CHAPTER 2
BACKGROUND AND HEALTH CARE SYSTEM IN VIETNAM

Because health behavior is related with the health sector and socio-economic sector, therefore, an overview of the socio-economic situation and the health sector in Vietnam is given in this chapter.

2.1 The Socio-economic Background of Vietnam

Vietnam is a south-east Asia country with an area of 332,000 square kilometers. It borders Cambodia and Laos in the west and south, China in the north and faces the Pacific Ocean on the east and south. The country is divided into 64 provinces with 600 districts and 10,331 communes. The population was 79 million in 2001 with 60 minority ethical groups, 78 percent of them residing in rural areas. The 3 biggest cities are Hanoi capital with 4.0 million in the River delta in the north of the country, Ho Chi Minh City with 6.0 million people in the Mekong delta of the south and Danang with 2.0 million people in the middle of Vietnam. The religion of the population is divided into two main streams: 70 percent follow Buddhism, 15 percent are Catholics. The other is non-religious or follows other religions. In term of culture, education and ethical behavior, Vietnamese were influenced by Confucian theory mixed with French style. In term of health care, because of poverty, the majority of Vietnamese are hesitant to do to hospital. Normally, they wait until their health situations are more serious before deciding to visit hospitals. The rich may come to private clinic but the poor usually go to public hospital, especial for people living in rural areas.

For thousand years of Vietnamese history is focused on defending attacks from foreign armies. In 1954, after 1 thousand years are dominated by France, Vietnam was divided in two parts, from the 17^{th} parallel of latitude to the north was Democratic Socialist of Vietnam followed the socialist system and in the south was Republic of Vietnam that dominated by American. Vietnam was unified in 1975.

The "doimoi" (innovation) reforms launched in 1986, the economic and political has been changing rapidly with a shift from a centrally planed to a "socialist oriented market

economy under State management" Although this process led to marked improvements in overall well being for most of the people of Vietnam, many still live at risk of falling back into poverty . However, reform was accompanied by a fiscal policy calling for a reduction in public expenditure, including cuts in allocation for health care. As a result, the health sector has been increasing under pressure. Public resources are no longer sufficient to respond to the need to improve the quality of care, especially in the poorest provinces.

Table 2.1 Government Expenditure on Health from 1999 to 2002

	1998	1999	2000	2001	2002
As % GDP	1.25	1.19	1.15	1.29	1.35
As % Government expenditure	5.50	4.95	5.06	5.0	5.2

Source: Ministry of Health

In 2003, Vietnam became the world's second-largest exporter of rice. Oil production was expected to reach 7 millions tons in the mid-1990s, compared with 1990 production of 2.6 million tons. Due to the fact that exports exceeded, the trade balance has been positive since 1994 and, as a result, the trend of payment deficit of government has been reduced, and hyperinflation has been cut down from nearly 40% in 1990 to around 10% in 1993-1998

Table 2.2 Inflation Rate in Vietnam from 1990 to 1998

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Inflation rate (%)	37.5	31.5	34.2	11.8	8.8	12.7	4.5	3.7	9.2

Source: Ministry of Finance

The average real growth rate if the gross domestic product (GDP) as 5.2% between 1986-1991, 10% between 1992-1995, from 9.3% to 5.8% between 1996-1998 and in 2002-2003, Vietnam is one of countries has the highest growth rate of GDP (7%). The GDP per capita is increasing from year to year (see Table 2.3).

Table 2.3 GDP per Capital from 1999 to 2002

Unit: '000 VND

	1998	1999	2000	2001	2002
GDP per Capita	4,779	5,220	5,716	6,116	6,724

Source: Ministry of Health

Despite the overall economic growth and the rise of private sector activities, the level of government taxation has remained low, due to difficult in tapping new sources of activity. It is manifests that the overall low level of government taxation hampers the financing of social expenditure, such as those on health services. Now, the situation has improves, the government revenue has increased step by step, from around 10% of GDP in 1986 to around 20% in 1998 and 16.9 % in 2002. (MOF, 2003)

2.2 Health Care System in Vietnam

2.2.1 Structures of Public Health Services in Vietnam

Health services in Vietnam are organized along a four-tiered pyramid. At the top of the pyramid is the Ministry of Health, which is the main national authority in the Health sector and, together with the provincial, District and Commune People's Committees, formulates and executes the Health policies and programs in the country. The Ministry of Health manufactures and distributes pharmaceuticals, is involved (together with the Ministry of Education and Training) in physician training, coordinates medical research, sets prices in private health facilities, and is ultimately responsible for the provision of all preventive and a large part of the curative health services in the country. (see Figure 2.1)

The Ministry of Health is supported by a number of Vice-Ministers, each with a portfolio of areas in Health for which he is responsible. When the Government finds it desirable to concentrate attention on a certain area related to health, for example, family planning, it can also create separate entities, which function outside the Ministry of Health. The National Committee for Population and Family Planning is one example, the chairman of which has a minister's status. This entity has established a structure parallel to the health

system with the specific task of providing population and family services, all financed from a national budget.

The Ministry of Health is assisted in its activity by a number of central specialty institutes, which function as tertiary care referral centers and professional training and medical research hubs. Among these are the Institute of Malariology, Parasitology, and Entomology, National Institute of Tuberculosis and Respiratory ... and a number of other institutes responsible for research, training and patient care in the areas of cancer, pediatrics ...

Table 2.4 Number of Facilities and Beds at each Level of Services, in Vietnam

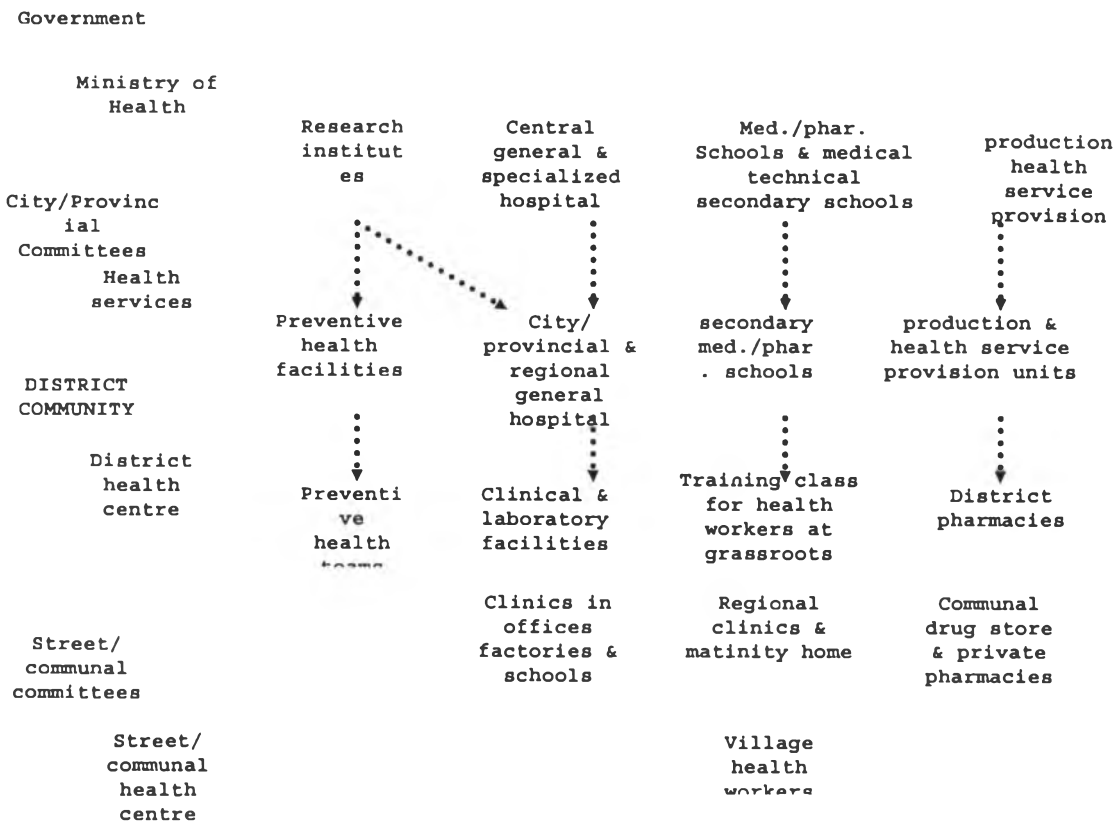
	Province		District		Commune	
Year	Hospitals	Beds	Hospitals	Beds	CHC	Beds
1999	297	57,431	519	37,411	10,052	42,939
2000	379	60,171	532	38,032	10,257	45,303
2001	348	60,547	541	40,927	10,307	46,378
2002	351	61,886	533	39,098	10,293	46,064

Source: Ministry of Health

At the second tier are the 64 Provincial Health Bureaus (PHB), each of which serves a population of 0.25 to 5 million. The PHBs have to follow the Ministry of Health policies, but are in fact an organic unit of the provincial local government under the Provincial People's Committees (PPC). This reflects the fact that the budgets of provincial health bureaus are part of the local government budget. The PPC can also supply funds directly to the district or commune, by passing the provincial health bureaus, which means that the provincial health bureaus may have little control, or even information, and can not always ensure that Ministry of Health policies are implemented at lower levels.

Planning of health services and programs is mainly the task of the provincial health bureaus, including human resources management planning. In each province, there is also at least one general hospital with 200-1000 beds that typically has all seven departments:

Figure 2.1 Structure of Public Health Services in Vietnam



Source: Ministry of Health (2000)

internal medicine, obstetrics and gynecology, surgery, pediatrics, infectious diseases, traditional medicine, and an emergency ward. The provincial hospitals are intended to be referral centers only, but the referral system does not always work well in practice even though number of hospital and bed in provincial level increased year by year (see Table 2.4)

At the third tier are the District Health Centers, each of which serves the population of their respective districts. The district health centers are in charge of health management in the district. Each district health center has anywhere from 2-9 different departments. While the district health center, in principle, is in charge of all health activities down to the grass-roots level, in some cases it is only responsible for personnel and salaries.
In each district, there is a district general hospital, including a laboratory and a post for hygiene, epidemiology and malariology (Number of district hospital and beds was showed in Table 2.4). Typically, a unit for maternal and child health care and family planning is attached to the district general hospital. District hospitals are supported to serve as referral institutions for all inter-communal policlinics in the district. They also provide training facilities for health staff working in inter-communal policlinics and commune health centers (CHCs) in the district. Each district also has brigades of hygiene and epidemiology, commanded by the regional branches of the central specialty institutes, which move around the district providing support to categories health programs, and two or more inter-communal policlinics, which are commune health centers that have been upgraded with selected laboratory and surgical equipment and 4-5 specialist doctors.

At the bottom of the pyramid are the Commune Health Centers (CHCs). Each of the commune health centers (see Table 2.4) is responsible for providing primary health care, including preventive, ambulatory and inpatient services, to between 2,000 and 10,000 people, and for referring complicated cases to upper levels of care. They are expected to implement national health programs, such as Acute Respiratory Infection, Expanded Program of Immunization ... and are generally responsible for the management of all health services at the commune level.

A CHC is supported to have 3-5 health staffs, under the leadership of the head of the commune health center, who may be an assistant doctor, or the other staff such as a nurse (Percentage of CHC has a medical doctor working is showed in Table 2.5). Often, one of

the staff is a pharmacist responsible for dispensing drugs as well. Sometimes, this team is complemented with an assistant doctor in traditional medicine, a health worker responsible for immunizations and sanitation and an auxiliary nurse. In exceptional cases, a full physician is also part of the health center staff.

The head of a CHC is selected by the Commune People's Committee and the district health center. Mostly, they are local people. All commune health center staffs are supported to work eight ours per day as civil servant.

During the past few years, the Government has revived and promoted the village health worker strategy of providing a minimum of health care to the inhabitants of the more remote areas. Member of the community receive training from the provincial health service, often at the district level, in a number of basic topics intended to enable them to cope with the most common medical needs of the population of the village or hamlet.

Table 2.5 Percentage of Commune Health Center has a Medical Doctor by Year

	1999	2000	2001	2002
Number of CHC	10,052	10,257	10,307	10,293
Percentage of CHC has a medical doctor (%)	33.92	51.1	56.1	61.5

Source: Ministry of Health

2.2.2 Framework of Private Health Sector in Vietnam

In 1998, following *doi moi*, the Vietnamese government began allowing the provision of private health services. This served as a means to retain retired physicians in the provision of health services and to meet a perceived unmet demand. The Government authorizes the Ministry of Health and the provincial health bureaus to manage private health activities. The provincial health bureaus are the health authorities that can issue licenses for private pharmacies. Licenses for private pharmacies are provided mainly to pharmacies that have a university degree, except in the case of remote areas, where assistant pharmacies can apply for licenses. Private pharmacies are allowed to sell drugs that are permitted by Ministry of Health and to sell medical equipments and supplies, veterinary drugs and cosmetics. They are not allowed to manufacture or produce drugs themselves.

The decree on private practice of medicine allows only retired health personnel to have licenses for full-time private services. Working staff in public health facilities are not permitted to operate privately during working time; they can apply for license for part-time private services. Nurses are allowed to work in a team lead by a private physician or to apply for license to run private health services, such as administering injections and massages.

Like public providers, private facilities have a responsibility to operate according to existing law and regulations. One of these is that they can not prescribe and sell drugs at the same time. And the provincial health bureaus, of course, are responsible for issuing licenses to private providers.

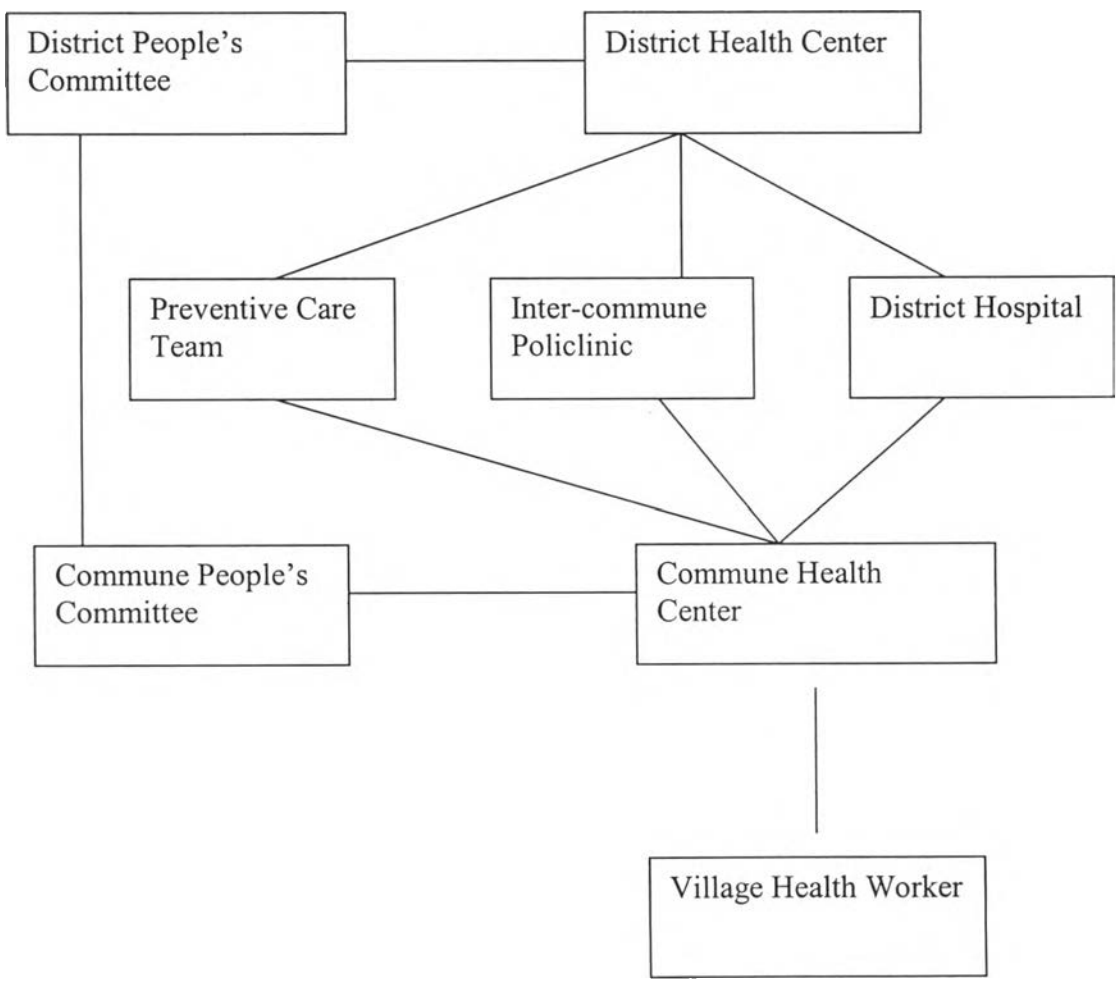
2.3 Health Care System in Hungha District

Hungha is a district of Thaibinh province in the north of Vietnam, 70 km far from Hanoi and 25 km from Thaibinh province. The district contains 253,006 people living in lowland areas with 34 communes. The Kinh tribe is the main group and people speaking Vietnamese only. Agricultural production and livestock breeding are the main economic activities of the local people. , with major products being wet rice, cassava, corn, soybean , green beans ... Other economics activities are small trace, handicraft and so on. Climate is divided four main seasons: spring with cool temperature and small rain, summer with hot temperature and storms, autumn and winter with cooler temperature.

There are 34 commune health centers (CHC) in Hungha district, one in each commune, one district general hospital with 110 beds and one region general hospital with 50 beds. Each commune health center has medical doctor working full-time. All communes are involved in primary health care and national health programs, for example, Acute Respiratory Infections, Expended Program of Immunizations ... and provide health education and communication programs.

There are few private providers that have licenses to practice, majority of them are public facility staff, and others are retired physicians or traditional health workers. From figure 2.2, for the Hungha health care system, it includes three levels. Firstly is district health center, including district hospital. Secondly is commune health center and finally is a health activity in villages. And health systems are managed both health district center and district people's committee. The same situation for managing at the commune level is applied

Figure 2.2 Health Care System in Hungha District



Source: Ministry of Health (2000)