Barriers to health care for the poor and ethnic minorities in Northwest Vietnam

By Bettina Schwind

Background

This paper presents some of the research evidence on barriers to health care services encountered by poor and ethnic minority people inhabiting mountainous Northwest Vietnam. It refers, in particular, to the Health Care Fund for the Poor – a social health insurance scheme aimed at people from these two social groups. The objective is to reflect upon what may need to be done in order to improve their situation and to achieve greater equitable access to health services. In conclusion, it highlights some of the implications for the tailoring of responsive and inclusive health policies that take into account challenging geographical terrains and diverse socio-cultural environments. This is of relevance to neighbouring Asian countries as well, which feature similar conditions.

The results presented here are part of two coordinated studies focusing on the access to health care services by the poor in Son La Province, Vietnam. These studies were carried out under the umbrella of two aligned health programmes, one managed by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, the other by the European Commission (2006 and 2007). Surveys applied a mix of quantitative and qualitative methods to assess access to health care services by HCFP beneficiaries living in the mountainous Son La province. Interviewees were almost entirely of an ethnic minority background. The overall aim was to understand their perceived needs so that policy responses for reducing hurdles to health care and improving the health status of the poor could be tailored accordingly.

The socioeconomic advancement that has taken place in Vietnam since the mid-1980s has resulted in strong economic growth. Vast changes have occurred that have significantly exacerbated the socioeconomic disparities between rural and urban areas, mountain regions and lowlands, as well as between the ethnic Vietnamese (Kinh) and ethnic minority groups in Vietnam. For example, ethnic minorities make up 39 per cent of all poor, while solely constituting 14 per cent of the entire population of Vietnam. Kinh have found greater overall prosperity, also those living in disadvantaged areas, whereas poverty reduction among ethnic people has made far less gains (Swinkels/Turk 2006).[1]

As elsewhere, poverty and health interact, are entrenched, and often mutually explained by each other. In Vietnam, it is an individual's or family's standard of living that has largely been determining access to health care. As a result, it is the poorest areas that are now lagging behind in health outcomes. For example, the national maternal mortality rate is between 130 to 135 per 100,000 live births. However, in some mountainous and ethnic minority-inhabited provinces the rate is up to three times higher. Ethnic minorities further display higher morbidity and mortality rates than Kinh of an equivalent age (Teerawichitchainan/Phillips 2007).

The implementation of the Health Care Fund for the Poor

To enhance the health status of poor people and ethnic minorities, and to improve their access to health care services, the Vietnamese government implemented the Health Care Fund for the Poor (HCFP or Programme 139) in 2003. This social health insurance scheme aims to reduce the financial barriers hindering access to health care services by minimising direct user charges for those most in need. The HCFP replaced a mix of fairly underfunded pro-poor approaches that had previously been implemented, such as user fee exemptions or health cards for disadvantaged groups. Hence, it needs to be (re)viewed within the greater

[1] Most ethnic minority groups are concentrated in the northern and central uplands of Vietnam, where they outnumber the ethnic Vietnamese.

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framework of ongoing health sector reform, including the compulsory and voluntary health insurance schemes that were implemented during the 1990s. In 2005, under Decree 63, the HCFP was integrated into the compulsory scheme. Therefore, it covers a benefit package identical to that of all other health insurance approaches, ranging from medical consultation, examination, x-rays, laboratory testing, treatment and surgery to antenatal care and delivery. Vertical health programmes provided, such as the expanded programme for immunisation (EPI), are excluded from the benefits delivered.

In 2007, about half of Vietnam's population was covered under these existing health insurance schemes. Compulsory health insurance schemes provided coverage to 41 per cent of the entire population at this time, with half of those covered being HCFP beneficiaries alone. Thus, the introduction of the HCFP extended health insurance coverage to around a further 18 per cent[2] of the population, and by doing so also significantly increased the level of (compulsory) health insurance (Rama 2007). However, as the relevant numbers would indicate, ongoing obstacles to reaching the whole populace persist. The original aim of achieving universal health insurance coverage for the entire population by 2010 has been replaced, with no specific target set.

It is since 2005 that all those identified as being poor, from an ethnic minority, or a resident of mountainous and economically disadvantaged communes (Programme 135[3]) are entitled to participate in this social health insurance scheme. The HCFP hence applies a mixed set of methods, including direct and geographical targeting strategies, but appears to emphasise the social integration of the disadvantaged and ethnic minorities inhabiting the mountainous regions of Vietnam.

Barriers to health care in a mountainous and multi-ethnic environment

Son La Province is a highland province situated in mountainous Northwest Vietnam, bordering the Lao People's Democratic Republic. It has a total population of about 991,800, covering 30 different ethnic groups that almost all speak their own distinct language at home. The majority of the people here are of Thai ethnicity (55 per cent), who for the greater part inhabit the river valleys Then follow those of Kinh ethnic origin (about 17 per cent), mainly inhabitants of urbanised areas; and after that the 13 per cent of Hmong ethnicity who predominantly live in rural areas, on more elevated hills. Therefore, about two thirds of rural interviewees were of Thai ethnicity, while around one third came from the Hmong ethnic group, and only a few were of La Ha, Kho Mu, Dao, Muong and Kinh ethnicity.

Communes are usually heterogeneous in their ethnic composition, whereas the inhabitants of a single village mostly come from one exclusive ethnic group. This fragmented heterogeneity of communes certainly challenges health planners in terms of tailoring a primary health care solution that reflects the culturally diverse needs of respective communal populations. The linguistic plurality among these diverse groups further tests health care design, with different ethnic groups speaking their own distinct languages. It is almost impossible to mirror the linguistic and socio-cultural plurality of an entire commune within a single attributed communal health station (CHS). Yet, and as this paper is about to show, this is of key relevance to providing quality and responsive primary care to those in need.

The steep hills of the Northwest further impede effortless access to medical services. Accessibility is a major issue and at times more relevant than measurable distance. During the rainy season, roads turn into slippery paths that are impossible to pass by foot or motorbike and which, thus, pose an immense hurdle to the timely access of medical care. Particularly among those living on far-flung hills, stories of lost lives abound that frequently worry hamlet inhabitants. Due to the distinct geographical distribution of ethnic people in the Northwest, some groups in the more elevated areas may face greater obstacles to accessing care than others who, for the most part, populate the valleys where communal centres with public health facilities are usually located. Hence, ensuring quality first aid at the village level was a major concern. The delivery of regular preventive services to those who are faraway and difficult to reach was at times fairly neglected by communal health staff. Village health workers (VHWs) filled in the resulting service delivery gaps, though every so often by violating national guidelines. To ensure a protective environment for those most in need, general policy not only needs to allow and support such practices, but health planners need to shore up their capacities for delivering primary and preventive services, such as regular and timely immunisations for children.

Moreover, inhabitants frequently challenged HCFP policy by not accessing care at the CHS specified. At times, the CHS of a nearby commune was closer than the assigned one or more accessible due to the infrastructure set up and/or deterioration of roads. Respondents made their own use of the health care system, depending on their medical needs, possible choice in the quality of care, and their own financial resources - they accepted the likelihood of out-of-pocket (OOP) spending, but carefully assessed the (financial) pros and cons involved such as time spend on travelling against possible loss in productivity or income. There-

[2] In comparison, voluntary health insurance primarily serves school children and students, and provides coverage to about 11 per cent of the total population. Another three per cent is covered by special provisions under health insurance regulations and includes groups such as retirees, dependents of military and police officers, as well as people of merit (Ekman/Nguyen/Axelson/Ha 2008).

[3] Programme 135 or "Programme for Socioeconomic Development in Communes Faced with Extreme Difficulties" was introduced in 1998. It seeks to promote infrastructural development, including the improvement of communal health stations. With the Committee for Ethnic Minorities and Mountainous Areas (CEMMA) being in charge of verifying selected communes, the programme shows an emphasis on ethnic minority-populated areas.

fore, it is suggested that the HCFP should allow for more flexible solutions, whereby measures to reduce barriers to health services for those most in need take account of the local geography and infrastructure, while simultaneously helping to reduce indirect costs (e.g. expenses for travel and related loss of earnings) for the poor.

Barriers to health care and the health insurance card for the poor

By 2007, almost all HCFP beneficiaries were in possession of a valid health insurance (HI) card (around 95 per cent) whereas a year previously plenty of respondents had carried invalid ones. Obviously, the distribution of HI cards (valid for one year only) improved dramatically, underlining the increasing capacity of Vietnam Social Security (VSS)[4] to manage the fund and the timely dissemination of the cards. Despite this positive factor, the few beneficiaries still carrying expired HI cards (about 5 per cent) were not well-informed about their right to continuously use and obtain health care services at no cost. The HCFP acted swiftly to overcome the problem of delayed card deliveries and, thus, to ensure continuous coverage for the poor. However, the disadvantaged with expired HI cards either refrained from accessing health care services or were denied medical services free of charge by health personnel. As this suggests, mis- and disinformation about HCFP regulations is continually present, both on the side of demand and supply. Improving knowledge and awareness about the HCFP and related rights and duties is necessary in order to enhance user trust and confidence in the scheme. Improving the competence of suppliers to deliver health care that is fairly financed and equitable is also required.

The relatively low public awareness of the great policy shift from user fee exemptions/health cards for the poor towards a social health insurance scheme was further demonstrated by a particular habit among those targeted. They often referred to the HI card as the "card for obtaining an examination free of charge".

However, greater awareness about this significant policy change may be crucial to promoting confidence in the scheme, especially given the fact that earlier pro-poor approaches regularly faced funding shortages that resulted in implementation difficulties on the ground. Any association with past approaches that faced hurdles in reaching those in need is to be avoided. All the more so, as the scope of funding and benefits covered by the HCFP goes beyond that of user fee exemptions/health cards. It is, thus, imperative that beneficiaries are made aware of the specific benefits and advantages of this pro-poor approach implemented nationwide.

[4] In 2005 Decree 63/2005/ND-CP was promulgated, mandating the formation of a unified health insurance fund managed by Vietnam Social Security. In addition to the premiums paid by members, other sources of revenue for this fund include state contributions, private donations, as well as the financial support from several donor agencies.

That the HI card was popularly considered as described above was attributed to the overall limited scope of information given to beneficiaries on its receipt. This information generally highlighted the possibility of obtaining consultations and drugs free of charge, cautioned against the loss of HI cards, and noted the need to bring them along when visiting public providers. HI cards were commonly distributed by either VHWs (38 per cent) or village heads (VHs – 50 per cent), who provided information and instructions. However, whether or not respondents received any information did not significantly impact their level of knowledge on rights and benefits, despite information being provided in their specific languages. This further highlights the limited ability of VHWs and VHs to fulfil their assigned role of transferring knowledge to those in need and contributing to awareness about the HCFP scheme. Investing in developing the capacity of these key local stakeholders to fully comprehend the importance and advantages of social health insurance as an instrument for social security is essential. They need to be able to pass on the relevant information to beneficiaries, and are indispensible for reaching out to those targeted living on mountainous ground.

What is more, respondents also mentioned experiencing social hurdles when using their HI cards. These included, for example, the negative attitude of staff towards HCFP beneficiaries, particularly at higher health care facilities. Respondents felt that they received both lower and slower care than those paying for health care services, feeling ashamed of their poor situation This underlines the importance of extending health insurance coverage to the entire population and of further improving the financial base of the public health care sector. Ultimately, improving the quality of services, while also extending health insurance rights and benefits to the entire population, will reduce the stigma attached to coverage under the social scheme. In this respect, the inclusion of the HCFP into the compulsory insurance scheme was a step in the right direction.

Impact of the health insurance card on out-of-pocket spending

Even though awareness about the exact rights and benefits attached to the HI card and the implicit policy change was fairly low among the poor, almost every interviewee generally appreciated the HCFP and used the HI card when accessing medical facilities. Nonetheless, usage of the HI card did not significantly reduce average OOP spending on health care services. Most respondents (78 per cent) spent some money on transport (mean: 48,407 Vietnam Dong). About a third (29 per cent) spent money on food (mean: 103,113 Vietnam Dong), as meals are not usually considered a service provided to the sick within health facilities. However, and most worryingly, 62 per cent of all respondents continuously spend a fairly large amount of money on drug purchases (mean: 113,516 Vietnam Dong), despite the rule that drugs listed as "essential" should be provided free of charge to beneficiaries. Similar results have been highlighted

by other studies, indicating no significant reduction in average OOP spending, but instead emphasising a reduced risk of catastrophic spending along with increased utilisation of services, particularly with regard to inpatient care (Wagstaff 2007). CHS staff interviewed in Northwest Vietnam confirmed the overall increase in service utilisation by poor patients. And a greater level of poverty among respondents no longer significantly hindered their overall access to medical care. Thus, although average OOP spending might not have been significantly reduced through the HCFP, the scheme may nonetheless have had a positive impact and promoted more equitable access to health care for the poor. As demonstrated previously, expenses for purchasing drugs reached the highest mean, with the majority of HI card holders forced to pay out of their own pockets despite using the HI card. This continuing practice may to some extent explain the comparatively low reduction in average OOP spending among interviewees. Indeed, the fundamental impact of the need to pay for drugs on average OOP spending was also reflected in the outcome of focus group discussions. Throughout these talks, the main concern about the HCFP was invariably about access to free drugs and their availability at public facilities.

Access to drugs of good quality

In spite of this, the issue of access to (perceived quality) drugs is an extremely complex one. It not only represents one of the hurdles encountered upon the implementation of the HCFP, but also within the general framework of health sector liberalisation. For example, HCFP beneficiaries are frequently said to experience a ceiling for cost coverage of about 20,000 Vietnam Dong (VND) per month and HI card. This practice on the ground stems from the rather shallow coverage recommended per beneficiary at the beginning of the HCFP. Then, a 20,000 VND threshold was proposed to health workers as a simple rule of thumb for maintaining the sustainability of the fund. Although this was just a "rule of thumb", in some communes the 20,000 VND threshold was applied strictly, and HCFP beneficiaries were required to pay for any health care services costing beyond this point.

The HCFP applies a fee-for-service payment scheme. Higher levels of health care were indeed reimbursed according to financial means. On the contrary, the CHS relied on monthly drug provisions from district levels in compensation for serving HCFP beneficiaries exclusively. Without any further financial reimbursement under the HFCP, but facing an increased number of poor patients, the incentives for CHS staff to improve service provision remained comparatively low. CHS revenues call for an improvement in order to raise the financial incentives for personnel and to enhance health facility equipment, and thereby further the provision of quality care.

Moreover, a fairly vague pricing system for drugs and medications was observed. Neither tables nor price tags indicated or explained how related costs were calculated, leaving the poor in a rather weak position as regards controlling drug prices and, hence, OOP spending. The poor usually compared prices with those in private pharmacies and thereafter weighed the benefits of the HCFP against these. CHS staff reported repeated shortfalls prior to drug deliveries from the district level. This recurrent unavailability of drugs may explain the call frequently made by the poor and ethnic minorities for enhanced drug provision under the scheme so as to reduce their direct costs of receiving health care.

In some communes, a few respondents said they were required to pay cash under the table in order to receive medical attention and drugs. These informal payments also included the exchange of food against health care services. At times, public and private medical services were reported to have co-existed or overlapped, with public health workers or their relatives also owning the local private pharmacy. Hence, conflicts of interest may evolve. For example, medical staff reinforced the perception that higher quality drugs could be obtained at (their) pharmacies. Consequently, to regulate and harmonise often overlapping public and private activities in the medical sphere is important to ensure affordable access to health for the entire populace. Rational drug use needs to be promoted among beneficiaries in order to secure their health outcomes. Insurers have a vested interest in supporting rational usage of drugs to enhance confidence in their covered services.

Summing up, the HCFP has started to tackle financial barriers hindering access to medical care for the poor and ethnic minorities, but it has not been able to remove these hurdles entirely. Indirect costs have prevailed and social barriers such as the stigma attached to poverty remain. And as will be demonstrated subsequently, socio-cultural obstacles to receiving care after entry into health facilities further hamper equal access to care, particularly for people from ethnic minorities.

Barriers to health care after entering health facilities

Barriers to health care after entry into health facilities. The poor and ethnic minorities inhabiting Northwest Vietnam appear to have experienced a twofold medical encounter. While the majority of people from ethnic minorities sought care at the local CHS specified, they generally perceived that their experiences here were determined by a lack of resources. Their critique focused on the unavailability of quality equipment and drugs, deficiencies in hygiene and infrastructure, as well as a low quality of examinations. In contrast, where higher medical care was experienced, this was recognized as superior: quality equipment was available, standards of hygiene were higher, and the medical staff available was better trained.

However, at the communal level, the attitude of medical staff towards people from ethnic minorities was considered more satisfactory than that at higher levels of care. It is at

the local and communal level where a certain degree of familiarity is maintained. CHS staff may at times share the same ethnic background as communal residents and/or be able to speak (to some extent) local languages. VHWs as a whole come from the same ethnic background as their hamlet clients and are, therefore, well-versed in local cultures and languages. Indeed, those HCFP beneficiaries unable to communicate in Vietnamese showed a preference to seek out VHWs when sick.

In comparison, beneficiaries regularly talked of "being lost" in hospitals. Unable to speak or read Vietnamese, the medical encounter experienced was one of confusion - where the unknown occurs and is not understood, and where the bureaucratic and institutional procedures necessary to be followed can neither be deciphered nor comprehended. With language barriers in existence, the treatment provided by staff as well as their behaviour was perceived to be unfriendly and conflicting, resulting in difficult experiences for both clients and providers. Such experiences were particularly common among Hmong women who were the least likely to be able to speak and understand Vietnamese (75 per cent of all Hmong women were illiterate; only one had received some education). Thus, it was particularly Hmong women who needed to rely on interpreters, which may result in a role loss (younger generations are used as interpreters) and/or infringe on (perceived) confidentiality and privacy. Therefore, health planners may want to consider using "HCFP receptionists": who welcome beneficiaries and assist them with the bureaucratic and institutional procedures within hospitals and higher levels of care, essentially for the illiterate patients to cope with orientation and the necessary paperwork (all in Vietnamese); who may introduce some familiarity within the hospital system as a contact person; and who may get some training in key ethnic minority languages or expressions, especially as related to recurrent procedures, forms, and terms for illnesses/health needs.

The resulting implications for reducing barriers to health care for the poor and ethnic minorities

The aim of this paper was to present some research evidence on barriers to health care encountered by the poor and ethnic minorities in Northwest Vietnam, i.e. in order to specify some of the overall implications for the tailoring of responsive and sustainable health policies that take into account socio-cultural diversities and challenging geographical environments. What are the lessons that may be drawn from this material?

First, flexible solutions are required when designing health care policies: these should both accommodate and allow for the adjustments demanded by diverse geographical and socio-cultural environments and infrastructure. For example, referral systems may certainly control the problem of moral hazard regarding HI beneficiaries, yet, in a difficult geographical terrain with uneven infrastructure, may hinder equal access to health care for those most in need. Adaptive solutions are thus required that allow, for example, HI beneficiaries to choose their first entry point for receiving health care, albeit with modified control mechanisms carefully put into place. For instance, the scope of choice needs to be limited to a distinct level of health care provision. Or else, other approaches to tackle these indirect barriers would need consideration; such strategies may include financing of transport or food allowances. While often overlooked, the design of more responsive and flexible health care policies certainly requires sound assessment studies including local and socio-cultural determinants of health care. At the same time, quality monitoring systems for tailoring and fine-tuning programmes in response to a challenging terrain are needed. Often, data on ethnic minority groups in general and vulnerable groups in particular is fairly scarce as well as of a sensitive nature. But this is needed all the more in order to adjust policy approaches so that they work towards more inclusive health systems that promote social equity. An accompanying issue, of course, is the need for raising public awareness about these groups, both at a general level and in terms of the barriers to appropriate health care that they face.

Second, in order to increase access to health care for the entire population, medical services for differing levels of health care require complementary approaches and well adjusted inter-linkages. As the studies from Northwest Vietnam showed, it is particularly inhabitants of faraway, difficult to access hamlets that face the greatest barriers to care. Thus, VHWs require support and capacity building so that they can provide most primary health care services. Improving their skills and equipping them with the equipment necessary to deliver first aid and preventive medicine is recommended. This would ensure a safe and healthy environment for those far off the beaten track, while linking relatively inaccessible areas more tightly to communal health services and the wider health care net. When supporting preventive health care at the village level, one certainly needs to take into account its gender aspects. For the most part, as was the case in Northwest Vietnam, pregnancy and deliveries are considered to be part of the female realm. However, almost all VHWs were male. Thus, when targeting women for antenatal care and safe delivery programmes, it is necessary that gender concerns are given due consideration when deliberating the socio-cultural factors behind responsive solutions.

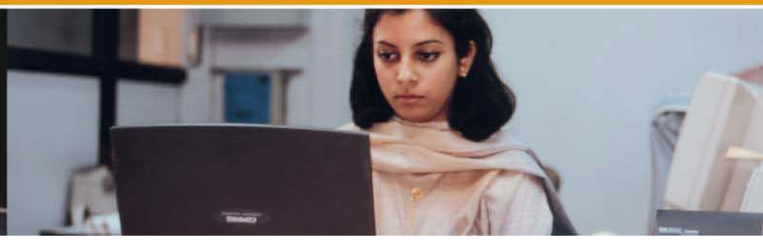
Third, this article looked at establishing a social health insurance scheme, particularly with regard to its main identified entry point, the CHS, while touching on the issues of health financing and the quality of health service provision. As shown, approaches to provider payment mechanisms are in place, but firm financial management is needed so that the financial base can support incentives for the staff of communal health centres. Advancing capacities for fund management at all levels is required. With sustainable and equitable financing options in place, improvements to the

quality of care may result. It is the health insurance agencies that want to assure the quality of health care in order to enhance consumer satisfaction and trust in schemes. Therefore, identifying and agreeing upon realistic standards and reasonable best practices for both the health care provided in facilities and health personnel is a prerequisite. Well-designed rewards and penalties that are implemented appropriately, and which encourage health staff to actively engage in the process, are crucial. Technical and financial support for the process is certainly needed.

Fourth, as studies have indicated, it appears the HCFP has so far not significantly reduced direct OOP spending by the poor and ethnic minorities, despite their increased uptake of medical services. Their spending was certainly linked to the private payments necessary for drug purchases. Hence, reimbursement mechanisms for providers (that reach the communal level) are needed to lower medical staff interest in engaging in the private medical sphere often linked to local pharmaceutical provision. Such mechanisms are also needed to help with the operating costs for communal facilities. Transparency in price calculations is required so that clients can properly assess the benefits of the scheme, and better control and understand (possible) private spending. Moreover, particularly local medical staff need support with comprehending, implementing, and managing a health insurance scheme and its related funds in a sustainable manner. Hence, further capacity development is certainly needed. In addition, public and private health services require improved harmonisation, standardisation and regulation to ensure that they complement each other. This is particularly the case at the local level, where private, non-standardised activities fill the gaps for the disadvantaged and most difficult to reach, often by endangering their health status. Furthermore, rational drug use requires promoting the HCFP among beneficiaries to improve their trust in the benefits of the scheme. Indirect costs for the poor may further be reduced through the provision of transport and food allowances.

Fifth, this article has demonstrated that the barriers to health care for the poor and ethnic minority groups go beyond financial obstacles. To reduce the hurdles encountered, it is essential to understand the medical experience from a socio-cultural perspective, so as to tailor a responsive but also workable and financially sound solution. In the case of Northwest Vietnam, poor people and ethnic minorities found themselves "lost" when encountering a higher level of care. They also had the perception that their HI cards, coupled with the stigma attached to their inability to pay, resulted in treatment delays. Improved familiarity and orientation, plus trust in a social health insurance approach, may result from an "HI receptionist" whose responsibilities may include welcoming HI beneficiaries on hospital entry, supporting them in unknown procedures, and assisting them with the paperwork necessary for obtaining care. HI receptionists could also serve as scheme intermediaries who receive and collect critiques and complaints and, thus, play an important role in raising confidence in the scheme among the targeted population. The introduction of HI receptionists could also be considered a good example of improvements to quality management. Another would be enhanced training of health care staff, i.e. via coaching in non-discriminatory behaviour and best practices for dealing with poor patients, particularly those from culturally and linguistically diverse backgrounds.

Sixth, general awareness among beneficiaries about the introduction of the HI scheme and the attached rights and obligations was fairly low. However, beneficiary awareness of these issues is essential when it comes to improving their health-seeking behaviour, as well as enhancing the quality of care. Improving client demand is critical to challenging and furthering the supply side. Thus, raising awareness about social health insurance and quality in health care involves the entire community. Capacity building for those transmitting knowledge and information is certainly needed, but consideration should also be given to improving information education and communication (IEC) materials. Gender and socio-cultural issues need to be mainstreamed into these approaches. For example, women from ethnic minority groups were often neither able to read nor speak Vietnamese, yet leaflets on reproductive health care were distributed in Vietnamese. Thus, a move away from traditional paths towards fresh IEC strategies – ones which take account of all the new media for the targeting of the poor and other vulnerable groups – is recommended.

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The paper is intended to contribute to the debate and offers an overview of the current international discourse and more profound insights into current practice.

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