Original Research

User fees and health service utilization in Vietnam: How to protect the poor?

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Summary

Objectives: Vietnam started its health reform process two decades ago, initiated by economic reform in 1986. Economic reform has rapidly changed the socio-economic environment with the transition from a centrally planned economy to a market-oriented economy. Health reform in Vietnam has been associated with the introduction of user fees, the legalization of private medical practices, and the commercialization of the pharmaceutical industry. This paper presents the user fees and health service utilization in Vietnam during a critical period of economic transition in the 1990s.


Methods: The concentration index and related concentration curve were used to measure differences in health service utilization as indicators of health outcomes of income quintiles, ranking from the poorest to the richest.

Results: User fees contribute to health resources and have helped to relieve the financial burden on the Government. However, comparisons of concentration indices for hospital stays and community health centre visits show that user fees can drive people deeper into poverty, widen the gap between the rich and the poor, and increase inequality in health outcomes.

Conclusions: An effective social protection and targeting system is proposed to protect the poor from the impact of user fees, to increase equity and improve the quality of healthcare services. This cannot be done without taking measures...
to improve the quality of care and promote ethical standards in health care, including the elimination of unofficial payments.

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**Introduction**

After the Declaration of Alma Alta in 1978, ‘Health for All’ was the core agenda of the World Health Organization. The Declaration shaped major changes in health policy in developing countries, which aim to improve health and to ensure the availability of primary health care for the most disadvantaged people in the world. The goal of ‘health for all’ also underlies health reforms proposed by the World Bank.¹ The objectives of these reforms are to improve equity, efficiency and effectiveness, and to build a sustainable healthcare system in both the for-profit sector and the public sector. The key components of health reforms promoted in the 1980s and 1990s were changes in financing methods, including the introduction of service charges or user fees and the decentralization of decision-making processes.² However, in developing and transitional economies, the introduction of user fees has not always been accompanied by an emphasis on social development.³ As a result, the implementation of user fees potentially contributes to inequality in health, education and income.⁶

In Vietnam, user fees raise revenue for public healthcare services which can no longer be provided for free given the shortage of the fiscal budget for health care due to the collapse of the cooperative system. Vietnam has experienced health reforms for two decades, initiated by economic reform (‘đoàn moi’ in Vietnamese) in 1986. ‘Đoàn moi’ significantly transformed the economy from central planning to a market-oriented economy. The reform also removed restrictions on the private sector and decentralized the decision-making processes. Under ‘đoàn moi’, health reform was associated with the introduction of user fees, the legalization of private medical practices and commercialization of the pharmaceutical industry. During this period, a major change in health and social policy was a shift from government subsidies to user fees. The health reform in Vietnam involved both the for-profit sector, mostly on curative care with the introduction of user fees, and public health administration and preventive care, which are under the jurisdiction of the public sector.

There have been positive outcomes, as user fees have contributed financial resources to health facilities and provided solutions to fiscal shortfalls.¹⁰ However, they have also created disparities in health service utilization and health outcomes among different socio-economic groups and regions, especially in remote mountainous and very poor areas.⁶,⁹ As a result, there is an urgent need to find a financing solution that creates a safety net for the poor to protect them from falling into impoverishment due to the rising costs of health care. At the same time, it is also important to provide all people with quality health services in order to ensure their well-being.

This paper focuses on addressing the following questions:

- How have user fees affected service utilization by the poor during the transition period of the 1990s?
- How have user fees influenced the poor and their health outcomes?
- How can the poor be protected from catastrophic health expenditures?

Using household survey data, this study found that user fees have a negative impact on service utilization by increasing inequality and catastrophic healthcare expenditures. It is argued that user fees can drive people into further poverty, widen the gap between the rich and the poor, and increase inequality in health outcomes.

This paper is divided into five sections. Section 1 introduces the objective of the study. Section 2 provides an overview of Vietnam’s healthcare system, together with its policies on user fees, health insurance and targeting system. Section 3 analyses the impact of user fees on service utilization and impoverishment. This section utilizes the Vietnam Living Standard Surveys (VLSS) 1992—1993 and 1997—1998 to construct a concentration index to analyse the utilization patterns and outcomes. Section 4 provides policy options, and Section 5 concludes with recommendations for changes in the healthcare system with a pro-poor orientation.

**Vietnam’s healthcare system**

The healthcare system in Vietnam is organized into four administrative levels (see Appendix 1). At the
national level, the Ministry of Health (MOH) is the highest government body. At the provincial level, there are provincial hospitals, maternal and child healthcare/family planning centres, and secondary medical schools. The provincial hospitals provide technical assistance to the district hospitals, and district hospitals supervise commune health centres (CHCs). The State budget spending on health care accounts for about 1.2% of gross domestic product, and 5.76% of the total State budget spending in 1999. In terms of total health expenditure, households account for 71% of total health spending in Vietnam compared with 34.6% in Thailand.

Policies on user fees

In Vietnam, a free healthcare system from central level to commune level was established in the north before 1975 and after reunification in the south. The Government provided and funded all preventive and curative care through community organizations, and cooperatives financed health care. Cooperatives were developed during the central planning period 1958–1986. They were the collectiveness of assets and labours, and were based on equal distribution. Cooperatives formed and operated under Central Government. During 1980–1990, Vietnam experienced socio-economic crisis because of the collapse of the socialist system in the Soviet Union and Eastern Europe, which resulted in a sudden cut of foreign aid. When the cooperatives collapsed, the basic healthcare system was also in trouble. Before ‘doi moi’, the cooperatives financed operation of the CHCs, which were used to provide free healthcare services for all people. The collapse of the cooperatives led to a budget shortage for the CHCs. The Government could no longer accept the fiscal burden of increasing expenditures. As a result, the Ordinance on Private Medical and Pharmaceutical Practices and the policy on partial hospital fees were implemented to sustain the healthcare system.

The first milestone of the introduction of user fees dates back to 1989 when the Minister Council issued Decision No. 45/HDBT stating that user fees would be applied to inpatient care, which includes nursing and hospital bed use, drugs, laboratory tests and technical services. User fees were gradually expanded to cover both inpatient and outpatient care, and have become a major financing source for health care. Out-of-pocket payment only contributed approximately 10% of the hospital budget in 1993, and this share increased substantially to 50% in 1997.

User fees in public and private health facilities

Public services

User fees raise revenues for public health services, particularly in public hospitals. They also bring benefits to health providers. About 25–28% of the revenues from user fees are allocated to health workers, resulting in an increase of 50,000–200,000 VND/month (US$1 = 15,000 VND) in health workers’ wages depending on the classification of the civil service system. Health workers are considered to be civil servants, and receive a basic wage similar to those working for the state-owned enterprises (SOEs). The civil service is classified based on academic degree, years of experience and work level, which scales from 1 to 8 (central, provincial, district or commune level). According to VLSS 1997–1998, the average basic wage for those working in SOEs was 734,550 VND and 217,320 VND for other benefits. According to Pham et al., the introduction of user fees motivated the healthcare system to improve management and finance. The introduction of user fees urges hospitals to enhance their management system to supervise the collection of fees and the procurement of supplies and equipment, and to maintain the financial balance. The finance and accounting departments of hospitals were mobilized to be involved in the planning process to increase the efficiency of cost recovery. However, there is no evidence that user fees increase the quality of care in the public health system. According to Pham et al. and Sepehri et al., despite the lack of prompt, thorough treatment and respectful attitudes (which constitutes quality of care) of health providers, patients have to pay informal fees in addition to user fees. These informal fees (i.e. under the table or envelope payment) add more burden to patients, especially in hospitals where this type of payment is reported to be even higher than the user fees. It is estimated that unofficial payments account for two-thirds of total expenditures. This payment is paid by patients both voluntarily and involuntarily in response to a discriminatory attitude and responsiveness of health staff. In addition to user fees, patients have to pay for direct official payments such as drugs, laboratory tests and other additional costs including food, transportation and accommodation for family members, and the loss of income of patients and accompanying family members. This is because when a sick person is admitted to hospital, the doctors and nurses will only provide examination and treatment. A care taker, typically from the patient’s family, has to accompany the patient
to provide food and all necessities and care. This poses a high cost associated with treatment if the hospital is far away from the patient’s house. All these expenses create a real burden for patients, especially for those from rural or remote mountainous areas.

Private services
In Vietnam, private clinics are typically praised for prompt treatment, easy accessibility and respectful behaviour of the health providers. Thus, in most cases, private physicians are the primary choices for patients. Using public hospitals is considered to be a ‘welfare stigma’ due to the lack of choice of services for patients. In private clinics, patients receive services of better quality as they are willing to pay out-of-pocket. There is no supervision of treatment protocols and no record keeping system, except for administrative procedures, in private practices. In 1993, after the implementation of Decision 45-HDBT, private clinics and pharmacies began to operate and then gradually expanded throughout the country, especially in major cities. Most private physicians are employed on a full-time basis in the public sector and work part-time in private clinics; thus, there is no clear boundary between the public and private sectors.

Health insurance and coverage
Vietnam’s national health insurance (NHI) was established in 1992 to manage insurance throughout the country with two forms of insurance: compulsory and voluntary. In 1999, 10.5 million people had health insurance, of which 6.9 million had compulsory insurance (66% of all insurers) and 3.6 million had voluntary insurance (34% of all insurers). Before the establishment of NHI, there was no voluntary health insurance. Three ministries including the MOH, the Ministry of Labour, Invalid and Social Affairs (MOLISA), and the Ministry of Finance (MOF) are responsible for compulsory insurance. Total health insurance programmes covered 13.77% of the country’s population in 1999, which increased from 11.8% in 1996.

Compulsory insurance covers the target population of current and retired civil servants and employees of state and private enterprises with more than 10 employees. It provides both inpatient and outpatient care benefits and also pays for drugs used for inpatient treatment (examination, tests and drugs within the list provided by the insurance company in agreement with the hospitals). However, it does not cover the costs of the accompanying care taker.

Premiums are the joint responsibility of employers and employees, with the employer paying 2% and the employee paying 1% of their official salary. This scheme covered 6.9 million people in 1999 (76.8% of the target population), via 66% of all insurers. In addition, social insurance also contributes to the financing sources of health care. Social insurance is also paid by employers and employees. The employer contributes 15% (of which 5% is used for paying sickness and maternity leave benefits, and 10% is used for retirement pensions, work accidents and industrial-related diseases, and survivor benefits) and the employee contributes 5% of their official salary.

The voluntary scheme still has low coverage, reaching only 5.34% of its target population, most of whom are children. In 1995, school health insurance was established as a joint effort between the MOH and the Ministry of Education and Training to provide voluntary health insurance for children, covering emergency health care, inpatient care and death. The premiums are low, ranging from 10,000 VND to 45,000 VND per year depending on regional socio-economic conditions, averaging about 40,000 VND, and accounted for about 1.2% of national average income per capita in 1998. This voluntary scheme reached 3.6 million in 1999 (5.34% of its target population), via 34% of all insurers. This scheme is quasi-voluntary as schools are under pressure from local authorities to enroll school children, who account for more than 90% of the membership.

It is recognized that insurance plays an important role in financing public health spending in Vietnam. Health insurance contributes 15% of the total hospital revenue. However, the compulsory and voluntary programmes do not reach the poorest people, which is evidenced by the fact that only 6% of the poorest individuals have insurance coverage, compared with 29% in the richest quintile (Fig. 1). Figure 1 also shows the distribution of all insurance enrollees, with 37% from the richest quintile and only 8% from the poorest quintile.

Targeting system and healthcare financing for the poor
The Government has issued policies to improve primary health care at the commune level and establish a targeting system for the poor. A targeting system is a mechanism related to raising revenues and improving equity. There are two types
of targeting groups: (a) characteristic targeting is the provision of free or reduced-price health services to groups of people with certain attributes, regardless of income level (e.g., children, patients with tuberculosis, pregnant women); and (b) direct targeting is the provision of free or reduced-price health services to the poor.

The direct targeting strategy was introduced by Decree 95/CP in 1994, which put into law that the poorest (representing approximately 30% of poor individuals) were partially exempted from user fees under the policy 'Health Care Funds for the Poor'. This targeting system involved the MOLISA, the MOF, the Pricing Committee and the People’s Committees, at different levels from commune to provincial, to identify the poor and provide them with a health card. Partial exemption implies that those who have a health card can be exempted from paying fees for examination and can be provided some drugs. **Figure 2** provides a chart of the Inter-Minister Circular 05/1999/TLTL-BLDTBXH-BYT-BTC on the implementation of partial exemption of user fees for health services. The health cost exemption was part of the Government’s National Target Programme for Hunger Eradication and Poverty Reduction (HEPR), which primarily provided subsidized credits to the poor to address some of the most pressing needs of poor households. In 2002, Vietnam introduced the ‘Free Health Card for the Poor’ scheme as part of HEPR. Central Government issued Decree 139/2002/QD-TTG on ‘medical examination and treatment for the poor’. The extremely poor are subject to receive a health card valued at 50,000 VND per year, which is paid for by funds from provincial People’s Committees. With a health card, a qualifying poor person will be entitled to free services including examination, certain simple tests and drugs worth up to 50,000 VND. The level of subsidization is at the discretion of the provincial People’s Committee. It is estimated that among the poor, 9.5% receive poor household certificates (certificates are granted to households living below the poverty line, ethnic-minority groups or those living in extremely difficult communes) and 9.9% receive health cards. There are many obstacles preventing the poor from receiving health services, including delays in the administration procedures associated with issuing the cards, inconsistent targeting criteria, and a lack of information from the poor to claim benefits.

**Impact of user fees on service utilization**

User fees have a large impact on the poor. They have created barriers to healthcare services, caused a greater financial burden to households, and even pushed the poor and the marginalized further into poverty. Data show that 45.6% of households in Tien Giang and 42% of households in Dong Thap provinces could not afford user fees. Another study by the NHI revealed that 34 million poor people could not afford a health card or payment for health services. The poor had a health service utilization rate of 30%,
compared with 40% for the rest of the population. Many poor people did not seek care when they became ill because they could not afford to pay the service charges.25

Inequality in health outcomes can be seen in child malnutrition, which is highest in the poorest quintile (34.2%) and lowest in the richest quintile (12.7%).23 The poor tend to have more severe illnesses compared with the rich, evidenced by the proportion of ill people who are unable to work, which is double in the poorest quintile compared with the richest quintile. In contrast, the poor are less likely to use health services. The average number of health service utilization visits per year for the poorest is 8.3, compared with 10.4 for the richest.23 The poor are more likely to use polyclinics (health facilities that provide healthcare services to several communes) and CHCs, while the richest are more likely to go to central and provincial hospitals which are better equipped and have better-trained physicians.

A major concern is that health payment should not drive households into, or further into, poverty. It is estimated that 5–10% of the population are vulnerable to fall into poverty due to common shocks, including healthcare payment for serious illness, failure of crops or investment (death of livestock), adverse movements in the prices of main agricultural commodities, unstable employment opportunities, and the occurrence of natural disasters.23 Between 1993 and 1998, most of the increase in the poverty gap was attributed to poor people getting poorer due to out-of-pocket payments, with non-hospital expenditures having a greater impact than hospital payments.26

To study health service utilization, concentration indices were constructed for hospital contacts and CHC contacts using VLSS 1992–1993 and 1997–1998. VLSS is a multi-purpose household survey that collects a wide range of information from all members in the household including household dynamic structure, economic condition, expenditures,
investment, etc. The sampling design for the household surveys is based on a random stratified sample of households. The selection of households is based on systematic sampling, with the probability proportional to size across provinces and communities. In each commune, households were selected from the registration list of all households. The concentration index uses two secondary data taken from VLSS: (a) distribution of service contacts with public hospitals (measured by the percentage of service contacts with public hospital for each quintile); and (b) distribution of service contacts with CHCs (measured by the percentage of service contacts with CHCs for each quintile).

The concentration index and related concentration curve are used to measure inequality in income-related health outcomes. The concentration index is used to measure differences in health service utilization (CHCs and public hospitals) as indicators of health outcomes of income quintiles, ranking from the poorest to the richest. The concentration index is computed using the following formula developed by the World Bank:

$$C = \left( \frac{p_1L_2 - p_2L_1}{p_2L_1} \right) + \left( \frac{p_2L_3 - p_3L_2}{p_3L_2} \right) + \ldots + \left( \frac{p_{t-1}L_t - p_tL_{t-1}}{p_tL_{t-1}} \right),$$

where $p$ is the cumulative percentage of the sample ranked by economic status, $L(p)$ is the corresponding concentration curve ordinate, and $t$ is the number of socio-economic groups. Table 1 provides the calculation of concentration index for hospital contacts, and Table 2 provides the calculation of concentration index for CHC contacts. A concentration index with a negative value indicates a disproportionate concentration of health service utilization among the poor, and a positive value shows a pro-rich concentration.

The concentration index is defined with reference to the concentration curve, with the cumulative percentage of the sample ranked by living standards, beginning with the poorest, on the x-axis and the cumulative percentage of the health variable corresponding to each cumulative percentage of the distribution of living standard on the y-axis. The concentration curve presented in Fig. 3 plots the cumulative percentage of health service utilization against the cumulative percentage of the income quintile. If everyone, irrespective of his or her living standards, has exactly the same value of health service utilization, the concentration curve is at 45°, running from the bottom left-hand corner to the top right-hand corner. This is called the ‘line of equity’ (no income-related inequality). The index has a negative value when the curve lies above the line of equality, and a positive value when it lies below the line of equality. If the curve is above the line of equity, health service utilization is more concentrated amongst the poor. The further the curve is above the line of equality, the more concentrated the health service utilization is amongst the rich. The further the curve is below the line of equity, the more concentrated the health service utilization is amongst the rich.

The concentration indices for CHC contacts were $0.11$ and $0.13$ for 1992–1993 and 1997–1998, respectively, indicating that healthcare use at this level has an increasingly pro-poor distribution. On the contrary, the concentration indices for hospital contacts were positive and more pro-rich; $0.24$ and $0.27$ for 1992–1993 and 1997–1998, respectively. Other studies have also shown that CHC contacts are considered to be inferior, as evidenced by the negative relationship between income level and utilization rate.

The concentration indices for service contacts at public hospitals and CHCs show that inequality

<table>
<thead>
<tr>
<th>Table 1 Calculation of concentration index for hospital contacts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per-capita expenditure quintile</td>
</tr>
<tr>
<td>Poorest</td>
</tr>
<tr>
<td>Second</td>
</tr>
<tr>
<td>Third</td>
</tr>
<tr>
<td>Forth</td>
</tr>
<tr>
<td>Richest</td>
</tr>
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</tr>
</tbody>
</table>

exists in service utilization among different income quintiles. There is also a trend for increasing inequality in service utilization between the two periods 1993–1993 and 1997–1998. While the poor are more likely to seek services at lower levels of care (apart from serious illnesses which require transferral to public hospitals), the rich are more likely to seek services at public hospitals which are better equipped and have better-trained medical professionals. This has implications in terms of developing services at different levels of care and the need for improving the quality of healthcare services at commune level.

### Table 2 Calculation of concentration index for commune health centre contacts.

<table>
<thead>
<tr>
<th>Per-capita expenditure quintile</th>
<th>Distribution of service contacts with commune health centre</th>
<th>Cumulative of commune health centre contacts</th>
<th>Concentration index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>25.43</td>
<td>20.25</td>
<td>0</td>
</tr>
<tr>
<td>Second</td>
<td>20.52</td>
<td>24.99</td>
<td>25.43</td>
</tr>
<tr>
<td>Third</td>
<td>23.7</td>
<td>27.29</td>
<td>45.95</td>
</tr>
<tr>
<td>Fourth</td>
<td>17.92</td>
<td>20.64</td>
<td>69.65</td>
</tr>
<tr>
<td>Richest</td>
<td>12.43</td>
<td>6.83</td>
<td>87.57</td>
</tr>
</tbody>
</table>


### Figure 3 Concentration curve of service contacts with community health centres and public hospitals, 1993 and 1998.


### Policy options

In addition to their role in raising revenues for the health sector, user fees can enhance the quality and efficiency of the healthcare system through price signals, and equity through targeted prices and exemptions. According to the efficiency-enhancing argument, the introduction of user fees reduces the possibilities of over or irrational use of services from the users through price signals, with the assumption that users know enough about their own and their family’s needs. This was derived from the fact that a considerable amount of the ‘unnecessary’ care
can be initiated by patients. On the other hand, with the asymmetric information between providers and patients, it is assumed that providers will act in the best interests of their patients. User fees can promote better standards of care and ensure prompt treatment, especially in situations where providers are poorly paid and motivated, and drugs and supplies are in short supply. However, user fees can also increase inequality between the rich and the poor, and widen the poverty gap. There should be a balance between user fees as factors for motivation and contribution of healthcare costs, while not causing the poor to become poorer. Exemptions and targeted prices (affordable prices) for healthcare services are necessary to support the poor to deal with illnesses.

The beneficial effects of user fee policies have been examined and challenged by Gilson and Creese with respect to equity. In this paper, it is evident that while user fees contribute to the healthcare budget, they limit access to quality services and cause inequality in health service utilization. Official and unofficial user fee systems accompanied by low health insurance coverage may increase the financial burden on the poor, threatening their disposable income and widening the poverty gap. Policies to protect the poor from catastrophic health expenditures are therefore a high priority. In Vietnam, health insurance, as part of the national social security mechanism, must highlight the notion of catastrophe in health and poverty. The theme of ‘an equitable, efficient, effective, and sustainable healthcare system’ must be seen in light of an effective targeting system and selected subsidization or through universal coverage, which ensures the right of human beings to be protected from such adversity in health, i.e. illness, injuries and accidents. Two policy options to protect the poor are analysed below.

Universal coverage
In Vietnam, there is a need to extend health insurance to the poor and the marginalized; this could be done through a universal coverage system. The current compulsory health insurance only covers those who are employed and who work in the formal sector. Most of those remaining in the risk pool are rural residents, the unemployed and relatives of the employed. Pham et al. accounted for about 29 million people in the informal sector. Jowetta et al. showed that 37 million people in the informal sector, including school children, are uninsured (excluding children under 6 years of age who account for about 6% of the population since they have been insured automatically since July 2004). Insurance needs to reach these population groups to protect them from falling into poverty or deeper into the poverty trap because of healthcare payments. There are advantages and disadvantages to this option. The advantage of universal coverage is that it can embrace a large risk pool, allowing for cross-subsidization amongst different income groups, given the fact that a certain percentage of income is allocated to health insurance. The premium rate for compulsory insurance is 3% of the salary, where the employer has to pay 2% and the employee has to pay 1%. This strategy is progressive, and can be supported politically because it promotes equity.

The disadvantage of this approach is the financing difficulties at both individual and governmental levels. With a rather high percentage of the population living on less than $1 PPP per day (39.9% and 16.4% in 1993 and 1998, respectively), many poor people may not be able to afford even a minimal premium.

Improved targeting system
This approach directly targets people who need subsidies. In the context of fiscal constraints, this option is suitable and politically attractive. The target population and the beneficiary options can be expanded gradually based on the Government’s fiscal affordability, e.g. expansion of targeting to other vulnerable groups including migrants, homeless and near poor. However, administrative costs can be high. For instance, it has been reported by the MOH that the Management Committees of the Fund for the Poor do not have sufficient time allocated for management and supervision of the fund. In some villages, identification of poor households is based on the allocated number of poor households (decided by higher level authorities, thus it does not necessarily reflect the actual number in the areas) and subjective evaluation. Management information systems for insurance are not in place in Vietnam; much of the collection and payment has been done manually. This situation makes it difficult to gather information on the existing and potential beneficiaries, both at national and provincial levels.

A targeted system has been implemented by the MOH according to Decision 139/2002/QD-TTG. Evaluation of this programme revealed that it has received strong support from the Communist Party and the Government. The local authorities under the direction of Central Government have established a management system to expand the fund to the poor. Among the poor in Vietnam, only 9.9% have received a health card, as mentioned previously. The poor without a health card but living in poor areas (e.g. all ethnic minorities and 2175
poor communes identified by Decision 168/2001/QD-TTG and Decision 135/1998/QD-TTG have received free healthcare services; thus, support for healthcare costs goes beyond those with health cards. In 2003, approximately 11 million people received benefits from the health service scheme under Decision 139/2002/QD-TTG (which accounted for 76.7% of total beneficiaries who received a health card or were entitled to free examination and treatment). 31

Conclusions and recommendations

This paper presents the healthcare system in Vietnam during the transition period in the 1990s. A major change in health and social policy was the shift from solely government-subsidized health care to user fees. User fees contribute to health resources and have helped to relieve the financial burden on the Government. However, user fees have had a negative impact on service utilization by the poor, widening the poverty gap and limiting access to health care. These results contrast with the principle of social equity of development issued by the Government.

Equity in health care is considered differently from equity in income. Essential health care should be provided to the population according to their ‘need’, not according to their ‘ability to pay’. The Government reaffirmed the improved access to good-quality preventive and curative services for the whole population according to their need, with priorities given to the poor. It is challenging to make this a reality, and it requires effort and a strong political will to improve the healthcare system and increase its efficiency. Improving the NIS with an effective targeting scheme for exemption and improving quality of care are the main objectives on the health reform agenda in Vietnam. The current situation in Vietnam’s healthcare system calls for the application of an effective targeting mechanism with an orientation to universal insurance by 2010, as indicated by the Central Government. This cannot be done without taking measures to improve the quality of care and promoting ethical standards in health care, including the elimination of unofficial payments.

An effective targeting system with clear eligibility criteria to categorize the levels of subsidization and to ensure equity amongst different income groups and provinces is a critical issue in the healthcare policy agenda. Categorizing the levels of subsidy is very important for the poor, as it has been shown that catastrophic health expenditures have driven the near poor into poverty, and the poor deeper into poverty.

Ethical approval

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Competing interests

None declared.

References

Annex: Healthcare system in Vietnam

The healthcare system in Vietnam is organized into four administrative levels (central, provincial, district and commune) based on the structure of all provinces across the country.

At the central level, the MOH comprises of 16 departments including technical departments and administrative departments. The technical departments are responsible for different areas/themes and have networks at lower levels (e.g. Department of Therapy is responsible for all curative care including examination and treatment, the General Department of Preventive Medicine is responsible for preventive care, the Department of Reproductive Health is responsible for maternal and child health care, etc.). The administrative departments are responsible for cross-cutting issues and supporting systems which are related to all other departments (including Department of Planning and Finance, Department of Human Resources and Manpower, Department of Legislation, the Inspectorate, etc.). In addition, research institutes, training institutions and 32 national hospitals are subordinated to the MOH. National hospitals deal with the most complex cases and are mainly located in large cities such as Ha Noi and Ho Chi Minh City.

At the provincial level, the Department of Health has a similar structure as the MOH and is responsible for all health institutions in the provinces. It reports directly to the relevant departments of the MOH. There is typically one provincial hospital for each province (except in some of the large cities and some provinces that have one provincial hospital and one national hospital). Different centres focus on preventive medicine as their main activities (Centre for HIV/AIDS, Centre for Tuberculosis and Lung Disease, Preventive Medicine Centre, etc.). Secondary medical schools train nurses and midwives. There are about 1 million people per province, although Ha Noi has a population of 3 million, Ho Chi Minh City has a population of 6 million, and Bac Kan, the mountainous province, has a population of 300,000.

At the district level, district health centres (DHCs) have both curative and preventive functions which serve a population of more than 100,000 people. After 2006, the DHCs were terminated. The DHCs were divided into three separate administrative structures: the district department of health, the district hospital and the district preventive medicine centre.

At the commune level, the CHC is the first level of service accessible to the population in the state health network. It has the task of providing services in primary health care, early detection and control of epidemics, provision of primary health care and normal deliveries, provision of essential drugs, and education on family planning methods and health promotion. Vietnam has more than 10,000 communes, each with a CHC. A CHC serves a population of approximately 5000–10,000 people.