

Rural Health Services in Vietnam:

Their Contemporary Relevance to Other Asian Transitional Economies

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1 Introduction

The Socialist Republic of Vietnam is transforming its economy to a free market system. This transition is causing widespread change on a number of different levels, but the government is making significant efforts to preserve stability in specific socioeconomic and cultural areas, including public health care.

Vietnam's morbidity and mortality statistics are as good as or better than those of more prosperous countries in Southeast Asia (World Bank 1993), due to the extensive network of grassroots health services throughout the country. However, it is evident that the financial basis of primary health care (PHC) has been undermined, especially in the early years of the transitional period, calling into question the future of the public health system. The implication of Witter's article (see this Bulletin) is that Vietnam may benefit by watching closely the policies and progress of its northern neighbour. While this is undoubtedly wise counsel, Vietnam is remarkable for its resourcefulness and its ability to harness change. It also has had, as a result of international political and economic isolation, time to observe the activities of its Asian neighbours. This paper describes recent responses on the part of the Government of Vietnam to the need for adjustments in public health policy.

2 PHC Policy in Practice: Maintaining the Impetus of a History of Success

Vietnam's infrastructure for rural health was developed in the north of the country after independence and the momentum maintained during the war period. PHC in Vietnam therefore preceded its international launch at Alma Ata in 1978 and symbolised the country's political commitment to its nation's health. The government is reluctant to lose its reputation for spearheading PHC (the same could be said for Vietnam's achievements in literacy and education). In the midst of international political isolation, diminished economic support from its socialist allies, and the enormous economic hardship that followed the end of the war, the success of PHC in Vietnam is an indication of how Vietnam has determined not to 'lose face' culturally and politically. But recent liberalisation measures pose serious new challenges for primary health care.

3 Economic Reform and Public Health: a Decree to Protect Salaries

The Vth Communist Party Congress of 1986 ushered in *doi moi* – a new era of economic reform – with the process of liberalisation given further impetus in 1989. Significant changes in public health were introduced: private practice was legitimised, state control of the pharmaceutical industry was relaxed and user fees were introduced in the public sector for drugs and services. What followed was a proliferation in the health care options available to the public. But the options had costs attached: financial costs and costs in the quality of care. The newly emerged private health sector pupated into a considerable source of competition for a public sector demoralised by low and infrequently paid salaries, crumbling infrastructure, limited supplies of drugs and equipment, and the disintegration of the commune cooperative system that had previously been the source of collectively financed health care. Health workers at commune health stations (CHS) turned to farming and trading to secure food and income.

Confidence in public health care by both its providers and users dwindled. Potential users voted with their feet and either medicated themselves with drugs bought over the counter (World Bank 1995), or used the private sector. Many private practitioners are demobilised army medical personnel, retired public sector health workers, or public health staff earning a private revenue. It can be argued that the private sector, in response to the open market for health care, has become more sensitive to patients' needs than the public sector – offering home visits, a wide selection of drugs (albeit of uncontrolled quality), flexibility of payment, and a more caring and considerate service, by repute the largest draw of all (Tipping *et al.* 1995). A Ministry of Health study of health users and providers in 1991 estimated that the private sector saw five times as many patients a day as the public sector (MoH 1991). A more recent study calculated that private health facilities served 17 million people in 1995, an average of six to seven people per facility per day (cited in VIR 1996).

¹ P&FP Coordinators form a national commune level (population based) network of health volunteers trained to implement the national P&FP programme. The network is financed by the national P&FP Committee. Coordinators get a small monthly stipend to inform,

Public confidence in the quality of public health care plummeted with CHSs operating a skeleton service based on minimal resources. The MoH estimates that the average number of consultations per capita fell from 2.1 in 1987 to 0.9 in 1993 (cited in World Bank 1995). In 1995 the government responded by undertaking to place at least three staff from each commune health station on the government payroll and to subsidise village health workers in remote highland areas (S.R. Vietnam 1994). This policy boosted the morale of health workers and diminished the argument that they could not afford to work in public health posts. In return, CHS health workers were obliged to provide 24-hour care and to 'bring services to people's households' (S.R. Vietnam 1995). As a result of this measure to place part of the finance of PHC back under provincial government control, commune public health care services have been shored up and it appears that a measure of public confidence in them may have returned. The MoH calculates that the number of consultations per capita had risen back to 1.3 in 1995 (MoH 1995). Studies at commune level also indicate increased utilisation of services (see Oxfam 1996).

4 Economic Transition and Public Health Provision: Some Issues

4.1 The village health worker (VHW)

Prior to 1986, the VHWs (the equivalent of barefoot doctors) were paid by the commune cooperative structures. These structures are now largely disbanded and the Commune People's Committees (CPC), the first rung of the administrative ladder, are no longer obliged to pay VHW salaries. The government does not provide any funding for these personnel except for those working in the remote highland areas. The situation of the VHWs varies a great deal, depending on the priorities of the local CPC. In one commune, for example, a network of VHWs has been maintained by combining the role of the VHW with that of the population and family planning coordinator, thereby splitting the financial responsibility for salaries between two separate bod-

supply and monitor use of FP methods in women of reproductive age. The VHW and P&FP networks are administratively and functionally separate, but some communes have rationalised and therefore maintained both services by giving health workers a dual role.

ies.¹ Elsewhere, VHWs are working privately or not at all. However, the Ministry of Health is discussing the possibility of re-establishing the VHW network as an inexpensive way to provide basic services to poor households.

4.2 Subsidised health remains where the market economy has yet to reach

Economic reform has not meant a complete dismantling of the subsidised system for health care. The government subsidises health services in remote highland areas (currently the equivalent of 90 US cents per head per year) and pays the salaries of VHWs and CHS workers. These 'disadvantaged areas' – primarily populated by the country's 54 ethnic minority groups – are a strong focus for the government's poverty alleviation measures. The authors are collaborating with the Ministry of Health in a project aimed at strengthening the VHW network in remote communes of a northern province, using local army medical personnel or public health sector health workers as trainers and supervisors (Segall and Tipping 1996).

4.3. Poverty alleviation and access to health care

The government's programme to 'Eradicate Hunger and Reduce Poverty' (EHRP), partially introduced in 1989 and launched nationally in 1993, has made significant progress in reducing the proportion of the population that is poor from over 70 per cent in the mid-1980s to around 50 per cent in 1992 (World Bank 1995). Vietnam's General Statistics Office, using a different poverty line to that of the World Bank, calculates that 20 per cent of the population was poor in 1993 (GSO 1994), and that the proportion fell by a further six per cent between 1992 and 1994 (SPC 1995). The government's target is to reduce the number of poor households by 300,000 a year until 2000 (VIR 1996). The VIIIth Communist Party Congress of June 1996 in its review of a decade of economic reform stressed the socioeconomic and cultural implications of the increasing polarisation of

household wealth and proposed a number of policies and strategies to speed the government's poverty alleviation programme.

Vietnam has had an extensive programme of social protection for many years which suggests that the effective implementation of existing mechanisms may be as important as the formulation of new policy. For instance, an exemption system for hospital fees at the district level and above exists for the national policy group of 'war heroes-mother heroes', for children under six, homeless children, the poor, disabled and unsupported elderly, but the system is rife with difficulty. Lengthy bureaucratic procedures often deter application; the criteria for exemption are unclear and the decision to exempt (usually finalised by the hospital director) may conflict with the recommendation from lower levels. If exemption is granted, it may only cover part of the costs, and the substantial non-exempted costs of hospital inpatient care (food for the sick and the carers, transport costs, gifts to health workers and the lost capacity to earn income) may deter those in greatest need (Aduki 1995; Tipping *et al.* 1994; United Nations 1995).

The system of exemptions is even less clearly defined at commune level. All children under six receive free care and a number of national programmes are subsidised centrally such as the supply of Vitamin A, and the treatment of tuberculosis, goitre, malaria and leprosy. However, there is no official policy for exempting other services provided by CHSs. Payment may sometimes be deferred or, less often, waived, but the decision is left to individual health workers, who must personally cover any financial loss to the CHS. Most CPCs have no policies concerning exemption from charges, but they may subsidise the poorest households on a case-by-case basis. People who cannot afford CHS fees and who cannot negotiate any flexibility of payment with the CHS worker or the CPC, have to seek help outside the public health system. Future anti-poverty programmes may include exemptions for the poor at the CHSs, but the situation is unclear.

² A recent example of the MoH's response to access issues is found in a circular issued by the MoH which followed a recent official nationwide visit to 22 hospitals. The circular requires hospitals to instantly treat emergency cases without demanding pre-payment

or the appropriate paperwork and proposes penalties for any physician or administrator found responsible for causing harm as a result of delayed treatment (quoted in the **Vietnam Investment Review**, 21 January, 1996).

The government is exploring options for ensuring that the poor have access to essential health care² and is interested in extending the current coverage of health insurance for government employees and children under six, to households defined as poor and hungry. The district governments are responsible for financing this provision, with some assistance from central funds. Current health insurance schemes cover care at district facilities, but not at the grassroots CHSs.

These schemes face a number of difficulties. It is unclear whether district governments will have the resources to provide adequate coverage for all poor households. There is a trade-off between providing high levels of coverage for health care charges that may provoke cost increases, and providing lower levels of coverage that deter the poor from using services. Decisions have to be made regarding the coverage of services at commune health facilities. As Witter suggests (in this Bulletin), China's experience with models of local health insurance could be instructive.

Financial support for the poor also comes from community donations, a form of voluntary (but obligatory) taxation that local political authorities draw on to support the finance of a range of social relief and infrastructure funds such as road and bridge building, dike repair, national defence, public security and health care, amongst others. With Vietnam's long history of collective activity, this more recent form of community participation reflects the process of economic reform, with its shift away from a collective agricultural product-based contribution to a household monetary contribution. One example is the poverty alleviation fund that is currently being established. It will seek annual contributions from the population ranging in size from the equivalent of 45 US cents for rural households, \$4.5 for small traders, two days salary for state workers and larger sums (minimum \$18) for business enterprises (VSED 1996). Local and central levels, therefore, continue to depend on the

participatory ethos of the community to support the finance of a wide range of social funds.

4.4 Monitoring private practice

Private practice is burgeoning in Vietnam, but there is no framework of inspection and monitoring. The MoH only issues licences to doctors and qualified pharmacists, but in reality many unqualified and/or unregistered workers provide services. A recent inspection of health facilities and pharmacies by the MoH resulted in orders for improved management and stronger control of the private sector (VIR 1996). The MoH has recently made a series of policy responses to inform and protect the public about the rational use and purchase of drugs and to improve the regulation and monitoring of the private sector³. The process of granting business licences to private practitioners as well as the issuing of regulations and guidelines to private practitioners for implementing PHC are both to be improved. Regular inspection and monitoring of the range of private health facilities – both modern and traditional – is being called for and, following the Government's National Drugs policy (approved in August 1996), a new Department of Pharmaceutical Management was set up in September 1996 to oversee the screening, testing and approval of drugs.

4.5 Supervision

The District Health Centres (DHC) have been made responsible for the technical supervision of the CHSs. The DHC will supervise the implementation of national health programmes, monitor patient record books, check water and sanitation facilities, observe service delivery (i.e. implementation of night duty), and so forth. While the quality and effectiveness of supervision varies between districts, the mechanism is in place and guidelines exist for both the DHC and the CHS (MoH 1994). At the same time, the CPC acts as the administrative and financial supervisor for the CHS, monitoring the

³ In response to the need for appropriate monitoring of the private sector, one intervention activity of the authors' current research is to negotiate a collaborative agreement between the public and private health sectors of one district in northern Vietnam. The private health workers have been invited to work as 'health volunteers' to the public sector, to assist the CHS with preventive

care activities, to maintain private patient records, attend public health sector meetings and to help devise local strategies to improve health care for the poor. In addition to this official role in public health, the volunteers will be included in supervision and retraining opportunities. If successful the model will be applied to neighbouring districts and provinces (Segall and Tipping 1996).

income and expenditure of the CHS on a regular basis. While these supervisory systems could benefit from enhanced management skills and streamlined administration, a structure exists by which to improve the accountability of providers to users and of providers to health and political managers.

5 Health Care Financing

According to a number of reports, government spending on health more than doubled between 1986 and 1989 and by 1995 real per capita health expenditure was three times that of 1986 (United Nations 1995). The World Bank (1993, 1995) and UNDP (1995) estimate that in 1989 government spending on health was \$0.83 per capita and total health spending was \$2.50, or two per cent of GDP. By 1993 public spending on health had risen to \$1.42 per capita, private spending had shot up to \$7.27, and total spending was \$8.69, or almost four per cent of GDP (United Nations 1995).

The public health sector allocates a very low proportion of its budget to prevention. In 1993, the World Bank (1995) estimates that 90 per cent of the state budget expenditure on health was spent on curative hospital care, as opposed to three per cent on preventive care and two per cent on commune health stations (although the latter will have increased since 1995 with the responsibility for CHS health worker salaries being taken up by the state). The high ratio of recurrent health expenditure on curative as opposed to preventive care reflects the strong curative base of the health sector (Favereau, *et al.* 1995-1996).

A study of the pattern of expenditure and sources of income of four commune health systems was analysed for the period 1991-1995. The study indicates that there has been a real increase in total commune public health expenditure. The basic salary of CHS staff has more than doubled in real terms and there has been a real increase in the salaries of contract CHS workers and VHWs. CHS expenditure on consumable items showed a real increase, mostly funded from user fee income, but there was a considerable decrease – in absolute and relative terms – in the funding of recurrent health costs by the CPC, although in three of the four communes, considerable CPC resources have been shifted to capital CHS projects (Segall and Tipping 1996).

To summarise, the government is faced with a delicate balancing act in the current period of transition while the roles and responsibilities of the public and private sectors are being sharpened and revised. The rapid expansion of the private sector demands systems of inspection and monitoring to safeguard service quality, at the same time as the public sector requires the appropriate and effective allocation of funds in order to balance the government's political commitment to providing inexpensive commune level curative and preventive care with the increasing demand for higher level, technologically sophisticated hospital care.

6 Summary

Vietnam has instituted rapid change on numerous levels at the same time as it has precipitated the need to safeguard certain aspects of the country's cultural and political heritage – a commitment to public health being one such priority. By assuming responsibility for staff salaries at the commune level, the government helped reverse the disintegration of commune health care that marked the late 1980s. The focus on poverty alleviation and the development of mechanisms to ensure access by the poor to basic PHC services is a top priority. Economic reform does not appear to have eroded the participatory ethos of the country and reliance on 'voluntary' household contributions to bolster the finance of social funds, including health, is widespread. However, this form of community finance is only tenable when the majority of households can afford to pay. Since much of the financing of health care at the commune level depends on local political will and the ability of users to pay health fees, the need to ensure that PHC is a political priority in all communes and that services are accessible by those who need them is critical. As a result, the need to reinstate the VHW network as an inexpensive and accessible first option for care is under review. The private sector provides an increasing share of health services, which may allow the public sector to redefine its role and to shape the delivery of its services in such a way that meets the needs of its users at each level of the health system, especially the needs of the poor and vulnerable. However, adequate inspection and monitoring systems of the private sector are required and are in the formative stages of development.

To conclude, while Asian transitional economies may share similar features and act as useful mirrors for each other, there are differences that reflect different strategies for managing the reform process itself. Vietnam's 'transitional style' derives in large part from its unique social and political history, from its past and present political priorities and

from its national characteristics of independence, self-determination and collective resourcefulness. The combination of these factors make it highly probable that Vietnam's public health system will survive the current momentum of rapid and successful economic transition.

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