



YOUNG LIVES STUDENT PAPER

Healthcare Choices in the Context of Reform: Perspectives of Young Lives Caregivers in Vietnam

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Paper submitted in part fulfilment of the requirements for the degree of MSc in Global Health Science at the University of Oxford.

The data used in this paper comes from Young Lives, a longitudinal study investigating the changing nature of childhood poverty in Ethiopia, India (Andhra Pradesh), Peru and Vietnam over 15 years. For further details, visit: www.younglives.org.uk.

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This placement in Vietnam had three major components. The first was assisting with a sub-study of Young Lives children in DaNang to familiarize myself with qualitative data gathering and analysis. The second component involved time in Hanoi to work at the Young Lives office and utilize available resources. The third component consisted of informal interviews and document gathering from key researchers and policy makers. These interviews were crucial in gathering unpublished reports, providing a framework for analysis within the existing literature, as well as providing a comprehensive overview of healthcare in Vietnam. Living in Vietnam also allowed insight in the healthcare context including the availability of private providers and the influence of pharmaceutical companies, all informing the context in which this analysis took place.

A special thank you to Dr. Birgitta Rubenson for her kindhearted support and intellectual guidance during our time together in Vietnam. My Oxford based supervisors, Proochista Ariana and Laura Camfield, for their patience, resilience and understanding as I battled through thesis topic changes and struggled in the new world of qualitative analysis. Warmest appreciation to Dr. Hoa Dinh Phuong (Ministry of Health), Dr. Toan Ngo Van (Hanoi Medical University), Dr. Khe Nguyen Duy (Ministry of Health), and Hang Mai Thuy (Save the Children) for their informative discussions, tutorials and kindness. Dr. Duc Le (Young Lives) for your hospitality. Anne Yates (Young Lives), for your constant ability to find data when needed. Inka Barnett (Young Lives) and the rest of the Young Lives team for your consistent support. And finally to my husband, Geoff, for his loving encouragement, support and careful reading.

Abstract

Since the late 1980s, Vietnam has implemented market-based economic and healthcare reforms, destabilizing the publicly funded healthcare that had gained international renown. These reforms initiated substantial changes in healthcare provision and financing, which involved the introduction of user fees, legalization of private practices, and liberalization of pharmaceutical companies. In response to the impact of user fees on equity of healthcare access, the government has introduced compensating measures that aim to assist poor households and young children overcome new barriers to access. Using existing qualitative data of caregivers within a sub-sample of Young Lives Project participants, this study investigates the experiences and perceptions of caregivers as they seek care in this mixed healthcare system of public and private providers. Emphasis is placed on issues of quality and accessibility. Where do caregivers take their children when they are sick? What are the important determinants of health seeking behaviour within this sub-sample? This study finds that households, regardless of poverty status, perceive quality and accessibility of care to be highest in the private sector. Caregivers suggest that improvements in resources and quality of care offered by the commune health clinic would influence their choice of care, if quality could be guaranteed. This study also confirms gaps and inconsistencies in the existing compensation measures, such as free care for the poor and for young children, in their implementation and coverage.

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Chapter One

Introduction and Historical Context

1.1 Overview

In 1989, the Socialist Republic of Vietnam introduced market-based reforms to its renowned system of publicly funded healthcare. Over the intervening 20 years, the government has created compensating measures to attempt to help poor households and young children overcome new barriers to access. This mixed system of healthcare provision and insurance has profound implications for the health seeking behaviour of Vietnamese households, particularly the poor. While significant research has been conducted on the consequences of Vietnam's healthcare reforms, the impacts on children who live in poverty have been generally neglected.

This thesis aims to address this research gap by drawing upon existing data from the Young Lives Project,¹ a study of childhood poverty, to understand how the health seeking behaviour of caregivers is affected by the results of Vietnam's healthcare reforms. It will begin by reviewing the history of Vietnam's healthcare system, with a focus on post-1989 reforms. Next, it will discuss the literature on healthcare choice and utilization, with attention drawn to how existing theoretical frameworks inform concepts of quality and accessibility. The methodology of data collection and analysis will be presented, after which the results of the research will be reviewed and discussed.

¹ Young Lives is an University of Oxford based study with researchers in Vietnam, India, Peru and Ethiopia. This study follows two cohorts of children and their caregivers: the younger cohort consists of 2000 children (aged 11-12 months) and the older cohort of 1000 children (4.5-5.5 years) in each country. These children were selected in the Millennium and will be followed until 2017. To date, two rounds of quantitative data gathering have occurred in 2001 and 2005/6. The third round of data gathering is ongoing.

1.2 Introduction

Vietnam is a country that has experienced significant political and economic volatility over the past century. After achieving de-facto independence from the French in 1945, it took 10 years for this to be ratified through the signing of a treaty at the Geneva Conference of 1954. The Geneva accord divided the country in half, pending unification through national elections. Ho Chi Minh, a nationalist and socialist, led the North, and Emperor Bao Dai led the South. Despite the terms of the accord, the country would not be reunited peacefully. The government of the State of Vietnam (South) refused to submit to nation-wide elections, and guerilla fighters loyal to Ho Chi Minh increasingly staged attacks in the South. The United States became progressively involved in supporting the South and initiated combat in 1965. What was known in the west as “The Vietnam War” was a protracted civil conflict that finally ended in 1975, when Saigon (South) fell to Ho Chi Minh’s forces and the country was officially united as the Socialist Republic of Vietnam.

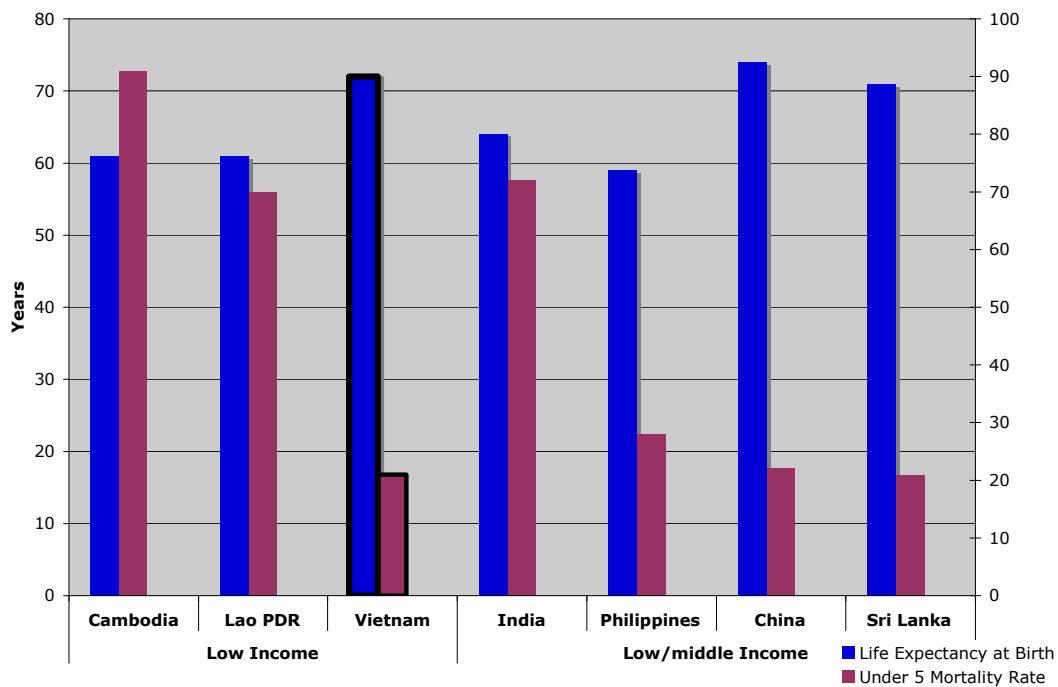
With its violent history behind it, Vietnam is developing into a modern economy and society. It has a large population of 85.1 million people, most of which live in rural areas (World Bank 2008). Since its transition towards a market economy in 1986, Vietnam has been acclaimed for its economic achievements through international trade and development (World Bank 2001). As an indicator of its economic development, the percentage of households living in absolute poverty has decreased from 75 percent in the 1980s to 18 percent in 2007 (World Bank 2007a).² Although Vietnam is rapidly progressing in macroeconomic terms, there are growing income disparities between

² Absolute poverty is defined as those who live under a designated absolute poverty line. This poverty line is established in each country based on the cost of buying a basket of food items ‘commodity-based’ assumption (World Bank Institute 2005).

geographic regions and ethnic groups. For example, it is estimated that 10 percent of the Kinh majority live in poverty relative to the 55 percent of the ethnic minority groups that live in poverty (World Bank 2007b).

Despite its income disparities, Vietnam has achieved remarkable advances in health indicators. In the early 1950s, as a country based on socialist principles, the North established a primary healthcare network that was expanded to the rest of the country after reunification. Relative to other low-income countries and some countries with higher per capita income, Vietnam has made impressive achievements in under five mortality and life expectancy (Lieberman and Wagstaff 2009). In a recent World Health Organization Statistics Report (2009), the life expectancy in Vietnam has reached 72 years at birth, which is comparable to middle income countries such as China and Sri Lanka. Vietnam's under five mortality rate is 21/1000 live births, which is lower than both China, India and the Philippines (See Figure 1).

Figure 1: Life Expectancy and Under Five Mortality Rate (2007)



Source:³ WHO: World Health Statistics 2009

Many authors conclude that these health achievements are attributable to Vietnam’s public healthcare system and the promotion of multiple components of health and healthcare of the population (Teerawichitchainan and Phillips 2008; Hien et al 1995; Bloom 2008; Fritzen 2009). Lieberman and Wagstaff (2009) go so far as to proclaim the Vietnamese healthcare system as ‘legendary’ given its efforts to advance community level health and infrastructure, measures that are seen in other socialist countries such as Cuba and China (Djukanovic and Mach 1975).

The healthcare model that received so much international acclaim has changed dramatically in the last 20 years as Vietnam has implemented major economic reforms. Transition towards a market-oriented economy caused a flood of private providers and

³ World Bank Classification of Income Categorizes: <http://go.worldbank.org/D7SN0B8YU0>

independent drug vendors into the health sector, while healthcare reforms increased the cost of care through the introduction of user fees for public health services. In their interactions with an evolving healthcare system, households have been adapting their choice of healthcare to take into account the accessibility services and quality of care in the private and public sectors.

1.3 Healthcare in Vietnam: A History of Reform

After independence from the French in 1945, the Democratic Republic of Vietnam (North) implemented extensive primary healthcare coverage (Witter 1996; Segall et al 2002). The socialist system in the North was characterized by a network of local health clinics, improvements in education, preventative and curative programmes, food distribution and high employment or access to productive land – measures that were common among other socialist countries (Bloom 1998, pp. 234).

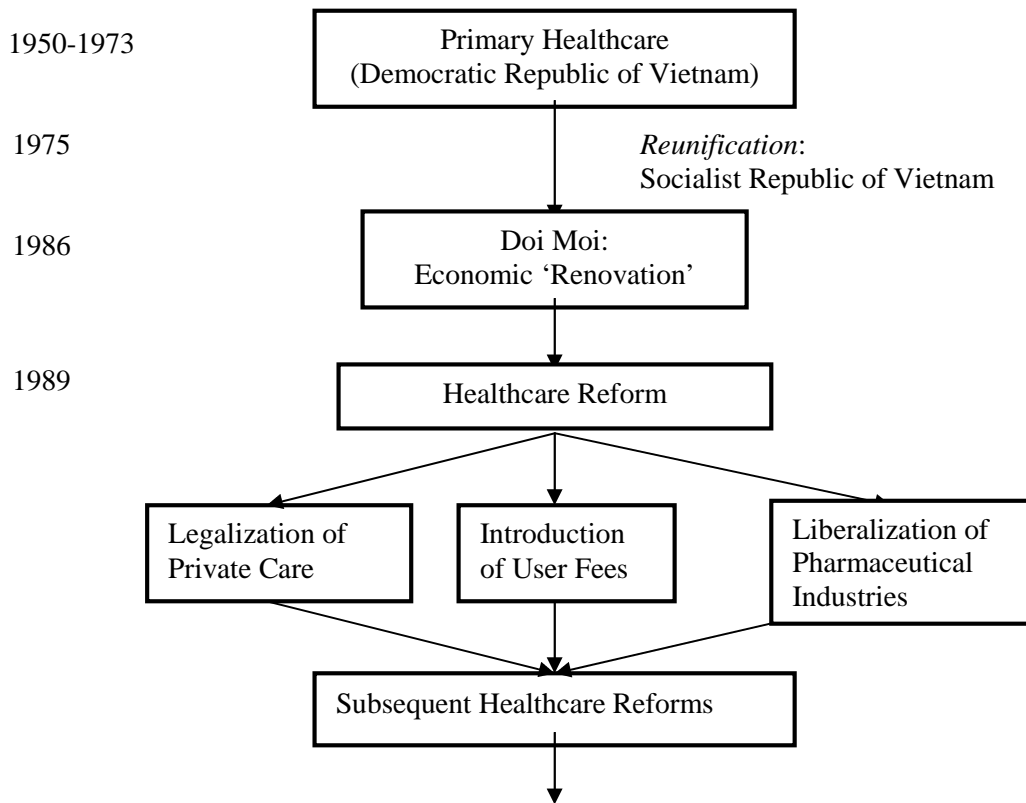
After the reunification of the North and South of Vietnam, the government strained to implement the same level of access and free healthcare to the South of the country. Public finances were also more restricted because of the 1979 US embargo and the decline of international assistance from the former socialist bloc, and together these conditions led to an economic crisis (Sepehri et al 2003; Witter 1996; Hong Ha et al 2002). With these financial constraints, the maintenance of healthcare facilities and payment of public workers became increasingly difficult to sustain through a publicly funded system. Healthcare workers began to establish informal (and technically illegal) health centers to supplement their meagre income, a development that highlighted the disintegration of the public healthcare infrastructure (Sepehri et al 2003, p. 137).

Economic and Healthcare Reform

In 1987, the government of Vietnam designed a strategy for renewal to address the economic crisis. 'Doi Moi', which means 'renovation', was based on using market mechanisms to achieve sustainable growth and development (Boothroyd and Nam 2002; Do 2009). Doi Moi can be summarized by with three key features: liberalization of the agricultural sector, protection of private property rights, and redirection of production for export (Ekman et al 2008, pp. 253).

As these major reforms were transforming the economy, healthcare reform was on the horizon. In 1989, the Ministry of Health (MoH) began to implement a model of healthcare reform based largely on consultation with the World Bank to achieve a financially viable healthcare system (Lieberman and Wagstaff 2009) (See Figure 2). The reform had three main components: introduction of user fees, legalization of private practices, and liberalization of pharmaceutical companies. The changes transformed a free and accessible healthcare system into a decentralized, two-tier market oriented system (Segall et al 2002).

Figure 2: Vietnam's Healthcare Reforms



- 1992: National Health Insurance Plan (compulsory vs. voluntary)
- 1994: User fee waivers introduced for poor, orphans, elderly, people living in remote and mountainous regions, people with mental health problems and TB.⁴
- 1994: Change of Payment for Commune Health Clinics (Provincial Funding)
- 1995: Schedule of user fees implemented for costs of treatment and care.
- 2002: Healthcare fund for the Poor: Health Insurance for the Poor
- 2003: Reform in Health Insurance: Extension of coverage
- 2004: Children Under 6 free health insurance

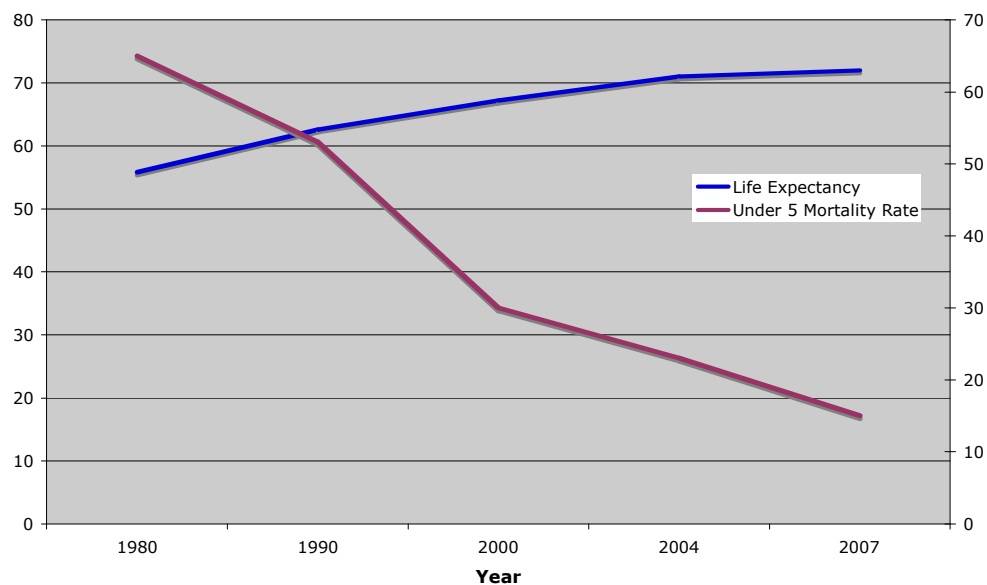
Adapted from Lieberman and Wagstaff 2009/Ministry of Health 2007

The first change to occur was the legalization of private medical practices, primarily due to pressure from physicians already working (illegally) in private practice (Do 2009). The private sector included retired doctors, doctors employed by the public system running private clinics after hours, and others who left the public sector entirely (Hong Ha et al 2002). Private practices flourished in the country, reaching across rural and

⁴ Khe D.N., 2004, 'Socioeconomic difference in a rural district in Vietnam: Effects of health and house of health services', PhD thesis: Karolinska Institute, Sweden.

urban settings and becoming a major provider of care (Hien et al 1995; Segall et al 2002; Tuan et al 2005). The early 1990s saw the liberalization of the pharmaceutical industry, which generated a flood of drugs of unknown origin and quality into the public domain (Gian et al 2003; Fritzen et al 2007; Hong Ha et al 2002; Sepehri et al 2003). User fees, introduced as a cost recovery mechanism (Hien et al 1995), had an impact on the utilization of healthcare for the population, particularly those living in poverty, leading to delayed use of service or self-medication (Jowett et al 2003). While some have argued that these reforms have had "adverse consequences for access, efficiency and equity' (Sepehri et al 2008, pp. 398), Vietnam's overall health indicators have steadily improved over the last 20 years (see Figure 3).

Figure 3: Under 5 Mortality Rate and Life Expectancy in Vietnam (1980-2007)



Source: UNData and World Health Organization Statistics 2009

1.4 Organizational Structure of Healthcare

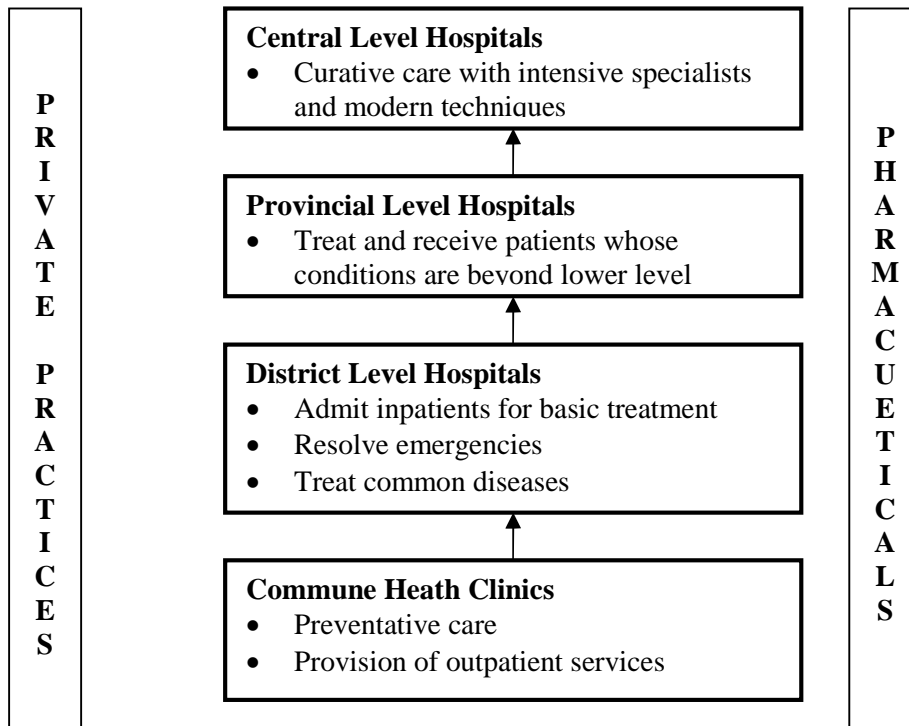
As a socialist country, the ideals of social cohesion and community are reinforced by a commune-based political structure: each city, town and rural village is grouped into communes that encompass approximately 2,000-10,000 households under a commune ward leader (Khe 2004). Approximately 95 percent of the communes have a commune health clinic (CHC) that serves as a base for primary healthcare and health promotion activities, as well as a referral center (MoH 2007).

The Vietnamese healthcare structure is based on a referral system connecting the CHC, district hospitals and the provincial and central hospitals. If the basic treatment offered at the CHC is not sufficient, patients are referred to the district level hospital which has inpatient facilities as well as limited treatment options. The next stage is the provincial hospital, which is equipped with more doctors and facilities, and finally the central hospitals that have specialized services (MoH 2007). Ideally, patients move from the commune level through a referral process, depending on the severity of their situation. However, as seen with many studies including this one, the referral system is often ignored, and steps and stages are bypassed in the name of urgency and quality of care (Segall et al 2000; Lieberman and Wagstaff 2009; MoH 2007).

The structure of healthcare and its use has been significantly influenced by the introduction of private providers and pharmaceutical companies, increasing the choice and availability of treatment throughout the country (Sepehri et al 2003; Hong Ha et al 2002). The use of traditional medicines derived from plant or animal products is still prevalent in both public and private sectors, adding an extra dimension of choice for

treatment in both the urban and rural communities (Ladinsky et al 1987; Ekman et al 2008). See Figure 4.

Figure 4: Vietnam’s Healthcare Infrastructure



Source: Public Health Report: Ministry of Health Vietnam 2007

1.5 Financing of Healthcare: Response to Doi Moi

The major reforms in healthcare provision and financing have jeopardized the previous achievement of publicly funded healthcare, in pursuit of a financially sustainable, market-oriented system. The new healthcare system features two methods of financing: user fees and health insurance. In response to the negative impact of user fees – particularly by limiting access to healthcare by the poor – the government has implemented new public insurance schemes and special exemptions from user fee payment. These compensatory measures are slowly increasing coverage of the

population with the aim of reaching universal insurance coverage in the future (MoH 2007).

User Fees

User fees apply to inpatient care, hospital bed use, certain drugs, laboratory tests, nursing and technical services (Dao et al 2008). However, the fee schedule differs across regions and depends on the type of clinic and hospital as well as the procedure (Sepehri et al 2003), making it difficult to monitor and apply universally. Though user fees achieve the aim of contributing to the public funds, they negatively impact healthcare utilization among those who are socially disadvantaged and from remote areas (Dao et al 2008; Thuan et al 2008).

Insurance and Exemptions

In 1992, the government introduced a public health insurance scheme with three key aims: to contribute to poverty alleviation; to raise additional resources for the public sector; and to protect against catastrophic household spending on healthcare as a result of user fees (Jowett et al 2003, pp. 334).⁵

There are two types of National Health Insurance: compulsory and voluntary (Ekman et al 2008). The compulsory insurance scheme, covering approximately 41 percent of the target population, is for current and former civil servants, employees of the state, and private enterprises with more than 10 employees (Dao et al 2008; Ekman et al 2008). The voluntary national health insurance is for those ineligible for compulsory insurance, which includes self-employed farmers, employees or owners of small enterprises, university students, school children (over 6 yrs), and those exempt from the premiums

⁵ Catastrophic spending can be defined as expenditures on healthcare that surpass a given percentage of food consumption (Lieberman and Wagstaff, pp. 9).

(the poor and all children under 6) (Jowett et al 2003, pp. 335). It is estimated that 51 percent of the eligible population is not covered by either health insurance schemes, with the majority of these being the self-employed (Ekman et al 2008). See Table 1.

Table 1: Vietnam’s Health Insurance Coverage

Insurance Scheme	Population Coverage	Target Groups
Compulsory Health Insurance	9 %	Formally employed, retired, disabled and people of merit.
Voluntary health insurance	11 %	self-employed, informal sector workers, students and school children
Healthcare fund for the poor	18 %	Poor, ethnic minorities in mountainous areas, inhabitants in disadvantaged communities.
Under 6 Exemption	11 %	All children under the age of 6
Total	49%	

Source: Adapted from Ekman et al 2008, table 1 pp. 255

As a strategy to exempt the poorest from user fees⁶ the Healthcare Fund for the Poor pays the voluntary insurance premiums for eligible poor households (Wagstaff 2007; MoH 2007).⁷ However, there are major difficulties in implementing this programme due to eligible households’ lack of awareness of the Fund, and administrative obstacles with distributing the cards and confirming eligible status (UNDP 2004). In 2003, 99 percent of the eligible population was awaiting coverage due to lack of government funds (Jowett et al 2003, p. 335).

In 2005, the government instituted free healthcare for children under the age of 6, which follows a similar premium exemption as the Healthcare Fund for the Poor (MoH 2007).

⁶ The Vietnamese Poverty line (per person) is defined by MOLISA (Ministry of Labour, Invalids and Social Affairs) as <80,000 VND/month for mountainous regions, <100,000 VND / month for rural households and <150, 000 VND / month for urban households, roughly 4.5, 6 and 8 USD respectively (International Monetary Fund 2004).

⁷ Originally titled Healthcare Cards for the Poor and partially exempted the poorest households from user fees as part of the National Target Programme for Hunger Eradication and Poverty Reduction.

The government also exempts those who are pregnant, as well as those suffering from particular communicable diseases, such as HIV and tuberculosis, from paying user fees (Dao et al 2008). The implementation of insurance and programmes to exempt those in need from user fees highlights the challenge of reconciling socialist ideals with market principles. The main purpose of user fees is to provide additional public revenue, which is in turn used to cover costs a significant proportion of the population. If not adequately implemented, this redistributionist approach to healthcare provision creates new barriers to access for some elements of the population, while lowering them for others. It also raises questions of how perceptions of quality are affected, and the criteria by which people choose to access healthcare.

The children in poor households are especially vulnerable to problems of access and quality. The healthcare reforms have not only influenced the cost of care, they have had significant impacts on the quality of care, in particular, that of the commune health clinic (MoH 2007; Do 2009; Fritzen 2007). The health seeking behaviour of households is shaped by their perception of trade-offs between affordable, accessible and quality care (Segall et al 2002; Okumera et al 2002; Chang and Travedi 2003). The next section examines theoretical frameworks of health seeking behaviour that cast light on themes of particular relevance to Vietnam: quality and accessibility.

Chapter 2

Healthcare Choice and Utilization

2.1 Introduction

The choice of healthcare and treatment is dependent on many factors that relate to individual perceptions of service, level of illness, affordability and accessibility in the context of available options. Health seeking can be classified as the different steps in the decision-making process, or the determinants associated with the choice of services (Kroeger 1983). To conceptualize these processes in the use of healthcare, theoretical models such as the health belief model, the health utilization model, and the 'Four As' model have been established to provide a framework for analysis and research. These models will be reviewed and relevant elements will be adapted in a discussion of quality and accessibility in health seeking behaviour.

2.2 Theoretical Frameworks

The health belief model was developed in the 1950s to integrate psychological characteristics with demographic variables that influence beliefs and motivations in response to illness (Hausmann-Muela et al 2003). This model links perceived susceptibility to and severity of illness with the perceived benefits and barriers to action (Sheeran and Abraham 1995). Anderson and colleagues' (1973) health utilization model provides another framework for analysis, categorizing choice into three main components: predisposing, enabling and need factors. Predisposing factors include age, gender and past experiences; enabling factors encompass availability of services, financial resources and social support; and the need factor includes the perception of severity (Anderson et al 1973). Kroeger (1983) adapts this model with the inclusion of available treatment options: traditional healer, modern healer, drug vendor and self-

treatment, adding further dimensions to the complexity of choosing healthcare providers. One last framework is the 'Four As' model: Accessibility, Acceptability, Affordability, and Availability. This model was adapted by Peters et al (2008) with the additional dimension of quality and further elaboration on accessibility and acceptability in terms of cultural and social expectations.

These models bring attention to the complexities of the factors that operate at multiple levels to influence choice, and they highlight the competing approaches to analysis within the healthcare utilization literature. Given the broad-based nature of existing data from Young Lives interviews, one isolated model will not be used as the theoretical framework for analysis; rather, key components of the models of healthcare utilization will be drawn upon to suit the needs of the study. A focus on quality and accessibility will be adopted, in the context of three main choices of care: private physicians, public providers (CHC and hospitals) and self-medication. Drawing on existing literature, these key components will be investigated using qualitative analysis of Young Lives interviews with caregivers regarding their experiences with and use of healthcare when faced with illness.

2.3 Literature: Healthcare Utilization

The international literature on healthcare utilization connects theoretical frameworks with families' decision-making processes within varying contexts. This section aims to draw attention to areas emphasized in the literature regarding Vietnam's experiences, as well as the experiences of countries undergoing similar economic transformations.

Accessibility and Quality

Quality

Peters and colleagues (2008) explain the concept of accessibility in healthcare utilization to encompass the multi-dimensionality of access that includes geographic accessibility, availability (hours of operation, appropriate services, waiting times), financial accessibility (cost and ability of user to pay), and acceptability (culturally and socially). This review will focus on how the availability and financial accessibility of services affects health-seeking behavior.

Financial accessibility has been at the centre of debate in Vietnam because of the introduction of user fees. User fees have been found to affect utilization of formal care, generate strain on the poor (causing households to borrow money or reduce essential consumption), raise levels of self-medication and increase the use of unregistered and registered private providers (Tipping and Segall 1996; Segall et al 2002; Sepehri et al 2003; Jowett et al 2002). A study conducted by Khe et al (2002) found that 34.8 percent of households experiencing illness did not use public health services because of a shortage of money. These findings are again echoed by a study conducted by Dao and colleagues (2008) with data from the 1993 and 1998 Vietnam Living Standard Surveys (VLSS). They found that poor households are at risk of falling deeper into poverty due to the economic demands of seeking care, and that households do not seek healthcare because of their inability to pay.

Inability to pay for care leads to inequity in the burden of cost and health status among different socioeconomic groups in the country (Labonte and Schrecker 2006). This disparity is not limited to differing economic groups in Vietnam, but is also witnessed

across different geographical regions (Sepehri et al 2008). An example would be the cost of care for the rural Northern ethnic minority in Vietnam's highlands, who spend 19.3 percent of their annual income on healthcare, compared to the national average of 7 percent (Ensor and San 1996).

The availability of services is also an important consideration when seeking care: Are the hours of operation usable? Are there long waiting lines? Are there sufficient resources and staff? A study by Segall et al (2000) of the public sector found that the opening hours of the clinic were not accessible for the poorest households. Members of these households often worked through the day to provide for their families, and therefore could not use the provided services. Vu and Le (1999) found that private physicians were more willing to visit patients at home, give credit and receive payment in forms other than cash.

Quality

As seen in the adapted Four A's model, quality of care is an important factor in the decision making process for healthcare utilization, and it is a powerful incentive for households to overcome healthcare costs or other barriers to care, including distance (Ensor and Cooper 2004). Quality of care can be defined in terms of price, adequate drug supply, convenience, as well as staff attitudes (Tipping and Segall 1996; Samuelsen 2004). A study in India of maternal healthcare use found that socioeconomic status was not a barrier to use, when there was a perception that the benefits outweighed the costs (Griffiths and Stephenson 2001). Using data from the 2002 Demographic and Health Survey of Vietnam, Do (2009) studied the decision making of mothers in the use of skilled birth attendants from either private or public providers. The study found that

the perceived quality of services and socioeconomic status were major determinants in utilization. These findings were supported by a study conducted by Duong et al (2004) of households in rural Vietnam that found that the poor quality of service provided by the CHC was a key determinant for the low rates of delivery service use, rather than geographic accessibility.⁸ Tuan et al (2005) study of Vietnamese healthcare provision in both the private and public sector found that over-utilization of tertiary health sectors and high rates of self-medication were associated with the low quality of care provided by the CHC.⁹ This is confirmed by Dollar et al (1998) in their analysis of the VLSS, which found that those seeking care at the CHC are more likely to be faced with severe drug shortages and only have a 10 percent chance of being treated by a doctor, hence their selection of other providers.

Alternative Choices: Self-Medication and Private Providers

It is because of poor quality and limited availability of the public sector that households are turning to self-medication and private providers (Fritzen 2007). Drug vendors and private providers are more available both in terms of location and hours of access, and are more likely to have the needed resources to respond to the needs of those seeking treatment (Segall et al 2000).

Self-Medication

Self-medication is found to be common among societies with histories of traditional healing, such as Vietnam (Fosu 1989; James et al 2006). The 2002 Vietnam National Health Survey showed that an estimated 54 percent of the population resorts to self-

⁸ Quality in this study includes adequacy of medical equipment, quality of drugs and clinical examination, communication and conduct of personnel and access to services (Duong et al 2004)

⁹ Quality in Tuan et al (2005) was based on three domains: structural (availability of equipment, drugs, and quality and quantity of health personnel), process of care (quality of performance in diagnosis and treatment) and system outcome (patient satisfaction)

medication (MoH 2007). Self-medication is prevalent in both rural and urban settings and across all income groups within Vietnam (Sepehri et al 2005). In an environment where the CHCs are challenged with retaining staff and maintaining adequate resources and the user is faced with the direct and indirect costs of formal care, self-medication is an attractive option (Schmidt 2008). High rates of self-medication also relate to accessibility and affordability of drugs, made possible in this context of a flourishing market of uncontrolled pharmacies (Witter 2006; Hoa et al 2007). With this demand for drugs, market forces generate drugs that are cheap and easily accessible, feeding the existing cycle of self-medication (Chang and Travedi 2003).

Private Providers

Households frequently use private practitioners, especially when the quality of public providers is perceived to be poor (Bloom 1998). Hong Ha et al (2002), using data from the second Vietnam Living Standards Survey (1998), found that 60 percent of outpatient contacts used privatized care. Giang and colleagues' (2003) confirmed this finding, with the reported use of private facilities surpassing that of public facilities in their sample. A study by Do (2009) found that private sectors in rural areas did not necessarily provide better care compared to the public providers, but the poor and less educated tended to use the private services because public services were not accessible.

The use of private services in Vietnam is a growing phenomenon for many reasons. The quality of care is perceived to be better than that available from public providers, and they are at times more accessible and even more affordable. A recent study by the Ministry of Health found that in 2004 there were 23,000 private pharmacies and outlets and up to 64,000 private health facilities (MoH 2007). The two largest groups of

registered private providers are drug vendors and general practitioners, though many have not formally registered. Researchers estimate that some provinces may have twice the number of private providers versus public providers (Lieberman and Wagstaff 2009). As an example, a study of private providers found that only 20 percent registered their practice with the government, 11 percent had no professional qualifications, and 58 percent provided treatment while selling medications (Tuan et al 2005). Similarly, Hong Ha et al (2002) confirmed that the cost of using private healthcare facilities was less than half that of using public providers. Deolalikar (2002) found a trend with the poorest households more likely to use the CHC, but with increasing income, households were more likely to use hospitals and private physicians.

The literature on health seeking behaviour and healthcare utilization in Vietnam paints a picture of poor public services and increasing use of private providers and self-medication. This thesis will attempt to understand the process of decision-making by caregivers, given the options of private, public and self-treatment. The role in these processes of factors such as quality, cost, and government policies, including which are most important when making choices will be examined in both rural and urban settings using a sample of Young Lives households.

Chapter 3

Methodology

3.1 Young Lives Project

The Young Lives Project is a longitudinal study of children in poverty from four countries: India, Ethiopia, Peru and Vietnam. Qualitative research with a sub-sample from both cohorts began in 2007. In each country 50 children and caregivers were interviewed using various methods, including individual interviews and focus groups (Crivello et al., 2009). Due to the nature of Young Lives as a multi-disciplinary research project, data gathering in both the qualitative and quantitative approaches provides broad insights into children's lives covering health, education, economics, social capital and wellbeing at individual, household and community levels.

Young Lives does not attempt to provide nationally representative data as it only works in five provinces (Lao Cai, North East Region; Hung Yen, Red River Delta; Da Nang, Central urban; Phu Yen, South Central Coast; and Ben Tre, Mekong River Delta) (see Nguyen, 2008 for further information on sampling). Instead it provides in-depth insights into the key factors and experiences that shape the lives of children and families living in poverty (Wilson et al 2006; Boyden 2006).

3.2 Qualitative Methodology¹⁰

Of the 20 sentinel sites,¹¹ four were selected for the qualitative study. Pacheo (Lao Cai):¹² a mountainous rural northern province of the H'mong ethnic minority; Long Hung (Hung Yen): a populous peri-urban delta region in the north close to Hanoi; Chinh Gian (DaNang): a rapidly urbanizing coastal province and home of the third largest city; and Suoi Bac (Phu Yen): a rural southern coastal province with high rates of poverty and ethnic minorities. In total, 30 caregivers and children aged 6-7 were interviewed from the younger cohort, 20 caregivers and children aged 11-12 from the older cohort, as well as key informants in the health and education sector.

The first round of qualitative research took place in autumn 2007.¹³ Caregivers,¹⁴ the majority of which were mothers of the Young Lives children, were interviewed through individual interviews as well as in focus group discussions. Key informants, such as the Heads of CHCs, were also interviewed in each site. The interviews were recorded, transcribed, translated into English, and checked to ensure accuracy. The themes of the interviews and focus groups ranged from school transitions, time use, education

¹⁰Sentinel sites in each region were selected based on pro-poor criteria related to the poverty ranking in each commune. These rankings were based on infrastructure, percentage of poor households and child malnutrition status. In order for the sentinel sites to be eligible for participation in the study, key criteria such as pro-poor sampling, representation of common regional features, commitment from local government, feasibility for research logistics and population size were required. A total of 31 communes were selected for the country sample, which, in addition to the above mentioned criteria, represented rural, urban and mountainous regions, was pro-poor, and sites that had a unique factor such as natural disaster and consequences from the war. The households within these communes were then selected randomly, after a list of eligible households was generated. For further details on qualitative sampling and methods see: Phuong, T.A. and Huong, L.M, 2008,

¹¹ Pseudonyms are used when referring to the names of the sentinel site communities.

¹² Given the poor quality of the Pacheo transcripts and the limited grounds for comparison with other communities, data from this research site will not be included in this analysis

¹³ In collaboration with Vietnam's Social Science Academy, 18 student researchers in social work, sociology and community development were employed from Ho Chi Minh City. These researchers were trained by two qualitative researchers from Oxford University

¹⁴ In interviews where this is not the case, it will be highlighted in the results section.

expectations, wellbeing and ill-being, and health and healthcare (Phuong and Huong 2008).

3.3 Methods of Analysis

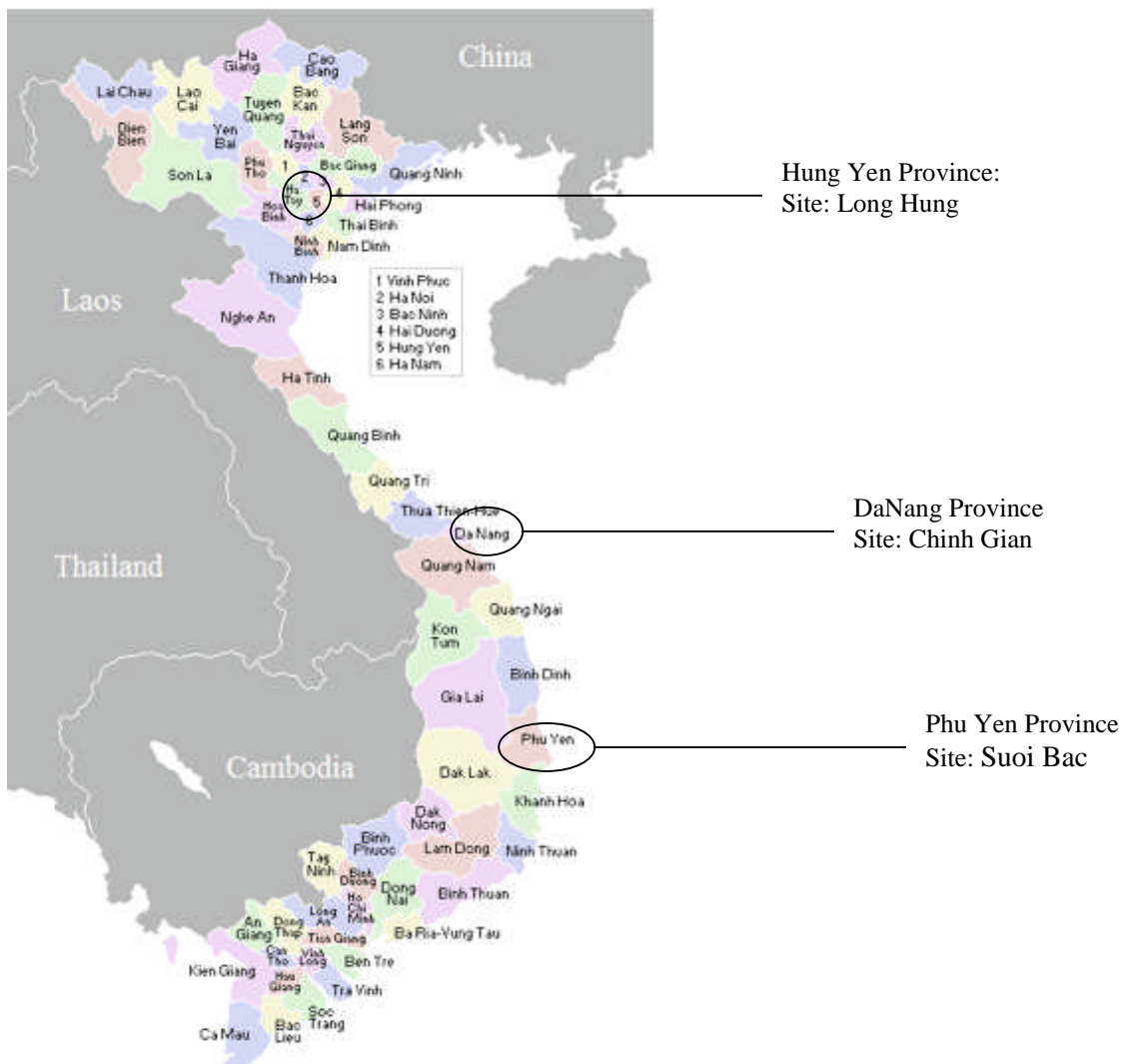
Analysis of quantitative variables from the Round Two data was done using STATA 10 to provide relevant descriptive community characteristics such as parental education, classification of poor households, consumption index,¹⁵ illness, and percentage of household expenditure on healthcare (see Table 2). The analysis of qualitative transcripts provides the bulk of the data for this thesis, namely translated group and individual interviews for caregivers of both the younger and older cohort children and interviews with the Head of the CHC. As healthcare was an area of interest for the qualitative research team, data was gathered during both the caregiver and child interviews. Given the nature of the questioning and the variability of researchers' methods of inquiry, however, children's transcripts (and some of the caregivers' transcripts) were not sufficiently forthcoming to be included in this analysis. The excluded transcripts did not provide adequate reliable data to conduct analysis from the perspective of children. The analysis is therefore based on caregivers and the Head of the CHC in each commune. In total, 31 transcripts are used, with another 15 sets of researchers' notes from where audio-recording had failed (see Table 2).

¹⁵ Consumption Index: Sum the estimated value (approximated to the past 30 days i.e., a month), of food (bought + home grown + gifts/transfers) and non-food (excluding durables such as furniture, gold jewelry and one-off expenditure). [R2, HH questionnaire section 4] This monthly figure is then divided by household size.

Table 2: Qualitative Transcripts

Site	Number of Translated Transcripts (caregivers + CHC)	Excluded: Only summary provided or insufficient interview transcripts)	Usable Transcripts
Suoi Bac	7	0	7
Long Hung	17	5	12
Chinh Gian	22	10	12
Total	46	15	31

Figure 3: Map of Vietnam (Sites Highlighted)



Manifest content analysis, which can be described as analysis and review of the visible, obvious components of the text and interviews, was used in this research (Kondracki et al 2002; Graneheim and Lundman 2004). This differs from latent content analysis, which involves searching and interpreting underlying meanings of the text and would not be appropriate with translated material (Kondracki et al 2002). The framework for the analysis, particularly of the thematic categories and domains, was based on the literature review, which guided my investigation. The content analysis framework was loosely based on the six key steps outlined by Pope et al (2002): familiarization, identifying key thematic frameworks, indexing, charting and mapping and interpretation. The transcripts were printed and reread multiple times prior to distilling the content, which involved highlighting all health and healthcare related sections that were then extracted into another document. These sections were then categorized into four main areas: main choices of provider when ill, reasons behind choice (quality and accessibility), quality of health commune centre, and insurance and related exemptions. Following the broad categorization of the related text into 'key thematic areas', the sections of the transcripts were then indexed based on specific domains. These domains related to the specific types of care: private, public CHC, hospital and self-treatment; and reasons behind choice in relation to quality and accessibility as well as perception of the CHC on those same quality and accessibility components.

3.4 Fieldwork

Fieldwork in Vietnam consisted of initially participating in a sub-study with children from DaNang, where I familiarized myself with the cultural context and qualitative methodologies. I visited the Young Lives Project office in Hanoi, where I met with leading researchers on Vietnam's health system: Dr. Hoa Dinh Phuong and Dr. Khe

Nguyen Duy (Ministry of Health – Department of Child Health), Dr. Toan Ngo Van (Hanoi Medical University), and Mrs. Hang Mai Thuy (Save the Children). These informal interviews were invaluable in providing resources that otherwise would not have been accessible, instruction and guidance in the history of Vietnam's healthcare provision, and current key research and issues relevant to the current discourse. While in Vietnam, I also had the opportunity to informally observe and discuss healthcare choices with Vietnamese colleagues, friends, and acquaintances. On a day-to-day basis, I noted anecdotally the presence of pharmaceutical companies in the city streets and television programming, and pervasive presence of private practices in between local cafés and fruit markets in urban settings. This experience was crucial to developing a local understanding of the current climate of healthcare in Vietnam, as well as understanding the key issues which local researchers and government officials thought were relevant to the present period.

Chapter 4

Results and Analysis

4.1 Overview

The transcripts from Young Lives Project qualitative interviews provide insight into healthcare utilization in Vietnamese communities through the perceptions of caregivers and heads of CHCs. The evidence for this thesis draws on responses to three key questions during interviews: What do you do when your child is sick? Why do you choose this specific provider? What are your thoughts on the quality of care of the CHC?

When analyzing the interviews, several limitations of the data had to be considered. Some caregivers provided extensive and descriptive responses while others gave short answers, so presenting the view of caregivers requires one to rely on comprehensive transcripts to illustrate the key themes. To provide a structure for analysis of interview transcripts, frequency counts, in regards to the type of healthcare provider selected, were used to highlight key themes that relate to the choices of determining primary choice of treatment and care.

The presentation of the results of analysis proceeds as follows. An overview is given of the research sites where Round 2 quantitative data was collected.¹⁶ The results are discussed separately for each site to respect their individual characteristics. In the last section, however, experiences of government policies to help the poor and children under 6 will be discussed across the cases of Long Hung and Chinh Gian. The bulk of

¹⁶ Round 2 data gathering occurred in 2006/7 and consisted of individual interviews with caregivers and children through the use of a questionnaire.

the data is drawn from caregivers in Long Hung and Chinh Gian, and those from Suoi Bac are also included.

4.2 Site Overview: Long Hung, Chinh Gian, Suoi Bac (see Table 3)

Chinh Gian is the only urban center selected for this study. Located in the central coastal region, it is a site of rapid urbanization, international investment and tourism development. Caregivers in this sample have relatively high rates of education (the highest among the qualitative sites), with an average of 11 completed years for the fathers and 10 years for the mothers. Approximately 12 percent of all households in the sample are considered 'poor' by national standards. The average consumption per capital index is in the top quintile, relative to other Young Lives sites. Though it is among the wealthiest in the sample, there are high rates of reported illness among the caregivers, with 23 percent of fathers and 25 percent of mothers reporting serious illness in the previous four years. Caregiver-reported child illness is also high with 14 percent experiencing long-term illness and 3 percent of children having some sort of severe injury or illness in the last four years. 12 percent of average household expenditure is on healthcare.

Long Hung is a peri-urban northern site near Hanoi and the Red River Delta. The rates of education are above average for the Young Lives sample, with both parents receiving an average of 9 years of schooling. As a province with a small percentage below the poverty line, only 3 percent of the households report that they are considered poor by the government standards. The consumption index per capita for this site was in the fourth quintile. Of those in the younger cohort that have a medical card, 55 percent state

that they have not used their exemption card for their children under the age of 6. Overall, an average of 14 percent of reported household expenditure is on healthcare.

Suoi Bac is a rural site situated on the southern central coast. Within the Young Lives sample, 41 percent of the households are considered poor by government standards. The consumption per capita index this sub-sample relative to the rest of the sample is in the third quintile. The caregivers in this site have relatively low levels of education, with four years completed for the mothers and six years for the fathers. Levels of reported parental illness are above average ranging between 10 and 18 percent, for fathers and mothers respective. The reported illness of other household members is over 50 percent. Reported child illness and injury is under 10 percent of the sample population, and 80 percent of caregivers for the younger cohort report using their child exemption card to obtain healthcare for children under 6. Within the Young Lives sample, 25 percent of total household expenditure is on healthcare costs, which may be evidence of catastrophic spending.

Table 3: Site Statistical Overview

	Long Hung (n= 144)	Chinh Gian (n=148)	Suoi Bac (n=145)	Young Lives Sample (n=2946)
Type	Rural	Urban	Rural	
Percentage of HH registered as a 'poor household' by government	3 %	12 %	41 %	19 %
Education of mother (years)	9	10	4	8
Education of father (years)	9	11	6	7
Ethnicity of mother:				
Kinh	99 %	100%	51%	87 %
Other	-	-	49%	8 %
H'mong	-	-	-	5 %
Mean Consumption Index per capita (quintile)	606 (4 th)	809 (5 th)	375 (3 rd)	491
Illness of mother (last 4 years)	6 %	25%	18 %	9 %
Illness of father (last 4 years)	8 %	23%	10%	8 %
Long-term illness of child (last 4 years)	9 %	14%	3%	10 %
Severe illness or injury (last 4 years)	1 %	3%	8 %	5 %
Percentage of access to CHC	100%	100%	99%	99 %
Percent of household expenditure on healthcare	14 %	12%	25%	17 %

Source: Young Lives Vietnam Dataset Round 2

4.3 Qualitative Results

Long Hung

When caregivers are asked how they respond to the illness of their child or other family member, all but one caregiver describes the use of either the hospital or private doctors as the primary source of care relative to the commune health clinic (CHC). Only one caregiver describes purchasing medicine instead of using the CHC.

The CHC is not the first choice of caregivers in the treatment of their children. Caregivers, when comparing the CHC to hospitals, consistently refer to CHCs having few resources or trained staff. The head of the CHC confirms this perception, explaining that “to handle a commune with 12,000 inhabitants, the local medical station seems to

be overloaded with only 5 working staff and 1 additional staff who has not been experienced enough ... however, we always try to fulfil the task.” In terms of treating minor illness, however, two households describe the CHC as being sufficient. Mr. Dinh,¹⁷ a 70-year-old grandfather taking care of three of his grandchildren, remarks: “some units have recently been repaired. Looking good enough. For normal diseases they [CHC] can treat but for heavier cases they forward to the upper level.”

The strain felt on the CHC influences caregivers’ perceptions of its quality and subsequently influences their choice of care. During a group interview of eleven caregivers, the interviewer summarizes their opinions into the following: a need for more doctors, equipment not being sufficient in quality and quantity, it taking too long to be examined and frustration about not being adequately cared for when sick.

During individual interviews, these same issues are again stated: “Medical equipment in our locality should be reviewed and upgraded,” describes Mrs Phan, “so that, when getting ill, children will be taken to the health station nearby, no need to go far for medical examination and treatment.” Mrs Tran, adds that “the health station should be improved... [it] lacks many modern facilities.” When asked about the quality, Mrs Phung, describes it as “not really good, in general, there is a need of a lot of things over there...” Mrs Nguyen says: “Its facilities are poorly equipped in comparison to big hospitals. It lacks both doctors and equipments. I am surer that even doctors in the local hospitals aren’t as good as doctors of central hospitals.”

These perceptions are confirmed by the Head of the CHC, who describes the current situation as a condition of ‘inefficiency’: “In order to implement the work well, to make

¹⁷ All names in the results section are pseudonyms generated by the qualitative research team.

it easier for the local people to access initial healthcare service...facilities should be upgraded” and an “increase in qualified manpower [doctors and nurses]” is required.

For these reasons, when deciding upon healthcare for their children caregivers usually choose either the hospital or private doctors. Mrs Do, a mother of three, describes how “when my child get sick, I do not take her there [CHC]. I take her either to the suburban district-level hospital or up to Hanoi for better medical examination. In our locality, healthcare equipment and facilities are not so good.”

Mrs. Nguyen, a mother of a young boy who had recently fallen ill, describes the process of going to a hospital for medical examination. Living in financial difficulty relative to other households in the community, she nonetheless bypasses the CHC located 2.5 kilometers away to travel to a hospital further away, “I go straight to the hospital, or I get the village doctor here unless I need an ultrasound test, I have to go to hospital.”

Another caregiver, Mrs. Do, also describes her choice:

If child gets ill and need to see the doctor, we usually go to the hospital or go to Hanoi for medical examination. We seldom go to commune-level healthcare station or in most cases we ask doctor to make home visit. People often go to commune level healthcare station mainly for vaccination.

The other main option among caregivers in this sample is to use private providers. Private doctors who are either retired, working both in the public and private sector with after hours clinics, or purely private physicians, are consistently preferred over the CHC and are used more frequently than hospitals. The head of the CHC describes the private practices available in the commune:

In our commune, there is a lady doctor who works for a hospital in Hanoi as the assistant head of pediatric ward. She receives a lot of patients. Besides, there are two other doctors and a herbalist. But most people choose the lady doctor.

The reasons behind the use of hospitals and private physicians and clinics in Long Hung relate to the severity of the illness, convenience and quality. Although cost is mentioned, the quality of treatment appears to be of greater importance. As a site located close to the capital city and among the wealthier of the sites, households have increased access to secondary and tertiary public care and private physicians.

The cost of a private doctor is reported to be between 50,000 to 70,000 Dong compared with the 20,000-30,000 Dong cost of using the CHC.¹⁸ The head of the CHC notes that many accept the extra cost because “they give them advanced medicines.” Given the cost of private care, the head of the CHC perceives that it is not utilized by poor households: “Rich families usually go to private doctors, because it saves time and take effect quickly. Poor families choose medical insurance.” The experiences of caregivers in this sample suggest otherwise, however. This research shows that poor households frequently visit private clinics and retired doctors. Although Mrs Duong is described by the person who interviewed her as visibly poor and struggling to feed her family, she also prefers private doctors and explains that it is the trust and qualifications of the doctor that make them an attractive option: “Private doctors are also doctors working in district hospital. They do extra work at home in their free time, so parents do not worry much about their professional skills and knowledge.”

Another example of a poor family using private physicians is Mrs. Tran, a caregiver living in a household listed among those ‘living in poverty’ by the government:

Interviewer: Do people around here usually go to the health station [CHC]?

Mrs. Tran: Rarely. They usually ask retired doctors for help.

Interviewer: Why?

Mrs Tran: It’s more convenient to stay at home. Going to the clinic means I

¹⁸ 17,500 Dong = 1 USD

need other people to take care of me.

Mrs. Phung, whose primary source of income is cultivating oranges, also describes her choice of using private doctors:

Mrs Phung: There's a retired doctor, he visits you at home and checks your health status and you don't have to go to the health station. They are the same. It is not easy to get benefit from the local health station even though we contribute to it very often by rice.¹⁹

Interview: Does it cost a lot if people use the private clinic?

Mrs Phung: It does, but it's worth it... we do have to pay too if we want the doctor or nurse in the local health station to visit us. If we don't pay, we don't get good health checking and medicines.

Self-medication is mentioned as a treatment option for households, but because questions focus on the quality of the CHC and the use of private providers, it is not explored further.

The interviewees highlight concerns with the adequacy of the care provided by the CHC and express a desire for a better-equipped health station in their commune. In the meantime, households are utilizing private services and higher-level hospitals, even in the face of higher costs for care. As discussed below, quality and access are also common themes in the urban site.

Chinh Gian

In Chinh Gian, a community with a rapidly growing urban center, caregivers most frequently state that they would bring their ill child to the nearby district hospital. The use of the CHC is mentioned only in the context of either buying drugs or vaccinating their children. Self-medication is proposed as the first line of treatment for minor illness

¹⁹ The contribution of rice is part of the CHC's environmental hygiene policy. Six individuals in the commune are hired to collect garbage throughout the community. Each individual receives payment in the form of 600kgs of rice and a monetary salary equivalent 15 USD every month.

among half of the respondents. A potential reason behind the high rates of hospital use in this region is the increased accessibility of hospitals, with both district and general hospitals in close proximity.

The head of the CHC explains that “people rarely come to the [CHC] to have a check up, they often go to hospital because they believe that it is better to come to hospital with advance medicines.” She later adds that “it is inconvenient for [patients] to be transferred to the hospital. If everything is done at the [CHC], both staff and patients [would] feel more comfortable.” As it is now, they go to the clinic and “must be transferred to another place.”

Mrs Tran, who also prefers using the hospital over the CHC, describes that when her child suffered from a bladder infection “I took him to the local healthcare service [CHC] to [be] examined and was prescribed with some medicines. Yet, the disease has not been cured up to now.”

The limited usage of the CHC in this site may be explained by its poor accessibility, as it is only open for treatment in the morning from 7:30 a.m. to 11 a.m., Monday to Friday. If sick people come in the afternoon, they are referred to the hospital as the afternoon is scheduled for health promotion activities. This is a source of frustration for many caregivers. Mrs Mai, for example, receives free insurance because of her family’s classification as a poor household, and describes that she has to buy medicine because “we don’t have time. They only work in the morning, but I have to [do] things in the morning: how annoying!”

Among the interviewed caregivers in this site, health insurance is consistently discussed, whether households decided to use it or not. However, benefits of insurance are disregarded depending on the severity of illness due to the processes involved in using the services. “In the case they have some trivial illness,” describes Mrs Bui, “I will buy medicines, sometimes they cost only more than 10,000 Dong; the kids will recover after taking the medicines for some days.” She later adds, “I don’t wait for insurance.” The likelihood of caregivers self-medicating when illness is perceived to be trivial can be understood in the context of insurance coverage for prescription drugs at the clinic. The head of the CHC describes the role of the insurance programme to cover the cost of drugs up to 30,000 Dong (approx. 2 USD) per prescription.²⁰

The primary choice of care is hospitals, with private physicians as the secondary option. With negative experiences of the hospital, caregivers turn to private providers. For example, when Mrs. Phan’s child became sick with a fever, he was taken to a hospital for treatment. In her opinion, however, he did not get better. She states that now she rarely goes to the hospital because, “when we went to the hospital, they gave us bad medicine so we went to the private doctor’s... we feel more comfortable when coming to the private clinic.” This is a theme that reoccurs in the caregiver transcripts, with perceived quality being a major determinant of treatment options.

In both Chinh Gian and Long Hung, quality of care is often related to the “strength” of the drugs provided. Prescriptions and drugs are mentioned in every interview as the means of treatment for any condition. They appear to act as a common indicator for adequate treatment. Regarding the quality of treatment received at a Long Hung CHC,

²⁰ The availability of drug vendors is somewhat astonishing in Chinh Gian. From personal observations of one main street in the city, there were approximately five vendors along four blocks, all fully stocked shelves with prescription and non-prescription drugs.

Mrs. H, referring to drugs, remarks, “treatment is so light it cannot make the children be well again.”

In another conversation regarding the quality of services offered by the CHC, the distinction between foreign and domestic medicine is used to describe the lack of provisions available at CHCs. “Let’s take medicines as an example,” explains Mrs. Dang from Long Hung. “There is only domestic medicine and there is not any imported medicine.” Mrs. Mai from Chinh Gian describes the limitations of the CHC in similar words: “They only give weak medicine at the health station [CHC], when I give these medicines to Mrs. H [commune committee member] she said the medicine is not strong enough to cure the disease; we have to buy foreign-made medicine.” The head of the CHC in Chinh Gian, when describing the reasons behind decreased use of the CHC states, “they think that medicines are insufficient for patients.”

These discussions contribute an added dimension to our understanding of the perceived quality and accessibility of care in these sites. Further study is needed of how perceptions of prescription drugs relates to choice of healthcare providers. Such research would have to take account of the role of pervasive pharmaceutical advertising within these communities.²¹

Suoi Bac

As a rural mountainous community with the majority of its population living under the poverty line, Suoi Bac differs both geographically and economically from Long Hung and Chinh Gian. However, within this sub-sample of Young Lives caregivers, the most

²¹ Pharmaceutical companies have largely invested in advertising both on billboards and television. While watching 10 minutes of TV, one would be exposed to roughly 6 different drug companies advertising for skin care, energy, depression, etc. The major city centers are also bombarded with advertising for various drugs and treatments.

common choice for the treatment of illness is still the hospital, with private clinics and CHCs as the next most likely places for treatment.

Mrs Truong, a mother of three children, describes her reasons for not taking her children to the CHC: “The hospital offers better and safe services. The doctors are more qualified. Nurses at the communal clinic aren’t as good as the hospital’s staff.” Mrs. Tran, a local farmer and member of the H’Roi minority, notes that the choices she makes for her children depend not just on quality of services provided but on the severity of illness of her two sons, “If he is not too ill, I bring him to the medical station[CHC], but mostly I bring him to the hospital.” This is reiterated by Mrs. Dang (also a member of an ethnic minority): “If we’re sick, we go to the [CHC]. But if our illness is serious, we’ll go to the hospital in town.”

Insurance Coverage

Three themes relating to insurance emerge from the transcripts: the under 6 coverage, exemption of user fees for poor households, and the purchase of compulsory health insurance.

Households with the poverty status required to be a recipient of government healthcare coverage discuss the benefits of that coverage. Other households that were poor but had not acquired the necessary government documentation highlight a gap between many poor households and the required official recognition needed to obtain benefit packages.

Mrs. Dang from Suoi Bacg provides an example of the limitations of government implementation of its Fund for the Poor. As a mother of four working as a subsistence farmer, she describes the results of being on the poverty reduction list:

Interviewer: Do you have any document that proves you are on the poor families list?

Mrs. Dang : No, we haven't been given any such thing.

Interviewer: Are your children exempt from school fees?

Mrs. Dang: No, we have to pay unless we have the document that proves that we qualify for the poverty reduction policies.

The Young Lives interviews took place when the children were between the ages of 5-6 and 11-12, so many families were in the midst of a transition between having their child covered under that policy to losing that benefit within months. Transitioning out of the government protective policies can place families in a precarious position. This can be illustrated by a case study of the Luong family from Chinh Gian, who were relocated from their previous home (the prospective site for a new supermarket) into a small brick home with a leaking roof. They adjusted to the transition by moving Mrs. Luong's shop, and Mr. Luong found new customers for his barber services. As a household constantly struggling for financial stability, providing for their family has been difficult. Only able to send their child to pre-school due to the kindness of their neighbour, they have benefited from the Fund for the Poor. However, in 2007 the commune leader decided that they were no longer in sufficient financial difficulty, proceeding to remove their state-provided insurance coverage. They cannot afford the premiums of the voluntary insurance.

Another government policy covering children under 6 has provided assistance for all applicable families in the study, with frequent reference by respondents to the use of the *Children under 6* policy 'medical insurance card', allowing free medical care and check up for their children both at the CHC as well as higher level hospitals. Mrs Phan from Suoi Bac describes, "We have health insurance that offers free treatments for children under six. We only had to pay for the traveling costs". However, this coverage does not

continue after age 6, which means that households need to take out insurance. The Ly family, also from Chinh Gian, but in a better financial condition, describes this process:

Interviewers: But when the child was under 5 years old, she was issued the health insurance care free of charge, wasn't she?

Mrs. Ly: Yes, that's right. But she now is older than six, so we have to pay.

Interviewers: did you pay money for the child's health insurance?

Mrs. Ly: Yes, I did. I just paid for health insurance. I didn't have money for body insurance.²²

Among the respondents in the sample, only one discussed the concept of requiring referrals from the CHC to access higher levels of care. Mrs. Truong from Suoi Bac describes how “the medical station just needs to write a letter of introduction, and then patients can move to the town hospital, and then province hospital if needed. In brief, it's not difficult.” The heads of the CHC also firmly enforce the referral process for those seeking insurance to receive their exemptions. The head of a CHC in Chinh Gian describes that children under 6 receive free medical care, “but must start at the commune line before go further to the central line” in order to benefit from that scheme. However, as seen in the above discussions, the role of the CHC has become increasingly negligible for treatment, particularly for children aged over 6. Even in communities without much choice it serves primarily as a pharmacy and vaccination centre.

²² Body insurance refers to accident insurance. There are two purchasable forms for children in school: health insurance and body insurance. Body insurance covers accidental death and the use emergency services.

CHAPTER 5

Conclusion

This study used qualitative data from interviews with children's caregivers from the Young Lives sample to analyze how perceptions of quality and access to care have been influenced by healthcare reforms in Vietnam. What is especially apparent from this study is that the private sector is of increasing importance in both rural and urban areas, and it cannot be neglected in the analysis of healthcare provision in Vietnam.

Most significantly, the widespread use of private providers by those considered 'poor' by government standards provides grounds for further research. These findings highlight misconceptions that only the poor use the CHC. A point of concern is the perceived quality and provision of drugs, and the significance of their role in treatment. The phenomenon of reliance on high dosage and foreign made pharmaceuticals is widespread, particularly with Vietnam's neighbour, China, which also has increasing concerns of over prescription (Shaokan et al 1997).

The study also highlighted how poor people can fall through the gaps of public health insurance. Dahlgren (1999) estimates that 28 million Vietnamese are too poor to pay for hospitals fees but not sufficiently poor to be exempted from the user fees. This brings attention to the potential gap that exists for future healthcare seeking behaviour as private providers take an increasingly dominant role in care provision.

Caregivers consistently discuss the importance of quality of care as they seek care for their children. This highlights the role of perceived quality in leading caregivers to overcome potential barriers of cost and distance to ensure that adequate treatment will be provided. There was also evidence in this study that perception of poor treatment led

to changes in healthcare choice, whether from the private sector to the public or vice-versa. The views of caregivers and heads of CHCs on the poor quality and accessibility of care are confirmed by the Ministry of Health's recent report (2007), which found that the CHC performs poorly in almost all domains of care and attributes this decline of care to lack of staff. This is confirmed by Bloom (1998), who describes how loss of skilled personnel and lack of medical supplies has been a major source of deterioration of the utilization of CHC services.

The government is determined not to lose the role of the CHC and is attempting to find new means to improve accessibility in primary care provision and subsequently decrease the workload of the public hospitals. Its current policy aim is to achieve commune health clinics for all by 2010 (Fritzen 2007). In response to the demand for greater accessibility and availability, the CHC may require a review of its working hours to provide care for those in greatest need, particularly the poor who cannot afford to miss work (Segall et al 2002).

Overall, this thesis provides fresh insights into health seeking behaviour within the current period of Vietnam's healthcare reforms. It draws attention to further areas of research, including the role of exemption policies when selecting care, the quality of drugs being prescribed, and the potential role of CHCs in responding to the needs of the community.

Though these findings cannot be generalized to the Vietnamese population, they highlight the challenges that CHCs face when providing healthcare for their population. They indicate that caregivers seek the best possible treatment for their children, whether

it involves extra cost or distance, and that the role of the CHC is increasingly marginal. This study also highlights the desire of caregivers to have an adequate CHC in their communities that is both enhanced in terms of human and material resources as well as more accessible. Improving trust in and perceptions of CHC care has the potential to be a major influence on the health seeking behaviour of families, poor and wealthy alike. Improvements, however, must be done in a context of monitored private practitioners to ensure adequate provision of care and increasing regulation of pharmaceutical companies. Given the current health seeking behaviours found in the literature and this study, Vietnam still faces the challenge of reconciling market principles to socialist ideals.

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