PAHE

Partnership for Action in Health Equity

HEALTH EQUITY IN VIETNAM

A Civil Society Perspective

WORKERS' PUBLISHING HOUSE

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Vietnam Partnership for Action in Health Equity

PREFACE

The evidence from routine data relating to health indicators suggests that the Vietnamese health care system is making rapid and laudable progress. Yet a closer examination would reveal a widening gap in the distribution of gains in health outcomes across regions and income groups. The grassroot care, historically the backbone of the health system, is in disarray, having suffered heavily from government expenditure cuts. Health policy has shifted its focus from grassroot to a complex network of health care providers, ranging from public hospitals to private practitioners. But the scale and heterogeneity of this network and the overall decentralization of government decisions to local levels make the governance and management of the system increasingly challenging. Although government continues to subsidize the poor, reflecting its socialist orientation, the increased reliance on market mechanisms has led to a neglect of social mandates and growing health costs. The dilemma for the government is that it has to rely on market mechanisms to mobilize resources for the increasingly costly system, but the market mechanisms are not ideal in maintaining equity. Meanwhile, state subsidization has not resulted in lower out-of-pocket expenditure (accounting at present for over 70% of total household spending on health), leading to further medical disadvantage and entrenching poverty. Increasingly, the insurance market 'segments out' higher income groups into a separate health care system distanced from the public system. The private system siphons resources from the public sector, weakening social commitment to cross-subsidization, risk sharing and equitable health care. Greater market-driven care also results in associated problem of 'over-servicing', bias towards biomedical interventions at the expense of public health approaches, provider competition, and deteriorating trust between patients and providers.

These unresolved problems have remained in the health system for decades due to, in the main, the absence of evidence-based policy development, effective health stewardship, including reliable quality-control mechanism and monitoring, responsive partnership between the public and private sectors of health care, as well as the voice of the civil society. In particular, the voice of the civil society is most critical in advocating and promoting health equity on behalf of the poor and the vulnerable population.

In 2009, a group of Vietnamese NGOs, namely the Institute for Social Development Studies (ISDS), Center for Creative Initiatives in Health and Population (CCIHP), Center for Community Health Research and Development (CCRD), and professionals from Department of Ethics and Social Medicine and Center for Health System Research of Hanoi Medical University established the Vietnam Partnership for Action in Health Equity (PAHE). The mission of the Partnership is to build and advocate for constructive voices of the civil society on critical issues regarding health equity that the Vietnam health system encounters in the country's rapidly changing context.

One core activity of PAHE is to do research that inform policies and programs. The plan is to produce a series of report on critical issues that affect the status of health equity in Vietnam. The focus of these reports will vary yearly and be based on extensive consultations between PAHE with health system stakeholders. This publication is the first in the series to be produced by PAHE. It is made possible with a generous fund from the Rockefeller Foundation. The reports in this publication however reflect the views of the authors only and do not represent the views of the Foundation.

CONTENT

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INTRODUCTION

Le Minh Giang, Hannah Olson and Le Bach Duong

1. HEALTH EQUITY: NOTES ON A GLOBAL GOAL

A healthy population is necessary for the achievement of all kinds of social and economic development. Good health increases the quality of life, improves workforce productivity, makes education possible, strengthens communities and reduces poverty and social exclusion. The health of a population, however, must be measured not only in its health outcomes, its innovation and the quality of its healthcare but also in how fairly health is distributed throughout society. The concept of fairness and social justice in the distribution of health is health equity. Though health differences occur naturally - populations have genetic differences and everyone make lifestyle choices that impact their personal health outcomes- many health differences in society are systemic, that is to say, they are caused by social advantages and disadvantages. Because such health inequities are caused by social factors, they are, by definition, avoidable. The very word equity connotes justice and fairness; health inequities are injustices in health. Health equity, the ideal, exists when everyone in a given population has "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance' (Braveman 2003)".

Every aspect of a national and international governments and economies has the potential to affect health and health equity - finance, education, housing, employment statuses and environments, and means and systems of transportation all directly impact the health of a population. The development of a nation's health system likewise impacts all areas of societal development: adequate and equitably distributed health makes education, economic growth and social progress possible.

Though most experts agree that health inequity is a disparity in health outcomes that is systematic, avoidable, and unjust, (Braveman 2003) there are diverging ideas about whether this inequity should be measured by differences in health outcomes alone or also through the distribution of health resources among a population in addition to health outcomes. The two areas, of course, are interconnected and impact one another.

2. HERE AND NOW: VIETNAM'S HEALTH EQUITY IN 2011

Though health equity carries a timeless and universal importance, its study has grown increasingly relevant in Vietnam since the 1986 Doi Moi reforms. Many changes have taken place in Vietnam's health system as a direct result of the

economic renovations including the introduction of user fees, the legalization of private medical practices in 1989, and the initiation of national health insurance plans in 1992.

The vast changes caused by new policies in Vietnam's health system have prompted government action toward the goal of ensuring health equity in a number of areas. In 2002, the Government legislated in support of health care financing for the poor and, in 2005, implemented free health services for children under six years of age (Vietnamese State and Government Decision 2002). In 2005, the Government stated its support for health equity by resolving that the State and Government of Vietnam aims to build an "equitable, efficient and developmental health system" (Vietnamese State and Government resolution 2005). In perhaps its most ambitious effort toward ensuring health equity, the Government passed the 2008 Law on Health Insurance, which aims to have all Vietnamese citizens insured by national health care coverage by 2014.

Despite Governmental efforts and progress toward health equity, heightened health inequity in transitional economies is a well-documented global phenomena and Vietnam is not exempt from the challenge (Tran Tuan 2005). The nation's gap in access to healthcare services between the rich and the poor has increased since Doi Moi in 1986, due to income disparities and varying degrees of geographical proximity to health centers (Tran Thi Que 2003).

Along with posing challenges to patient access, the privatization of health care has significantly increased out-of-pocket expenditures in Vietnam. Currently, almost 60% of health spending comes from direct private payments, (Hoang Van Minh this report) a proportion that is higher than many other countries in the Asia-Pacific region. Because private payments disproportionately affect the poor[1], higher shares of private health expenditure are generally associated with rising health inequities.

The legislative prioritization of health equity by the Government is a formidable step toward improving the state of health equity in Vietnam. Much must be done, though, to ensure that laws translate in to action, and that the action to improve health equity is effectively implemented. Much of the existing research on health equity in Vietnam is on small segments of the population, is out-dated or was conducted using sample sizes that are too small to draw nationally-relevant conclusions (Tran Tuan 2005). There is an overwhelming need for research with regard to health equity in Vietnam.

[1] A 2003 analysis by Xu Ke et al. showed that the proportion of Vietnamese households facing catastrophic health spending from out-of-pocket health expenses in Vietnam in 1998 was 10.5%, the highest level found in the 59 countries included in the study. Another study by Van Doorslaer et al. In 2006 found that the rate of impoverishment as a result of out-of-pocket expenses was "by far, greatest in Vietnam [as compared to other nations included in the Asia-based study], where the poverty rate rose by a third" after catastrophic health expenses.

Before the Doi Moi reforms, much of the research assessing health equity was done by the state. Since 1986, along with the restructuring of the health system, there has been an influx of foreign interest in Vietnam's health system. In the post-Doi-Moi era, much of the research on the state of health equity in the country has been conducted by international organizations. To work toward a sustainable and self-regulating system of health equity, there must be Vietnamese civil society involvement in the monitoring of the nation's health equity. This discourse, within Vietnam, will serve as the building blocks for creating an effective, equitable health system accountable to the people of Vietnam.

25 years after the Doi Moi reforms, on the brink of health insurance changes and in the midst of high private expenditures, it is more important than ever to assess the state of health equity in Vietnam. Working toward the establishment of a national civil society dialogue on health equity, PAHE's first "Health Equity Watch" has been written as a platform for discussion of differing areas on the vast and important topic of health equity.

The four reports included in this first "Health Equity Watch" interrogate the very concept of health equity, investigate the role of health financing in determining health equity, analyze health equity at the individual level through the lens of patient-clinician relationships and medical professionalism and assess the current and potential future role of civil society in steering Vietnam toward more equitable health outcomes.

The overarching goals of the report are as follows:

- Draw attention to health inequities that exist in Vietnam.
- Illuminate the definitions and measures of health equity.
- Provide a platform to discuss the current state of health financing and the equity of Vietnam's system of distribution of health resources; highlight the role of civil society organizations in shaping this discourse.
- Show the current challenges in determining health equity in Vietnam and suggest studies and methods to improve understanding of Vietnam's status of health equity.

This report is by no means exhaustive; the discussions on the concept of health equity, health financing in Vietnam, medical professionalism and ethics and the potential role of civil society are meant to illuminate slices of health equity for further public discussion rather than provide a complete evaluation of each of these complex topics.

3. A HOLISTIC VIEW OF HEALTH EQUITY: THE IMPORTANCE OF THE SOCIAL DETERMINANTS OF HEALTH APPROACH

Whereas health policy was once conceived of as strictly the provision and funding of medical treatment and services, it is now widely understood that societal factors impact health. Contrary to the once widely held assumption that individuals have control over their health outcomes, in most cases the conditions of our health -for better or worse - are imposed on us by the quality of the housing, community, work and social circumstances in which we live and interact. Health is often a passive outcome of larger social circumstances. Because many of the behaviors that impact our health (sexual relationships, transportation options, drug and alcohol use) are socially influenced, they must be evaluated vis-à-vis larger social patterns and policies. Because of this reality, the study of health has largely been expanded to evaluate underlying issues such as access to health care, housing options, transportation choices, the availability of clean water and the safety of working environments. "Closing the Gap in a Generation", the World Health Organization's seminal report on the social determinants of health, underscores the concept that health and health equity may not be the aim of all policies, but they will be a fundamental result (WHO 2011)". The report asserts that, "in countries at all levels of income, health and illness follow a social gradient[2] - the lower the socioeconomic position, the worse the health (WHO 2011)".

The notion that health is socially determined has certainly proved to be true within Vietnam. In an effort to gauge economic liberalization's impact on poor communities, a 2007 report found "significant differences in child well-being outcomes based on ethnicity, household poverty status and vulnerability to declining living standards, parental (especially maternal) education levels, children's involvement in work activities, and access to public services (Jones et al.2007)". A 2004 report by UNICEF on maternal and child health equity found that the "degree of inequality in the underlying factors themselves, finds that the main factors contributing to the observed inequality in maternal and child health outcomes are the living standards measures themselves and both observed and unobserved factors related to location (UNICEF 2004)".

The findings above, which point to systemic factors as the cause of health inequity, highlight the importance of studying health inequity though the lens of the systemic causes in Vietnam. Toward this end, this report will use the social determinants of health - the holistic understanding of the cause of a society's health - as the

[2] "**What is meant by social gradient?** The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that, in general, the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high-income countries. The social gradient in health means that health inequities affect everyone". - The World Health Organization, Closing the Gap in a Generation, 2011. Pg. 9

framework for the study of health inequity in Vietnam. Fourteen main areas of social determinants of health have been established (Raphael 2010):

- Income Distribution
- Education
- Job Security (rates of unemployment)
- Employment and Working Conditions
- Early Childhood Development
- Food Insecurity
- Housing
- Social Exclusion
- Social Safety Networks
- Health Services
- Ethnicity
- Gender
- Race
- Disability Status

Using the above-mentioned indicators, the World Health Organization report "Closing the Gap in a Generation" interrogates the causes of health equities and inequities and prescribes the following recommendations for improving health equity globally and within every country:

1. The improvement of daily living conditions
2. The closing of gaps in the inequitable distribution of power, money and resources
3. Assessments of problems of inequity and evaluation of the impacts of action

The first goal of the commission, the improvement of daily living conditions, focuses particularly on early childhood development, women's health, fostering healthier working conditions and social protection. Early childhood development, in particular, "provides one of the greatest potentials to reduce health inequity within a generation (EDCKN 2007)" in part because of the high sensitivity of early childhood development to controllable external factors. The report calls for "policy coherence, commitment and leadership" toward comprehensive early childhood development at international, national and local levels.

The improvement of workers' health is also an important step toward reaching health equity - it has been proven that mortality is significantly higher among temporary workers than it is among permanent workers (WHO 2011); workers who

"perceive work insecurity" experience significant adverse effects on physical and mental health (WHO 2011). Stress at work is likewise associated with a 50% raise in risk of coronary heart disease (WHO 2011). To combat health inquiry because of work inequities, the Commission calls for full and fair employment policies a national and international priority and worker protection policies.

The holistic view of the social determinants of health is evidenced in the commission's second goal. Working to end inequities in the way society and government are organized "requires a strong public sector that is committed, capable and adequately financed (WHO 2011)". The report emphasizes the continued importance, even in an increasingly globalized world, of strengthening civil society and local organizations to work, especially on ensuring fair financing and bottom-up political participation. Of course, such coordination must be coupled with international policies that foster reducing inequities globally and within countries.

The third overarching goal of "Closing the Gap in a Generation" - the assessment of problems of inequity through expanding the knowledge base, improving training systems and establishing domestic and international health equity systems - highlights the importance of research, education and further study into health equity. It is this third and final goal that is likely most apparent in the writing of this report.

Perhaps the most important take-home message from "Closing the Gap in a Generation" and from the social determinants of health approach in general is that it always important to scale-outwards and look at underlying and indirect factors to health, as often such factors (employment status, housing, early childhood education) have the largest impact on health.

4. REPORT HIGHLIGHTS

4.1 International Definitions and Health Equity Indicators in Vietnam: Report Highlights *(Tran Hung Minh)*

The first report included in *Health Equity Watch* provides a multitude of definitions through which health equity can be evaluated. First, the report distinguishes between the two main criteria used to measure health equity: resource-based and welfare-based.

The resource model is based on the notion that health equity is achieved through *the equitable distribution of material and social resources toward health.* Within this model, there are two divergent approaches on how health equity is achieved: the horizontal approach, which sees the equal distribution of health care resources

(social and material) as the optimal way to meeting health needs of a population, while the vertical approach argues for the progressive distribution of such resources based on need.

The welfare-based model, on the other hand, posits that the achievement of health equity is best measured not by the distribution of health resources but through *health outcomes.*

The report then traces the development of concepts of health equity from the original holistic definition of health by the World Health Organization as "as a state of complete physical, mental and social wellbeing" in 1948 through the present day - passing through the 1978 Alma-Ata resolution highlighting health equity discrepancies between developed and developing countries and the terming of these vast inequities politically, socially and economically unacceptable to its global neo-liberal backlash, to the establishment of the social determinants of health by the World Health Organization in 2000.

After listing five areas of health equity measurement and indicators - *resource allocation, access and utilization, quality of health services, the social determinants of health and health status (health outcomes)* - the report then outlines some of the challenges in measuring health equity along these lines. Several of the challenges are listed below:

- Difficulties in defining the needs of health care as individual health care. Such individual health care needs depend on many factors: the prevalence of disease in various regions and the particular needs of different populations and peoples.
- Challenges in selecting a method of measurement of health difference. There are two methods for presenting the health disparities between two groups: the absolute difference and the relative difference. The selection of the calculating method impacts the magnitude of the difference between the groups being compared.
- Difficulties in the availability of a "control" population. When studying more than two population subsets, it is difficult to determine which population group should be chosen as reference group.
- The difficulty of measuring health disparities over time. The evaluation of achievements and shortcomings in health equity depends largely on the rate of health disparities over time. However, over time, there are also changes in population growth, development, education and migration. Thus, the change in health disparities may not truly reflect the achievements of health equity policies or programs.

4.2 Assessing Equity in Health Financing in Vietnam: Report Highlights *(Hoang Van Minh, Nguyen Thi Mai Huong)*

The second report included in Health Equity Watch provides a summary update on health financing in Vietnam and underscores the importance of the role of national health financing to an effective health system.

As stated by the World Health Organization's Commission on Social Determinants of Health, increasing funding or re-allocating funds toward the social determinants of health is essential work toward the goal of health equity (WHO 2011). In addition to this rethinking of health financing to include the holistic ideas now widely accepted in the international community, the Commission on Social Determinants of health also recommends progressive financing and taxation structures (WHO 2011). Using the Social Determinants of Health as the critical framework, this second report examines Vietnam's progress in health financing.

The current health system in Vietnam is a mixed public-private provider system organized at three levels: centrally, provincially and by district. Vietnam uses three funding mechanisms to finance its health system:

- National expenditures for health facilities and personnel
- Nationally-funded health insurance
- Private payments by individuals for health services

The total health expenditure at a national level has more than doubled (when adjusted for inflation) from 1998 to 2008 (VND 12,784 billion in 1998 and VND 32,035 billion in 2008) (Vietnamese State and Government National Health Account 2010). Per capital health expenditure has likewise risen, from VND 237,000 (US$ 17) in 1998 to VND 1,095,000 (US$ 66) in 2008 (Vietnamese State and Government National Health Account 2010).

Despite the raise in national funding for health care costs, Vietnam continues to rely very heavily on private expenditures for health care costs: currently, nearly 60% of health financing comes from private sources (Vietnamese State and Government National Health Account 2010). A higher share of private health expenditure can exacerbate inequity because, without assistance from the State, people who cannot afford care cannot access services, and will run the risk of impoverishment when paying for health care costs. An analysis by Xu K. et al. showed that the proportion of households facing catastrophic payments from out-of-pocket health expenses[3] in Vietnam in 1998 was 10.5%, the highest among the 59 countries included in the study.

[3] Expenditure is hereby defined as catastrophic if a household's financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met.

Despite the growing challenge of high private expenditures, Vietnam has increased the state budget for health to cover recurrent health expenditures and continues to subsidize health insurance for the poor and children under six years of age, and invested in the upgrading of district hospitals, CHCs, and provincial hospitals (Vietnamese National Assembly Resolution #18).

Vietnam has also made significant progress in the area of national health insurance, an important step in reaching heightened equity (WHO 2011). Introduced in 1992, Vietnam has two insurance plans: a compulsory plan for the unemployed and poor and a voluntary plan targeting students and families of those covered by the compulsory plan.

The number of people with health insurance coverage has increased sharply since 2005, mostly as the result of government policies promoting the purchase of health insurance for the poor[4]. In 2008, 37.7 million people were enrolled in health insurance plans, 43.7% of the nation's population. The contribution of the health insurance fund as a portion of total health expenditure has increased over time, growing from 7.9% in 2005 to 17.6% in 2008 (Vietnamese National Assembly Resolution #18).

The coverage of health insurance in Vietnam has a fairly wide breath, but the depth of the coverage remains low:

- Funding from health insurance accounted for only 17.6% of total health expenditure in 2008 (MOH 2010).
- National health insurance continues to leave 30% of insured households incurring catastrophic health spending (Lieberman 2008).

This modest impact of insurance on financial protection reflects the incomplete nature of Vietnamese health insurance coverage; much of the out-of-pocket payments in Vietnam are made on over-the-counter drugs, while insurance covers only approved drugs used during treatment. One of the important recommendations by the Commission on the Social Determinants of Health is the minimization of out-of-pocket payments (WHO 2011), it is important that this goal is front and center as Vietnam works toward establishing universal health care coverage.

4.3 Health Equity in Vietnam: Patient Perspectives: Report Highlights *(Tran Thanh Huong, Mai Khanh Linh, Le Minh Giang)*

The third report uses the social determinants of health framework to re-examine the changes in Vietnam's health system at a personal level: through the views of patients with regard to health equity and health practitioners. The study deliberately

[4] The government budget share for procuring HI cards for the poor increased significantly over time. The premium increased from VND 60,000 (2006) to VND 80,000 (2007) and VND 130,000 (2008).

pulled a section of people who remembered health services before the Doi Moi economic renovations and a section of people who would have been too young to remember Vietnam before 1986, as to gauge changes in patient opinions before and after the reforms and differences in current perspectives between groups.
Though Vietnam has a proven legislative commitment to health equity (Law on the Protection of People's Health), there is still lack of clear policy on medical ethics regulating the relationships between doctors and patients. Changes in Vietnam's economy and society since the Doi Moi reforms have greatly complicated the relationship between medical practitioners and patients.

The study questioned 25 subjects about whether or not they thought that health equity exists in Vietnam, and whether or not it existed before the Doi Moi reforms; whereas only three respondents felt that health equity did not exist before the Doi Moi reforms, an overwhelming 14 of the 25 respondents felt that health care does not exist currently. Reasons cited for this inequity included the clumping of qualified clinicians at central hospitals, the lack of regulation of under-the-table payments to doctors, and general clinician understaffing.

The study focused, also, on patient agency and investigated patient options to try to ensure quality or timely medical services for themselves. Interviews revealed that, generally, patients had three options when faced with what they perceived as insufficient or slow medical services:

- Change the location of medical services
- Provide covert payments to clinicians (known as giving "envelopes")
- Use their personal network of friends and acquaintances to connect to a clinician (nepotism)

The majority of the patients interviewed in this study had covertly given money to clinicians in hopes of improved services. Such a high prevalence of under-the-table funds points to problems of inequity and the need for monitoring mechanism and the institutionalization of medical professionalism.

The notion of giving gifts to clinician in hopes of better services or in thanks for services rendered, however, proves older than the Doi Moi reforms. The study interrogates the methods of such gifts before 1986. The continuing existence (and speculated growth) of the phenomena, however, reinforces the need for systemic response to the problem.

Several other trends noted in patient perspectives included in the study include:

- The widespread notion among patients that medical costs are on the rise
- Patients felt as though the use of health insurance to pay for medical services often resulted in diminished quality of services

- A patient-perceived gap in the capacity, equipment and level of professionalism between doctors at district hospitals and doctors at centralized hospitals

To further the rights of patients and reconcile some of these inequity-producing trends, the following steps are recommended:

- Increased monitoring of medical professionalism, especially by independent associations
- Further research (culturally and socially specific) on the effectiveness of the application of medical practitioner payment in Vietnam
- Measuring tools for the attitude and behavior of clinicians to assess the equity and effectiveness of health care services in Vietnam

4.4 The Role of Vietnamese Civil Society toward Health Equity: Report Highlights *(Hoang Tu Anh)*

The World Health Organization's Commission on Social Determinants of Health highlights the important roles that civil society can play in working toward increased health equity: one, evaluating and monitoring health services, and supporting or delivering health services locally; and secondly, monitoring the specific social determinants of health. The report underscores the notion that action toward health equity necessarily involves civil society.

The final report in this series underscores the notion that the role of Vietnamese civil society is complex because it differs from other civil societies developing in the Asia-Pacific region because of its general willingness to work for change with the state rather than oppose or act as a watchdog against Vietnamese Government and State legislation.

Not incidentally, many of the organizations interviewed in this study self-identified their role as supplementing government services, as opposed to advocating for changes in government services or serving as a government watchdog agency.

The HIV/AIDS epidemic in Vietnam has provided a formidable example of the potential for civil society to provide services and education, influence policy and advocate for socially marginalized populations.

The progress exemplified by the civil society in response to the HIV/AIDS epidemic, however, does not necessarily translate directly to national progress. There are vast and urgent needs for the growth of civil society. The particular nature of Vietnamese civil society begs a set of goals for the building of health equity vis-à-vis the building of a more effective civil society:

- Capacity-building. Especially regarding the ability for Vietnamese civil society to generate sound evidence-based tools for advocacy is lacking because Vietnam, like most developing countries, lacks the necessary human resources and funding sources to conduct sound research
- Transparency. The lack of a system of transparency for lobbying has hindered the effectiveness of civil society to advocate for policy changes
- Participation of civil society groups in policy development. Civil society currently lacks the capacity to participate meaningfully, and the Vietnamese government lacks a mechanism to encourage participation from these organizations
- Coordination among civil society groups. A coherent network for communication and strategy largely does not exist for Vietnamese civil society

5 Moving Forward: Furthering the Role of Civil Society

In 2010, the World Health Organization produced the Adelaide Statement to outline the global need for a new social contract between all sectors to advance development, equity and to improve global health outcomes (WHO 2011). Along with the need for the creation of common goals, integrated responses, government transparency and accountability, the Statement underscored the importance of civil society in acting to ensure these goals and move the every nation toward more equitable health.

Such a rubric is especially important in the Vietnamese national context, as we try to build the nation's civil society capacity.

The Adelaide Statement provides a rubric of suggestions to move toward health equity, stating that "health in all policies", in other words, promoting national policies in all areas to better everyone's health circumstances works best under in the context of:

- Civil society and government cooperation
- Systematic procedures that account for work across societal sectors
- Mediation across interest groups
- Accountability, transparency and participatory processes
- Engagement with stakeholders outside of the government
- Practical cross-sector initiatives that build partnerships and trust (WHO 2011)

Such a rubric highlights the necessity of civil society action toward the goal of health equity, a task that is of the utmost importance for the improvement of health equity in Vietnam. The actions suggested by the Statement, which incorporate the

need for attention to such far ranging issues as housing, environments, land and culture, underscore the importance of using a holistic social determinants of health framework to gauge health equity.

Health equity is not only determined by the distribution of health resources or by health policy alone. To achieve health equity, the social determinants of health, which are affected by all areas of policy, must be addressed. To address living, working, and lifestyles in addition to the evaluation of economic, social and health policies, the cooperation and support of civil society organizations must be invoked.

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INTERNATIONAL DEFINITIONS AND HEALTH EQUITY INDICATORS IN VIETNAM

Tran Hung Minh

EXECUTIVE SUMMARY

Health equity has emerged has a key issue in the development of health systems, however although it has been a concern for some time, there are still many different views about how it should be defined. Within Vietnam, the Government has clearly stated equity as an important goal for the development of the health care system. However, specific indicators that measure porgress towards this goal have not been systematically developed. This paper highlights the results of a literature review into international definitions of health equity and associated indicators and relates this to perceptions and views of health equity within Vietnam.

The literature review illustrates that different views of health equity are rooted in various theories of social equity. However within the global conversation about healthcare two main points of view prevail on how to define health equity. The first is resource-based and the second approach is welfare-based. The resource model posits that health equity is achieved through the equitable distribution of material and social resources. Thus the resource based model, health equity is defined as the equitable provision of health-care. Within this model there are two divergent approaches on how health equity is achieved, one takes a horizontal approach and argues for equal health care spending for all who have the same health care needs, whilst the other takes a vertical approach and argues for greater health care spending for those with greater needs. In contrast the welfare-based model argues that the achievement of health equity is best measured not by the distribution of health resources but through the acheviement of equitable health outcomes. Within this school of thought

More recently health equity has been viewed within a broader perspective taking into account social factors. The model of "Social Determinants of Health and health equity" has been introduced and adopted by the World Health Organization (WHO). In accordance with this framework, health inequity is defined as *"potentially avoidable differences in health (or health risks that policy can influence) between groups of people who are more and less advantaged socially"* [Braveman, 2006].

This framework, introduces five groups of indicators to measure health equity: 1) Allocation of resource and finance for health care; 2) Access and utilization of health care services; 3) Quality of health care services; 4) Key determinants of health and 5) Health status.

Using this as a comparative framework to analyse health equity within Vietnam it was found that the data of health equity indicators in within the Vietnamese health system were rather limited [GSO, 2005,2006,2008; JARH, 2009]. This was especially the case in data for indicators that measure equity in the quality of health care services. Many indicators were presented without classification by group characteristics such as: ethnicity, gender, geography or economic status. In addition, data was often not collected systematically over time. These facts make it difficult to measure and to follow up the achievements in health equity over a period of time. Data collected for some specific health equity indicators are shown in Table 5.

1. INTRODUCTION

Why should we discuss health equity?

Social justice is an issue of concern of most nations and health equity is a domain within the sphere of social justice. Currently, health equity becomes more and more a global concern because health inequity is present at both national and international level (WHO 2008). In some countries, all people in the group of the 20% richest got access to health services while a half of children falling in the group of the 20% poorest could not access to these health services. The gaps between countries were also very big, for example the mortality of children under 5 years olds in the United States was of 7%o while the rate in Mali was of 126%o (World Bank 2006).

Equity is one of the leading goals of health care system of Vietnam (IX Party Congress Document, 2001). Reports on health equity in Vietnam, however, remain limited in scope and scale (Dam Viet Cuong, 2005; Pham Manh Hung, 2004). Additionally, the indicators of health equity were not available among the list of health indicators within the health information system. The lack of available information on the indicators of the nation's health equity narrows the knowledge of clinicians, researchers and policy makers and hinders the development of health equity interventions.

Objective

This paper seeks to contribute to the understanding of health equity by presenting the definitions and methods of measurement of health equity used internationally to provide a framework for further nation-specific discussions of health equity.

Method

A desk study was performed to collect relevant information from various sources, including: Internet, libraries of universities, documents, reports, research papers. Much used sources include websites and reports of Ministry of Health, Ministry

of Labour, Invalid and Social Affairs, Ministry of Education and Training, General Statistic Office, National Committee on Population, Family and Children, National Institute on Nutrition, World Health Organization, World Bank.

Limitation

The paper focuses upon indicators and quantitative methods for measuring health equity. Other qualitative methods such as policy and political environment analysis were not applied due to the fact that information collected from these methods are mainly used for comparitive purposes between countries. Moreover, with limited time and resources the data collected may not represent all indicators of health equity in Vietnam.

2. HISTORY OF HEALTH EQUITY

In order to have deeper understanding on definitions and different concepts on health equity, we should look back to explore from the origin of these definitions.

The concern about health equity has been manifested in several periods (A.Irwin and E.Scali, 2007)[1]:

- **WHO 1948:** In 1948, The World Health Organization issues a clear definintion of health (Health is a state of complete physical, mental and social well-being) and set a goal to reach the best state of health to all people. So, the social aspect of health and health equity were already included within this definition and goal.
- **In 1950s:** This was the period which was most affected by the cold war especially after the withdrawal of Soviet Union and other Socialist countries from the United Nations, WHO was dependent on the United States of America and American senior officials didn't support the health care models which linked with the social determinants of health. Moreover, during this period the booming of medical technology, medicine, vaccine made people think that scientific technology would be the answer to all health issues. In developing countries and countries under colonization, the health care system was set up to serve the ruling class, focusing on medical technology at urban hospitals. Public health programs were mainly vertical programs such as: Tuberculosis, malaria, and just focused on technology. These programs were focused because they were seen as efficient and able to measure results. To conclude, in this period of time, the social determinants of health were not greatly considered, health issues of poor communities were unsolved.
- **In 1960s and early 1970:** While the health programs were unable to meet the health needs of majority of people due to the fact that they focused too much on hospitals and technology, some other initiatives were formed which focused

[1] The presentation of the two authors mainly reflect the Western's view hence it might not fully reflect the particular changes in Socialist Countries.

on the participation of the community in order to enhance community capacity and engage health to human rights, social justice and other more influenced determinants such as economy, politics and environment. Health education and diseases prevention became focal point in health programs. In this period, together with the expansion of health care services for disadvantaged communities and solution to non medical determinants of health in order to overcome health inequities the slogan of "Health for All by the year 2000" was presented at World Health Assembly in 1976.

- **Alma-Ata conference in 1978:** The conference agreed on the goal of "Health for All by the year 2000" and the application of primary health care in order to reach this goal. The philosophy of primary health care once again reaffirmed the concern about health equity and social determinants of health which includes: the expansion of basic health care services to grassroots level to meet the health needs of majority people, more resources for poor communities, less dependence on medical experts and linking health with social development. Many developing countries gained great achievements in the improvement of health indicators and health equity through programmes that applied intersectoral action for health.
- **Selective primary health care in 1979 - early 1980s:** Although many developing countries gained a lot of successes, the primary health care model was not maintained in many other countries because of the fact that they were unable to implement the intersectoral actions for health. Moreover, the philosophy of Alma-Ata about global economic inequality and the call for development in the spirit of social justice was spposed by other groups who promoted market based approaches, including the US government and the World Bank. Though agreeing that the primary health care model was ethical many donors and leaders of development organizations argued that such amn approach was too large and would not bring specific outcomes. Moreover, medical associations and leaders of the health sector percieved community empowerment as a threat to their authority. As a result, the selective primary health care model was first introduced in 1979 at a workshop in Bellagio. The most well-known GOBI model was later introduced and got the great support from UNICEF during 1980.
- **Neoliberalism in 1980s:** In early 1980s a new economic and political model was first developed known as "Neoliberalism" with the support from the United State Government, World Bank and International Monetary Foundation (IMF). The main theory of this model was that: free market without interference from government are most efficient for production and distribution of resources, including health. Hence, in order to reach the development goal, it is necessary to limit the role of the government in some ineffective economic activities including health field. In the light of this theory, economic development policies were given more priorities and government social expenditures were reduced. This was supported by the argument that the 'short term pain' for disadvantaged communities will be compensated by the 'long term gain' of the economic development. Developing countries were affected by neoliberalism

because of the requirement for economic reform from bilateral cooperation programs, aid sources and loans from World Bank or IMF. Health sector was also requested to reform because of its ineffectiveness. As a result, the government's expenditures on public social services were cut down such as education, nutrition, water and sanitation and housing. Among 37 poorest countries at that time, expenditures on public education reduced by 25% and health expenditure reduced by 50%. Meanwhile the economic growth was not reached, as the expected increases in GDP did not materialize.

- **In 1990s:** Neoliberalism continued to expand during 1990s, however, the 'short-term pain' didn't result in considerable 'long term gain'. Facing the criticism and anger from communities, the developed countries such as G8 and international financial organizations started to adjust their strategies such as debt relief for the poorest countries (mainly African countries) and increased social expenditures including health and education. After a long time of leaving the global health management to World Bank, WHO started to have some adjustment such as setting up a Task force on health and development in 1994 and continued developing policies to reach the goal: Health for All in the 21st century. Later on, the Commission on Macroeconomic and Health was formed and it showed that the expenditures on ill health among the poor accounted for a big amount in the global economy. The figures on economic effectiveness when investing on health care shows that health is one of the development factors that needs to be reinvested. With the "economic effectiveness" approach, it seemed to have attracted more concern from policy makers and more practical than the previous ethical approach.
- **In early 2000s:** With evidence from a number of research which showed the health gaps between countries and different social groups. and the relationship between health and social determinants were simply, persuadably presented for policy makers, many countries in Europe developed policies to solve the health inequity and the social determinants of health. In 2005, WHO set up the Commission on Social Determinants of Health aiming to push the process to reach health equity.

3. TERMINOLOGY AND DEFINITIONS OF HEALTH EQUITY

3.1 Terminology

Though many of the terms used to discuss health equity are nebulous and are often interchangeable, a few of the main concepts used to discuss health equity are stated below.

- **Equality:** Measuring the same in value, status, quality or quantity.
- **Equity:** Fairness in law. The concept of equity is based on moral standards. Equity manifests in balance.

- **Health Disparities** (or Health inequalities, used interchangeably): are "differences in the incidence and prevalence of health conditions and health status" (CDC, 2008).

3.2 Definition of Health Equity

Health equity is one domain of Social justice and based on different theories of distributive justice, there are some different points of view on health equity:

- According to the Resource based Principles[2] paradigm, health equity is seen as equity in health care where resource allocation, access and utilization of health care to be determined by health needs not capacity to pay. People who have the same health need will receive the same treatment (horizontal equity) and those with different health need will receive different treatment (vertical equity) (Mooney 1983).
- The Welfare based principles[3] supposed that health is welfare of people and health equity is manifested in equal health outcomes. So, equity in resource allocation and access to health care is meaningful only when it brings about equal health outcomes.

Table 1: Some brief definitions

No.	Authors	Definitions
1	Mooney 1983 (and others)	Horizontal equity requires equal treatment for equal need Vertical equity: different treatment for different need
2	Aday 1984	Health care is equitable when resource allocation and access are determined by health needs
3	Whitehead 1990, 1992	Health inequities are differences in health that are avoidable, unjust and unfair
4	Culyer &Wagstaff 1993	Equity in health care means equal utilization, distribution according to need, equal access and equal health outcomes
5	International Society for Equity in Health (ISEqH), 2005	Health equity is the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population subgroups defined socially, economically, demographically or geographically

Source: Braveman, 2006

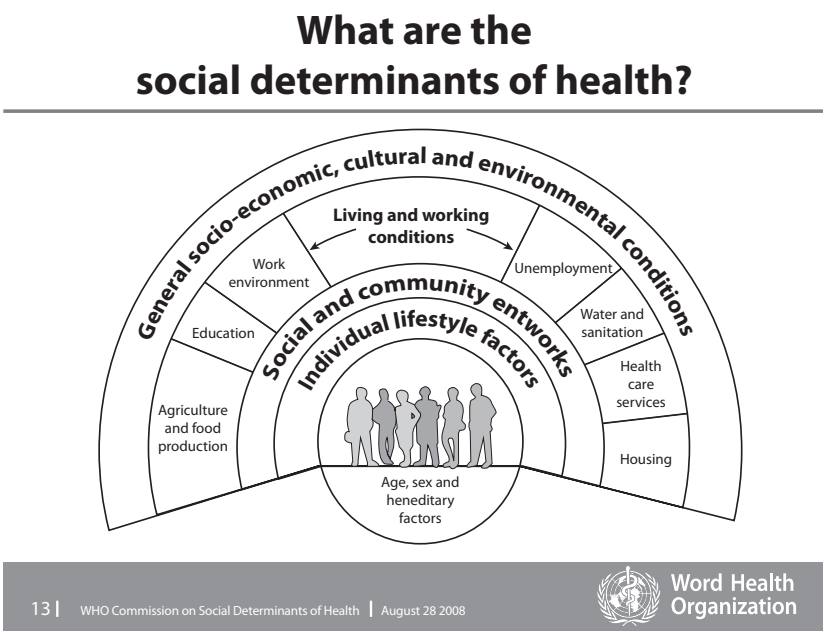
[2] **Resource based Principles:** Supposes that all people must have the same resource to develop, but the development results depend on the choices of each person.

[3] **Welfare based Principles/Utilitarianism:** People's welfare is primary important and equity must be manifested in the welfare allocation. If equity in resource allocation doesn't bring equal outcomes in welfare that equity is not meaningful.

So, we can see that there is a change over time in definition of health equity. The definitions shown in the above table focus on 2 main components, including: 1) Equity in health care (resource allocation, access and utilization of health services according to need) and 2) Equity in health outcomes.

- Currently, the definition in health equity has been broadened with model of Social Determinants of Health and health equity.

Figure 1: Social determinants of health and health equity



Definition on Health Equity: Many definitions were delivered, however, this paper presents the definition of Braveman in 2006 because it is in line with the model of Social Determinants of Health of WHO: ***"Health Equity is the absence of potentially avoidable differences in health (or health risks that policy can influence) between groups of people who are more and less advantaged socially".***

- For monitoring, health equity is further broken down into 5 specific components:
  a. Equity in resource allocation for health care.
  b. Equity in access and utilization of health services.
  c. Equity in the quality of health services.
  d. Equity in key determinants of health such as: clean water and sanitation, nutrition and food safety, living environment, working environment, education and health risk behaviors.
  e. Equity in health status.

In Vietnam, most documents and materials mentioned equity in health care instead of health equity with focus on solving the issues related to: access, utilization and quality of health services, resource allocation and financing health care [Dam Viet Cuong, 2005). The other two main components which have not been clearly mentioned are: equity in health status and risk factors.

4. HEALTH EQUITY MESUREMENT AND INDICATORS

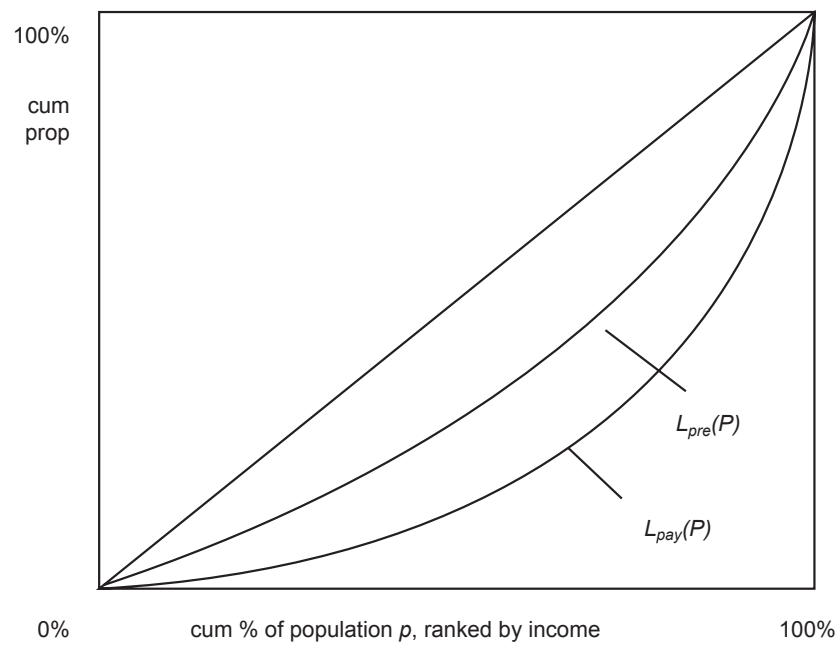
Both qualitative and quantitative methods can be used to assess health equity. Policy analysis and cultural and social mapping are the two main techniques used in qualitative assessment of health equity. However, this paper mainly focuses on the quantitative methods to measure health equity.

4.1 Indicators and measurement

Group 1: Resource allocation for health

- In order to analyse vertical equity in health finance, the traditional method is to measure the progressivity of the health financing system (Eddy van Doorslaer et al. 2008). A commonly used indicator is Kakwani's progressivity index. Kakwani's index is based on the Lorenz curve for pre-payment income *(Lpre)* and the health care payment concentration curve *Lpay(p)*. If *Lpay(p)* lies below *Lpre(p)* then Kakwani's progressivity index is positive (the source of finance is progressive). The opposite is when *Lpay(p)* lies *above Lpre(p)*, and Kakwani's progressivity index is negative (Wagstaffs et al. 1998).

Figure 2: Lorenz curve for prepayment income and concentration curve for health care payment



- The issue of horizontal equity in the finance of health care has received relatively little attention. However, a number of measures of horizontal inequity have been developed and the approach suggested by Aronson et al. is mostly used. This method measures the variation in health care payments amongst groups of pre health payment equals. If there is no variation, there is no horizontal inequity (Wagstaffs et al.1998).
- However, whether the above mentioned indices can exactly measure the equity in health resource allocation or not depends a lot on the sources of health finance (from tax, health insurance or out-of-pocket payment). In those countries where health finance mainly comes from the out-of-pocket payments, the fact that the better off contributing more in the total health expenses does not truly reflect equity. Because it is the direct payment for the health services they have used, it is not the contribution for a pooled fund like the tax or health insurance. Besides, poor people contribute less to the health expenses because they have no money to use the health services not because they can use the health services with lower payment. Therefore, the above mentioned indices are more relevant to be applied in developed countries with wide coverage of health insurance (Eddy van Doorslaer et al. 2008). In poor countries with narrow coverage of health insurance where the health expenses mostly come from the out-of-pocket payments, the two indices: Catastrophic health payments and Impoverishment are applied.
- **Catastrophic health payment index:** Catastrophic heath expenditure occurs when a household's total out-of-pocket health payments equal or exceed 40% of household's capacity to pay or non-subsistence spending.
- **Impoverishment:** A non-poor household is impoverished by health payments when it becomes poor after paying for health services.

In order to calculate the above mentioned indices, it is necessary to conduct a representative household surveys that include: 1) Individual level: Socio-economic information and health service utilization; 2) Household level: Total household consumption expenditure; food expenditure (not include tobacco and alcohol) and out-of-pocket health expenditure and private health insurance premium (WHO 2005).

Group 2: Access and utilization

Internationally there are two main approaches: The first considers access and utilization as two separate groups and the second mixes up these two concepts into one group for measurement.

- Some frequently used indicators for access to health care include: having health insurance, household income level and accessibility to the primary health care delivery point (including: distance, travel time and language).

- Utilization of health care: Horizontal equity principle has been applied to assess the equity in health care utilization. There are two main methods to calculate the concentration index of horizontal inequity: a) indirect standardization-(Wagstaff and van Doorslaer. 2000); b) Decomposition method (Eddy van Doorslaer et al. 2008). If the index equals to zero, it means that equity is reached.

In order to make it easier for measurement and comparison, the assessment of the equity in health care utilization is often applied for some basic health care such as: vaccination, prenatal care, regular health check.

Group 3: Quality of health services

There are many ways to classify the indicators for the quality of health care services. This research combines the classification of Joint Commission on the Accreditation of Healthcare Organizations (JCAGO 1996) and Institute of Medicine (IMO 2001) because this combination is relevant to compare the equity between geographical areas (such as: compare the quality in health services in medical clinics in delta and mountainous regions) and between social groups. Following are the sub-group indicators:

- Appropriateness
- Availability
- Continuity
- Effectiveness
- Safety
- Time lines
- Satisfaction

Group 4: Some key social determinants of health

Table 2 presents some key determinants of health.

Table 2: Some indicators for group 4

Content	Indicators (examples)
Living condition	• Clean water • Latrine utilization • Housing conditions • Contamination status: foods, water, air and noise. • Traffic safety • Crime • Social environment: social capital,stigma and discrimination

Content	Indicators (examples)
Job	• Unemployment • Job quality • Working safety
Education	• Rate of enrolment • Drop-out rate • Illiteracy
Behavior	• Smoking • Alcohol use • Drugs injection • Violence • Diet and exercise

Other factors such as policy and politics are not mentioned in this section because these factors are normally assessed by using qualitative methods to compare between countries.

Group 5: Health status

Currently, there are two main approaches to measure health status, including: the measurement of individual indicator for a particular health status and aggregate indicators such as: life expectancy, mortality and Disability Adjusted Life Year (DALY).

Table 3: Some indicator for group 5

Content	Indicators (examples)
Expectancy and mortality	• Neonatal/Infant mortality • Age specific mortality • Life Expectancy
Disease	• Prevalence • Incidence
Function	• Functional impairment • Disability

DALY index: Measures the burden of diseases by combining the mortality and morbidity into a single measurement which is the healthy time lost from specific diseases and injuries in a population. Using DALY index calculation makes the comparison of the health status among different groups of people, different communities easier.

DALY index is calculated as follow:

DALY = Years of lost life (YLL) + Years lost to disability (YLD)

In order to calculate the YLL, it is necessary to have the following data:

- Life expectancy at age of death
- Age at death

In order to calculate the YLD, it is necessary to have the following data:

- Duration of disease/injury
- Disability weight of disease/injury

4.2 Steps to assess health equity

There are often 3 main steps to go through:

4.2.1 Select the indicator(s) of interest for comparison among the 5 groups of indicators presented above. The selection depends on the purpose of assessment, the availability of information and financial resources.

4.2.2 Identify the variable for classification of groups. Some variables commonly used are:

- Geographical area
- Ethnicity
- Gender
- Poverty

Besides, in some studies, other specific variables could be used, including different vulnerable groups, such as disabled people, prostitutes, men have sex with men.

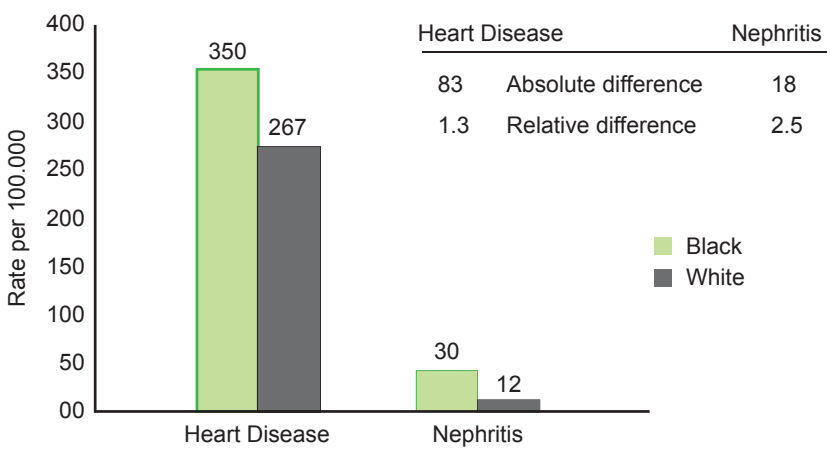
4.2.3 Choose the method for comparison. Depending on the characteristic of the selected indicators various methods could be used, for example: comparing the relative difference, regression.

4.3 Challenges

- Difficulties in defining the needs of health care: as mentioned earlier, in order to assess horizontal equity, we have to standardize the health care needs. However, health care needs depend on many factors, including the morbidity of diseases between regions, groups of people and individuals.

- Not all differences in health are inequity. For example: The rates of injury among athletes are higher than non-sport players. According to the above mentioned definition of health equity, it is not always easy to define the "avoidable differences in health" or the *"health risks that policy can influence"*.
- Using aggregate indicators or single indicators to measure health status? A lot of arguments about this question have been discussed. Using single indicators for specific diseases would make it difficult to compare the overall health status between different groups. For example: the prevalence of tuberculosis and malaria are often higher among the poor but in opposite, the prevalence of cardiovascular diseases is higher among the better off people. Using the aggregate indicators such as the DALY index, also faces some difficulties related to the level of validly of measurement and justice, especially when the adjustments for disease specific, age weighting and discounting are used.
- What unit of measurement should be used? There are two methods for presenting the health disparities between two groups: 1) Calculating the absolute difference by taking the data of one group to subtract the data of the other; 2) Calculating the relative difference by taking the data of one group divide by the data of the other. The selection of the calculating method will affect the assessment on the magnitude of the difference between two groups. For example, looking at the absolute difference in the graph below, the difference in heart diseases was higher than the difference in nephritis (83 compared to 18) between the Black and White. But the difference was opposite in the term of relative difference (1.3 compared to 2.5).

Figure 3: Lorenz curve for prepayment income and concentration curve for health care payment



Source: John Lynch and Sam Harper 2003. Measuring Health Disparities - University of Michigan School of Public Health

- Compare which group to which group? This question is not a matter when there are only two groups for comparison, for instance, the male and female group. However, when there are more than two groups, which group should be chosen as reference group? For example, compare the health status of the poorest group (20 percentile) with the richest one, the 50 percentile group or with the aggregate data of the whole population? The selection of the reference group will definitely influence the magnitude of the difference about health status.
- Measure and compare health disparities over time: in order to evaluate the achievements in health equity it is necessary to follow up the health disparities over time. However, over time, there are also changes in population growth and migration. Thus, the health disparities may change just because of the big change in population size. The change in health disparities may not truly reflect the achievements of health equity then.
- Information sources and methods of data collection: there are some debates on the quality of information collected from the big surveys, especially when collecting the data about income and family expenditures, including the health expenditures.

5. STATISTICS ON HEALTH EQUITY IN VIETNAM

According to the above mentioned definition in health equity, the team of researchers did a literature search and classified the statistics of Vietnam into 5 groups of indicators. The findings show that there were still differences in some indicators between different areas, ethnic groups, gender and the level of poverty. In addition, the data for health equity indicators were not systematically and constantly collected over the years. Data for some health indicators were available but the variables for group classification were missing and that made the comparison impossible.

Table 5: Indicators in Vietnam

Groups of indicators	Statistic	Year	Source
Group 1: Health resource and finance allocation			
Catastrophic Index	13% (95% CI: 12.5%-13.2%)	2002	CCSE - WHO group, 2006
Beneficiary rate in public hospitals for different income groups	The poorest: 10.7% The richest: 31.4%	2002	World Bank 2005, Vietnam development report

Groups of indicators	Statistic	Year	Source
Group 2: Access and utilization of health services			
Fully vaccinated rate (EPI)	Red River Delta: 88.4% Northern mountainous area: 45.1% Northern Central Area: 55.9% Coastal southern central area: 76% Highland: NA Southeast area: 76% Mekong delta river 60.8%	2002	Population and health survey in 2002
Prevalence of modern contraceptive methods used among married couples at reproductive age	Kinh: 79.5% Ethnic Minority: 70.6%	2007	Baseline survey of Cordaid programme in 6 provinces, sample size: 700
Access to information about contraception among married couples at reproductive age	Kinh: 85.2% Ethnic minority: 63.7%	2007	Baseline survey of Cordaid programme in 6 provinces, sample size: 700
Group 3: Quality of health services	Not Available		
Group 4: Some key determinants of health			
Percentage of households having access to clean water	Kinh: 99.5% Ethnic Minorities: 44.5%	2007	Baseline survey of Cordaid programme in 6 provinces, sample size: 700
Percentage of households having hygienic latrine	Kinh: 78.9% Ethnic Minorities: 14.6%	2010	Baseline survey of SNV project in 1 district of Dien Bien and 1 commune of Bac Ha, Lao Cai province (30 clusters with the sample size of 560 households)
Rate of enrolment in Secondary School	Male: 87.6% Female: 72.7%	2008	VHLSS 2008
Group 5: Health Status			
Mortality among children under 5	Urban: 16.2%0 Rural: 35.6%0	2002	Population and health survey in 2002
Infant mortality	Urban: 9.7%0 Rural: 20.4%0	2004	Survey on population and family planning 2005
Perinatal mortality	Poor: 5% Average: 2.4% Rich: 2.1%	2002	VNHS 2001-02

Groups of indicators	Statistic	Year	Source
Rate of malnutrition among children under 5 (weight for age)	Lowest income (20%): 28.5% Highest income (20%): 10.4%	2006	Statistic General Department 2006, Multiple Indicator Cluster Survey
Rate of malnutrition among children under 5 (weight for age)	Red River Delta: 16.8% Northeast: 22.4% Northwest: 24.7% Northern central area: 22.1% Central Southern coastal area: 19.4% Highland: 28.6% Southeast Area: 16.5% Mekong Delta river: 18.8%	2009	National Institute for Nutrition,Statistic General Department, 2009
Rate of communicable diseases	Poor: 19.9% Average: 11.6% Rich: 9.2%	2002	VNHS 2001-02
Rate of non-communicable diseases	Poor: 34.8% Average: 49.8% Rich: 51.1%	2002	VNHS 2001-02
Traffic accident fatal rate/ 100,000 people	Male: 35.7 Female: 8.7	2007	JARH 2009
Rate of unwanted pregnancy during the past year among married women at reproductive age	Kinh: 4.8% Ethnic minority: 8.5%	2007	Baseline survey of Cordaid programme in 6 provinces, sample size: 700
Abortion rate during the past year among married women at reproductive age	Kinh: 3.2% Ethnic minority: 6.0%	2007	Baseline survey of Cordaid programme in 6 provinces, sample size: 700

6. CONCLUSION

Globally, concerns and opinions about health equity have changed substantively over recent years, for example, different definitions about health equity and the provision of health care has emerged. One model that has emerged takes into account the social determinants of health and health care equity. This social determinants model was recently introduced by the WHO and it takes a comprehensive approach to health equity and balances different viewpoints.

Within this model, there are 5 groups of indicators for measuring health equity: 1) Equity in resource allocation for health care; 2) Equity in access and utilization of health services; 3) Equity in the quality of health services; 4) Equity in key determinants of health and 5) Equity in health status. For the first, fourth and fifth groups, specific indicators together with methods and unit of measurement have been comprehensively developed, whilst for others, such as accessibility and quality of health care services, further discussion is required to agree indicators.

Within Vietnam, equity is clearly stated in the directions of the Party and State as an important goal for the development of its health care system. Based upon existing literature, it seems that in Vietnam, the concept of equity in health care is being used in stead of health equity. Indicators of equity in health care have not been clearly defined within the health information system and as a result, information and statistics for monitoring the achievements in health equity have not been systematically and consistently collected.

As Vietnam's health system developments in response to changing needs and global pressures it will become important for the Government of Vietnam to review how it defines health equity and to consider the use of international definitions. This will the help the development of specific indicators that will enable the Vietnam's progress towards achieving health equity and provide a sounder basis for comparison.

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ASSESSING EQUITY IN HEALTH FINANCING IN VIETNAM

Hoang Van Minh, Nguyen Thi Mai Huong

1. INTRODUCTION

Health financing system is one the building blocks in a health care system. The health financing system clearly affects almost all the goals of the health care and plays a central role in improving equity, risk protection and efficiency (1). All health financing systems share three key ***health financing functions***:

- **Revenue collection** collects and organizes financial contributions to the health system from different sources
- **Risk pooling** is the collectivizing of risk so that the risk borne by each contributor individually
- **Purchasing is about how these funds are used to purchase effective health services**

Of these functions, ***risk pooling*** is important for ensuring household financial protection. ***A good health financing system*** raises adequate funds for health in ways that ensure that people can use needed services, and are protected from financial catastrophe or the impoverishment associated with high health care costs.

The way that a country chooses to exercise the three above-mentioned functions comprises ***health financing mechanisms***. Common health financing mechanisms include:

- Tax-based health financing-revenues from taxation are the predominant source of healthcare spending;
- Social health insurance-fund raising is tied to the income of members, typically in the form of a percentage of members' wages, in this type of scheme. Premiums are collected separately from general state revenues. Health insurance can also be expanded to cover other population groups in the society such as the poor, children, and those who are entitled to social security, etc. with health insurance premiums paid through a government subsidy or other sources of contribution;
- Private health insurance based system- a form of for-profit, privately managed voluntary health insurance. Premiums are paid directly from employers, associations, individuals, and families to insurance companies, under this type of scheme;

- Direct out-of-pocket payments by households to health service providers at the time the household uses or purchases goods or services;
- Health financing from external sources (loans and external aid coordinated by the state). This financing source is often allocated directly to providers to implement priority health programs.

Health equity as a general concept and equity in health financing in particular are very important issues in Vietnam. In recent years, policy makers in Vietnam have considered implrementing various financing strategies to improve the equity of health care financing. Several of these considerations have been put into action and health-financing reforms are underway in Vietnam. Because of these developments, it is crucial for health policy makers to understand the course of implementation and potential impacts of the policies. This paper aims to assess the progress and impacts of the policies and actions targeting health care for disadvantaged populations in Vietnam.

2. HEALTH SYSTEM IN VIETNAM

The current health system in Vietnam is a mixed public-private provider system. Administratively, the public health care system is organized at three levels: central (Ministry of Health); provincial (provincial health departments (PHDs, sometimes referred to as the provincial health offices or provincial health bureaus); and district level (district health offices (DHOs)). Four levels of organization officially exist to provide service delivery: (a) central level (central and regional hospitals) managed directly by the Ministry of Health; (b) provincial level providers managed by PHDs; (c) district level providers, also managed by the PHDs; and (d) commune level providers managed by the DHOs. According to the 2008 Ministry of Health Health Statistics Yearbook, there were 44 state curative care facilities at the central level managed by the Ministry of Health. There were 383 provincial-level facilities, 1366 district -level facilities, and 10,866 facilities at the commune level(2). The public health care system still plays a key role in health care, especially in prevention, research and training. The private sector has grown steadily since 1989, but mainly in the area of outpatient care. Little is known about the performance and quality of services provided by the private health care providers, especially since many private providers are not licensed (3).

Since the 1986 Doi Moi economic reforms[1], many changes have been made in Vietnam's health system. Central among these were the introduction of user fees, the legalization of private medical practices in 1989, the initiation of health insurance schemes at the national level in 1992; and the take-over by the central government of the responsibility for paying salaries to the public health staff at the

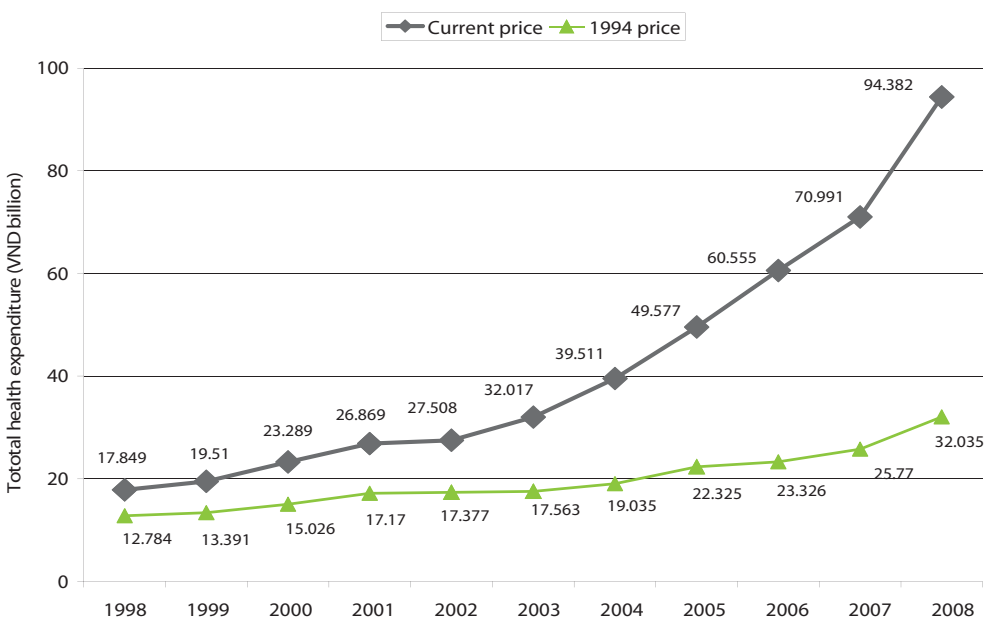
[1] The Doi Moi programme instigated the transition transforming Vietnam from a planned economy to a market economy

commune level in 1994. More recently, to support health care for disadvantaged populations in Vietnam, the Government launched Decision 139/2002/QD-TTg on health care financing for the poor and Decree 36/2005/ND-CP on free health services for children under 6 years of age. The Communist Party of Vietnam also issued resolution 46, 23 February 2005 NQ/TV, which stated that Vietnam aims to build an "equitable, efficient and developmental health system". In 2006, the Government issued Decree 43/2006/ND-CP on financial autonomy, ownership and accountability of public administrative organizations. As part of policy effort aimed at strengthening the Vietnamese health care system and moving towards universal health care in Vietnam, on November 14, 2008, the National Assembly passed the Law on Health Insurance, which aims at the insuring of all citizens by 2014.

3. HEALTH FINACING IN VIETNAM

Like many other developing countries, Vietnam uses three main options to finance national health care expenditure: the state budget, prepayment funding (social and health insurance) and direct out-of-pocket payments by households (4). Total health expenditure in Vietnam has significantly increased during the past ten years. In nominal terms, the increase was more than 5 times (VND 17,849 billion in 1998 and VND 94,382 billion in 2008). If 1994 constant price was applied, the increase was more than double (VND 12,784 billion in 1998 and VND 32,035 billion in 2008) (Figure 1). Per capita health expenditure went up from VND 237,000 (US$ 17) in 1998 to VND 1,095,000 (US$ 66) in 2008 (Table1).

Figure 1: Total health expenditure, Vietnam 1998-2008



Source: National Health Account 2010

Table 1: Per capita health expenditure (current price), Vietnam 1998-2008

Year	VND	US$
1998	237,000	17
1999	255,000	18
2000	300,000	21
2001	341,000	23
2002	345,000	23
2003	396,000	26
2004	482,000	31
2005	597,000	38
2006	720,000	45
2007	834,000	52
2008	1,095,000	66

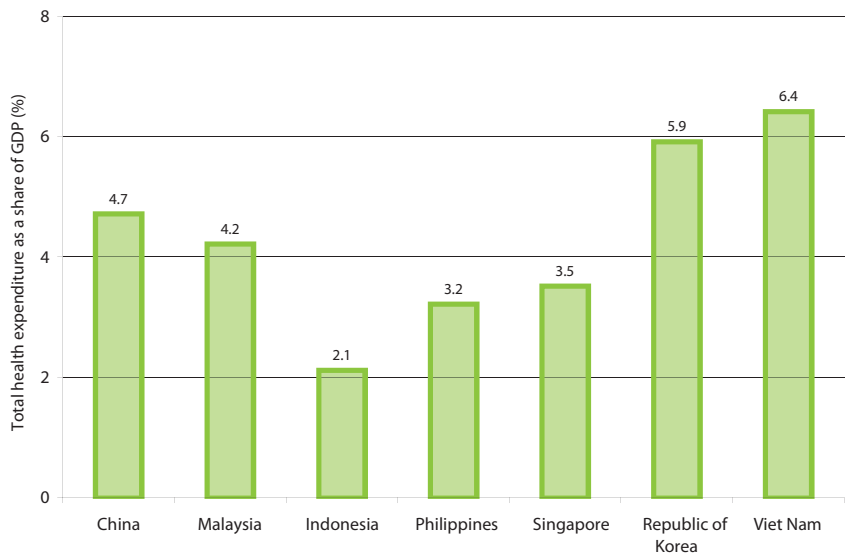
Source: National Health Account 2010

The total health expenditure as a share of GDP rose from 4.9% in 1998 to 6.4% in 2008 (Figure 2). The figure was higher than that of some other countries in Asia (Figure 3). national economy. According to the WHO, the total health expenditure as a share of GDP of at least 4-5% is considered as a good indicator that reflected positive achievements towards universal health care (5).

Figure 2: Total health expenditure as a share of GDP, Vietnam 1998-2008

Source: National Health Account 2010

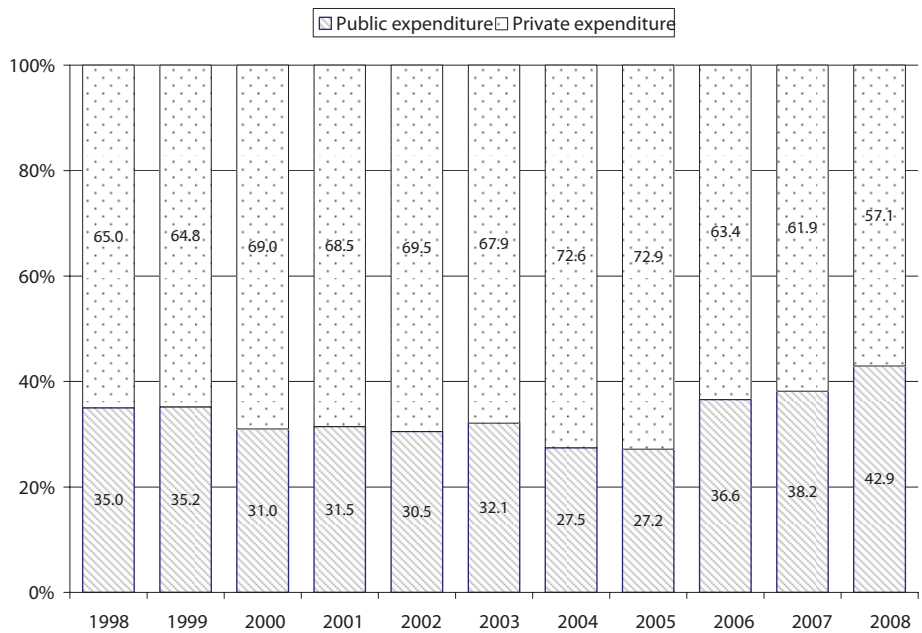
Figure 3: Total health expenditure as a share of GDP in some countries in Asia



Source: WHO Statistical Information System (WHOSIS), 2008 and National Health Account 2010)

Figure 4 shows the 1998-2008 structure of health expenditure in Vietnam by source. The figure indicates that health financing in Vietnam has been heavily dependent on private expenditures (nearly 60%, including out-of-pocket household payment, health expenditure of charitable organizations and businesses, and private health insurance expenditure) while public health expenditure (including state budget,

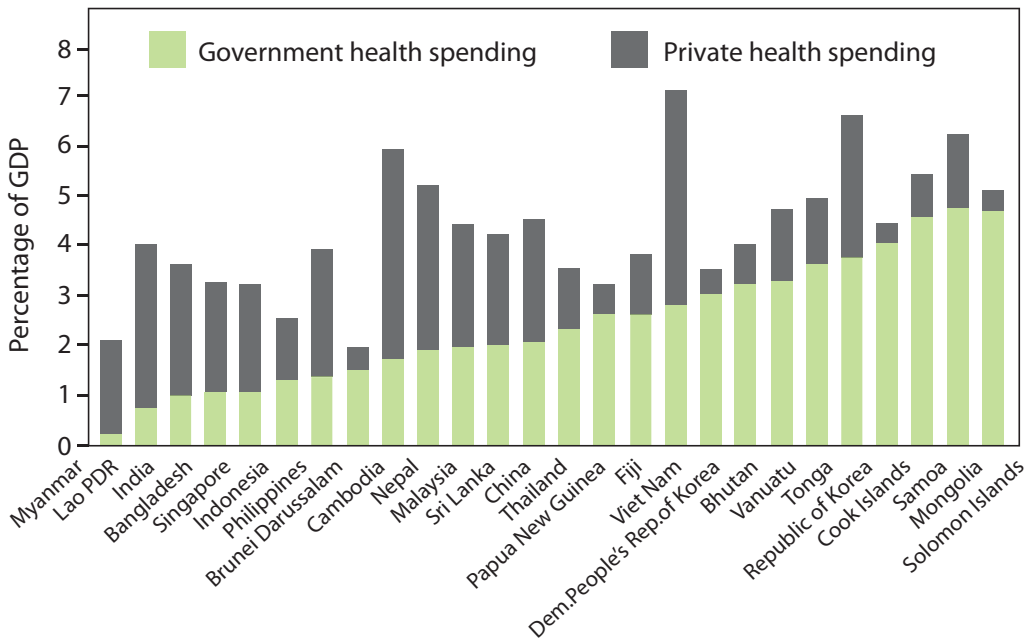
Figure 4: Structure of health financing, Vietnam 1998-2008



Source: National Health Account 2010

social health insurance fund and external support) made up a smaller share (around 40%). The share of private health expenditure in Vietnam is higher than that of other countries in the Asia-pacific region (Figure 5). Higher share of private health expenditure is usually associated with inequity problem. Without assistance from the State, people who cannot afford care will not be able to access services, will receive services of lower quality, or run the risk of impoverishment in paying the costs of care.

Figure 5: Percentage of GDP of government and private health spending and total expenditure in the Asia Pacific region



Source: WHO Provisional 2007 NHA data

4. EQUITY IN RECEIVING BENEFITS: WHO BENEFIT FROM STATE BUDGET FOR HEALTH?

In recent years, the Vietnamese state budget for health care has considerably increased, better satisfying the funding needs to provide health care for the poor, children under 6 years, implementation of national health target programs, epidemic control and district health system upgrades. Funding for provision of health services at all levels also received a significant boost in 2006 (Table) (4).

Such growth can be explained in part by the increases in the allocation norms for financial support to the poor in accordance with Prime Ministerial Decision No.139/2002/QD-TTg and changes in the mechanism to use this funding through purchase of compulsory health insurance for the poor under Decree No.63/2005/ND-CP. Furthermore, the disbursement rate of funds used for free health services for children under 6 years of age in 2006 also increased considerably compared to 2005.

Table 2: State budget for health, 2002 - 2006 (VND million)

Year	State budget allocated to different levels of health services	State budget allocated via health insurance	Total state budget for health
2002	5,840,730	451,111	6,291,841
2003	7,201,414	514,223	7,715,637
2004	6,930,263	1,026,827	7,957,090
2005	7,968,197	1,112,889	9,081,086
2006	11,233,000	2,391,074	13,624,074

Source: Ministry of Health 2008

To implement Resolution No.18 of the National Assembly, the Government increased the state budget for health to cover recurrent health expenditures and subsidize health insurance for the poor and children under six years of age, and invested in the upgrading of district hospitals, CHCs, and provincial hospitals. In addition to government finances, the health sector also received government bonds to invest in local health facilities and provincial general hospitals. The project on upgrading district and inter-district general hospitals funded by the government bonds received VND 3,750 billion in 2008 and VND 3,000 billion in 2009.

Recent data showed that the state budget for health as percentage of total state budget has increased to 10.2% in 2008 (Figure 6) (6), which approximates the level recommended by the World Health Organization for a health system that ensures that essential health services are provided to the population (5). The Resolution No. 18 of the National Assembly states that “at least 30% of the health sector budget should be allocated to preventive care activities” and state budget allocated to preventive care activities as a share of the total state budget in Vietnam has also increased, reaching 30.7% in 2006 (7).

Figure 6: State budget for health as percentage of total state budget, Vietnam 1998-2008

Source: National Health Account 2010

Even though the state budget for health in Vietnam has significantly risen, the subsidization of health care from the Government in Vietnam is still skewed to the wealthy. Analyses by O'Donnell et al.*(8, 9)*, using Benefit Incidence Analysis (BIA) approach[2], found that in 1998, inpatient care accounted for by far the greatest share of the total subsidies (87%) and the the majority of benefits from government subsidies in Vietnam. Vietnam scores fairly poorly by regional standards in terms of the degree to which government health spending reaches the poor, though Vietnam was a bit better in this respect than China, India and Indonesia *(8, 10)*.

A recent research by Wagstaff (citation needed), analyzing the VLSS 2006 data, also showed that the rich in Vietnam still receive more subsidies for health care from the state budget, especially from using the outpatient care services at hospitals. In contrast, commune health center (mostly primary health care and reproductive health services) brought more public health benefit to the poor (Table 3: Concentration index showing inequities in receiving*(11)*.

[2] BIA describes the distribution of health sector subsidies across individuals ranked by their living standards. The aim of the analysis is to identify whether the public health care subsidy is well targeted on poorer individuals.

Table 3: Concentration index[3] showing inequities in receiving subsidies for health care from the state budget, Vietnam, 2006

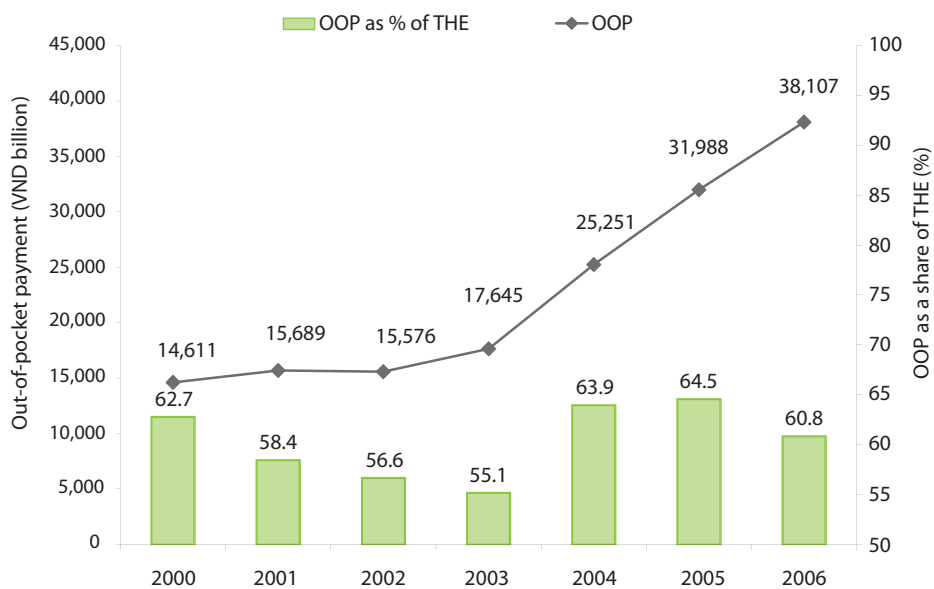
Commune health center	Polyclinic	Hospital outpatient cares	Hospital Inpatient cares	Total
-0.14	0.394	0.424	0.395	0.399

Source: Wagstaff (11)

5. EQUITY IN FINANCIAL CONTRIBUTION: LEVER AND IMPACTS OF OUT-OF-POCKET PAYMENT

Household direct out-of-pocket payment (OOP) is an important indicator for assessing equity in a health system in general and in a health financing system in particular. Direct out-of-pocket payment for health care refers to the expenditures households make directly when they use services, primarily purchase of drugs, payment of hospital user fees, diagnostic service fees and other indirect expenses related to seeking medical care at state or private facilities (including self-medication) *(4)*.

Figure 7: Out-of-pocket (OOP) payment in absolute number (VND billion) and as a share of total health expenditure (THE), Vietnam 2000 - 2006



Source: National Health Account 2008

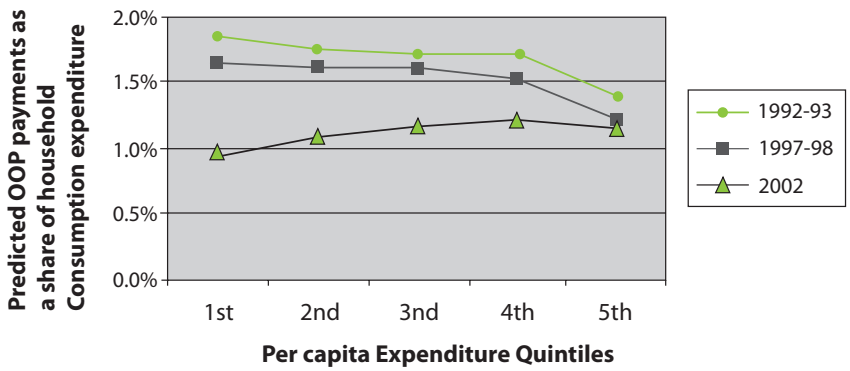
[3] Concentration index (CI) is a means of quantifying the degree of inequality in a specific variable. In this case, negative CI implies that the subsidies for health care from the state budget are better targeted towards the poor. Positive CI means that the rich received more the subsidies. The closer value of CI to 1, the greater extent of inequity exits.

In Vietnam, the absolute OOP has increased over the years and although OPP as a share of the total health expenditure has been declining, it has been always greater than 50% (Figure 7) (4, 12). According to the WHO, the level of OOP as a share of the total health expenditure greater that 40% can result in inequity in health care in a variety of ways *(5)*.

Results from the 2001-2002 Vietnam National Health Survey found that if a poor person is hospitalized without government support, on averageeach inpatient episode costs the equivalent of 17 months of household non-food expenditures. If covered by health insurance, a poor person's out-of-pocket health expenditures decline considerably, though they are still required to cover the cost of items not covered by health insurance: drugs, materials, IVs, health expenditures still cause a considerable burden for the household. Thus, when it comes to illness, if the out-of-pocket resources are the only resort, some households may not use health services because they simply cannot afford them. If they do use medical services, many will have to sell their property or means of livelihood to pay for the hospital costs and this may set them on the road to poverty *(4)*.

Equityof a health financing system can be assessed by looking at the relation between OOP level and the household Ability To Pay (ATP). Ability-to-pay is measured as the amount of income remaining to the household after paying for food costs *(13-17)*. A health payment is progressive if it accounts for an increasing proportion of ATP as ATP rises. A progressive system means that the individuals or households with greater ATP are paying more proportionally in financing health care. Health financing systems are proportional if individuals or households with different ATP are spending the same proportion of ATP in financing health care. *(13-17)*. A recent study by Chaudhuri et al., using data from 1992-93, 1997-98 and 2002 Vietnam Living Standard Surveys (VLSS), revealed that payments increased with increasing ATP, but the consequent financial burden (payment share) decreased with increasing ATP, indicating a regressive system during the first two periods. However, share of payments increased with ATP, indicating a progressive system by 2002 (Figure 8)*(18)*.

Figure 8: Payment share for healthcare costs across per capita consumption expenditure quintiles, Vietnam



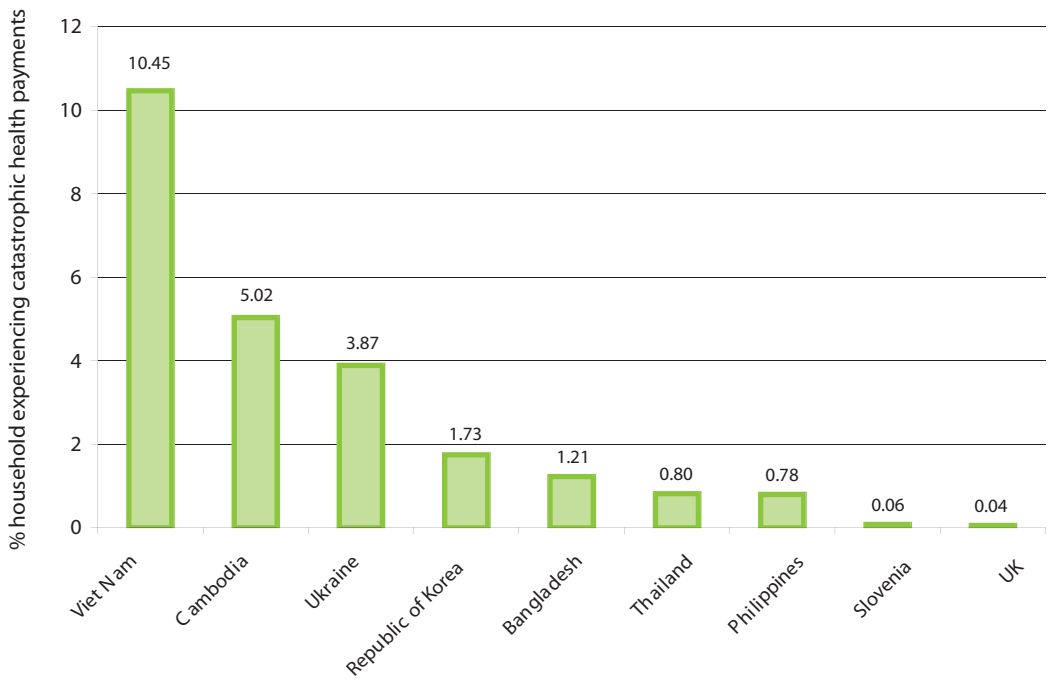
Source: Chaudhuri et al. 2008)(18)

The study also found that well-educated males who live in urban areas are less likely to report healthcare encounters and are associated with lower OOP expenditures. Married individuals and children aged less than five years are more likely to report encounters with providers and are associated with higher OOP payments. The ethnic minorities are associated with lower OOP payments *(18)*.

OOP in the health system can reach catastrophic level. Catastrophic payments are direct out-of-pocket payment that exceed household ability-to-pay based on a standard threshold (for example, health spending accounting for 40% or more of total non-food household expenditures). Household ability-to-pay is measured as the amount of income remaining to the household after paying for food costs *(14-16)*.

An analysis by Xu K. et al. showed that the proportion of households facing catastrophic payments from out-of-pocket health expenses[4] in Vietnam in 1998 was 10.5% in Vietnam, the highest among the 59 countries included in the study (Figure 9)(14). Another study by Van Doorslaer et al., using various cut-off points to define catastrophic levels, confirmed the fact that the rates of catastrophic payments in Vietnam were very high compared to other countries in Asia *(15, 19)*.

Figure 9: The incidence of catastrophic spending in 59 countries



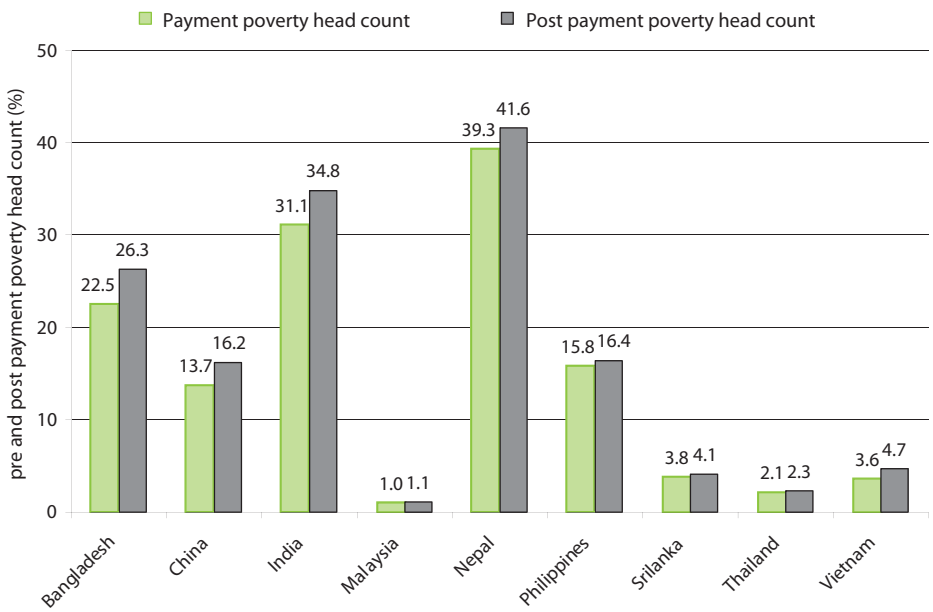
Source: Xu K et al.)(14)

[4] Expenditure is defined as catastrophic if a household's financial contributions to the health system exceed 40% of income remaining after subsistence needs have been met.

Recent analyses of VLSS data found that the proportion of households in Vietnam who had to pay for health care costs equal to or exceeding 40% of their capacity to pay in Vietnam in 2002, 2004, 2006 and 2006 were 4.7%, 5.7%, 5.1% and 5.5%, respectively. The incidence of catastrophic spending were highest among the households belong to the 1st quintile and among the households living in rural area.*(20)*.

Paying for health care pushes households into, or further into, poverty *(21)*.Van Doorslaer et al. used data from 11 Asian countries to compare pre-payment and post-payment poverty headcounts and poverty gaps using the World Bank's dollar-a day poverty line (as well as its $2-a-day poverty line). Vietnam had 1.1 percentage points higher after deducting out-of-pocket spending from household consumption (Figure 10) *(15)*.

Figure 10: Poverty head counts: effect of out-of-pocket payments for health care



Source: van Doorslaer et al. (15)

The analyses of VLSS data also showed that the overall rates of impoverishment in 2002, 2004, 2006 and 2008 were 3.4%, 4.1%, 3.1% and 3.5%, respectively. The rates of impoverishment were highest among the households belong to the 2nd quintile and among the households living in rural area. *(20)*.

6. HEATH INSURANCE: COVERAGE AND IMPACTS ON FINANCIAL PROTECTION

In Vietnam, health insurance was introduced in 1992 as a solution to help mobilize resources and create a more appropriate mechanism for payment of health care user fees. The financial resources provided by the social health insurance fund are considered a public financing source and have a particularly important role to play in guaranteeing equity in financial contributions through a risk sharing mechanism. Formally, Vietnam has two insurance set-ups -a *compulsory plan* and a *voluntary plan*. The compulsory scheme consists of two separate sug-programs: the social health insurance (SHI) plan for the unemployed and one the program for the poor (the health care funds for the poor (HCFP)). In addition to these two plans, children under the age of 6 are provided with free health care. Voluntary health insurance refers to the not-for-profit health insurance[5]. The voluntary plans target full-time students, and family members of those ensured under the compulsory plan. A summary of the Vietnamese health insurance system by program is shown below:

Table 4: Summary of Vietnam health insurance system

Scheme	Target group(s)	Financing
Social health insurance (SHI)	Formally employed, retirees, disabled, meritorious people	3% payroll tax (2% employers and 1% employees)
Health care funds for the poor (HCFP)	The poor, ethnic minorities in mountainous areas, inhabitants in disadvantaged communities	General government revenues (75%) and Provincial resources (25%)
Programme of free health care for children under 6 years of age	All children under 6 years of age	General government revenues
Voluntary health insurance(VHI)	Self-employed, informal sector workers, dependents of CHI-members, students and school children	Private premium contributions based on ability to pay

Source: Adapted from Ekman et al. (22)

The health insurance benefit package covers most outpatient and inpatient care in government facilities, excluding interventions covered by vertical programs such as HIV/AIDS, drugs not on the MOH list, treatments not yet approved by MOH, various interventions such as cosmetic surgery, dental care, treatment of self-inflicted injuries, treatment for drug addiction, etc. Currently, health insurance cover 80% of almost all health services and the out of pocket expenses are responsible for the remaining 20%.

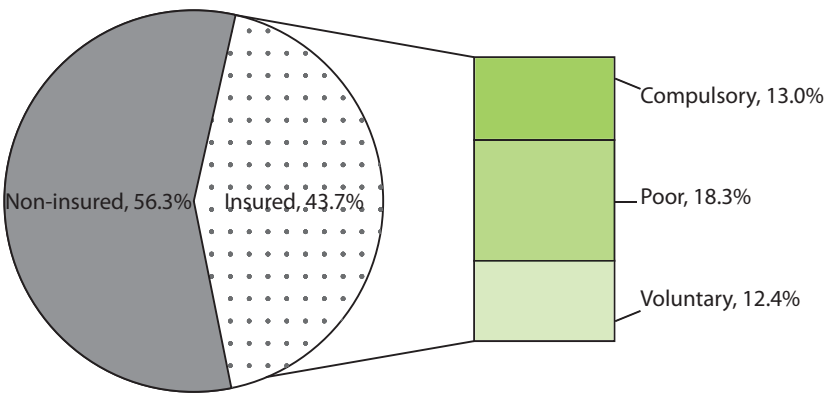
[5] This is different from the concept of commercial or for-profit (voluntary) health insurance found in some other countries The premium is set based on the probability of illness among people or groups of people enrolled in the insurance scheme.

The most common provider payment method in Vietnam is the fee-for-service (FFS) mechanism. Health insurance reimburses approved facilities, including fees from contracted private facilities. Enrollees are required to register with a local facility (not necessarily a primary care facility) and are expected to use that facility when they require treatment. Referrals are sanctioned when the registered facility lacks the necessary expertise to treat the patient's condition and in a context of relatively weak regulatory oversight there is a risk that providers treat patients more than is clinically motivated. Recent health insurance policies have identified alternative reimbursement mechanisms, including capitation and case-based reimbursement plans that shift the incentives presented to the providers *(22)*.

The number of people with health insurance coverage has increased sharply since 2005, mostly as the result of government policies promoting the purchase of health insurance for the poor[6]. In 2008, 37.7 million people were enrolled in health insurance plans, 43.7% of the nation's population (compulsory: 11.2 million, 13%; poor: 15.8 million, 18.3% ; and voluntary: 10.9 million, 22.4%) (Figure 11). The contribution of the health insurance fund as a portion of total health expenditure increased over time, from 7.9% in 2005 to 17.6% in 2008 *(6)*.

However, the coverage significantly varies accross different target groups. A study by Liberman S et al. found that, as of 2006, 2 million public sector employees and 3 million of their immediate family members, almost 1 million children under six years of age, nearly 5 million people in poverty, nearly 4 million students, and 24 million other people lack health insurance coverage of any type *(10)*.

Figure 11: Coverage of health insurance, Vietnam 2008

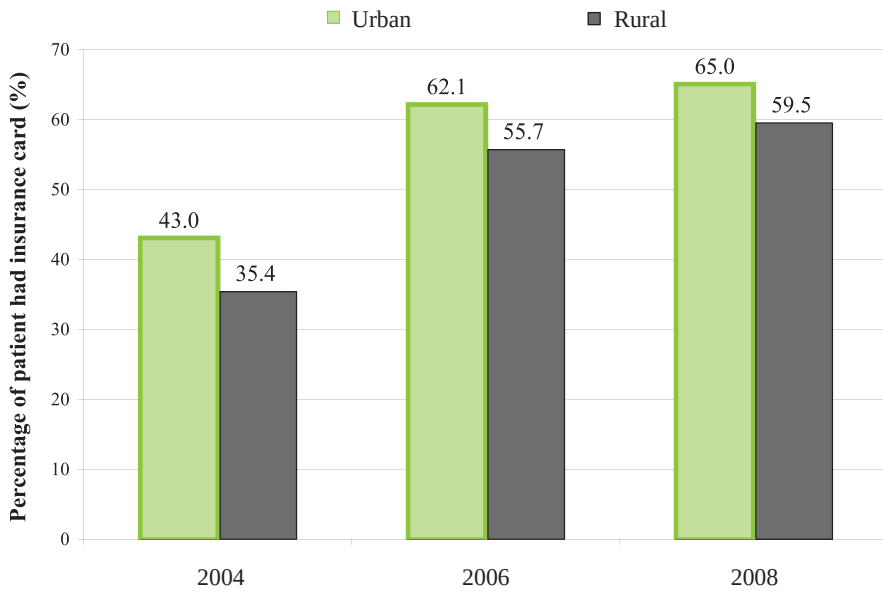


Source: Health Statistics Year Book, 2008.

[6] The government budget share for procuring HI cards for the poor increased significantly over time with the premium increased from VND 60,000 (2006) to VND 80,000 (2007) and VND 130,000 (2008).

Data from Vietnam Living Standard Survey (VLSS) showed that the percentages of patients who did not have health insurance at the time they had treatment were still high (more than 35% in urban area and more than 39.5% in rural area in 2008) (Figure 12).

Figure 12: Percentages of patients who have health insurance while having treatment



Source: VLSS 2004, 2006, 2008

The VLSS data also showed a gender inequality in the coverage of health insurance. The proportion of women who received treatment in the last 12 months was higher that that in men; the proportion of female patients who had health insurance while having treatement were lower than the conresponding figures in male patients (Table 5).

Table 5: Coverage of health insurance among male and female patients

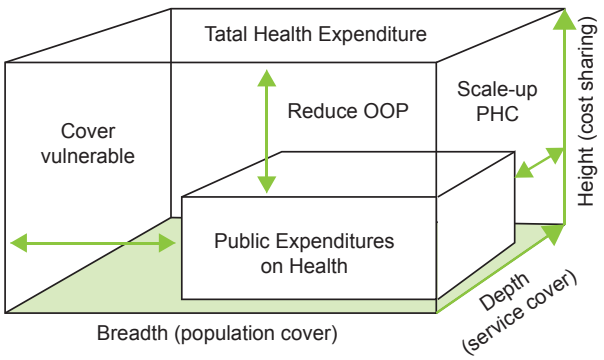
Year	Men		Women	
	% people received treatment in the last 12 months	Of the patient, % had health insurance while having treatment	% people received treatment in the last 12 months	Of the patient, % had health insurance while having treatment
2004	30.7	40.5	37.7	35.0
2006	31.6	59.9	38.7	55.4
2008	30.6	63.9	37.7	58.3

Source: Wagstaff (11)

According the WHO, the coverage of a health policy/action has at least three separate and inter-related dimensions (Figure 13) (5, 16):

1) The number of people covered by public and private financing initiatives (breadth of coverage);
2) The extent (number and type) of services covered (depth of coverage);
3) The resulting impacts on financial protection against high out-of-pocket expenditures (cost sharing or height of coverage).

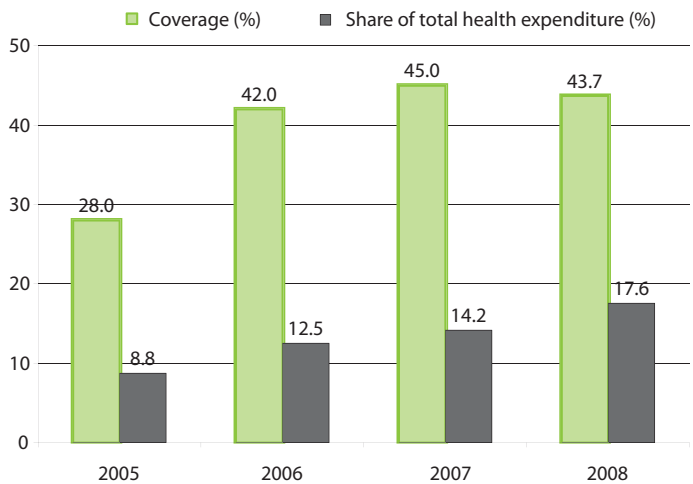
Figure 13: Three dimensions of health coverage *(5)*



OOP = out-of-pocket
PHC = primary health care

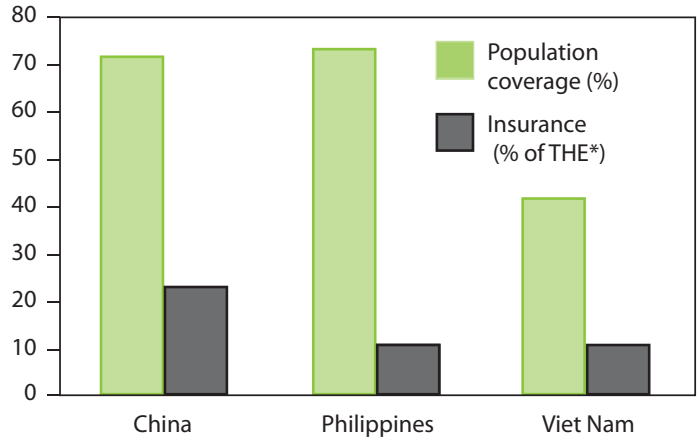
As shown in Figure 14, coverage of health insurance in Vietnam has a fairly wide breath of coverage (43.7% in 2008), the death of the coverage, however, remains low (funding from health insurance accounted for only 17.6% of total health expenditure in 2008). Similar patterns were found in China and the Philippines (Figure 15).

Figure 14: Social health insurance coverage and social health insurance expenditures in Vietnam 2005-2008



Source: National Health Account 2010

Figure 15: Social health insurance coverage and social health insurance expenditures in China, Philippines and Vietnam, 2006



Source: WHO 2006 NHA data)(5)

Financial protection is the most important aspect of health insurance coverage. Wagstaff A et al. found that the introduction of a social health insurance policies in Vietnam in 1993 reduced the incidence of catastrophic expenses *(23, 24)*. Sepehri et al. also found that the compulsory social health insurance program significantly lowered out-of-pocket spending:out-of-pocket expenditures were reduced between 16 and 18 percent with a more pronounced reduction for low-income individuals *(25)*.

In 2006, the number of poor people receiving health insurance had tripled since 2005 to cover more than 15 million. The government budget share for healthcare of under-6 children has likewise increased significantly, from VND 890.1 billion in 2005 to VND 1,102 billion in 2007 (*28)*. 66% of under-6 children received free healthcare cards. According to the Law on Health Insurance, from 1/7/2010 all the under-6 children will receive free HI cards *(7)*.

There have been several studies that have measured the successes and limitations of government initatives to expand health care coverage. Wagstaff et al. examined the impact of Decision 139 (HCFP) in Vietnam using data from the 2004 Vietnam Household Living Standard Survey and found that while HCFP increased use of health services and reduced catastrophic expenditure, there was little impact on OOP expenditure and utilization in the poorest decile *(24)*. Households interviewed in a WHO study in Bac Giang and Hai Duong provinces reported increased utilization of health services after implementation of the HCFP, especially for inpatient care (Axelson et al. 2005). The study found a significant increase in health care seeking at the CHS as the first contact among HCFP beneficiaries *(29)*. Another study by Axelson H et al. reported that HCFP would increase health care utilization, especually at public health facilities and reduce OOP and catastrophic health expenditures (Table 6) *(30)*.

However, most of the studies on impacts of health insurance found that insurance plans have only a modest effect on out-of-pocket payments *(10, 23, 24, 31, 32)*. Mandatory health insurance, for example, is estimated to have reduced the incidence of catastrophic health spending (spending in excess of 10% of nonfood consumption) by 3-5 percentage points. But it still leaves 30% of insured households incurring catastrophic health spending *(10, 33)*. The modest impact of insurance on financial protection reflects the incomplete nature of Vietnamese health insurance coverage; and much of the out-of-pocket payments in Vietnam are on over-the-counter drugs while insurance covers only drugs used during treatment on the MOH list, etc.

Table 6: Estimated impact of HCFP on health care utilization and health expenditures 2004

	Treated	Untreated
No of outpatient visits during the last 12 months	0.818	0.786
No of inpatient admission during the last 12 months	0.125	0.118
Annual household health expenditure (VND 000)	615.193	757.514

Source: Axelson H et al. 2009(30)

In addition to of the challenge of increasing the breath, depth and height of its health insurance coverage, Vietnam must generate a way for the plan to be financially sustainable. Since 2003, outlays have risen faster than revenues in both the compulsory and voluntary programs *(10)*. By 2007, overall health outlays exceeded its revenues (Table 7) *(2)*. This reflects the fact that health insurance contributions do not cover the cost of the expanded package of services. Liberman et al. reported that both adverse selection and moral hazard appear to be contributory factors in cost escalation, and tackling both are major policy challenges on top of the challenges of expanding and deepening coverage *(10)*. There is some evidence to suggest that voluntary health insurance in Vietnam is indeed experiencing a process of adverse selection*(22).* In addition, the issue of supplier-induced demand may lead to substantial cost escalations *(22, 34)*. This is very relevant to the current context in Vietnam, where the autonomy to public health entities under Decree No. 43/2006 of the Government have been promoted. On the other hand, much qualitative evidence in Vietnam has testified to the poorer services provided to patients covered by prepayment as compared to those who pay out-of-pocket *(35)*. The policy of free health care to children under six has not yet been formally evaluated.

Table 7: Health insurance revenues vs. outlays

Year	Revenues (VND billion)	Outlays (VND billion)	Outlays/Revenues (%)
1997	540 000	517 000	95,74
1999	767 000	604 000	78,75
2001	1 151 000	1 063 000	92,35
2003	2 027 000	1 524 000	75,19
2005	2 973 614	2 774 833	93,32
2007	6 284 000	8 124 000	129,28
2008	9 609 000	10 114 000	105,26

Source: Health Statistics Year Book, 2008

7. CONCLUSION

Vietnam has made impressive improvements in health financing reform over the past 20 years and that has helped improve the coverage of health care in the country:

1) Total health expenditure has significantly increased during the past ten years, accounting for 6.4% of GDP in 2008.
2) The state budget for health as percentage of total state budget increased to 10.2% in 2008, which nears the level recommended by the World Health Organization for a health system to be able to ensure that essential health services are provided to the population. The share of the state budget allocated to preventive care activities (the services that could bring more benefits to disadvantage people) has also increased.
3) The coverage of health insurance has been considerably expanded.

However, there are still several equity-related issues in health financing system in Vietnam that need to be addressed:

1) Health financing in Vietnam remains heavily dependent on private expenditures, especially out-of-pocket payments. The share of private health expenditure continues to account for more than 50% of total health expenditure.
2) Subsidization of health care from the Government in Vietnam is still skewed to the wealthy.
3) The absolute value of out-of-pocket payments has increased and now makes up more than 50% of total health expenditures. The proportion of households

facing catastrophic payments from out-of-pocket health expenses in Vietnam is higher than in most other countries. Additionally, many households were pushed into or further into poverty due to health expenditure.

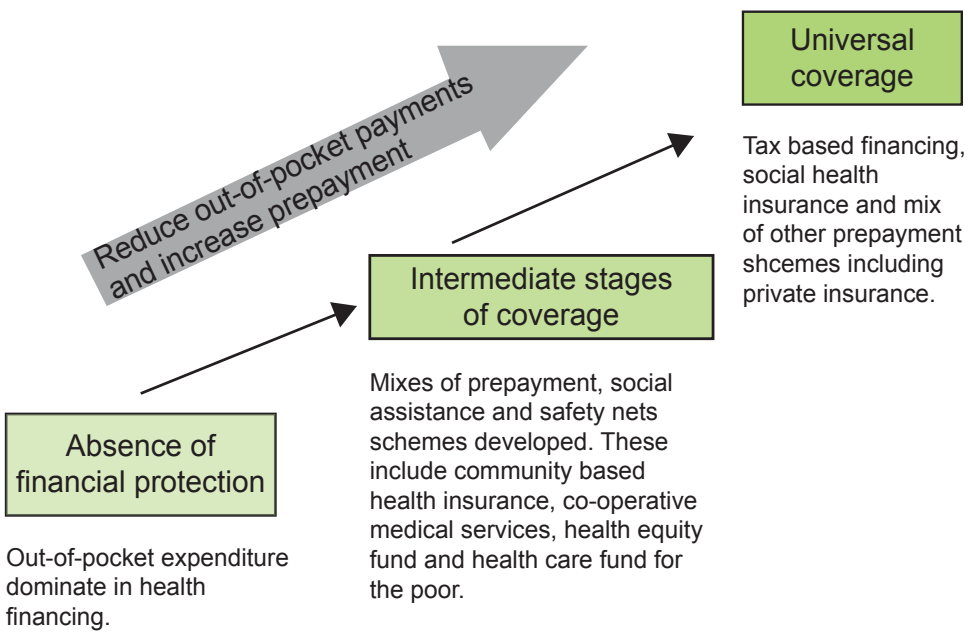
4) About 50% of the population contines to lack any form of health insurance. Coverage of health insurance in Vietnam has a fairly wide breath of coverage (43.7 in 2008), but the depth of the coverage remains low (17.6% in 2008). The impact of health insurance on financial protection is still modest.

5) Vietnam's health insurance program faces a further challenge regarding the financial sustainability of the scheme: health insurance contributions are too low to cover the cost of the expanded package of services. Both adverse selection and moral hazard appear to be contributory factors in cost escalation, and tackling both are major policy challenges on top of the challenges of expanding and deepening coverage.

8. POLICY IMPLICATIONS

In achieve universal coverage through effective health financing, Vietnam can adopt the model recommended by the WHO which step by step reduce out-of pocket payment and increase pre-payment mechanism (Figure 16).

Figure 16: WHO model to achieve universal coverage *(5)*



In Vietnam, specific actions should be taken as following:

1) The government should commit to maintain the budget for health of at least 10% total state budget.
2) Coverage of health insurance should be increased through and management capacities of health insurance system should be strengthened.
3) Ministry of Health should develop and issue a written national standard therapeutic guidance to be a basis for assessing health services.
4) The data for policy makers must be improved. The reporting system on government budget expenditure on health should be consolidated to provide accurate information for health financing planning.
5) Regular implementation of monitoring and evaluation of policy changes. The policy of free health care to children under six should be assessed as there is no study on this issue.

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EQUITY IN HEALTH CARE: PATIENT PERSPECTIVES

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1. RATIONALE

The Doi Moi reforms of 1986 brought a host of changes to everyday life in Vietnam. Along with the social and economic changes caused by Vietnam's transition to a market economy, the nation's health systems have also undergone drastic changes: new regulations and policies, a completely reformed method of payment for health services, and the introduction of national health insurance plans. Though these changes differ in scope, scale and results, as a general statement, market-driven health care in Vietnam has promoted the quality and efficiency of health care but resulted in widened inequities in health.

The above-mentioned changes in Vietnam's health system trickle down into Vietnamese society and raise questions about how these national changes are perceived at an individual level. This study seeks to examine changes in patient opinions on health equity as well as on the changed relationship between practitioners and patients with regard to payment, equity and the quality of treatment.

To assess these changes, this study has invoked the social determinants of health framework to re-examine the changes in Vietnam's health system at a personal level: through the views of patients and health practitioners. We seek to examine the differences in opinions on equity before and after Doi Moi and to look closely at the determinants on these changes (Michael Marmot 2005).

2. RESEARCH OBJECTIVES

- Examine patient and family opinions of equity in health care through their experiences with the health care system
- Describe the way that views on health equity have changed since the 1986 Doi Moi reforms
- Use the social determinants of health framework to look closely at the way that health equity plays out at the individual level

3. DEFINITIONS

3.1. Health equity in the concept of medical ethics, medical profesionalism

3.1.1. Health equity:

Health equity plays an important part in social equity. The World Health Organization (WHO) has indicated that health equity is based largely on the social determinants of health; health in society accordingly exists under a social gradient. is the WHO defines health equity as "the state of no differences in health system and social determinants of health among different groups in society" (WHO 2008). Health equity, as such, is commonly measured by the following indicators:

(1) Equity in resources and financial allocation for health;

(2) Equity in patient ability to access and utilize health services;

(3) Equity in quality of health care and services;

(4) No differences in the social determinants of health (clean water and environment, nutrition and safe food, living environment, working environment, education and risk behavior related elements);

(5) No difference in health status among different populations.

3.1.2. Equity: a fundamental principle of medical profession morality

According to the World Medical Association, equity in medical professionalism includes: equity in allocating medical resources (vaccines blood, etc.); equity in implementing human rights and obedience to the national law: Everyone is equal to the law (World Medical Association 2009, National Assembly of Socialist Republic of Vietnam 2009).

3.1.3. Medical professionalism

Ethical issues related to medical professionalism have existed indefinitely but a concrete definition for medical "professionalism" only surfaced in Vietnam two decades ago, along with the development of science and technology in the field and the influence of socio-economic changes of the late 1980s and early 1990s. Along with the rapid development of the health care system, the Doi Moi reforms also brought many challenges to clinical practices: the professional gap between clinicians in different sectors of health care results in the centralization of patients seeking health care at one, central location (generally the location with the best medical technology); patient access to quality health services has been complicated by the influence of the market economy on the established medical network. These challenges evidence the complicated role medical professionals

play in juggling their obligations to patients and to society at large. The United States Internal Medical Association delivered three fundamental principles and ten commitments to guide medical practitioners (Internal Medical Association 2002):

Fundamental principles of medical professionalism:

- Primacy of patient welfare
- Patient autonomy
- Social justice

Commitment of physicians as following:

- Professional competence;
- Honesty with patients;
- Patient confidentiality;
- Maintaining appropriate relations with patients;
- Improving quality of care;
- Improving access to care;
- A just distribution of finite resources;
- Scientific knowledge;
- Maintaining trust by managing conflicts of interest, and
- Professional responsibilities, such as regulating members and setting standards.

3.2. The concept of health equity and the way it influences patient-clinician relationships

Vietnam has illustrated a legislative commitment to health equity (National Assembly of Socialist Republic of Vietnam 2009). However, changes in Vietnam's economy and society have complicated the relationship between medical practitioners and patients, and legal documents have only gradually begun to address this growing complexity (National Assembly of Socialist Republic of Vietnam 2009).

4. OBJECTS AND METHODOLOGY

4.1. Research subjects

This research focused on patients whose latest use of health care services was within the past two years. Families of patients were also interviewed. The study was primarily conducted within central Hanoi and in the Soc Son suburb of Hanoi.

4.2. The selection of research subjects

This study interviewed a total of 25 subjects. Subjects over 35 years old and under 35 years of age were selected. We hope that these age requirements enable us to adequately sample patients who experienced the subsidy period and those who do not remember it.

It has been theorized that economic status of a family affects the process of medical service selection and the relationship between medical practitioners and patients, because of this, we made sure to include two economic categories into the base of study participants: people who have comparatively stable income and people who have unstable or low incomes.

4.3. Research methodology

Since interview practices are relatively new to Vietnam, this study used in-depth interviews to generate a hypothesis for the implementation of later research with an expanded scale.

4.4. Instrument

A guiding questionnaire for the interviews was developed to follow patients through their initial diagnosis through their treatment and eventual discharge.

Content of interview guidance was divided into 2 parts following experiences from patients during both before Doi moi and recently period.

4.5. Research process

Our research team included five members. Clinicians, philosophers, public health experts and sociologists were represented in the team.

The questionnaire for in-depth interviews was used to train to researchers. Afterwards, research subjects were divided among researchers. The PI and other researchers routinely met to discuss challenges in the practice of interviews and problem solve together.

Because we sought to gather information over time for each individual subject, each patient/family member was interviewed twice. After the first interview, each researcher presented their initial results to the research group for analysis and group preparation for the second interview.

The first interview generally lasted two hours; the second interview generally lasted 45 minutes.

Interviews took place at the subjects' houses, researchers' houses or in comfortable and confidential private places. Hospitals and other clinics were deliberately avoided to avoid conflicts of interest.

All information from the interview was recorded and treated confidentially. Transcriptions were processed immediately after the interview in an effort to retain interview information.

4.6. Data analysis

After each interview, recording files were transcribed and each text file was saved. A form was created by the research group for coding of the research content, which was based on the aforementioned research objectives and theory framework.

Each of the interview sheets was coded by two independent researchers. Coding contents were exchanged and approved within the research team.

After coding completion, the main contents of each of the interviews were divided into following categories:

(1) What is patients' opinion on the existence of equity in health care?

(2) What are the similarities and differences between current equity in health the state of equity pre-Doi Moi?

(3) What is the relationship between the attitudes and behaviors of medical practitioners and patients?

(4) How do patient opinions of health equity relate to the social determinants of health?

4.7. Ethical considerations

Researchers presented and explained the research objectives to each interview subject. Subjects made informed consent to participate in the research. Personal information was treated confidentially.

5. OUTCOMES

5.1. Demographics of interview subjects

Of the 25 people interviewed, 15 were female and ten were male; 8 lived in the district of Soc Son (suburb of Hanoi) and 17 lived in downtown Hanoi at the time of interview. Nine people interviewed held a bachelor's degree; six had attended secondary and high schools.

11 of the 25 interview subjects had received direct health services and/or accompanied health service treatment for a family member during the subsidy period (pre-1986).

16 of the interview subjects were under 45 years old and nine were older than 45 at the time of interview. 17 were covered by health insurance. 10 subjects identified their family's monthly earnings matched or exceeded 10 million VND, 4 subjects had monthly earnings of their family from 5 to less than 10 million VND and 11 family's subjects had monthly earning less than 5 million VND.

5.2. Patient opinions of equity in health care

5.2.1. Equity in access and using health services

Table 1: Patient opinions on the existence of equity in health care

	Equity in health care exists	Equity in health care doesn't exit
Post Doi Moi	5	14
Pre Doi Moi	2	3

Our research indicated that 14 subjects think that medical clinicians are currently unable to ensure equity in access and using of health care service:

> *"I don't see that the equity exists because…when you go to see doctors, it is clear that those who give clinicians money can be checked first, even more carefully and they enjoy talking to doctors. If you do not give them money, they will ignore you. Furthermore, if you have a relationship to doctors, you will be given priority. This society respects money. Doctors must treat patients equally, regardless rich or poor, who come first can be checked first, who have severer diseases are given priority to be treated first".* (Patient, female, 28 years old).

> *"The line is very long queuing up for turns to see doctors, sometimes taking hours, but someone who is acquainted to the doctor or staff working in the hospital do not need to be in the line to buy the check-up notebook while a bunch of others have to wait for hours..."* (Patient, female, 26 years old).

> *"It is inequity. Good doctors are just seen at big hospitals, while none can be see at lower level hospitals in districts and communes...."* (Patient, female, 28 years old).

On the other hand, five interview subjects said that medical practitioners were able to ensure equity in health care:

"I see that doctors manage to ensure equity in health care because I see that all patients regardless rich or poor are receiving the best and same care..." (Patient's family member, female, 26 years old).

When discussing equity before the Doi Moi reforms, two out of the 11 subjects who received health services during the subsidy period claimed that doctors were able to ensure equity:

"During the subsidy period, people respected lives, sentiment and were very enthusiastic. Doctors, patients and patients' family members are like a family. I really liked that atmosphere in the subsidy period because doctors really respected human lives, they worried and took care of patients". (Patient's family member, female, 53 years old).

"We can call it equity at that period of time" (Patient, male, 55 years old).

However, many interview subjects indicated that they thought equity lacked during the subsidy period:

"In the subsidy period, all people went to see doctors following the regulations by the State basing on their jobs and positions to enjoy the different levels of health care, which resulted in inequity or people have social capital like being acquainted with doctors then they would have been given priorities…" (Patient, male, 45 years old).

"It is easier for government officials to go to see doctors and receive medicines than normal people which is also an inequity. Government officials can go to see doctors and receive medicine without paying anything like monthly.." (Patient, male, 70 years old).

5.2.2 Equity in health care quality

Five people said that medical practitioners have the capability to ensure equity:

"It is my opinion that equity exists. All patients are receiving good care from doctors and nurses even when they are not given money or gift. Therefore we can not say equity does not exist". (Patient's family member, male, 26 years old).

14 subjects said that doctors are unable to guarantee equity in health care quality to patients:

"The difference here is that doctors provided more detailed explanations for those patients with more pleasant voices, so I guess that they gave much money to doctors then were provided more care...". (patient, female, 24 years old).

"Or giving priorities to acquaintances who never have to queue up in the line or someone who gives money to doctors and enjoy good care…" (Patient, male, 45 years old).

5.2.3. Equity in physician-patient relationships

Equity in receiving services in a fair and timely fashion:

20 people said all patients should be seen at a first-come, first-serve basis:

"I think that ....equity is when who come first can see doctor first and doctors provide the same care to every patients regardless rich or poor" (Patient, female, 26 years old).

Three interview subjects felt that priority should be given to patients with urgent medical needs:

"I felt bad when seeing patients with bad injured had to wait for a long time..." (Patient's family member, male, 42 years old).

"Of course there will be priority given to more severe cases or emergency cases, which is still considered to be equitable". (Patient's family member, male, 30 years old).

Equity in clinician attitudes toward patients:

"Because doctors usually give priority to their relatives, acquaintances and receive money from patients, which is not called equity". (patient, female, 26 years old).

"To my opinion, equity is supposed to be when all people - rich or poor, with or without health insurance, acquainted or not are provided the same service". (patient/patient's family member, male, 30 years old).

Three subjects thought that the attitude of the clinician toward the patient depended primarily on the severity of the patient's medical needs:

"It depends on the seriousness of diseases then decide the attitude". (Patient, male, 42 years old).
"I think equity…can be like when there is emergency case, it can be given priority without asking them to be in the line." (Patient's family member, male, 42 years old).

Equity in compatent of physicians at different hospitals and different level of health care system

To many of the patients interviewed, equity is primarily manifested in the quality of medical services received:

> *"...all patients are provided the same check up and care...it's not likely that different patients are given different kinds of services...for example: it's not likely that I am diagnosed exactly with my disease and the others are not. There should be the same enthusiasm by doctors..."* (Patient, male, 26 years old).

> *"Equity is shown in the equal quality of doctors..."* (Patient, male, 40 years old).

> *"…a disease deserves to be given the priority mode, medicines for that disease should be given exactly according to the priority…"* (Patient, female, 52 years old).

> *"No equity in hospital routes, good doctors gathered in big hospitals while none of them works at lower level hospitals and at these routes medical equipments are not even invested…"* (patient, female, 26 years old).

> *"...It is necessary to have enough good doctors in all hospitals of all levels from district to central level"* (patient, male, 70 years old).

5.3. Patient behavior and habits in seeking quality and timely access to health care

To improve access to and quality of health services, the interviewed patients reported that they generally have the following options:

- Change the location of medical services.
- Provide covert payments to clinicians (known as giving "envelopes").
- Use their personal network of friends and acquaintances to connect to a clinician (nepotism).

5.3.1. Change of service location

Six out of the 25 people interviewed said that they have changed hospitals in hopes of accessing better quality health care services:

> *"In spite of the fact that the Than Hospital is further away than Soc Son hospital, I still go to Than because the service quality over there is much better and cleaner".* (Patient' family member, female, 52 years old).

Other people interviewed switched location of medical services because they trusted a specific hospital:

> *"First, I intended to let my wife give birth at Son Tay hospital but then we changed the plan when we went to see doctor for the pre-natal check up, one day after there was still no move then doctor said that we should wait for another two or three days due to the limited amniotic fluid but I don't feel safe then I took my wife to Hanoi Maternity hospital for another check up...".* (Patient, male, 29 years old).

> *"Because I don't trust in what they diagnosed to me and my disease gets worse then I decided to move into another better hospital".* (Patient, male, 42 years old).

5.3.2.Covert payments to clinicians

Table 2: Experiences with covert payment pre and post Doi Moi among interviewed subjects

	Have given covert payments to clinicians in exchange for services	Have not given covert payments to clinicians in exchange for services
Post Doi Moi	17	5
Pre Doi Moi	4	7

The majority of the patients interviewed in this study had covertly given money to clinicians in hopes of improved services. However, the purposes for these covert payments vary from patient to patient:

Some patients paid doctors under the table in hopes of expediting services:

> *"Because with money doctors will be more careful, enthusiastic and pleased".* (Patient's family member, male, 29 years old).

Some patients felt obligated to pay doctors an additional sum in thanks for medical services:

> *"They treated us well so we want to express our thanks to them by giving them some money…it is just a way to say thanks to them and show our sentiment..."* (Patient, male, 40 years old).

Other patients felt that they or their family members were in a particularly precarious situation and needed additional care, and therefore gave money under the table to doctors:

"I gave an envelope to a nurse to make sure that my wife who was about to give birth would not have to queue up and, in the mean time, the amniotic fluids was going to be running out which is very dangerous for my baby". (Patient's family member, male, 29 years old).

Many patients felt that giving money under the table was standard practice and that they ought to follow suit in order to receive equal services:

"I did ask women who gave birth prior to me [about giving money covertly] and women still staying at hospital and they also provided me with their experiences…and I had no more questions". (Patient, female, 24 years old).

"When I visited my wife at the hospital, I met some family members of patients who shared the same room with my wife and I asked them what should I prepare. They said that I should prepare "envelopes" for nurses, then I followed their advice". (Patient's family member, male, 30 years old).

Some patients who paid clinicians did so because the clinician specifically asked for money:

"My mom was hospitalized for an operation. We had to wait for long time until she could be operated so I had to "envelope" doctors then finally she was operated". (Patient's family member, male, 26 years old).

"I don't like that "envelope" issue because I don't like to spend "unofficial expenditures" while the receivers are also not good people. Like in my wife's case, if we didn't give that money to doctors, they might have separted my baby then we couldn't control so it was better spending that money like that". (Patient's family member, male, 30 years old).

The five people who had not given money under the table to clinicians had likewise neglected to do so for varying reasons:

Some did not feel that the severity of their situation warranted a covert payment:

"I didn't give them money because I thought that my case is unnecessary to spend money on that so we can wait". (patient, male, 45 years old).

"If the situation is severe like traffic accident or pains/injuries that need to be immediately treated, I would definitely "envelope" even though I would not feel happy with that. We are not rich but when I either my family members got into that troubles, we could not wait". (Patient, female, 26 years old).

Others were unable to because of their own financial constraints:

"I am not rich so I want to save money". (Patient, female, 26 years old).

"If my economic condition allows, I would definitely "envelope" doctors to make them more enthusiastically and take care". (Patient's family member, female, 28 years old).

Some patients felt the practice was unnecessary because they were covered by health insurance:

"With health insurance, we don't need to "envelope" them, just need to wait". (patient, female, 66 years old).

Covert payments to clinicians before the Doi Moi reforms:

Four of the 11 subjects who received medical services before 1986 affirmed that doctors received varying forms covert payments before the Doi Moi reforms:

"The envelope issue didn't exist at that time. But the gift for doctors includes just beans and peanuts". (Patient's family member, female, 52 years old).

"No money but instead gifts were given in the subsidy period, which were candy, cakes or wheat". (Patient, female, 66 years old).

Therefore, when asked about apparent contrasts between the two periods, they replied:

"I think that in every period of time, patients will still give money to doctors". (Patient, male, 42 years old).

"The difference is just in the manner of the issue. But for me, it's the same". (Patient's family member, female, 52 years old).

5.3.3. Nepotism

Eight patients asked relatives, friends or acquaintances to help them during their health care.

"So I have to continuously ask my friend to help and she also said that she is all the time contacting to doctors in the operation team to seek for their attention and help". (Patient's family member, 29 years old).

"Before I took my mom to hospital, I had called my friend who was working there asking for his help. He were there when we came and I took my mom to his working room and he introduced me to the doctor and supported me in doing the hospitalization procedures". (Patient's family member, male, 42 years old).

"Fortunately, the father of my friend is a head of a department in that hospital then I enjoyed the fast procedures and check up then he pointed me to be operated because my case was very emergency also". (Patient, male, 45 years old).

"The line is very long queuing up for their turns to see doctors for hours, but someone who is aquaintant to the doctor or staff working in the hospital do not need to be in the line to buy the check up notebook while bunch of others have to wait for hours...". (patient, female, 26 years old).

"My wife knows some doctors in the hospital so she asked them to help with the check up. Because they are acquaintances to my wife so she received a thorough check with enthusiasm". (Patient 's family member, male, 30 years old).

5.4. Expectation of Health patients on health equity

Twenty subjects expected that all patients are treated equally as friends or acquaintances of physicians.

"...Not too much priority to acquaintances and relatives of doctors in hospitals or money and gifts are unnecessary for doctors"(patient, male, 45 years old)
"Whoever come to see doctors will be equally provided check up, treatment and care". (Patient, male, 42 years old).

Three subjects supposed that equity is that it is necessary to give priority to more severe disease and emergency cases:

"I think that..patients of emergency can be treated first without queuing up regardless rich or poor, acquainted to doctors or not". (patient, male, 45 years old).

"…Emergency cases should be treated first and it is also equity". (patient's family, male,30 years old).

Two subjects expected the State to support:

"My expectation is that the society will support people with expenditure for them to have equal check up and treatment". (Patient's family member, female, 53 years old).

Four subjects wished the State would enact reasonable health policy:

"My understanding is that the State has to enact reasonable policies to ensure the equity in health care for people". (Patient, male, 55 years old).

"Good doctors almost work at big hospitals while none of them work at lower level hospitals, even though medical equipments are not invested which is the reason why all patients are just going to upper level hospitals no matter how far they are". (Patient, female, 26 years old).

6. DISCUSSION

6.1. Equity in health care before and after the Doi Moi reforms

The majority of interview subjects in this study believed that equity in health care exists primarily as shown through equity in access to health services and equity in quality of health care treatment and services.

Many patients observed equity differences in the service attitudes of clinicians. Many patients speculated as to the cause of changed clinician attitudes after having observed changed differing attitudes toward patients with and without health insurance; much anecdotal evidence was brought forward about patient experience with changes in clinician attitudes before and after receipt of covert payment for medical services. The attitude of clinicians was frequently brought up in interviews; some related the disparities in clinician attitudes to differing personal sets of ethics, others linked the disparities to the fact that Medical Universities in Vietnam have not yet developed the curriculum to teach ethics to medical students (Le Thu Hoa and cs 2009).

This research shows that patient attitudes on health care equity have not changed considerably since the 1986 Doi Moi reforms. Before the economic renovation, inequity in health care was evidenced through varying types of nepotism and through personal gifts to clinicians in exchange for improved services. Though the methods of bribery have become cruder since the Doi Moi reforms, the underlying social tendencies behind the transactions (social and monetary) far outdate the 1986 reforms.

The study of medical professionalism and ethics calls into question the role of clinicians in society: especially since the Doi Moi reforms, clinicians in Vietnam play a complex role mitigated by the government, society and filtering down into each patient interaction. The transition in the role of doctors from a strictly curative role before the Doi Moi reforms to an increasingly profitable career role after the 1986 reforms calls for further study into emerging health equity concerns with regard to medical professionalism and ethics. Such complexities are not limited to Vietnam alone, and have been observed in transitional economies worldwide (Cruess.R 1997, Fuchuan Sun 2010).

This study is by no means exhaustive. We have used patient perspectives to mark several trends in the relationship between equity and medical professionalism:

- Patients felt as though the use of health insurance to pay for medical services often resulted in diminished quality of services. Interview subjects reported that clinicians *"failed to use good medicines if the patient was using health insurance to see doctors", and observed, "the grumpy attitude of medical staff toward patients who use health insurance."* Finally, patients with health insurance *"usually have to wait for a long time until they can be called for their check up turn"*…
- There is a gap in the capacity, equipment and level of professionalism between doctors at district hospitals and doctors at centralized hospitals. This gap results in the crowding of centralized hospitals. One subject noted, *"patients move to higher level hospitals due to the fact that no improvement exists in the district level hospitals".*
- Many patients used their own knowledge to *"assess the quality of the health care service".* One interview subject noted that they *"didn't trust the doctor's diagnosis as being accurate"*; others discussed the tendency for doctors to prescribe brand-name medications over generics. With mass-media influence and increasing levels of education, patient awareness will only continue to rise in Vietnam.
- Some of the interview subjects theorized as to whether the *"expensive prescription"* by doctors relates to *"profit committed with the pharmaceutical companies?"* This topic has been discussed at length in outside research on a global scale (Rothman D. et al 2009, Brand R. et al 2008).

After reviewing all interviews included in this study, no patient recalled invoking an independent organization to monitor and assess clinical professionalism. External research has found no such watchdog organization in Vietnam.

The above-mentioned observations evidence the challenges that arise from Vietnam's current lack of governmental tools to measure and assess the standard of clinical ethics. Without government involvement in clinical ethical standards, clinicians face criticism on a personal, as opposed to systemic, level. Many studies in more developed countries have pointed to the necessity of the development of medical professionalism. According to the Internal Medical Association, "medical professionalism is considered to be an escrow between doctors and society". Doctors are bound to patients as well as society at large as they fulfill the professional duties. The clinician relationship to society, though, works two ways: his responsibilities and obligations of clinicians and the relationship between clinicians and patients will likewise be affected by the health system, regulations and policies.

Because of the complexity of the relationship between clinicians, society and government, Vietnamese clinicians would benefit from a medical society where professionalism, ethics and equity could be discussed. Changing of medical profession are discussed in many articles in both Western and Asian countries'

(Field MG 1989, Light D. and Levine S. 1988, Yang J 2009). Changing of professional value from Vietnamese physician's mind need to be investigated in the near future.

6.2. Social determinants of health equity

The WHO bases is conception of health equity on the "social determinants of health". The social determinants of health are the social and institutional factors that influence health on the individual level. Such determinants are divided into institutions, policy, health system-related determinants, and two-way interactions between the individual and society.
Our research shows that with the inequity in service utilization is evidenced by patient "response behaviors": individual desire to receive faster and higher quality services for themselves or their families.

6.2.1.Treatment-seeking behaviors

Some people in our research claimed, "Equity in health care means the same quality of clinicians". This shows that the levels of professionalism among clinicians varies. Studies showed that the number of beds is higher than the number of clinicians in Vietnam: the number of clinicians per 1000 people was 0.6 (as of 2008), whereas the rate of patient beds per 1000 people was 1.7 (as of 2008). These rates are lower than some countries in the Southeast Asia region, namely Thailand, China, and Singapore (Bộ Y tế 2008, Economic Intelligence Unit 2010).

Our research revealed that many of the healthcare patients interviewed perceived of the social determinants of health care equity as measurements of the capacity of clinicians, facility and equipment. Such an understanding helps to explain why health care service users frequently move to centralized locations for treatment.

6.2.2. Payment policy for clinicians

The quantification of health services preformed by clinicians as a way to calculate prices for services continues to be a controversial issue. Globally, the most frequent payment methods include payment to clinicians by service fee, package payments, salaries and payment by medical specialty (WHO 2010, Wynia M.2009). Each payment method comes with and disadvantages and obstacles to the implementation of clinician commitment to medical ethics.

Our research results reveal that one of the most common ways for patients to ensure timely and quality health services is to pay clinicians and medical practicioners covertly. Our research results also reveal that this practice existed well before the 1986 Doi Moi reforms: during the subsidy perdiod, patients "thanked" clinicians by giving giftsy. The current common practice of giving money to clinicians under the table and the outdated practice of giving clinicians "material products" during the subsidy period evidence the same social tendency, the difference is only in form.

Currently and prior to the 1986 reforms, clincians in Vietnam are paid according to time worked. Therefore, whether receiving “thank you gifts” or money under the table, this practice raises ethical issues. Many articles have shown the disadvantages of paying clinicians fixed salaries because it discourages efficency and quality services, and does not encourage clinicians to implement useful interventions to patients (Tran Thanh Huong, Le Minh Giang 2010).

6.2.3. Social network and social capital

Our research shows that many people using health services in Vietnam sought improved access to or quality in services by way of “an acquaintance”. This method of service access relies on the level of “social capital” of the patient. Bourdieu (1986) defines social capital as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition - or in other words, to membership in a group” (Bordieu 1986). One’s social capital is therefore determined by one’s relations and personal networks (relations, friendship, colleagues, trading partners and clients). Social capital necessitates upon cooperation between the parties participating in the exchange people: trust, mutual understanding and moral value sharing.

Some patients interviewed had formed communities around their specific illness, for example, there are several HIV/AIDS support networks for people living with HIV/AIDS. Through these groups, experiences in seeking the most reasonable health services and clinicians are also shared... Through patient network, experiences in seeking appropriate health care services and event how to access with the most revelant specialised physician are shared and this kind of network give great supports for patients and contributing in protect patient’s right.

7. CONCLUSION

Health care equity is impacted by a variety of factors. Equity will be increased when:

- The role of organizations supporting and monitoring medical professionalism will increase. Associations monitoring medical professionalism need to develop independently. The development of patient associations and social organizations will increase the rights of patients.
- There is further research on the effectiveness of the application of medical practicioner payment in Vietnam. Such culturally and socially specific research will enable policy makers to implement effective policy.
- Measuring tools for the attitude and behavior of clinicians are developed to assess the equity and effectiveness of health care services in Vietnam.

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PROMOTING HEALTH EQUITY IN VIETNAM: THE ROLE OF CIVIL SOCIETY

Hoang Tu Anh

1. INTRODUCTION

The 1986 Doi Moi economic reforms opened opportunity for the birth of the non-government sector in Vietnam. Though first with the economic sector, the increased need for participation of non-government sectors has risen to include government-subsidized sectors such as health services and education. The issuance of decree 35/HDBT by Council of Ministers "On the establishment of non-profit scientific and technology organizations" in 28 January 1992 is considered a starting point in the legal establishment of civil society in the form of non-governmental organizations. On October 17th, 2002, this decree was replaced by decree 81/2002/ND-CP, which provided support for the registration and operation of Vietnamese non-government organizations (VNGO). Since then, the number of VNGOs has increased substantially - for example, under the Vietnamese Union of Science and Technology Associations (VUSTA) alone, there were 125 associations and more than 500 organizations registered. The current document scope and influence of VNGOs includes everything from social work to service delivery and policy development. (Irene Norlund 2007, VUFO-NGO 2008).

Roles of civil society were included in the Communist Party resolution at its IX congress: *'Expanding and diversifying the forums for people to join mass-organizations, social organizations, professional associations, culture, friendship and charity works...' (Communist Party 2007).*

The HIV epidemic, which began in Vietnam in 1990, also boosted the civil society presence in Vietnam. In response to the epidemic, thousands of groups have been established to provide education, harm reduction materials, counseling, care and treatment to marginalized populations such as men who have sex with men, sex workers and drug users. Because of the frequent police involvement with the marginalized groups most afflicted by the HIV/AIDS virus, the Health Service Department, Red Cross and Women's Union were granted legal sponsorship for self-help groups so that they could work in the afflicted communities without legal recourse. USAID funds in Vietnam, for example, have a specific component on the building capacity of civil society under Health Policy Initiatives. The 2006 legal progress regarding HIV/AIDS policy was largely the result of effective involvement of civil society including people living with HIV (PLHIV) in the policy development process. 2007 marked the first formal and wide participation of Vietnamese civil society in preparing the UNGASS shadow report 3 (Greet Peersman et al 2009).

The government report showed that 51 to 75% of community and home-based care services for PLHIV were provided by civil society, including self-help groups of PLHIV, NGOs or faith-based organizations (Socialist Republic of Vietnam 2010). Significant roles of civil society in responses to HIV were also recognized globally by UNAIDS (UNAIDS 2010).

The progress exemplified by the civil society response to the HIV/AIDS epidemic, however, does not necessarily translate directly to national progress.HIV was a very specific case because of the global nature of the epidemic, of the high levels of stigma and discrimination associated with it and the relatively high amount of funding directed at combating the spread of HIV/AIDS. The question about the role of the potential for civil society to influence policy and to provide health services thus stands.

Regional reviews have indicated various examples of civil society organizations succeeding in providing health care information, services and support. However, the power for civil society to advocate on non-disease specific issues like health insurance, drug quality, prices and illness-prevention activities remains weak (Andrew Wells-Dang and Giang Wells-Dang 2011). A recent small-scale report about the capacity of VNGOs also showed that while VNGOs seemed to hold a high commitment toward well-being of vulnerable and marginalized groups, they lacked some crucial factors for sustainable organizational development, namely, governance and adaptive capacity (Ian Bromage and Hoang Tu Anh 2010). Another criticism noted was the high dependency of VNGOs on foreign grants.

Providing this backgound, this report seeks to map out the roles of civil society in promoting health equity in Vietnam. This study aims, also, to describe how Vietnam civil society has positioned itself in the delivery of health equity services and show the gaps in service and the potential growth areas. Findings from this study will serve as a foundation for strategic planning to promote the role of civil society in health equity and aid in capacity-building activities.

2. METHODOLOGY

The mapping was conducted through interviews with representatives of 31 organizations in Vietnam, including Vietnamese non-government organizations (24), private groups (3), community based organizations (CBO) (1), associations (1), mass organizations (1) and international non-governmental organizations (1). 18 of these groups are based in Hanoi and 13 are based in Ho Chi Minh City. The organizations questioned work specifically in the areas of health care services, community health and HIV-prevention, treatment and services, and in the broader fields of social and community development (in areas like women empowerment, gender equity, child care and care for people with disabilities). About 20 organizations were initially identified based on the list of organizations working with health, women, children and community development registered with Vietnam Union of Science and Technology Association. Then additional

organizations were added, especially organizations in Ho Chi Minh City were identified during the mapping process using the 'snow ball' technique and based on the recommendations of the LIN Center for Community Development. All interviews were digital recorded and transcribed; notes were also taken during interviews. To ensure confidentiality, direct quotes used in this study are provided annynamously.

To begin the process of mapping, the organizations were first contacted and a short information query form was sent to them to gather general information. Upon receiving their answer, the research team then followed- up with interviews. However, the return of the query forms was both lower and slower than originally anticipated: only 8 out of 20 organizations sent back their forms. Therefore, the research team decided to change the strategy and interview organizations directly, before the return of the query form.

In addition to interviews, our research team also reviewed on-line information, especially discussion forums of various health and health care related websites. Reviews of websites for the above-mentioned organizations focused on the quality and scope of information provided on the website, how websites were used to connect people and respond to the health and health care needs of users. In some cases, web-based information was the only information source of the study, as some of the organizations were not available to meet, namely webtretho.com and The Association for Sponsoring of Poor Patients in Ho Chi Minh City.

The key research questions in the mapping studies are as follows:

- What were health equity concepts that were used by Vietnam civil society organizations (CSOs)?
- What works toward health equity is being done CSOs?
- What were needs of CSOs to improve the impact of their works on health equity?
- How were CSOs linked to one another?
- What were various CSOs' thoughts about PAHE and the Health Watch and the possibility for future partnership?

3. FINDINGS

3.1. Concepts of health equity

Interviews showed that all organization leaders confirmed their works were in the framework of equity or aimed toward equity as they served marginalized and vulnerable groups. Interestingly, the word 'equity' except for the context of 'gender equity' was rarely used in any formal publicity documents of the organizations. 'Rights' was the word more widely used to describe this

kind of work; the word 'social justice' was also used by some organizations. The majority of organizations described the disadvantaged conditions and the high need for support for the populations that they served instead of using overarching theoretical arguments in publicity materials. Within the publicity material, it was taken for granted that these populations deserved the investment simply because they were receiving unequal treatment.

'Equity' was perceived as sensitive word to use in the context of Vietnam. One VNGO founder shared his experience:

> *"At first I wanted to name the center Health Equity Center. However, it was too sensitive so VUSTA refused my registration. We could take any name but not Equity. This was the work of only Communist Party. At the end, I had to take another name".*

When the concept of health equity was discussed, different expressions were found from different interviewees. For most people, health equity was understood simply as the notion of people having equal access to health care services and health care information independent of their social, geographical and economic status. Some involved with VNGOs used more sophisticated concepts, which emphasized the role of government and social systems system in providing and coordinating health care services and investments:

> *"Health equity at first is the equity between roles of state and people means the equity between obligations and responsibilities of each party. State was established by people and used people resources so it should serve people".*

> *"I like to think about Health Equity as Bill Gate said in his speech with Harvard students: "How could the world let these children die? The answer is simple, and harsh. The market did not reward saving the lives of these children, and governments did not subsidize it. So the children died because their mothers and their fathers had no power in the market and no voice in the system".*

While many emphasized access to services, there was high consensus among interviewees that quality in health services is key for health equity. All agreed that there should be alternatives in health services for people with different incomes; many voiced discontent with the notion that people with higher income could go to higher quality services, and even pay to receive health services overseas. However, many interviewed also stressed that basic health care services should also meet quality standards, not only the technical aspects of health care but also regarding ethical issues, such as under table payment and the way that clinicans and patients interact.

> *The biggest different between Vietnamese hospitals and foreign hospitals was how health providers valued the living time of patients. With foreign hospitals, every day or even every minute that the patients live is valuable and health providers would do their best to make it meaningful and enjoyable*

to the patients. With Vietnam hospitals, these days are just waiting for dieing. A common recommendation of Vietnamese doctors for patients with fatal diseases is "So please go home and eat good food". Vietnamese doctors are very good in terms of technical knowledge and skills. Vietnamese nurses are also very skillful. However, they do not have the sense of humanity in their services.

There was also concern that current health and health equity concepts were still too complicated and nuanced and thus would not translate easily into action. Also, because of the complexity of definitions, health and health equity were seen mainly as state responsibilities and not adopted by society at large. This mentality resulted in low motivation of civil society to enact change; this is a problem since public health issues and preventive medicine though private expenditure accounted for 57.1% of health financing in Vietnam (Ministry of Health 2010).

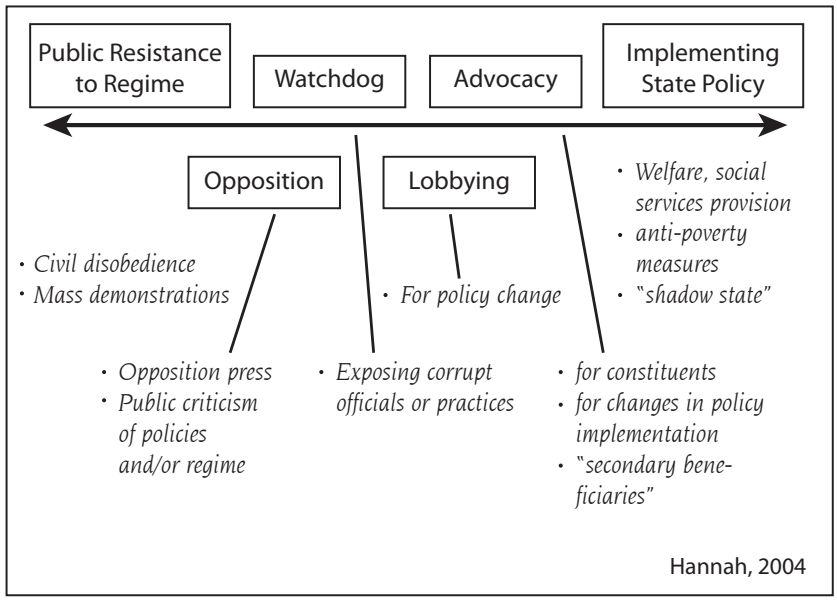
Health definitions likes the ones from the WHO are too difficult for people to understand. Let's look at the health definition of Ho Chi Minh 'Air and blood flows are circulated, mind is clear, that is health'. WHO definition is just for scientists, not for action. Meanwhile Ho Chi Minh's definition on health is definition for action. It is easy to understand. It also embedded the Oriental spirit as it mentioned 'air' (khí). I do not want to waste my time on definitions as they are just academic and not action oriented. We should look for concepts that action oriented. Only when people understand the concept, they can make indicators to evaluate it. When people understand they can have their voice.

Interviewees agreed that health care should be the responsibilities of both state and households. According to many interviewed, the state could not ensure health of individuals if each individual and household did not take care of themselves in first place. However, many agreed that it was the responsibility of the government to oversee the health of every individual and household. When talking about medical care (including equity in health care services), all interviewees said that this should be the role of state and system:

"Equity can be reached only when government can manage for doctors not to consider patients the source to earn money in such market economy".

3.2. Roles of civil society in health equity

This report usesJoseph Hannah's framework on possible roles of civil society (2007 examine the works of civil society in health equity; the six roles of civil society identified by Hannah ranged from civil society partnership with state in the implementation of state policies, to advocacy and lobbying for policy changes, to the monitoring of policies through public criticism and an independent press (see graphic below). As the last two roles are not possible in the current political context of Vietnam, analysis of this study focused on the other four roles.



3.2.1. Implementing State policies

Implementing state policies was important component in the work of most of the organizations that participated in this study. Many organizations interviewed stated that their work fuctions as a "supplement" to state works or 'filling in the gaps' to meet the needs of communities:

"We did things that the State did not do. We worked with groups who were not yet State's concern. Remote areas were not reached by the State so we approached them".

The most common work toward supplementing the implementation of state policies was the provision of health education, aimed at changing behaviours of specific target groups to reduce risks or to prevent illness or infection. The most common prevention campaigns were aimed at HIV and reproductive health issues.

Counseling and psychological support are also increasingly provided by civil society. While most of counseling services were provided outside of health facilities, there were nonetheless good examples of collaboration between government hospitals and civil society.

"Young people with spiral injury due to accident often committed suicide. Thus, providing counseling and psychological support for them was very important. We had two social workers working in a hospital to provide this free service. The hospital then recognized the importance of their work and hired them as formal staff".

Many of the organizations interviewed are capable in providing health services according to government regulation on private health services; they aim to provide quality health services that emphasize the role of a positive attitude on the part of health providers and the use of income from health services toward development and charity activities. Observations at these clinics emphasized the cleanliness of the facility and kind manner of health practicioners (in contrast to the lack of bedside manner at state clinics):

> *Our clinic targeted people who could afford the services and would receive quality services that worth their payment. We provided discounted and free services for special groups such as migrant workers, people with disabilities, and women who suffered from domestic violence.*

To help people better choose health service providers and clinics, some organizations focused on providing information about health services including the name of doctors and clinics, contact details, reviews on the quality of services (accounting for factors such as waiting time, attitude of clinicians and price and quality of services). This kind of information was often posted online so people could access it easily. People were encouraged to leave comments after using the service so that other people could learn from their experiences and make more informed choices.

Access to health services was the primary concern of several organizations in this study. Such organizations worked with reference system, helping people from other provinces to access to health care services in Hanoi and Ho Chi Minh City.

> *When the client came from province, we would wait for them here [in the city]. When he/she arrived the city, we would bring them to the clinic. This was to ensure that the client would get good treatment and care... We knew the doctors there so every thing would be quick.*

This was very helpful service because it is often very challenging for patients from provinces to find the hospitals in big cities and navigate the complicated network of logistics and lines to access health care services.

Some organizations provided health insurance for poor people and children, including orphanages and HIV-positive children. People in these organizations believed that providing health insurance was the most efficient form of assistance as it ensured a patient's long-term coverage.

Some individuals and organizations, such as the Sponsoring Association for Poor Patients and the Red Cross, supported patients by covering their medical fees. Free meals for poor patients were also provided by several organizations, especially in the South. Occasionally, people from the orgnizations interviewed provided volunteer nursing:

"I sent a post to the forum just before leaving for the hospital. In the post I called for the support of forum members during the time I was in hospital as I did not have any one to take care of me in the hospital. I sent the post but did not expect anything. To my surprise, of you came and gave me care, asif they were my family members". (quoted from one online forum).

Some organizations put their focus on the dissemination of state policies and laws. This was often seen in cases where the policies and laws themselves were developed with high level of involvement of civil society such as the Law on Gender Equity, Law on Domestic Prevention and Control, Law on HIV Prevention and Control, Law on People withDisabilities and National standard guideline on reproductive health care services. One organization in the study was working with the state-owned insurance company to promote the use of health insurance.

A common expression used by many organizations in this study in describing their partnership with state was: "civil society is an extended arm of state" (xã hội dân sự là cánh tay nối dài của nhà nước). This phrase also appears to be wider spread in capturing common attitudes on the role of Vietnamese civil society; an article followed a VUSTA annual meeting with its registered VNGOs. The subtitle for the meeting agenda was "Vietnam non-government organizations - the extended arm of government" (VUSTA 2010). It is also important to note that, in most of the cases, this partnership was a one-way partnership: civil society often identified the gaps in services and developed the programs by themselves, not per state's request. Even in the successful case of civil society intervetion exemplified by HIV, civil society did not get a budget share from government programs (Social Republic of Vietnam 2008). One reason to explain the voluntary nature of VNGOs in partnership with government to implement government's policies could be the fact that many founders of VNGOs were themselves former government officers (Hannah 2007). Greet Peersman and others also observed stronger relationships between government and civil society organizations with founders who were retired government officers (Greet Peersman et al 2009). Due to the high level of dependency on international grants, most VNGOs and CBOs programs were project-based. Because of the short-term nature of many of these interventions, it is difficult for the organizations to have a systemic change.

In the organizations interviewed, there were also almost no funds to build the organizational development capacity of civil society. Another factoring hindering systemic change was the fear of police intervention in activities: organizational staff who work with marginalized and vulnerable groups such as drug users, sex workers and MSM could be caught by the police. Though the Vietnamese government has loosened requirements for registration, it was still impossible for many organizations and self-help groups to register, especially for organizations in the South. This limited their opportunity to submit proposals and receive funds as independent organizations.

3.2.2. Advocacy work

Nearly half of the interviewed organizations worked primarily on advocacy. Evidence to advocate was established according to the research capacity of each of the organizations. Organizations with higher research capacities conducted quantitative and/or qualitative research as the foundation of their advocacy work.

> *"We wanted to provide evidence for government to develop policies. Thus, we should go to remote areas and work with ethnic minorities people. It was impossible for us to make policy but we can provide evidence. We should have sound evidence to advocate, so we did research".*

Organizations with comparatively lower research capacity used voices of insiders as evidence for policy recommendations:

> *"They [drug users] should fight by themselves, we could not do it for them. In the forum, we collected opinions of hundreds of people and sent to MOLISA. To do health care is small thing but to influence government in policy development is big thing. We care about policy advocacy. In order to do so we should have a big alliance to make a strong voice".*

Civil society organizations also formed alliances, as in the case of DOVIPNET to advocate for the passing of a law on domestic violence prevention and control. Many organizations, additionally, did their advocacy work in collaboration with other international organizations.

Except for the cases of specific health issues, such as HIV/AIDS, most advocacy organizations focused primarily on needs like education, housing, job and economic support instead of health for target groups. However, advocacy on services for female survivors of domestic violence and trafficking was good example how advocacy for an issue directly improved health care services for these women.

> *"We often do not pay much attention to health issuse. However, in the case of domestic violence, we advocated so that women did not have to pay a fine when they were in health facilities and their treatment could be covered by health insurance. Or in the case of trafficking, as most returned women have contracted severe STIs, we worked with health clinics so they could get treatment for free".*

There is an emerging advocacy network of civil society organizations in partnership with 'mediated' state agency such as VUSTA, the Central Propaganda Committee and the Committee for Social Affairs of National Assembly.

> *"Together with the Center Propaganda Committee, we conducted research on impact of health expenditure on poor economic status of Vietnam. Data from research was posted on Communist Magazine. The Center Propaganda Committees used this data to organization series of workshop from North to South".*

Mass media was also often involved in advocacy activities to raise awareness for campaigns. To make media work effective, a group of people working with mass media were identified, trained and provided with evidence and materials about the particular issue. The media campaigns often aimed at eliminating stigma and lessening discrimination against target groups.

There was evidence of advocacy work of civil society, which could change political and societal awareness on different issues and potentially lead to policy changes, as was the case with laws reagrding HIV/AIDS prevention and control, laws on domestic violence prevention and control and abortion laws. However, in many other cases, advocacy work could not move past the point of education and awareness-raising campaigns.

> *'We have the right to make recommendations, but if those in authority will listen ornot, we had to wait to see. We could not rush. I made recommendations but the state did not respond. There was nothing more I could do".*

> *"The information was very much appreciated by National Assembly delegates. However, they still gave a pass for the law as was the suggestion of the Ministry of Health. I was happy with this result. I think the role of scientists was just to identify the problems. Voting for a policy would be related to many things".*

The largest challenges with the advocacy role of civil society, especially in health equity, were the lack of expertise in doing health system research and the limited funding sources for conducting such research.

3.2.3. Lobbying

While lobbying is considered a formal job and is regulated by law in the United States and many European countries, it is still a relatively new role for civil society organizations in Vietnam. Only two of the 31 interviewed organizations said that they lobbied for policy changes.

In Vietnam, lobbying is not recognized as a profession and there are no laws regulating the role of civil society in lobbying for policy changes. This brings about concerns about the lack of transparency and effectiveness of such activities in Vietnam (Quynh Nhu 2010, Minh Minh 2010, Pham Mai 2010 and Nguyen Nga 2011). Because of the absence of regulation, lobbying is often perceived negatively, as "going by back door" *(đi cửa sau)*, or "going in the night time" *(đi đêm)* and is associated with bribery. It was not mentioned by the mass media until 2007. However, recently lobbying has receivied more public attention in light of the challenges that Vietnam has had in international trade negotiations (i.e. tax on exported shoes, tax on catfish and in country scandals related to medicine import and production). Improving the capacity of civil society in lobbying and promoting lobbying regulations are potential future measures to improve the effectiveness of policy advocacy programs of civil society.

3.2.4. Watchdog

None of the organizations interviewed asserted their primary role as monitoring of national laws or policies. However, five out of the 31 organizations had been involved in writing shadow reports or producing publications on the implementation of laws on HIV prevention and control, laws on domestic violence, laws regarding gender equality, and laws on child protection, care, education and rights. Shadow reports of international commitments were the result of requests by international organizations. Monitoring reports of domestic laws and policies are often conducted adhoc as they heavily depend on the availability of funds. Research and report quality were also often not high as they are conducted in brief, while involvement of different organizations in the study often need more time for negotiation and agreement. Low funding sources severely limited organizational ability to involve senior researchers in the research. Except for some international commitments, which had clear indicators set for monitoring, most of the current reports to monitor the implementation of national laws and policies are not based on standard indicators.

3.3. Collaboration in civil society with regard to health equity: challenges and opportunities

Though showing high commitment to the well-being of disadvantaged, vulnerable and marginalized groups and individuals, collaboration among civil society groups is not common practice. Working on health and health related issues continues to be observed mainly in organizations or groups with the word 'health' in their name. Organizations outside of the health field often ranked health as a lower priority than other welfare indicators such as counseling, social support, education and income generation, etc. For example, while research shows that almost half of the people living with disabilities (PWDs) have difficulties in accessing health care services because of their physical limitations, lack of appropriate services for some specific needs and stigmatization and discrimination at healthcare facilities (Le Bach Duong et al 2008), none of the interviewed organizations working primarily with PWDs had health programs. One common reason cited by many organizations to explain this absence was that this issue was out of their capacity and should be the responsibility of the government:

> *"I knew that health care was also important for people with disabilities. For example, in our training, participants also asked about reproductive health information and services. One participant told that her friend had a miscarriage because she fell down from the table while having pre-natal check up. Or I got one email from a doctor asking me if deaf people are even sick as he saw none of them in the hospital. Of course they were sick but it was difficult to them to go to the hospital so they just stayed at home. There were a lot of things about their health but it was out of my capacity to take".*

Even for organizations working in health, this study observed almost no example of collaboration between civil society organizations. Differences in approaches, interests and competition for resources were main barriers for effective collaboration between organizations.

> *"At first we also worked with another organization but then we could not reach an agreement in the plan of implementation for the project because of differences in perspective. Thus, in the second phase we did not work together any more. If each organization has its own project and we meet together to share experiences or have collaboration in some activities to make them more effective, it is ok. But we should not share a project. Sharing a project is complicated".*

However, discussion with organizations showed opportunities for collaboration and networking among civil society organizations. First, all health and non-health organizations found health equity an important issue that needed immediate and strong action. All participants in interviews showed their upset with the current health system and services. During interviews, they all shared unpleasant experiences with health providers that they themselves or of their close friends, colleagues and family members had experienced, They confirmed their desire toparticipae in network of civil society working on health equity if the network could build their capacity to work on health equity and help them to integrate health equity effectively in their current work. Organizations with strong research orientation, meanwhile, emphasized the importance of building a group of senior researchers who shared common interests and concerns in health system and policies and having different forums for this group to meet and share their research and writing. Among suggestions were online discussions and even thematic journals on health equity.

> *"I want that you have a mechanism for researchers to meet and discuss together. And this should be in Vietnamese. If we want to influence policy, we should use Vietnamese, not a foreign language. We should start with issue of their hearted concern. For example, all the every good writing about bauxite did not need any money but that was the thing that people put their heart in. When we do not think about money, we can have good article. Example of a hearted concern is why 3-4 children have to share a bed at National Pediatric Hospital".*

Long-term financial planning was also concern of participants. Some participants doubted the concept of a project-based approach for this kind of study; according to them, changing the health system in Vietnam requires time and long-term resource support. All related stakeholders, including state and private agencies, should work together to make a comprehensive master plan and then look for resources to implement it. They argued that we should not limit our activities or number of stakeholders participating in the process to the project's life-span and budget. Mobilizing support of in-country sponsors was emphasized as crucial and sustainable sources for actions toward health equity.

"We should count on in-country resources. Like us, we took resources from one thing to feed our passion on another thing. We should have sponsors. For example, if we want to study issue of overload at Central hospitals and call for donation, there will be people who pay attention. I like that way of doing work rather than project based".

4. CONCLUSIONS AND RECOMMENDATIONS

Civil society organizations in Vietnam hold different views of health equity framework: some view health equity as equity in accessing to health care services and information of different groups, others view health equity as the accountability of government to a people's right to health. Civil society organizations holding the former view tend to accept the reality of inequity and saw their role in reducing the inequity through the provision of information and services to disadvantaged groups. They could be considered "service providers". Organizations with the latter view were more likely to challenge the status quo. They positioned civil society as actors for change by holding the government accountable to people's health rights and empowering disadvantaged groups. They could be considered "activists". Some organizations, though, hold the second view but also provide health information and services. In order for civil society to be actor for change, there should be an increased number of capacity-building programs and forums about the health determinant framework to promote critical views on health and health-related issues, including health insurance. This will help bring solidarity in civil society and increase effectiveness of their work.

Implementation of State policies was main component of civil society work in Vietnam. This reflected the history of civil society which started with retired government officers. This also showed the specific characteristic of civil society in the context of Vietnam who aimed to make social changes based on positive partnership with State rather than becoming State's opponent as in other countries in the region. To make this partnership meaningful and not weaken its capacity in social appraisal, civil society also put its effort as individual or collective organizations on policy advocacy including wide participation in policy and law development. However, lack of profession and transparent lobby, several policy advocacy efforts could not come to desired results. Another factor that limited the effectiveness of advocacy works was the lack of a monitoring system of civil society which was strategic, systematic and planned. There were high needs on capacity building regarding establishing sound evidence for advocacy, doing effective and transparent lobby and conducting systematic, effective and efficient health watch. There should be also discussion among civil society about different possible roles of civil society in promoting health equity in Vietnam context to get consensus and involvement of organizations at different levels and doing different works.

4.3. Civil society was not homogenous in terms of capacity, scope and perspectives about working with health and health related issues. Emerged conflicts had been not handle thoroughly and discussed openly. They threatened the solidarity and

strength of civil society. In addition, equity in health currently was not among the most concern for many organizations. Thus, to have collective voice on health equity advocacy, it was important to mainstreaming health equity in all social and community development works on health and non-health fields. Sub-same interest groups should be identified among civil society to have better discussions and involvement of different groups in policy advocacy, lobbying and system monitoring. Capacity building programs should also be tailed for the needs of each specific groups depending if they were researchers, service providers or activists.

4.4. PAHE's initiatives on Health Watch and network of organizations working on health equity were appreciated by participants. Because of extensive impact of health on people's life and the commonality in suffering of health system problems, health equity was potentially strong entry point for organizations of different fields to work together. Specific themes of health equity should be identified collectively by main stakeholders in health care, services and policies including representatives of beneficiaries to ensure their active and effective participation. The PAHE program should also not be limited in the frame of a project. Strategic planning was important to ensure its effectiveness.

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