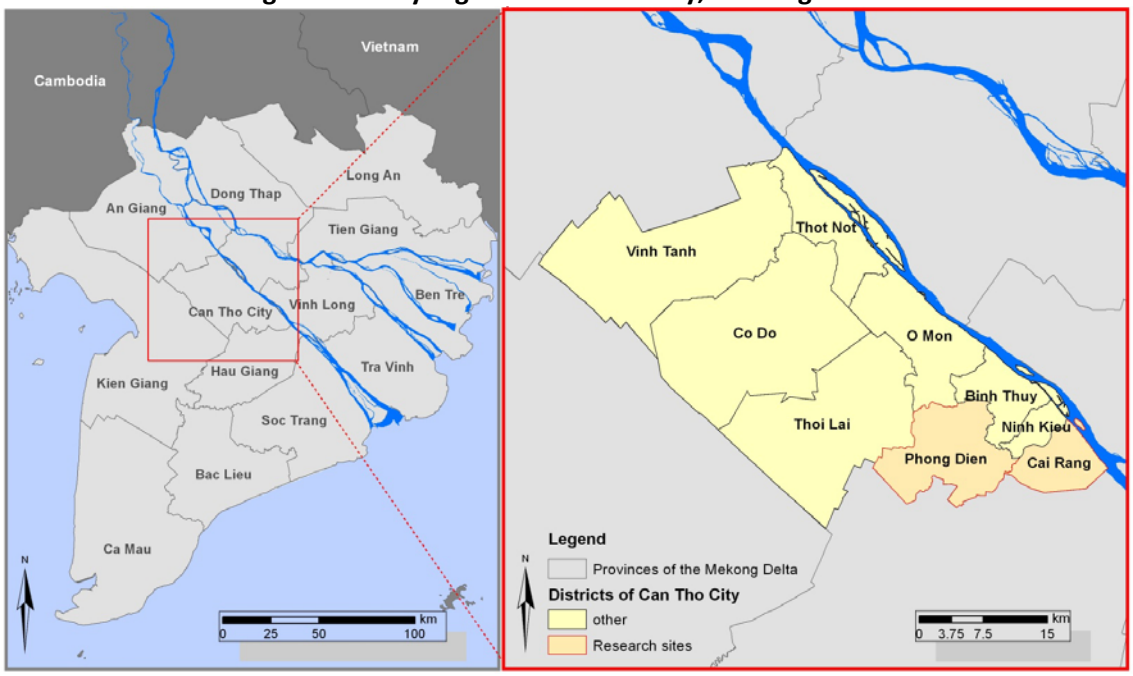
The Vietnamese saying "sức khỏe là vàng," meaning "health is gold," indicates how much Vietnamese people value good health. With the abovementioned institutional shortcomings and persisting access inequalities, the above quote can easily carry connotations of connections between

health and wealth. Problematizing equity and how "public" the public health sector in Vietnam really is, London's (2008) remark says it well:

> "Vietnam's health sector is very much in the process of becoming. Just what it is becoming, remains unclear"
>
> (Ibid., 2008: 127).

This paper aims to trace shortcomings in the way the current health system in Vietnam functions and to highlight the implications that this has on socio-economically vulnerable groups. By delineating the health care system, a picture of its structure and function is set forth. Underlining some of the most important policies defining health access and quality of services, the paper examines the reality and impact of their implementation as studied in the Vietnamese Mekong Delta region. Information and data were gathered throughout a research period of 10 months in Can Tho City (Fig 1), during which a number of semi-structured interviews took place with citizens, health workers and representatives, local cadres and policy-formulating offices from the lowest to the highest administrative levels[1].

Figure 1: Study region of Can Tho City, Mekong Delta



Cartography by: Sven Genschick

[1] **Methodological note:**
As part of the wider WISDOM project (http://www.wisdom.caf.dlr.de/) research was conducted during the period May 2011 – March 2012 for the purpose of a PhD dissertation. Research activities were funded by the German Federal Ministry of Education and Research (BMBF) and facilitated by Can Tho University.

Findings are based on semi-structured interviews held with local cadres and health representatives, preventive health offices as well as health experts, medical personnel and professionals in the health sector. Discussions were held with residents of the study areas through household visits in the framework of a survey held in the districts of Cai Rang and Phong Dien, as well as through in-depth interviews with some selected households. Personal observations, note-taking, and photographic material were collected to complement the research findings. Secondary material in the form of statistical health records, reports from Vietnamese authorities and NGOs, as well as legal documents and local media material were examined and analyzed.

Guidance on the structure and the content of this working paper were provided by Dr. Saravanan Subramanian, whom I thank deeply. Advice and comments offered also by Dr Gabi Waibel are very much acknowledged and appreciated.

2 Institutional structures of health

The Vietnamese State has taken important steps to change and regulate the health sector over the last 20 years through a number of legal documents, strategies, policies, laws and plans (MoH, 2010). The "Master Plan on development of Vietnam's health care system up to 2010 with a vision to 2020," which was formulated and has been approved since 2006 (Government of Vietnam, 2006b), covers a wide spectrum of issues such as preventive medicine, grassroots health care, medical services and drug regulation (MoH, 2007a). The guiding objective of the plan is:

> "... to build Vietnam's health care system step by step, modern and complete, to achieve equality, effectiveness and development; to meet the increasing and diversified demands of the people for health protection, care and improvement; to reduce morbidity and mortality rates, increase life expectancy and improve living quality."
>
> (MoH, 2007a:172).

The plan focuses on the prevention and control of major epidemics as well as non-infectious diseases. A second priority of the plan is to base the network of local clinics on residential areas and not on administrative barriers, in order to make health care more reachable and available for all. The target concerning local health care for 2010 is for 80% of all communes in the country to have a clinic that fulfils national standards. Financial provisions for the following years give priority to consolidating and perfecting grassroots health care and provincial – and district-level – hospitals (especially those in the vulnerable regions of the Highlands, Central Vietnam, the northern mountainous regions and the southern Mekong Delta) while ensuring funds for the poor, the under-6s, and other beneficiary groups. On the other hand, the plan generally pushes to end gradually public health expenditure on treatment facilities, as they are expected to become unnecessary through the successful performance of the health insurance scheme and hospitals' autonomy. In the same spirit, the plan also provides for preventive medicine services starting to charging fees for parts of their services.

The responsibility for the success of all the programs lies with the Ministry of Health, which in coordination with other ministries and local governments has to organize and coordinate their implementation while reporting frequently to the Prime Minister on progress (MoH, 2007a: 191). The most recent of such evaluation reports conducted by the Ministry, regarding the health sector, is the *Five-year Health Sector Development Plan for 2011 – 2015*, which also reviews and assesses the implementation of the Health Plan so far (MoH, 2010). Shortcomings and areas that still need improvement are numerous (Ibid., 2010) and include disparities in health status and health coverage across regions and income/social groups, huge difficulties in the grass-roots health care network, especially in remote areas, and limited collaboration and public participation in a generally weak preventive medicine sector, especially at the district level. Moreover, responsiveness in the curative sector is judged as limited, the quality of service as poor and the phenomenon of over-crowding in hospitals ever-present, while the financial mechanism of hospitals' management also remains a problem. Further issues include policy gaps, low technical abilities on the collection of health information and management, as well as ineffective human resource management throughout the whole health sector. The ministry also recognizes that public spending on health is low and the existing capacities in health strategy planning, inspection, monitoring and supervision are weak (MoH, 2010).

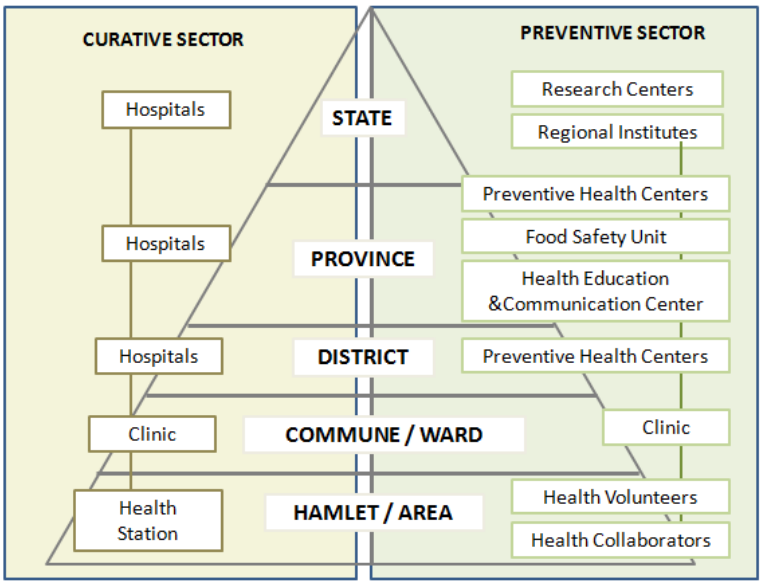
2.1 A pyramid with weak foundations

The health delivery system is organized according to administrative divisions following a managerial pattern of decentralization up to district level (Fig 1 in Annex), which is observed as much in health as in most sectors in the country. The main control of and responsibilities for implementing plans and

policies remain with the Ministry of Health, under the direct management of which are a number of high-level institutes, colleges and central (level-3) hospitals[2] (MoH, 2007a :178). At the province level, each local government (People's Committee), through the Department of Health, manages units such as preventive health centres (PHC), provincial hospitals (level-2)[3] and district hospitals. Health offices in each district act basically as conduits between hospitals, district PHCs and the district PC by collecting statistical information, writing reports and drafting local plans concerning health care and prevention (Co Do Office of Health, 2009). District PHCs have responsibility for offering preventive medicine services and for managing and guiding commune clinics within their jurisdiction (MoH, 2010).

Through the above described organizational structure and distribution of roles, policy formulation, organization and supervision of health operate at higher levels of the state hierarchy, but basic health care provision and preventive health activities mostly take place at the local (commune and district) level (Fig 2). In the communes, both of these functions are met by clinics, whereas curative treatment and prevention at the district level and above are implemented by different bodies. In the smaller divisions of hamlets and areas, there are health stations, health volunteers and collaborators, the curative and preventive roles of which are often intermingled and unclear (section 2.1.3 in this paper). Higher-level supra-institutions, such as the Food Safety Unit, the Health Education and Communication Centre, or the Institute of Public health and Hygiene, have specialized roles in different areas of the health sector.

Figure 2: Health institutions offering curative and preventive services in Vietnam



Design by: author, based on fieldwork results

[2] Level-3 hospitals are "those grade-I or special-grade standard hospitals that provide highly specialized techniques, conduct scientific research and concurrently operate as practice establishments for students of medical and pharmaceutical universities" (MoH, 2007:178).

[3] Level-2 hospitals consist of "general and specialized hospitals of provinces or centrally-run cities, private hospitals and some hospitals run by different branches but still fulfil grade-II or higher standards, provide medical examination and treatment needs and operate as practice establishments for students of medical and pharmacological schools in the provinces and cities" (MoH, 2007:177).

2.1.1 Hospitals

Starting with curative services, all hospitals are graded (I, II, III, IV) (Government of Vietnam, 2005) according to a point system of evaluation that follows the criteria of location, mandate, number of beds, organizational structure, human resources, qualifications of staff, available expertise, technology, infrastructure, equipment and the number of specialization units. The administrative position of public hospitals under higher-level control "rewards" them with points, as does the possession of more resources and expertise proven through the above indicators. The grading system corresponds to the classification of hospitals as Level 1, 2 or 3 (MoH, 2007a), a result of which is, for example, that most grade-I hospitals are Level 3, usually directly under the administration of the MoH or the province. They will also be expected to offer a better quality of services, though the connection between quality and administrative position is not legally binding. Corresponding to the pyramid model, there is a hospital in each of the districts and it can be of any grade, according to its capacities. Part of any public hospital is also a public pharmacy, meant to provide prescribed medication to visiting patients and thus completing a legally regulated cure path under state control.

Hospitals are the main units offering examination and treatment, and their usage is very popular for inpatient conditions, whereas outpatient cases – suffering from what is usually referred to as "normal" sickness[4] – are most likely to turn to private practitioners and private pharmacies or follow in-the-house treatment (Fritzen, 2007a:1617; Nguyen, 2011:12). A combination of factors, including the force for financial autonomy, the so far ineffectiveness of the health insurance mechanism and the fee-for-service system that hospitals follow, together with poor management and monitoring, result in high costs for patients while the quality of services and in-hospital conditions remain low (MoH, 2010).

2.1.2 Commune clinics

Moving down levels, health clinics in communes (rural) or wards (urban) offer basic examination and treatment services. According to regulation (MoH, 2007a:180) there should be one commune clinic worker per 1,000 – 1,200 inhabitants. In Can Tho City there are 72 health clinics in a total of 85 communes, showing a relatively good coverage, although capacities, conditions of facilities and the skills of workers can vary across the network (London, 2008: 122). The statistical yearbook of each district visited during fieldwork showed an average of one worker per 2,300 inhabitants[5], about double the standard set out by the Health Plan (Statistical Division of Phong Dien, 2010; Statistical Division of Cai Rang, 2010).

According to new legislation (Government of Vietnam, 2011), all local clinics should be equipped with the following: one doctor employed at least three days a week, an examination room, traditional[6] medicine services, a pharmacy, a laboratory room (clinical), a sterilization facility, a first aid room, an emergency room, a room for pregnant patients, a room for gynaecological exams, a delivery room, a

[4] Interviews with 23 households referred to "normal" or "light" disease such as fever, diarrhoea, flu, light injury.

[5] In the rural case of Phong Dien district, there were a total of six clinics with 43 health workers (20 of which were doctors and nurses) for a population of 99,727 people, thus meaning one clinic worker per 2,319 inhabitants (Statistical Division of Phong Dien, 2010).
In the urban case of Cai Rang there were 39 clinic workers (of which there were 33 doctors and nurses) in a total of seven clinics servicing a population of 86,150 – a similar average of one worker per 2,209 inhabitants (Statistical Division of Cai Rang, 2010).

[6] Traditional medicine in Vietnam has been influenced greatly by traditional Chinese medicine and involves the use of special herbs and plants together with other types of alternative therapies (interview with Director of Traditional Medicine Hospital in Can Tho, 28.06.11). It has been officially part of higher education in Medicine since 1984, and exclusively traditional medicine hospitals and pharmacies coexist with Western medicine counterparts throughout the country, as described by Ladinsky et al. (1987) and witnessed during fieldwork.

vaccination room, a population and family planning counselling room and an administrative room. In 2009, only 69% of communes had doctors, while the nurse-to-doctor ratio, an indicator of health care quality, was found to be among the lowest in the South East Asian region (MoH, 2010). Facility requirements were not met in any of the three clinics visited in Can Tho, and the literature suggests that such exemplary clinics are very hard to find, especially in rural and remote parts of the country (DSW, 2011:9; MoH, 2010).

As mentioned, apart from providing basic health examination and medicine, commune clinics hold a very important role in coordinating, supervising and executing preventive health programs under the wider preventive action plan of the province. According to relevant regulation (Government of Vietnam, 2011) a commune clinic is responsible for mobilizing citizens to participate in the implementation of health programs and for training hamlet health workers on how to integrate their activities with these programs. Health education and training responsibilities are also mentioned in law but are not given specific content or concrete direction:

> "Commune health clinics will deploy communication and health education activities, population and family planning through mass media and communication in the community, when visiting families and when people come to have examination and treatment in commune clinic and in schools."
>
> (*National criteria for commune clinics period 2011 – 2020* issued together with Decision No. 3447- Government of Vietnam, 2011).

The list of 10 criteria for commune clinics, which basically describe responsibilities and targets, expands into the areas of food hygiene control, malnutrition, population control, maternal health care and others, all of which the clinic has to organize and implement. Considering multiple constraints (infrastructure, human resources, funding) and the fact that the clinics operate principally to offer curative services, health prevention activities constitute a real challenge.

2.1.3 Health stations and local health workers

Last in the pyramid of health units are health stations, which we find in most of the smallest administrative divisions (rural hamlets and urban areas). These establishments cover on average 1,000 – 2,000 people each, and observations in the five stations visited in Can Tho (Picture 1, right) show how they are usually run by one or two people, have restricted facilities for inpatient treatment, and their availability is not guaranteed in all the hamlets or at all times because their operation depends on a health worker who works on a semi-voluntary basis.

Picture 1: Left**:** Entrance to a ward clinic in Le Binh ward, Cai Rang district. The medication available for sale can be seen in the background. The rest of the clinic consists of an examination room and a laboratory.
Right: One of the area health stations of Le Binh ward. The examination, sale of medicine and temporary treatment areas (bed in the right-hand corner) are all in the same space.
Photos by: the author.

The relevant recent regulation (Government of Vietnam, 2010a) states that health workers are entitled to a monthly allowance from the state and from funds (if any) from other undefined sources, as well as a medical bag with devices, prescribed by the MoH. Bloom (1998) on the other hand reports that health stations have been operating at their own expense and workers receive no salary or any kind of financial support from the government. Interviews with NGO representatives, officials and health workers confirm such findings, indicating that the rather "open" legislative framework leaves space for funding cuts or shortages (interviews with NGO representative, 11.12.11; Health officer in a remote rural commune 18.07.11; Hamlet clinic in a rural commune 15.12.11; Area clinic of an urban ward 13.12.11).

A minimal fee is charged to visiting patients and the retailing of medicines is allowed in health stations, but only from a set list of medications provided by the MoH (including drugs manufactured within the country and at a lower price). Professional requirements for the recruitment of health station workers are not demanding, as they include (i) having a basic level of health education and upwards, acquired through training for a minimum of three months, (ii) living and working permanently in the locality, (iii) having a sense of responsibility and enthusiasm for participating in social activities and (iv) being physically fit to perform the prescribed duties (Government of Vietnam, 2010). As a consequence, one can find in a health worker's post a wide spectrum of health-educated individuals, from academically trained retired doctors to physicians, nurses, pharmacists, or just people who have received some training over a period of months (interviews with health officer in a rural remote commune 18.07.11; Hamlet clinic in a rural commune 15.12.11; Area clinic of an urban ward 13.12.11). Efforts to take better educated and experienced personnel from higher levels down to the health stations, in order to train and provide station workers with a better level of expertise, are mentioned in the report by the ministry (MoH, 2010) but in none of the 45 interviews with health cadres and medical personnel in Can Tho.

Altogether, the impression obtained through nine in-depth interviews held with inhabitants from rural areas and 70 household visits in urban as well as rural areas was that local health stations, and to an extent commune clinics, are perceived by many as curative units of inferior quality. The literature also indicates such perceptions (London, 2008:122) and the ministry recognizes this by acknowledging the problem of 'bypassing' (people avoiding commune- and district-level care and seeking treatment in what are considered better quality central units for diseases that, according to the report, could be handled by local units) (MoH, 2010). Interviews with officials on the issue were often contradictory:

> "For the serious diseases they will go to the hospital, but for the 'normal' ones they will just visit the pharmacy or a private doctor…."
>
> (Interview with a health officer in a rural district, 18.07.11)

> "There are very few people nowadays that just visit the pharmacy; they know the steps that they are supposed to follow and go to the doctor first."
>
> (Interview with a health officer in an urban district, 20.07.11)

> "This is a place to treat simple diseases and the people don't have to go to the higher levels of health care for that. They just come here and get cheap medicine: only 10,000 for three doses of medicine for 'normal' diseases and the people get well; they are satisfied with the treatment."
>
> (Interview with a hamlet clinic in a rural commune, 15.12.11).

2.2 Planning and implementing prevention

As mentioned at the beginning of this chapter, the prevention, forecasting and control of major epidemics is prominently placed in the first lines of health objectives defined by the Ministry for the

next 10 years (MoH, 2007a). With Decision 255 of the same year (Ibid., 2007a), the *National Strategy on preventive medicine to 2010 and orientations towards 2020* was approved. The central role of active and proactive preventive measures is recognized, and diseases such as HIV, malaria and child malnutrition are mentioned repeatedly. Changing the awareness of people through comprehensive education activities is punctuated as a strong means of prevention. The strategy also recognizes existing preventive health policy challenges such as low quality, bad infrastructure and lack of staff.

The objectives and directions of the policy documents are translated into specific health programs organized and supervised by the network of PHCs situated in the provinces and districts (MoH, 2007a :89 -90). Provincial PHCs are principally consulting and supervising bodies for programs that include prevention and control strategies against diseases, the promotion of children's health, and measures to expand and improve sanitation, public hygiene, and health education activities. Apart from managerial responsibilities, PHCs at this level also have adequate equipment and expertise to perform certain preventive health medical activities. The PHC of Can Tho City, for example, has laboratory equipment to test samples for infectious diseases, to run analyses of water samples from water stations, companies or private wells and to check for compliance with quality criteria.

In the districts, PHCs are much simpler establishments that carry out programs following the directions of ministerial-level guidelines on prevention, while there might be slight adjustments on selecting which programs will be emphasized, depending on human resources and the level of coordination with other authorities (like the office of health, the hospital, civil society groups such as the Women's Union, etc.). Their role is mainly to collect data from the communes (or wards), organize district-wide activities (place up banners with preventive health messages, hold speeches in schools), gather and provide educative health material, guide and supervise lower level health units and of course provide monthly and yearly reports to higher levels.

At the commune and hamlet levels there are two types of institutionalized health posts directed at health prevention, namely health volunteers and health collaborators. Health volunteers' duties are mostly connected with aspects of health and disease, as they are supposed to spread information and knowledge on prevention through person-to-person communication. According to respondents from local health clinics, health volunteers are trained in the Health Education Program of the city's PHC on measures regarding sanitation, hygiene and diseases.

As the title insinuates, they do not get paid for their services and their selection is made by the health clinic from a number of people in the local community, but whether this involvement initiates in a completely voluntary manner is unclear (interviews with: A hamlet clinic in a rural commune, 15.12.11; An area clinic in an urban ward, 13.12.11). The same in-depth interviews indicate that health collaborators are trained specifically for carrying out activities for the PHCs' family planning programs. They interact closely with households in each locality under their jurisdiction, as they report frequently on the demography of the community. Due to this 'licence' to enter households and gather information, they are often also assigned to reporting on the sanitation and water supply situation as well as holding discussions with household members around these and other issues of preventive health. They are thus fulfilling the role of the health volunteer, for which they receive some extra funds on top of their monthly salary (100,000 VND = 4.77 USD) with which they are supported by the government in a rather symbolic manner. From what was observed in the two case study communes, it seems that health collaborators outnumber health volunteers, and their presence is indispensable for the reporting machinery of the country (three to four times more in each case study commune).

However, nowhere in the official Plan for Health or Prevention Strategy (MoH, 2007a), or any other legal document collected, were their duties and rights officially declared. In the ministry's report (MoH, 2010) it is mentioned that the preventive health network does reach the village level, but there is no mention specifically of the 'health worker' 'health volunteer', or 'health collaborator'. The

distinction between these health post categories remains blurred, judging also by the interviewees' responses:

> "In this commune there are 13 health volunteers – some of them are also health collaborators and some of them are the same people who run the health clinics in the hamlets. They don't get paid; they do it from their hearts... They will go around and talk to people, tell them how to prevent accidents (keep electricity cables higher than the ground, be careful with the pesticides they use, etc.) but also regarding diarrhea, they will talk about keeping a clean home environment and be hygienic in eating and drinking."
>
> (Interview in a commune clinic in a rural district, 15.12.11)

> "There are also the health care units who are basically retired doctors or nurses that offer health care services in return for a very small payment. They don't get paid by the government, they are somehow volunteers. They have a sign outside their doors so that people know who they are and where they are. They also have the right to sell some 'normal' out of counter medicine."
>
> (Interview in the PHC of a rural district, 18.07.11)

> "Health volunteers or collaborators are people that talk to people and work towards family planning (contraception) and HIV prevention. These people are trained about these issues (malaria, malnutrition, prevention, etc.) by the district or the city's PHC. Some of them have some specialization in these issues, but many don't and just get the training."
>
> (Interview in the PHC of a rural district 15.09.11).

Overall, the structure of the preventive mechanism still focuses on the local level, with great responsibilities placed on local health staff for whom economic incentives provided by law are insufficient. Despite the strong the willingness and sense of communal responsibility – which, according to the interviews, push people to participate and contribute with their work – the available infrastructure and human capacities in the local levels are need of support. The existing distribution of funds does not reflect the legally prioritized interactive, awareness-changing approach that relies on the function of those grass-roots health institutions:

> "Preventive medicine work at the grass-roots level (district, commune and village) has not been fortified compatibly with their tasks. Relations between the preventive medicine and other sectors, as well as local mass and social organizations, are not tight. Incentive policy for preventive workers is not satisfying."
>
> (MoH, 2010).

2.3 Reporting mechanism: the example of diarrhoea

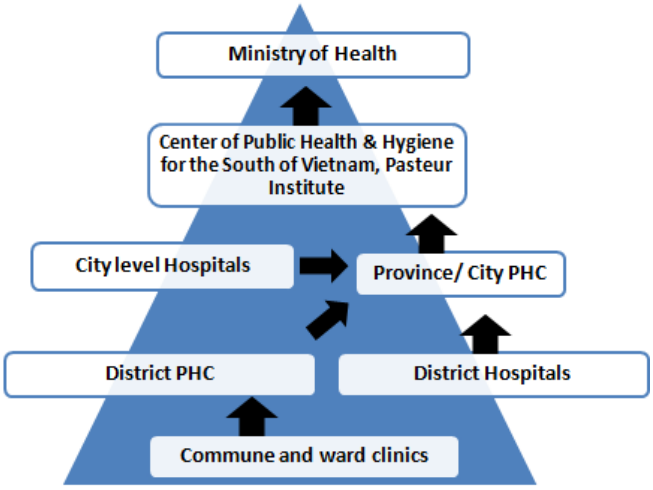
Health Information is a vital part of policy formulation and serves as a base for assessing health status, the impact of interventions, and therefore the success of policy direction. Furthermore, circulating health information between and within health units is important for their efficient coordination in managing disease epidemics. Despite efforts to produce health data via routine reports, surveys and the Ministry of Health's joint annual health reviews, there is no clear policy or plan on how reporting from various regions and levels for every disease and every indicator should happen. As a consequence, information is often unavailable, inaccurate, or unreliable (MoH, 2010).

Diarrhoeal disease is a very common health problem in Vietnam and has registered persistently high incidence rates for the last 10 years (MoH, 2012). Diarrhoea remains one of the leading causes of morbidity (WHO, 2012d), while serious forms such as cholera and typhoid fever are still present in

the country (WHO, 2012c). It has also been targeted by numerous policies (CDD program) and international organizations (UNICEF) as a threat to children's health. As such, it has been selected as an example to illustrate how health information and reporting take place, based on research and data collected in the wider Can Tho City area.

Generally, the system of reporting diseases follows a bottom-to-top route (Fig 3), from the commune clinics up to regional-level institutes on daily, weekly, monthly and yearly bases (Government of Vietnam, 2010b).

Figure 3: Reporting System for Infectious Diseases in Vietnam



Note: arrows indicate the direction of reporting

Source: own elaboration based on fieldwork and documents

When an epidemic appears in any health unit, it must be reported immediately to the higher level, which will then act according to "case management plans" (article 47 in Government of Vietnam, 2007). The disease surveillance system that has been set up in the country with the help of the World Health Organization, to monitor and control outbreaks, is based on this reporting system. An outbreak is considered official when the number of inpatients (and not all check-ins) goes beyond a set baseline, which is grounded on average numbers of incidences of the previous five years (interview with a WHO representative, 29.07.11).

The agency responsible for monitoring and guiding action in the case of a serious epidemic in the south of Vietnam is the Pasteur Institute. If, for example a hospital experiences a lot of incidences of diarrhoea, which is an indication of an outbreak, it must report this matter to the PHC of the city, which in turn will then instruct field staff to (i) sample the local environment where the patients came from (i.e. water supply, other water sources) and (ii) take stool samples, which will then be analyzed in a laboratory. If a high-risk disease like cholera is identified, the hospital will be notified and expected to follow an internal "case management" strategy accordingly (MoH, 2007b). Also, there will be coordinated action from central and provincial PHCs to eliminate risk factors in the area to where the incidences were traced back. Summarizing, outbreak control depends on reporting coming from health units as well as on the fast communication and coordination capacities of the organizations involved.

Specifically in the case of diseases, problems initiate when different diagnoses and categorizations take place in each institution, combined with unspecified differences between the subset of patients that is being reported in each report (which age group, inpatients, outpatients or all checked-in) as well as incompatibility of reported cases coming from different offices or levels concerning the same

population group. Such obstacles were continuously appearing during the collection of health data (the specific case of diarrhoea) from the various health units and offices. What was discovered from the interviews with local health clinics and hospitals is that in various reports, diarrhoea records are only gathered for child patients under five years old due to the focus of projects, NGOs and international health indicators on this age group. This selective data gathering, however, easily goes unnoticed when not specified, adding confusion and leading to misinterpretation of data. In the example of the PHC in Binh Thuy district there are 140 cases, specified as child patients, for the first half of 2011 (Tab 1- Annex). However, this number is not reflected in the specific report of infectious diseases in children, compiled by the city's PHC for the same year, where there are only 10 reported cases. Another example of data collected from the children's hospital in Can Tho reports an average number of 1,500 cases of acute diarrhoea in its annual reports (Can Tho Regional Children's Hospital, 2011a), but it does not specify that those numbers represented inpatients only. A closer look at internal detailed statistics from the hospital's records show around 12,000 check-in visits from children with diarrhoea, most of which were simply not diagnosed as severe cases in need of hospitalization and were therefore sent home as outpatients (Can Tho Regional Children's Hospital, 2011b). Health data can provide various interpretations, depending on how much of the existing "meta-data" is known, and the final representation of the status of particular health threats relies deeply on the methodology and coordination of reporting.

Reporting problems go beyond certain diseases, though. As the WHO recognizes, the vital registration system in Vietnam is flawed and fails to provide accurate numbers of deaths and their causes (WHO, 2012c). Shortcomings can be explained partly by the lack of budget specifically assigned for the collection of health statistics at any level. While the WHO and other international organizations support some provinces with funds for equipment and technical training in reporting diseases, most places rely on government support or hospital and health insurance revenues, which have proven insufficient (MoH, 2006).

The point to be made, however, does not relate merely to reporting confusion and gaps; rather attention should be focused mostly on those cases that completely escape the reporting system. Large numbers of patients either do not turn to the public health system because they seek other means of treatment (traditional medicine and self-treatment, private doctors, or private hospitals) or they turn to pharmacies for the direct purchase of medication. A study by the Pasteur Institute in Ho Chi Minh City (Nguyen et al., 1997) using household surveys and patient monitoring, documented that in Cai Be district (Tien Giang Province, Mekong Delta) diarrhoea was a big problem in the 24 communes studied. New cases were highest for infants (71.2 episodes/100 children per year) and for the age group 6-12 months (60 episodes/100 children per year). Considering that about 25% of the country's population are children under five years old (CIA, 2012), and assuming the same for the population in that district, a simple extrapolation would produce an incidence rate of about 50,000 cases per year. This figure is at least ten times higher than found in any district reports for Can Tho City (Preventive Health Center of Can Tho, 2011). Although a lot of positive change has happened in preventing, combating and reporting diarrhoeal and other diseases ever since the publication of the above study, there is still much to be accomplished before the reality of health problems is fully addressed on paper and in action. As a high-level interviewee stated about waterborne diseases:

> "Numbers of reported patients are only the tip of iceberg visible on top of the ocean. What happens underneath is something that we cannot really know, but it certainly exists."
>
> (Interview with Institute of Hygiene & Public health 28.07.11)

3 Realities of access

3.1 Health insurance mechanism

Following changes in policy, and especially after the *Health Care Fund for the Poor* in 2002, the percentage of insured individuals in the country has increased significantly. When the health insurance scheme was introduced in 1992 the percentage of those insuring themselves stood below 10%, but this figure rose to 40% in 2006 and has recently climbed up to 60%, with the majority of the population now insured either through their work or by being beneficiaries of social policies (Nghiem Tran Dung, 2010). However, insurance remains voluntary for farmers and self-employed people, many of whom remain uninsured as a result of financial constraints (HSPI, 2012a). According to the plan formulated in the Law for Health Insurance (Government of Vietnam, 2008a), the government is aiming for universal coverage by 2014 (Vietnews, 2012).

Every employee has to pay one per cent of their gross salary for insurance, while the state has to pay double that amount. For the poor and near-poor the state provides a full or half premium accordingly, which corresponds to 4.5% of the minimum salary (830,000 VND[7] for 2011). Pupils and students also pay for insurance, a percentage of 3% of the minimum salary (Office of health of Phong Dien district, 2011), while for children under six years of age health insurance is offered for free. According to the VHLSS (Vietnam Household Living Standards Survey), in 2008, 72% of health care visits by poor people were paid for by health insurance or free health cards (GSO, 2008).

The Office of Labour, Invalids and Social Affairs (LISA) from each district has to produce an annual inventory of poor and nearly-poor households, complementing the results of a wider survey that is conducted once every five years (Department of Labour, Invalids and Social Affairs, 2010) – a necessary process for the execution of many pro-poor policies. The criteria used for this classification are presented in the document used for conducting the respective annual survey (Table 2 in Annex). Interviewees described how survey results are assessed via a public hearing held by representatives of local authorities and citizens to confirm or deny their validity (interviews with offices of LISA 26.09.11 and 29.09.12) This participatory process perhaps brings classification results closer to reality, but it also contains a certain amount of liquidity affecting the inclusion or exclusion of people in poverty-related policies. Officially, the final word on determining and recognizing the inventory of poor people is in the hands of the commune's People's Committee, while the *steering committee for the alleviation of poverty* in the city, the province and the district is responsible for checking inventory results on an annual basis (Department of Labour, Invalids and Social Affairs, 2010).

Health policy aside, this classification serves for other kinds of programs such as those involved in the issue of beneficial loans or subsidies (for example in the building of toilets or for connections with the water distribution network). The literature suggests that local authorities that are given these powers (according to Decision 139, 2003) distribute health insurance funds to people with high health risks, even if they do not fulfil the criterion of poverty, whereas central government pushes for the universal enrolment of the population into insurance schemes (Lieberman and Wagstaff, 2009). Hien et al. (1995) speak of cases where health cards are obtained by people whose incomes range from low to high, stressing how the system and the associated malpractice it allows for, are not always to the benefit of the poor. From a survey of 2,394 households, conducted for the MoH by the Health Strategy and Policy Institute (Dam Viet Cuong, 2009), it was found that 20 to 30% of the poor were still not insured, though it is not clear if this was because they were not classified as poor or because they had not been made aware of the free insurance policy.

A lot of people, and especially the poor, experience unbearable health expenses because there is no insurance to cover them in the case of severe sickness. Household out-of-pocket payments

[7] 1 USD = 20830 VND (buying rate of Vietcombank, 10.09.2012).

accounted for 64% of the total health expenditures in the country (Axelson et al., 2009; Ha Nguyen Thi Hong et al., 2002), which not only indicates the burden placed on users but also shows how the insurance scheme is not yet able to contribute to balanced fund circulation in health care – if it does not have enough "clients," the scheme cannot offer much in return. Generally, present-day issues of adverse selection and moral hazard jeopardize the longevity of the insurance scheme (Lieberman and Wagstaff, 2009), which has experienced serious financial pressure since 2005 (Nghiem Tran Dung, 2010). Overuse of services and increases in health care costs combined with corruption within the health sector contribute to this outcome (Vian et al., 2012: 54; Le Thanh Ha, 2011).

3.2 Access to what health care?

3.2.1 Impacts of economic liberalization and privatization

Since 1986 and the advent of the *Doi Moi* decentralization and marketization policies, the health sector has no longer been exclusively public. The country's central hospitals are allowed to financial autonomy and have to operate on a cost-recovery rationale (Government of Vietnam, 2002 and 2006a). The introduction of fees in return for services offered in the health sector was supposed to enhance hospitals' economic performance and allow them to provide better services in an effective and responsive manner. However, it also had profound impacts of restricting health care access opportunities (London, 2008; Minh Nguyen Thang & Popkin, 2003).

At the beginning of the reform period the state was already directing most of its national health budget (80%) at hospitals for curative health under central jurisdiction and away from the local level (Fritzen, 1999 cited in Fritzen, 2007). These big curative units remained under the administrational and regulative control of the MoH, while at the level of the province and below, local People's Committees would now implement and evaluate health policy, as well as manage the provision of financial incentives to health institutions. This left local networks of clinics subject to the financial success of each locality, whereas in the past they had been greatly supported by governmental funding (Tran Tuan, 2004 cited in Fritzen, 2007: 1613). Bloom et al. (2008) report on how changes in the health sector after the 1980s brought a sharp drop in the utilization of public services. This could be explained by a rather non-improved (Trang Minh Nguyen & Popkin, 2003: 260) or in need of more improvement (Tuan Tran Van et al., 2005:324) quality of local clinics over the last 15 years (Axelson et al., 2009). Since this time the government has been gradually decreasing its contribution to health in general, providing for only 38.5% of total health expenditure for 2008, equal to 7.3% of the country's GDP (about 7 billion USD) according to WHO (2012c). Unsatisfactory payments were blamed as constraints to good health care by doctors and staff in public hospitals and health clinics, as well as other health professionals, in a study conducted by the HSPI (2012b). A lack of financial resources because of low insurance rates and limited public funding often hampers hospitals' ability to provide good levels of staffing, organization and functionality (London, 2008:125). Another study on the impacts of autonomy policies on hospitals indicated the need for legislation to regulate financial and organizational matters, but more importantly for the state to increase supervision, monitoring and inspection (Nguyen Khanh Phuong et al., 2009).

Following liberalization, the nascence of privately offered health care increased continuously. Apart from private hospitals that have appeared principally in the densely populated urban regions of the country, there are now many independent professional doctors practicing medicine in urban and rural areas. A study carried out in major hubs of private health care (Hanoi, HCMC and Da Nang) showed that only 65% of private hospitals and 25% of private clinics contracted with the public health insurance program, while most of the clinics did not have sufficient conditions to support such a delivery of services (HSPI, 2012c). In rural areas, private clinics were found to have quality standards even lower than public health clinics (Tuan Tran Van et al., 2005), but for outpatient health care, a lot of people preferred them (Nguyen, 2011: 10).

For high-level care there is still a preference for public hospitals (Vian et al., 2012), which are usually in an overcrowded state, especially regarding inpatient bed occupancies, as a consequence of this preference (interviews with Children's Hospital 11.07.11 and 27.06.11; General Hospital of Can Tho 21.06.11). Another reason for this congestion might be that public hospitals use a system of fees based on per-diem and per-item-of-service charges (rather than per-case), which caters for the sustained placement of patients in beds, even if not necessary, rather than promoting their treatment in a lower level facility or being sent home (Lieberman & Wagstaf, 2009).

In an effort to regulate access to hospitals and relieve central hospitals from overcrowding, it is now the case that, according to a household's location, residents are assigned a corresponding hospital in their district where they can turn to when in need of medical care and, if insured, only pay 20% of contributions – as long as the expenses come to more than 120,000 VND (interviews with office of health in rural district 12.09.2011; Red Cross in district level 07.09.11). The district hospital will admit patients to higher levels if specialized treatment, which they cannot offer, is needed. However, if insured patients decide to go directly to a central hospital, they are charged 70% (instead of 20%) of the charged fee. Uninsured individuals have to pay full fees independent of the location or the category of the hospital, but none of these rules applies for medical staff and governmental employees. Insurance for the latter group provides free admission to any level of hospital and they only pay 5% of medication expenses if they reach over 100,000 VND (interviews with MD in General Hospital of Can Tho 21.06.11; household in Yen Hoa area, Cai Rang district, 18.10.11).

Despite efforts to regulate access to public health care and to ameliorate hospital and health care unit conditions across the country, the perceptions of the interviewed citizens about the quality of public health care suggest that the sector still has a lot to improve upon. A better-off household admitted that since insurance only allowed them to go to local hospitals, they preferred to quit their insurance schemes and just pay for treatment in central institutions (which are considered better), as for them health care in the local hospital is not worth it (Thoi Giai hamlet, Phong Dien district, 05.10.11). Another interviewee from a lower income household described the current division of services provided in the hospital:

> "There are two different sections in the hospitals: one where people get medicine and don't pay anything if they have insurance or a card, and one special 'service' where people have to pay. The 'health insurance' section is slower than 'services' and not effective."
>
> (Interview with household in Yen Hoa area, Cai Rang district, 18.10.11).

London also refers to this institutionalized division of service delivery in hospitals (London, 2008:125). A possibly related fact can be the observed divergence of people from public health units when health problems are not so alarming: results from the 131 interviewed households in Can Tho's rural and urban areas indicate such trends, with 40% people stating their first strategy in combating a "normal" disease like diarrhoea would be to visit a pharmacy or seek in-house treatment rather than going to a clinic or a hospital, unless sickness affects them seriously. Local clinics, though the easiest, closest and cheapest places one can turn to for expert medical advice, have been described as:

> ".. busy places where one has to queue, and that is inconvenient" and "the medicines sold there are not of good quality, not like the ones you can get in the pharmacy," whereas "going to the pharmacy is easy and fast."
>
> (Quotes from household interviews in Truong Phu hamlet/Phong Dien district, 14.10.2011 and in Yen Hoa area/Cai Rang district, 18.10.11).

Regardless of preferences or perceptions of quality, health expenses – even after the approval and implementation of pro-poor policies – pressurize many people, especially the poor. As Fleßa (2003) reports, even the smallest contribution to health expenses coverage might be too much for households whose income-generating activities have irregular patterns and cannot guarantee savings

or available assets at any time. Individuals belonging to the poorest quintile of the population spend on average three times less on health care than those belonging to the richest quintile (GSO, 2008), but this still constitutes 40.5% of a poor household's annual income (London, 2008). Turning directly to a pharmacy and only covering the cost of medicine when necessary makes financial sense to a poor household. A study by Okumura et al. (2002) revealed that one-third of the interviewed 505 households were keeping medicine for potential future illness, amongst which various types of antibiotics that were used for indiscriminate treatments of coughs and diarrhoea.

It is important to note at this stage that about a quarter of out-of–pocket payments for health go towards the purchase of medicine from the private sector (Lieberman & Wagstaff, 2009:6) and that the phenomenon of doctors selling medicine from their private working space is growing (MoH cited in Ha Nguyen, 2011:2) although prohibited. Pharmacists, as the author argues (Ibid., 2011), not only promote certain medicaments but also push patients to significant levels of drug over-consumption. Furthermore, some medicines are more expensive in Vietnam than in other countries, as in the example of antiretroviral medicine, which even if locally produced is sold at five to seven times higher prices than current international prices dictate (Kuanpoth J., 2007 cited in Anh Tuan Nguyen et al., 2009). While regulations exist on drug prices (MoH et al., 2007), they go for the most part uncontrolled (Le Thanh Ha, 2010) and at the same time large percentages of people are found to rely on them for curing disease (Nguyen Tho Hong Ha et al., 2002). What is more, untrained pharmacists in most cases are the ones deciding on the type of medicine provided, ignoring the requirements of medical prescriptions (Lieberman and Wagstaff, 2009; Okumura et al., 2002: 1876; Vian et al., 2012).

Despite changes in hospital financing systems, which produced a chain of reactions and unbalanced access equilibriums, changes towards more state control based on accountability have not materialized. As briefly mentioned before, especially within central units of high-demand but also across the health sector as a whole, multi-level corruption is experienced through informal payments and the misappropriation of funds (Hien et al., 1995; Vian et al., 2012; Thanh Nien news, 2012). During the formulation of the Law on Examination and Treatment (Government of Vietnam, 2009) there was an attempt to establish an independent body ("Medical Council") to control health governance, but political pressures led to the abandonment of that idea and to date there is no such body to regulate health or address quality and licensing problems, even when perceptions of corruption are high among the population (Vian et al., 2012).

3.2.2 Discrepancies in health capacity and quality of services

In Vietnam, we notice a spatial pattern of uniformity regarding the administrative structure, which is reflected in basically every aspect of official organization and function and expressed in the repetition of bureaucratic divisions in every spatially divided unit (the province, the district, etc.). In Can Tho City over the last four years, three of the previous six districts have been split, creating the need for new administrative divisions in line with People's Committees (Waibel, 2010). Relating to health, this has raised the need for new corresponding offices and facilities so that there will be one hospital per district, one clinic per commune, etc. A somewhat expected socialist need for equality, harmony and unanimity would translate into equally good services within these divisions (p.e in all district-level health units, or in all commune-level clinics).

Observations in Can Tho, indicate that hospitals in rural districts are in a worse situation than their urban counterparts (visits to four rural and three urban district hospitals in Can Tho city) and the exact reasons for this apparent difference could not be clarified through the interviews held with hospital directors and health officers. Since health is decentralized, it is in the hands of local governments to take decisions and allocate funds for the expansion, betterment and general support of the sector, as much as it is the hospitals' responsibility to raise adequate funds for their subsistence. Shortcomings in technical equipment, human resources, or infrastructure would logically go hand in hand, parallel to the above mentioned financial capacities of each locality. Nevertheless, hospitals built in Can Tho after the division of a district into two new ones, had an

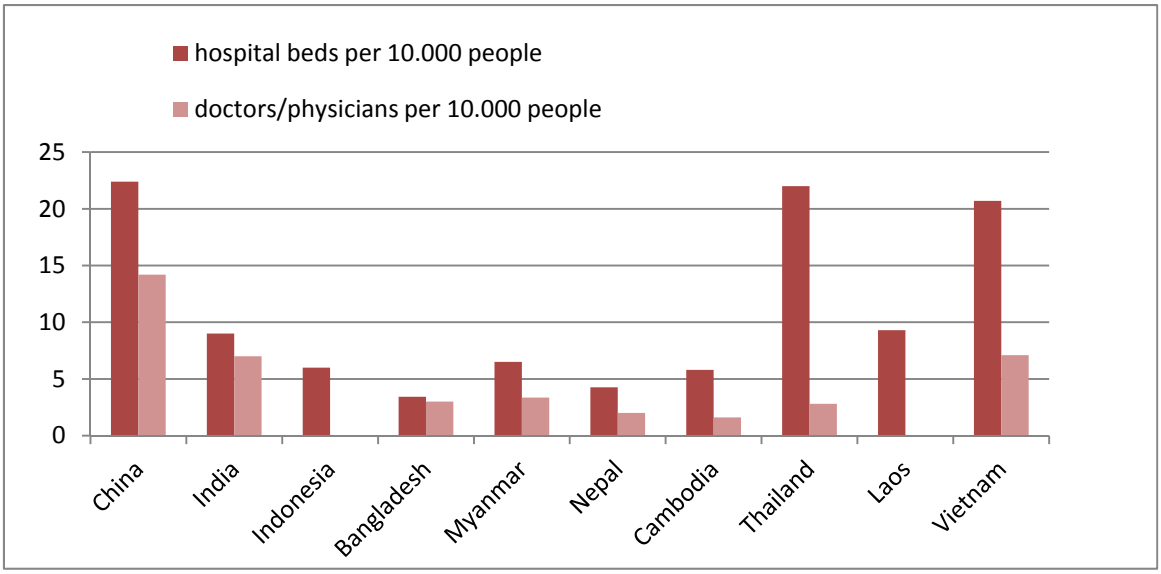
overestimated magnitude in terms of land occupation and size of construction, which over-exceeded the number of staff available and the average number of patients that usually visited the hospital (research observations from new district hospitals in Cai Rang and Phong Dien; interviews with medical personnel from the district hospitals 08.07.11, 07.07.11, 21.07.11, 13.12.11, 15.12.11). Upgrading district hospitals came to the fore in 2008 through a 3,750 billion VND (202 million USD) project, while the sum was slightly smaller for 2009 (Tran Van Tien et al., 2011). While more research is needed to clarify this subject in detail and greater extent, findings from Can Tho indicate that district governments spent this budget mostly on construction and not on other aspects of health care in need of improvement, such as medical staffing and technical equipment.

Apart from differences among districts, greater discrepancies are found when comparing state levels (centre) with the commune or the hamlet, in terms of services, equipment, infrastructure and capacities. As Bloom et al. (2008) state, the semi-skilled "plague" is continuing at the local level of health care in Vietnam, even if the times of emerging needs for untrained personnel have now gone:

> "By the early 1990s, most health facilities employed many assistant doctors and partially trained health workers who had very low workloads. In addition, most villages had at least one village health worker or drug seller... As a result, people had easy access to a health worker, but many of the health workers had limited skills."
>
> (Ibid., 2008:236)

In the produced reports, Vietnam is seen as performing well on the respective indicators, compared to other surrounding countries in the region (Fig 4), but this progress is by no means evenly distributed across different administrative levels.

Figure 4: Basic health care indicators in Vietnam and surrounding region countries



Design by author, based on data from WHO (2005)

Fleßa (2003) found, for example, that while in big cities all district hospitals are supplied with licensed doctors, only 5.8% of the communes studied in the Cao Bang district were found to have a doctor. Similarly, in one of the case study districts of rural Phong Dien, most licensed doctors worked in the central clinic while peripheral commune clinics had only three-year trained nurses or vocationally trained physicians. Allocating staff in remote and rural areas is not easy, as doctors choose to live in more central areas where living conditions are better and opportunities to work privately also increase (Ibid., 2003). This consequently forces official requirements for medical staff

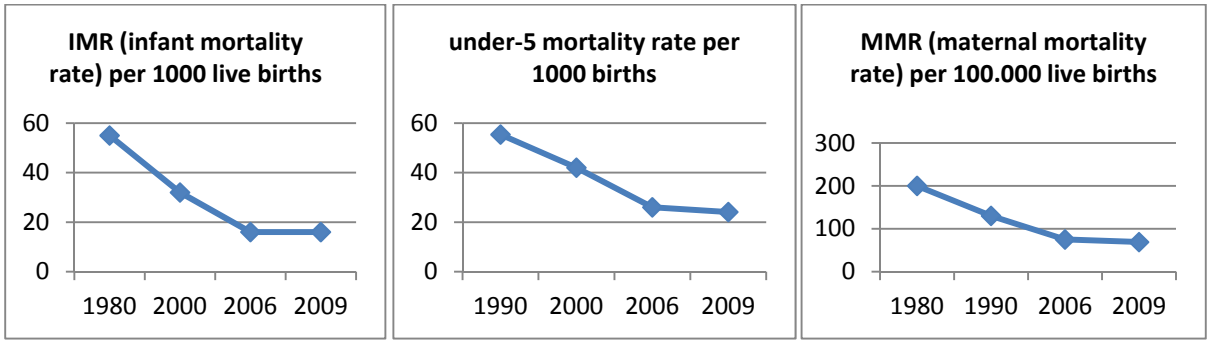
to fall greatly, as well as allows for a relatively lax attitude towards checking licence qualifications in rural areas (Ha Nguyen, 2011: 3).

A recent survey (GSO, 2008) has shown that rural inhabitants have fewer opportunities to undergo medical examinations and treatment in central hospitals (82%) in comparison to their urban counterparts (92%). Most of the rural inpatients belonged to the richest quintile of the population, while this disparity was larger when also considering the use of outpatient services (GSO, 2008). Reasons mentioned during the household surveys conducted in Can Tho, as to why people could not turn to big hospitals for health care, lay in practical difficulties (lack of transportation means or prohibitive travel expenses), time restrictions (time needed to reach a health unit and time spent waiting would result in loss of income for daily breadwinners) and a lack of health insurance to ensure the coverage of expenses (otherwise, expenses might be considered unnecessary or simply impossible to pay).

3.3 Current health status of the Vietnamese people

As mentioned at the beginning of this paper, compared to surrounding regions and other low- to middle-income countries, Vietnam has improved its basic health indicators from the 1980s to today by raising life expectancy at birth to 75 years of age (World Bank, 2011) and bringing down under-five and maternal mortality ratios drastically (Fig 5), to name just a couple of factors.

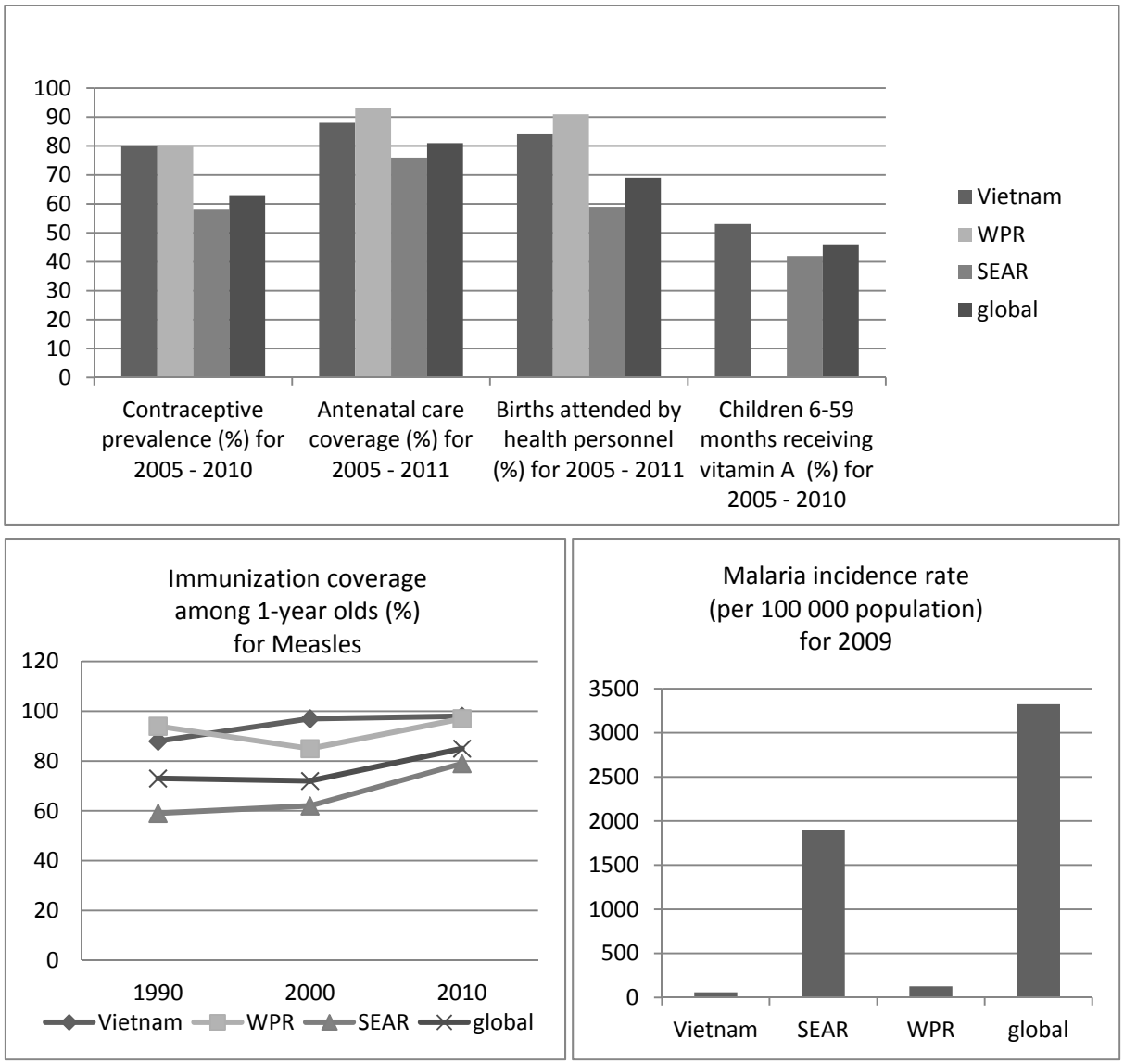
Figure 5: Child and maternal mortality rate trends in Vietnam



Design by author based on data from WHO (2008 and 2012d)

Undoubtedly the country's exit from extreme poverty, recovery from war and the fast-paced economic development over the last 20 years has helped to improve the health picture of its population. Looking at the latest health statistics provided by WHO (2012e), health service coverage (Fig 6) in Vietnam is better than the average of South East Asian countries but below the Western Pacific country group. The country has also managed to bring malaria incidences down to very low levels, following huge efforts and preventive measures that have finally borne fruit; a great achievement since the 1995 outbreak of over one million cases.

Figure 6: Selected health indicators for Vietnam and surrounding regions

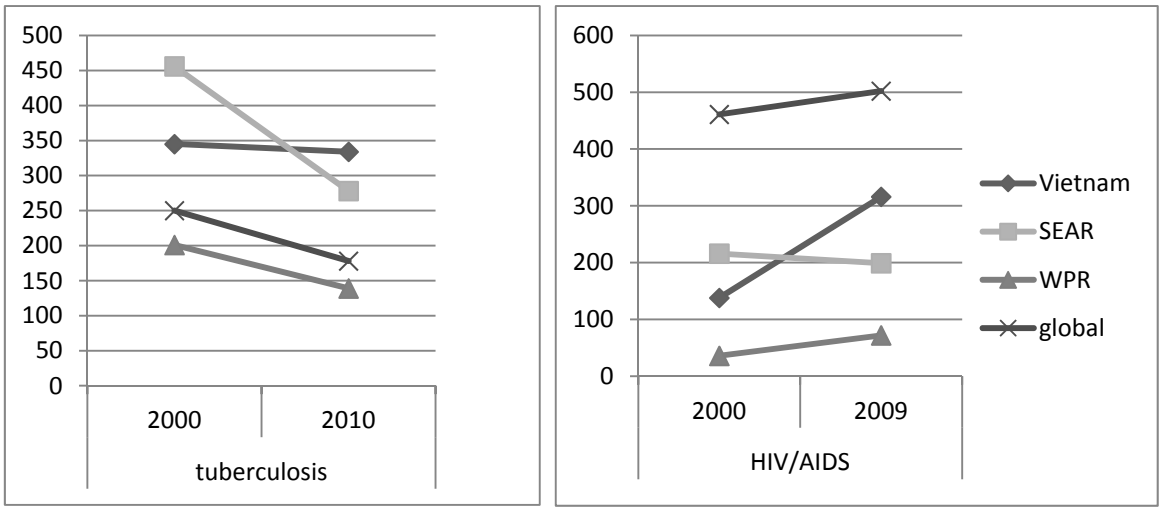


Note: WPR= West Pacific Region, SEAR = South East Asian Region

Design by author, based on data by WHO (2012e)

Measles immunization (one of the Millennium Development Goals parameters) improved throughout the 1990s and has rather stabilized during the last 10 years, apparently reaching all children under 1 year old (Fig 6). However, the prevalence of highly infectious diseases such as tuberculosis – and especially HIV – has not seen improvements over the same period (Fig 7), indicating the low effectiveness of the wider prevention mechanism in the country regarding these diseases.

Figure 7: Trends of the prevalence (per 100,000 people) of tuberculosis and HIV/AIDS in Vietnam

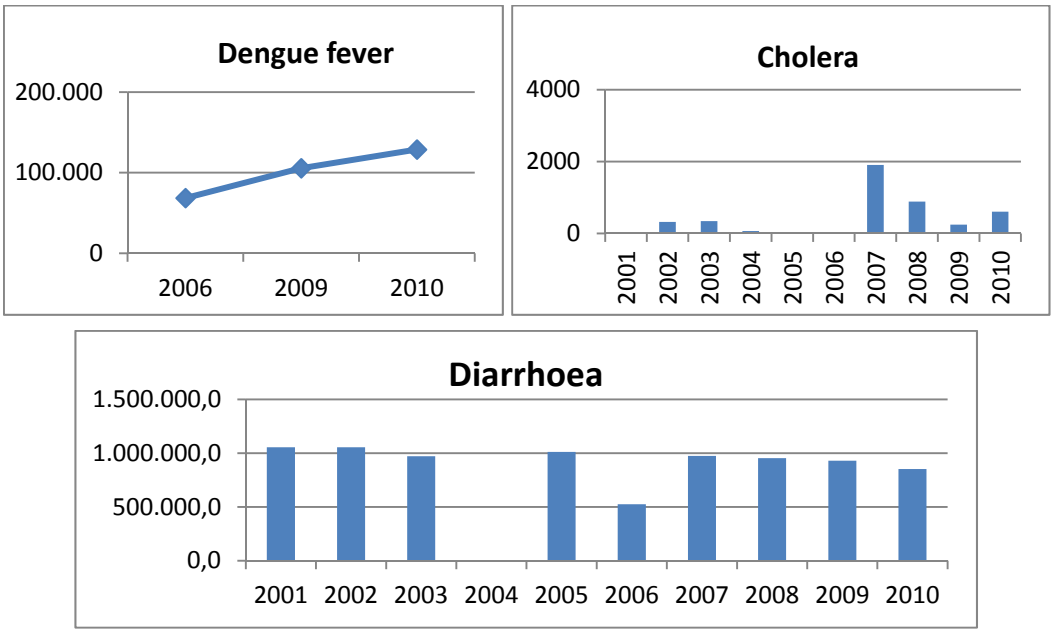


Note: WPR= West Pacific Region, SEAR = South East Asian Region

Design by author, based on data by WHO (2012e)

Some rising health threats over the last few years include severe acute respiratory syndrome (SARS) and influenza A (H5N1) – diseases that are proving extremely complex to control and prevent (WHO, 2012c). Water-related diseases are also widespread and recurring, indicating the rather unsustainable character of prevention measures, especially regarding people's awareness and behavioural changes (Ibid., 2012c; Herbst et al., 2009). Diarrhoeal disease (in the form of acute diarrhoea) remains one of the leading causes of morbidity, and dengue fever is in increasing prevalence (Fig 8), especially around the Mekong Delta area (WHO, 2012c).

Figure 8: Number of incidences of water-related diseases in Vietnam



Design by author, based on data by MoH (2012)

Living conditions such as unsatisfactory environmental sanitation and inappropriate hygiene facilities, combined with still limited clean water access so much in the rural as in the urban areas (Reis, 2012; Fig 2 in Annex) make it easy for diseases to spread. Rapid urbanization, environmental pollution and particular weather phenomena also favour epidemics (WHO, 2012c). Malnutrition, which is usually an under-5-year-old related indicator, is seen to decrease but significant differences exist between income groups, with the poorest being the hardest to improve – the gap of disease prevalence between the rich and the poor has widened from two times (in 1993) to over 3.5 times (in 2006) (Ibid., 2012c).

Such differences are important to remember when presenting or encountering data that refer to country averages. The same principles of regional and social discrepancies that have been observed in health capacity and access are expected to be reflected in health outcomes, although a detailed analysis of these trends is beyond the scope of this paper. As Few et al. (2010) observe, however, connections between economic poverty and vulnerability to health threats are strong. As has been discussed in earlier parts of this paper, part of this vulnerability can be the inability of the poor, socially marginalized or remotely situated people, to reach quality health care or to be reached by effective health promoting/disease preventing policies. Moreover, as the MoH (2006) also recognizes, the health information system in Vietnam, although improved, still produces statistics that are not regularly updated or completely reliable (such as for MMR, IMR, morbidity and mortality rates, specific causes of deaths by age/gender and more). Information from the private medical network is in short supply, and there is a general lack of coordination between levels and departments in the exchange of information (MoH, 2006:50). Data provided by authorities or presented in reports are therefore to be treated with caution, while more qualitative research and in-depth studies on each disease are expected to shed more light on their specific status.

4 Summary and Conclusions

Institutional and policy changes over the last 20 years have resulted in the central control and management of selected high-level and high-quality healthcare units but left the management of the rest of the health network (including hospitals, clinics and preventive health centres) under local People's Committees. State funding for health gradually lowered and hospitals were allowed to become financially autonomous. In addition, hospitals were expected to generate revenue through the provision of paid services, which would be financed in part by the expansion of the health insurance scheme and therefore provide a "healthy" circulation of funds. The overall intention of this policy was to protect citizens from catastrophic expenditure and guarantee affordable health care for all. However, this picture has not yet been realized in full.

Firstly, low public spending on health has caused good quality health services to be concentrated in public or private high-level hospitals, which basic health insurance may not cover. Higher-level hospitals, apart from being unreachable for some in terms of distance or cost, are often overflowing with patients and unable to function properly. Curative health in general is suffering from a lack of personnel, equipment and technology, while investments at the district level seem to focus on construction rather than on the provision of a higher quality of service. At the smaller scale of the commune, many public clinics do not fulfil the legal standards of professional qualifications, staffing levels and medical equipment – despite being the base of the health care pyramid to which most people have access.

Secondly, as the literature and research findings suggest, access to health has become greatly dependent on both the place where one lives (urban or rural, near or within a city, remote or easily accessed) and the economic status of one's household; two factors that are often co-dependent. In general, high-level units are located in the urban parts of districts or cities, whereas rural or remote areas mostly have access to low-level facilities (GSO, 2008). Policies protecting the poor, by reducing their contribution to health insurance and offering free health care for children under six-years of age, were initiated in the 1990s. Nevertheless, their success was hampered due to budget limitations (Ekman & Bales, 2008 cited in Axelson et al., 2009) and, moreover, due to the phenomena of adverse selection and mal-implementation noted during the management of pro-poor policies by local governments (section 3.1). As a result, the number of poor people experiencing catastrophic health expenditure has not decreased significantly, showing how the current system is failing to protect economically vulnerable groups (Axelson et al., 2009; Bloom, 1998; London, 2008; Lieberman and Wagstaf, 2009). Due to this failure of the system to respond to people's needs, citizens often reject the public sector and turn to private health or unregulated providers. This, combined with low levels of awareness and knowledge around health, disease and drug usage, often results in confusion and ill-advised medication practices.

Looking at the country's legislation one finds a strong focus on protecting the health of the Vietnamese people via measures that are perceived as effective and egalitarian. Currently, significant epidemics and infectious diseases are at the epicentre of efforts. Strengthening local health care networks is a main goal for the Plan in the upcoming decade; however, the policies and instruments that allow local governments assigned with the responsibility to achieve this goal have not been developed sufficiently. Prevention and grassroots health care are based on the function of health posts (workers, volunteers, collaborators) that, even though bolstered in policy documents, are still far from meeting legally defined standards. Overburdened with duties and requirements, but short of financial support and staff availability, health clinics and stations often fail to satisfy the local population in terms of their need for quality health care and preventive policies. Preventive health centres that operate at the provincial and district level play an important role in coordinating activities, but they mainly advise rather than practically help these local health networks.

Despite general improvements in various health indicators, the health status of the Vietnamese population still calls for more measures to be adopted. As recent health reports indicate, epidemics and increased occurrences of diseases are still to be found in the country. Much of what is required involves effective preventive measures and the efficient control of the spread of diseases, measures that rely as much on local health networks as on the reactions of the higher-level curative sector. While reporting is a core activity in which health offices and medical establishments at all levels engage, it still results in a rather unsynchronized and incomplete information exchange. Considering that the disease surveillance system is dependent on this reporting to effectively prevent and readily control epidemics, the mechanism needs technical and methodological strengthening.

In summary, despite efforts to ameliorate the health sector in Vietnam, it remains largely characterized by inefficiency and non-functionality while developing strong elements of inequality. This is manifested partly in the reported health status of the population, but also in the words of local people who express their discontent and describe difficulties in making ends meet when it comes to health care. Recognizing that the Vietnamese health system remains in a transitional state, the need to consider how it can address its emerging, as well as pre-existing, problems is imperative. More in-depth studies are therefore needed on the factors hindering people from joining existing health insurance schemes and governing their decisions around health issues. At the same time, the efficacy of financial instruments intended to pay for the health system in Vietnam needs to be re-assessed and their consequences on its people need to be evaluated. The goals of universality and quality of services at all levels should not be left behind in the course of the system's development.

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Annex

Table 1: Reported waterborne diseases from various agencies and different administrative levels (average number of incidences per year)*

Source	Years (average per year)	Respective level	Cases of diarrhoea	Cases of cholera	Cases of typhoid	Cases of dysentery	total cases of WDD
Ministry of Health	2001-2011	**National**	925.893	445	4.219	249.041	**1.677.679**
Institute of Hygiene and Public Health (HCMC)	2005 – 2011	**South Vietnam (20 provinces)**	220.476	23	1.563	41.541 (three types)	**303.495**
Children's Hospital (diarrhoea check - ins)	2009 - 2010	**province**	12.670,5	0	23,5	2.607 (two types)	**15.301**
Children's Hospital (diagnosed inpatients)	2009 - 2010	**province**	2.562	3	25	704 (two types)	**3.294**
Department of Health of CTC	2007 - 2008	**province**	20.102,5	0	2,5	169,5	**20.274,5**
Department of Health of CTC	2009	**province**	13.616	0	0	124	**13.740**
PHC of CTC	2008 - 2011	**province**	2.090	0	0	-	**2.090**
PHC of CTC	2011	**province (children)**	10	2	0	-	**12**
General Hospital of Can Tho City	2006 - 2011	**province**	1.528	1	10,5	-	**1538,5**
O Mon Hospital	2010 - 2011	**district**	931	0	21,5	115,5	**1.068**
O Mon Preventive Health Centre	2010 - 2011	**district**	868	0	10	26 (Bacillary)	**904**
Phong Dien Hospital	2010 - 2011	**district**	346	0	0	-	**346**
Office of Health, Phong Dien	2010	**district**	614	0	0	67 (three types)	**681**
PHC of Phong Dien	2010	**district**	76	0	0	-	**76**
PHC of Bihn Thuy	2009 - 2011	**district (children)**	562	0	0	-	**562**
PHC of Cai Rang	2007 - 2011	**district**	377,5	0	0	20,5	**398**
Commune clinics, Co Do	2010 – 2011	**district**	976	1	0,5	21	**998,5**

Design by author, based on various collected reports and statistics from offices pertaining to the MoH, 2011

Table 2: Example questionnaire used for the survey on poverty status (Office of Labor, Invalids and Social Affairs in Cai Rang District, 2010)

SURVEY OF A HOUSEHOLD'S INCOME

1. Name of household head ... ... Household number ……
2. Address: Province / City: ... ...District: ... ... Commune / Ward: ... ...
   Rural / urban groups: ... ...
   Area: 1. Urban 2. Rural
   Number of People in the Household: ... ...
3. Total income and total expenditure for production and business operation services in the last 12 months

Calculating unit: 1.000 VND

Revenue	Total Income	Total expenditures
1. Crop Production (including product sales and consumer products for household)		
● food crops		
● Industrial plants		
● Fruit trees		
● Crop by-products (coal, leaves, tree tops, straw, wood ....)		
● Other planting products (seedlings, ornamental plants ....)		
2. Livestock (including product sales and consumer products for household)		
● Cattle		
● Poultry		
● Other products (eggs, milk, cocoons, honey farming, seed)		
● Animal by-products (faeces, feathers, leather...)		
3. Agricultural service activities		
4. Forestry (including product sales and consumer products for the household) and forestry services		
5. Fisheries ((including product sales and consumer products for the household) and Fishery Service		
6. The business activities of non-agricultural services (including product sales and consumer products for household)		
7. Salaries and wages		
8. Other amounts (including items on revenue gathering, gifts, remittances from outside, interest savings, home rentals, pensions, grants preferential treatment of persons)		
TOTAL		

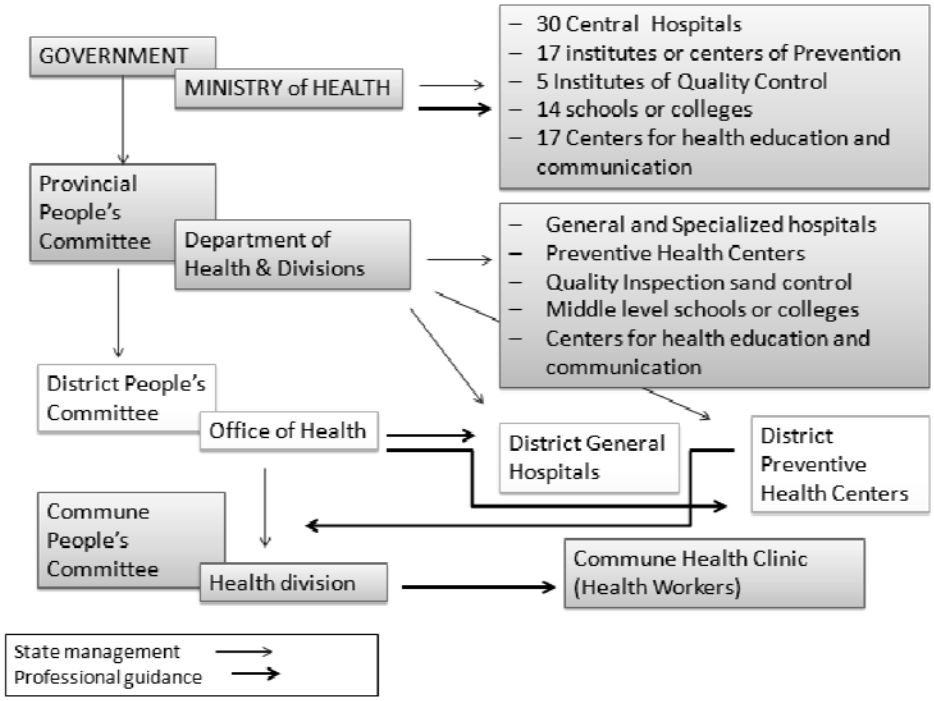
4. The income of households in the last 12 months:

TARGETS	VALUE
5.1. Total household income (= total income of question 4 – total expenditures of question 4)	
5.2. Average income / person / month (= total income in question 5.1 / demography of households / 12 months)	

CONCLUSION (Mark x in appropriate boxes)

POOR HOUSEH0LD Rural : < = 400,000 / person / month Urban: < = 500,000 / person / month	
NEAR POOR HOUSEHOLD Rural: > 400,000/person / month and < = 520,000 / person / month Urban:> 500,000 VND / person / month and < = 650,000 / person / month	
Non-poor households Rural: Urban	

Fig 1: Organization of the Health Sector in Vietnam



Design by author based on: The Viet Nam Health Information System's Review and Assessment (MoH, 2006)

Fig 2: Percentage of households using safe water (left) and percentage of households using hygienic toilets (right) in Vietnam

Adopted from: WASH working Group meeting Presentation (UNICEF, 2011)
Original source of data: Vietnam National Census (GSO, 2009)

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