CHAPTER 1
INTRODUCTION

1.1 Introduction

Health is fundamental right of every human being without distinction of race, religion, political beliefs, economics or social condition. As consequence, health or long life expectancy is worldwide ideal, which every society should devote all effort to eradicate disease and illness through creating equity of access to health and medical services. One of the major problems in the developing world is the lack of adequate and appropriate health care infrastructure. About 80 percent of the illness is preventable and their occurrence reflects poverty and inadequate health prevention and promotion measure.

For many years, the goals of Vietnam health systems were based on equity and appreciated efficiency. The Vietnamese long-term goals in health are: "Every people will be taken care as much as possible". Therefore, Vietnamese government subsidized financing for most of health programs. The preventive programs provided free of charge for everyone. However, these have become inappropriate in the current stage of socio-economic development.

In order to make health systems do better and perform to socialize health care systems, due to lack of budgets for health care, in 1989, the government announced four health policies: legalization of private medical practice, privatization of pharmaceutical production and sales, imposition of user charges in public medical facilities and the launching of national health insurance scheme, a compulsory insurance for employees and a voluntary insurance for others. (Ministry of Health, 1992).

Due to the legalization of private practices, there was rapid increase in the number of private health care providers, especially private pharmacies. There was a shift in health care utilization pattern in the whole country from the public health sectors to private health sectors. Vietnam Living Standard Survey (VLSS) recorded a dramatic decrease in use of

health care in the public sectors. In 1998 only 14 percent patients used public health sectors. Self-medication and health seeking in private medical practices have become more common. In 1998, the percentage of patient contacted with private medical practices and self-medication was 86 percent.

One of the basis objectives in health care is to deliver services. Indeed, many policy options are justified because they provide more services. Recently, substantial evidence has emerged suggesting that many unnecessary services are delivered by our health systems. Policy analysts are faced with difficult choices because they hope to maximize health outcomes while maintaining control over costs. Policy-marker needs to provide appropriate health services and set up relevant policies for each area.

In order to make an appropriate policy, the health-marker needs information about the demand for health care of population. One of the purposes of an analysis of the demand for medical care is to determine those factors which, on average, most effect a person's utilization of medical services. At any point in time many factors influence the consumer's choice to seek medical treatment of a given intensity. It would be virtually impossible to explain completely every individual's utilization of medical services, but certain factors are important for most people. Demand analysis seeks to identify which factors are most influential in determining how much care people are willing to purchase. The better our understanding of those factors, the better we will be able to explain variations in utilization among population group and among areas.

The aim of Vietnamese health strategies from 2000 to 2010 is "Equity in approaching and using health care services for people". With 80 percent of population living in rural areas, to achieve this goal, the policy-markers should know the factors that influence the utilization of health care services. From those, they can provide appropriate health care services; and can set up and adjust policies that are suitable with the currently socio-economic situations.

Health care costs are ranging out of control. Enthoven and Kronick (1989) noted that our health care system provides no budget within which physicians must manage their patients. It currency has no incentives for physicians to use less expensive methods in achieving the same health outcomes for their patients. In fact, the current health care system shuts out many of those patients who most need health care services because they can not afford it. But for all of the 1990s and until today, the country moved to a fee for services and privatization model. This model has led to significant hardship for the poor, especially (but not only) for inpatient services. Health service providers are encouraged to decrease the inequity in the economic access to services, but seldom do so. Four million free insurance cards were supposed to be issued to the poor, but this required funding which was only partially available and was to come from provincial governments, not the central government. Although more than 2/3 of the cards have been distributed (mostly in richer provinces), check empirical evidence suggests that this important measure has not improved the poor's access to hospitals to the extent intended. Therefore, the task of decreasing inequity in the utilization of services remains incomplete.

The full cost of health services includes not only the official fees charged, but also the costs of drugs, medical supplies, and informal (incentives) payments charged by providers especially for inpatient care.

The fee for services system has pushed a significant number of the people seeking care to self-medicate by buying drugs from unlicensed vendors and to seek care from a growing number of private practitioners all the way to the rural areas. At least for the last eight or more years, commune health stations are highly underutilized. (Around 38% of consultations at commune health stations are for curative services; an improvement in the perceived quality of care will increase utilization). Even where health care services are available, those with the most health needs either lack access to or are making insufficient use of them; individuals with more schooling are more likely to utilize health services.

In 2002, there were 12.5 % of population were coved by health insurance *(World Bank, 2002)*. The proportion of population paying out-of-pocket is 74% *(Ministry of Health, 2001)*.

Although, the public health budget per capital increase in recent years but the patient still has to face with out-of pocket payment.

The Vietnamese government is committed to improve access to health care by the poor groups in the society. However, in the light of the macro-economic changes, which also affect the health sector, the government is looking for evidence and direction for policy difference.

1.2 Research Questions

(1) What is the situation of health service utilization in Hungha district, Thaibinh province, Viet nam

(2) What are the factors affecting on health seeking behavior among patients in Hungha district for each kind of health services?

(3) How do patients finance their health care expenditure?

1.3 Objectives of the Study

(1) To study the situation of health care utilization in Hungha district, Thaibinh province, Vietnam.

(2) To identify factors affecting patient's decision for the different types of health services, i.e. commune health center, private doctor and drug vendor.

(3) To determine sources of finance for health care expenditure.

1.4 Scope of this Study

This study was to analyze the health seeking behavior and payment for health care services of patients in Hungha district, Thaibinh province, Vietnam in 2004.

1.5 Expected Benefits

This study will provide evidences for health worker to set up new policies and adjust current policies in order to make appropriate policies. It also gives information to health worker about how patient finance for their health care so that they will provide suitable policies for poor people in order to achieve the goal: access health care for all citizens.