The Impact

of the

Asian Financial Crisis

on the

Health Sector in Vietnam

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency virus
ANC	Antenatal clinic
BCG	Bacille Calmette-Guerin vaccine
CPR	contraceptive prevalence rate
CSWs	commercial sex workers
DPT	Diphtheria Polio Tetanus (vaccine – also known as triple antigen)
EPI	Expanded Program on Immunisation
EU	European Union
FDI	Foreign direct investments
GDP	gross domestic product
GOV	Government of Vietnam
HCMC	Ho Chi Minh City
HIV	Human immunodeficiency virus
IDUs	intravenous drug users
IFC	International Finance Corporation
JICA	Japanese International Cooperation Agency
MOH	Ministry of Health
NGO	Non-government organisation
NIHE	National Institute of Hygiene and Epidemiology
ODA	Overseas development assistance
SIDA	Swedish International Development Agency
TB	tuberculosis
TT2	Tetanus toxoid (vaccine)
USD	United States dollars
UN	United Nations

UNICEF	United Nations Children's Fund
VAT	value added tax
VLSS	Vietnam lifestyle survey
WB	World Bank
WHO	World Health Organization

Summary and Recommendations

Effects of the Crisis

The consequences of the regional financial crisis in Vietnam have been of an essentially different nature than in countries directly affected, eg, Thailand, Indonesia, and the Philippines. In fact, the Government has not recognised that there has been a crisis at all. The effects of the Asian financial crisis have been in some ways mediated in the same way as in Cambodia and the Lao PDR through decreases in regional trade and in foreign direct investment. Unlike the Lao PDR, **Vietnam has not suffered dramatic depreciation of its currency nor rapidly increasing inflation.** Changes in health expenditure and service utilisation reflect longer-term trends rather than direct effects of the crisis, however, in some areas; these trends may have been accelerated by the crisis.

Initially, the Asian financial crisis did not appear to affect Vietnam's economy to the extent witnessed in surrounding countries. However, 70% of Vietnam's foreign direct investments (FDI) came from other Asian countries - Taiwan, Korea, Japan, Singapore and Malaysia. As their economies declined, these countries reduced their imports and invested less in the country. **By 1998, exports and GDP per capita growth, which averaged 6-7% in 1990-97, fell to a level of 3.5% in 1998, increasing to an annualised rate of 4.3% in the first half of 1999.** The World Bank predicted that current downward trends in key economic indicators would continue through 1999 affecting all aspects of the economy and eroding earlier gains. In addition, El Niño-related flooding, storms and drought caused severe property and crop damage in Central and Southern provinces affecting agricultural yields in 1997-98 and further flooding occurred in late 1999.

The impact of the economic crisis, including **reduced revenue from exports and investment**, affects the Government's ability to maintain its already declining social services. Declining public financing for social services (in real terms) is seriously affecting the health sector and since increasingly more care is being delivered through the private sector, the poor may be losing out. As early as 1990, a survey found that the private sector share of total national health expenditures was 69% and privatisation of all social services is on the rise. The overall impact is that greater economic disparities and differential access within the population are increasing and the current economic circumstances are likely to further accelerate this trend.

The total indicative health budget for 1998 was slightly higher than 1997; however, there was a **10% cut in the MOH's budget in the last quarter of 1998.** Other negative trends included a 2% drop in the per capita public health budget; a 1% drop in the health budget as a percentage of the national budget; **a 20% drop in the health budget as percentage of the GDP; a 10% average decrease in provincial health budgets; and a decrease of 26% in the collection of hospital fees.** Whether any of this is significant is questionable and will have to be judged in the light of future trends.

About 50% of the government's health expenditure supports hospitals with very little increase in expenditure on health promotion and disease prevention which are

largely funded by donor agencies. At the end of 1998, there were 179 donor projects covering the whole health sector of which 70% were channeled through the MOH. In 1998, donors covered 26% of all public health expenditures. There are about 400 NGOs in Vietnam of which more than 100 work in the health sector.

There has been no detectable disruption to the existing level of basic health services during the past three years. Although there had been a decrease of 25% in inpatient admissions nationwide between 1993 and 1997, the total number of consultations, outpatient visits, and inpatient admissions all increased in 1998. However, there has been a long-term trend towards decreased utilisation of both private and public health care services by the poor while at the same time, the proportion of household expenditure by the poor on health has been increasing, reflecting rising costs.

Antenatal care, family planning, and child and maternal immunisation rates have remained unchanged between 1997 and 1998. MOH funding for health worker training activities actually increased by 14% from 1997 to 1998. Data were not available to assess whether there has been any negative change in expenditure on HIV/AIDS programs.

Trends in morbidity patterns have not altered since 1997. There was a substantial increase in the number of reported measles cases, doubling in 1998 compared with 1997; however, this cannot be attributed to any change in vaccination coverage and is probably an outbreak that would have occurred anyway. Reported TB cases have steadily increased in the last 4 years from 100,000 cases in 1995 to 142,000 cases in 1998, possibly reflecting improved case-finding and surveillance. Reported malaria cases have been steadily decreasing, a trend that continued in 1998. The chronic malnutrition rate (height/age deficit) among under five's declined from 46.9% in 1994 to 34.4% in 1998.

No major changes in the prices of drugs, contraceptives, and vaccines have been reported between 1997 and 1998. The estimated drug expenditure per capita increased from USD 5.2 in 1997 to USD5.5 in 1998.

A major new policy was launched in Vietnam in the spirit of the government's aim to eradicate poverty. In early 1999, it was decided to distribute 4,000,000 free health insurance cards to poor recipients; however, this initiative cannot be linked directly or indirectly to the Asian economic crisis. Nevertheless, only about 200,000 cards had been distributed by mid-1999 and the government evidently is seeking support to extend coverage by the scheme.

Responses to the Crisis

One cannot really speak of 'responses' to the Asian economic crisis in the health sector, because the crisis has not been recognised as having had a negative effect on health YET. This situation may change in the not so distant future if indicators begin showing significant downturns.

Recommendations

Recommendation 1: Provide support to address long-term trends in health indicators, expenditure, and the nature of health care services that reflect changes both in the nature of the disease burden and the capacity of the public sector to maintain effective health services.

- Specific initiatives related to the impact of the Asian economic crisis are probably not relevant for Vietnam, beyond strengthened impact monitoring systems. Given the likely slowdown in government revenue growth, it is unlikely that major new public investment in the health sector will be possible.

Recommendation 2: Consolidate support to the health sector in Vietnam while encouraging reforms that promote cost-efficiency but protect equity of access to health services.

- Progress has been made in addressing some of the conditions that make up what WHO calls the "unfinished agenda" of communicable disease control. The impact of control efforts has been documented most significantly on malaria. TB, HIV/AIDS, and Hepatitis remain critical public health issues that require continued or expanded support from donors.

Recommendation 3: Strengthen support for initiatives that will have greater long-term effects on health indicators than medical, or clinical, services.

- Most government expenditure is allocated to the treatment of diseases; however, health promotion and disease prevention programs are more cost-efficient in reducing the burden of disease, especially as the epidemiological transition gathers pace in Vietnam. Non-communicable diseases and injuries will increasingly be important causes of morbidity and mortality.

- It is unlikely, given the current stagnant economic situation, that the Government will greatly increase allocations to health promotion programs. Therefore, donors should lead these initiatives. Initial needs include relevant health research on disease burden, behavioural risk factors, and cultural attitudes to behaviour change. Health promotion institutions need strengthening of their capacity to conduct research, pilot interventions, and manage and evaluate health communication programs.

Recommendation 4: Provide support for a social impact monitoring system and focused studies on the social effects of Asian economic crisis in Vietnam, especially among vulnerable groups such as the urban and rural poor and certain ethnic minorities.

- The monitoring system should track trends in the key indicators recently recommended by the ADB as critical. Unlike other countries that have been more severely affected by the crisis, this system need not be separate but rather an extension of a strengthened national public health surveillance system.

- The extensive network of development NGOs and bilateral project staff could contribute to the implementation of an ongoing monitoring system.

Recommendation 5: Provide long-term support to improve the government health surveillance and monitoring system.

- The current system is weak, focussing primarily on morbidity trends and coverage of certain public health programs, such as immunisation.

- Long-term assistance is probably required to enable the generation of reliable, timely, routine data for the assessment of trends in other key health indicators, such as mortality, and health service access and utilisation.

Recommendation 6: Provide support for various initiatives to ensure health care access.

- Utilisation of health care services by the poor, both public and private, has been declining in recent years. The government initiative to develop a scheme of free health cards demonstrates a commitment to equitable access to health care services. However, this program is still in its infancy with low coverage achieved during 1999. In addition to support for this initiative, donors might support other mechanisms to ensure health care access, including co-payment schemes, such as the Voluntary Health Card scheme in Thailand.

- In the long-term, access to health services will probably be maintained only if comprehensive health insurance schemes can be implemented. These should be developed within the country based firmly on the capacity of rural and poor urban communities to contribute.

- These schemes have often failed in other countries because they were introduced in haste without adequate attention to community consultation and training in the requisite management skills.

Section 1: Background[1]

In the past year, the macroeconomic optimism which characterized Vietnam in the early and mid 90s changed to a cautious "wait and see" approach. Initially, the Asian currency crisis did not appear to affect Vietnam's economy to the extent witnessed in surrounding countries. Press reports suggested that Vietnam might be spared the worst of the crisis, because the country had no stock market or convertible currency. However, 70% of Vietnam's foreign direct investments (FDI) came from other Asian countries - Taiwan, Korea, Japan, Singapore and Malaysia. As their economies declined, these countries reduced their imports and invested less in the country. By 1998, exports and FDI declined and GDP per capita growth, which averaged 6-7% in 1990-97, fell to a level of 3.5% (World Bank website, Sept. 1999). Throughout 1998, there was actually a net outflow of foreign investors and foreign exchange reserves declined from $USD 8 billion to less than $5 billion. Despite a currency devaluation of 26% since December 1996, the Dong remains overvalued at around 14,000 to the US dollar in late 1999. Overseas development assistance (ODA), from the World Bank increased, but cannot counter the loss of FDI[2].

To encourage foreign investor confidence, the Government of Vietnam (GOV) initiated some procedural reforms, but many investors decried these steps as too little too late. The GOV eliminated a number of fees and reduced prices for some services, but the reforms did not fundamentally alter any of the "complicated bureaucratic procedures or the complex taxation system"[3]. The World Bank[4] recently predicted that current downward trends in key economic indicators will continue through 1999 affecting all aspects of the economy and eroding earlier gains.

In addition, El Niño-related flooding, storms and drought caused severe property and crop damage in Central and Southern provinces during 1997-98. Further extensive flooding occurred in November 1999. The GOV's response to the deepening crisis has been to try to maintain rural incomes for the majority of the people.

The National Assembly recently approved the GOV's optimistic goal of achieving 5-6% growth in 2000. In October 1998, the VIth plenum of the Central Committee announced a

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[1] Two sources are cited here for reference. The first one is adapted from the 1999 Population Council's (Hanoi) annual report to the Busset Foundation, and the second one is adapted from a memorandum of the president of the IDA and IFC to the executive directors of the WB (on a country assistance strategy of the WB group for the SR of Vietnam), dated July 1998 (pp3-5).

[2] The Japanese Government is currently investigating whether to provide assistance to Vietnam. Although they have a major bail out assistance package for the region, they may not provide assistance to Vietnam because of the slowness in the reform process and concerns about corruption.

[3] Vietnam News, "Foreign investors want more reforms", p.6, 14 April 1998

[4] Unless otherwise noted, all references to data from the World Bank are taken from "Vietnam Rising to the Challenge: An Economic Report of the World Bank Consultative Group Meeting for Vietnam, December 7-8, 1998".

"renewed emphasis on agriculture and rural development as one positive way of stemming economic decline and maintaining social stability"[5]. Party Secretary General Le Kha Phieu and Prime Minister Phan Van Khai publicly admitted that to attain this target, significant reforms are required. They proposed to implement measures to expand export markets, stabilize national finances, resolve social problems, and encourage the population to generate more savings. The international donors particularly supported the GOV's efforts "to attack Vietnam's rising tide of rural poverty"[6] and in early December at the Annual Donors Meeting in Paris donors pledged $2.2 billion in aid for fiscal year 1999 and an additional $500 million conditioned on accelerated reforms. While some donors argued that all aid should be conditional on reform, this approach adopted mostly by the World Bank over the last several years has not to date resulted in a significant transformation of the status quo.

Unemployment is a critical concern for all Vietnamese, particularly because unemployment rose for the second year in a row in 1998. The National Assembly delegates from provinces around the country echo their constituents' concerns that creating rural jobs is crucial[7]. Currently, only 30% of the rural poor rely solely on farming for their income[8]. Findings from recent Population Council studies suggest that jobs are also needed in smaller urban areas outside Hanoi and HCMC. Youth in Quang Ninh Province state that their greatest concern is unemployment and are pessimistic about their future prospects[9]. Sex workers in Can Tho report turning to the sex industry when unemployed and in debt although they may owe as little as $30[10]. With a renewed emphasis on stimulating rural development, the GOV wants to create more off-farm rural jobs but has no clear strategy for how to promote such employment. In an attempt to keep rural inhabitants in the countryside, the GOV announced in January restrictions on pedicab (*xich lo*) drivers in Hanoi, but provided no alternative employment. The GOV has also tried unsuccessfully to control rural migration to HCMC[11].

In January1998, and as a first step in developing a tax base, the GOV introduced a value-added tax (VAT)[12] to replace the turnover tax. The VAT is intended to create incentives

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[5] Vietnam Economic Times, "The Landmark Events", p.16-17, December 1998.

[6] Vietnam Investment Review, "International donors deliver strategy to attack rural poverty" 14-20 December 1998, p.4.

[7] Vietnam News, 28 November 1998.

[8] World Bank, p.13

[9] Through funding from the New Zealand Embassy in Hanoi the Population Council supports soccer teams in Ha Long City for 130 out-of-school youth. Most youth spend their time shining shoes, selling coal or helping their parents with housework.

[10] The Population Council recently completed a study for FHI on CSWs and IDUs in Can Tho and is overseeing data collection in Quang Ninh province by the Center for Social Science in Health.

[11] See the Council's Migration Conference Proceedings (1998), which suggests the inherent costs of this approach.

[12] Thanks to Brian Wurts of Price Waterhouse for an explanation of the VAT.

to export while reducing imports of luxury goods. However, implementation has been slow and uneven. While the VAT is expected to generate the same amount of revenue as the turnover tax, numerous special rules and exceptions create uncertainty about how much should be paid. State-owned enterprises also remit less. While the earlier turnover tax and the new VAT proceeds are divided 50/50 between provinces and the central GOV, there is too little budget transparency to evaluate these transfers to and from the provinces.

The deepening of the economic crisis affects the GOV's ability to maintain its already declining social services. The current plan is to "socialise" activities by instituting (or readjusting) user fees for most services. The GOV also encourages people to contribute additional fees, in-kind contributions, and their time to activities such as school construction, village road construction, and water and sanitation activities. These contributions are seen not only to improve social wellbeing but also to promote grass-roots participation in local development. Nevertheless, declining public financing for social services (in real terms) is seriously affecting the health sector and since increasingly more care is being delivered through the private sector, the poor are losing out. As early as 1990, a survey found that the private sector share of total national health expenditures was 69% [13] and privatisation of all social services is on the rise. The overall impact is that greater economic disparities and differential access within the population are on the rise.

Economic effects

Vietnam's closed capital account protected it from the early effects of the Asian crisis, but with deepening regional recession it is quite clear that the impact will be considerable (2/3 of the country's exports have been to East Asia and 2/3 of FDI to Vietnam has come from the region). Export growth has fallen sharply and FDIs fell by 40% in the first half of 1998. The Dong depreciated 11% against the dollar from mid-1997 to mid-1998. Vietnam's attractiveness in international markets and with foreign investors has fallen significantly. GDP growth in 1998 was 3.5% (down from 8.8% in 1997) and 4.3% during the first half of 1999[14]. This downturn is accompanied by lower than expected budget revenues and inflation rising from 4.5% at the end of 1997 to 7% in mid-1998, the highest rate in 2 years.

The Government is deeply concerned about these developments and is actively seeking solutions. There is no evidence that the response to the Asian crisis will be to "close the doors" as some observers had feared. Reforms are continuing though at a pace not sufficient to mitigate the impact of the harsh external environment

Despite the macroeconomic overview above, available sectoral data are not yet showing a sizeable impact of the Asian crisis on the health of the people in Vietnam. This does not mean that further negative trends may emerge or continue when the data for 1999 come

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[13] International Finance Corporation, 1995:14

[14] Source: World Bank Country Data (www.worldbank.org) accessed November 22, 1999

in. Most experts interviewed for this report agreed that the impact so far seems difficult to quantify, but were cautious to add that things may look different in a year's time. In other words, although the worst of the regional financial crisis is over, the social impacts (negatively affecting virtually all population groups) continue to unfold; we think the latter will be deeper and will last longer even after the crisis economies are back to positive growth.

Section 2: Health Impact of Crisis

What follows is a very focused view of key indicators that have a bearing on understanding trends in health in Vietnam that might have been affected by the Asian economic crisis. Most of the data that did not show significant changes -- as judged by the consultants and their interviewees -- were omitted. Instead, this report will be supplemented by the most important (and rich) background documents from which most of the data were drawn for this report.

Health care financing

Budgets

The population growth in 1998 was estimated at 1.75% and GDP/cap in 1998 at USD340/yr. The total health budget for 1998 was 4,512 billion Dong (MOH, 1998) which represents an increase of 0.29% over 1997. However, according to the MOH Policy Unit, there was a 10% cut in MOH expenditure (vis a vis budget) in the last quarter of 1998.

Other trends in 1998 included:

- Two percent drop in the per capita public health budget.
- One percent decrease in the health budget as a percentage of the national budget.
- Twenty percent drop in the health budget as percentage of the GDP.
- A decrease of 26% in hospital revenue.

Whether any of this of these changes can be attributed to the effects of the Asian financial crisis is questionable and will need to be judged in the light of future trends.

The proportion of the health budget derived from foreign donors continued to increase to almost 19% and overall donor assistance to the health sector continued to increase. However, the proportion of the EPI budget provided by donors has been steadily declining (see Table 1).

Table 1: Health expenditure and financing data, 1996-98

	1996	1997	1998	Remarks
Health budget/capita (Dong[15])	48,000	59,000	57,800 (- 2 %)	(MOH 1997 & 1998)
Health budget as a % of the national budget	4.76%	5.81	5.59 (- 4 %)	"
Health budget as % o GDP	1.39%	1.52	1.22* (-20%)	"
Percentage of total hospital revenues that come from hospital fees: All hospitals Provincial hospitals District hospitals	23% 28 7.7	22 27 8.2	? ? ?	"
Estimated revenues/resources, MOH (billion dong): From hospital fees From insurance From foreign aid From the govt. budget	472 520 350 2250	500 570 510 2470	370 (-26%) 609 539 2531	(MOH, 1998)
Donors' funding of the health budget: (as a %)	8.9%	18.1	19.7#	(MOH, Dept of Planning)
MOH budget: Government funds Donor funds (grants & loans)	2400 350 =14.5%	2780 510 =18.3%	2870 539 =18.8%	(Bill. Dong) (MOH, Dept of Finance)# #
External aid to the entire health sector (MOH and other)	48.5	67.5	74.8**	(Mill.USD) (MOH, Proj Coord Dept)

*: 1.77% according to Deolalikar AB. **: USD 49.5 million in 1999.

#: In 1996, 58% of the EPI budget was covered by donors; in 1997, 52%; in 1998, 40%.

(MOH, Department of Planning)

##: Note the different % found in MOH, Department of Planning, in the row above.

[15] Throughout most of 1998 and 1999 the exchange rate was around USD = 13,900 Dong.

Expenditure on health programs/services

Government health expenditure on civil works and new equipment declined during 1998 by 16% and 9%, respectively (Table 2). However, the per capita budget allocation for drugs increased significantly. The budget for EPI increased from 60 billion dong in 1997 to 65 billion in 1998; however, a cut of 2.5 billion dong was projected for 1999. Six donor agencies provide 80% of all ODA: the WB, the EU, the ADB, JICA, UNICEF and SIDA. The MOH alone had 99 projects totaling USD 469 million; at the end of 1998, 200 million had been disbursed (Carlsson, BT). In 1998, donors covered 26% of all public health expenditures (Deolalikar AB, 1999).

There are about 400 NGOs in Vietnam which spent an estimated USD 78 million in 1997/98. More than 100 NGOs work in the health sector; officially they spent USD 4.5 million in 1997 and 7 million in 1998. However, unofficially, the total figure for 1997-98 is estimated to be closer to USD 25 million (Jacobsen R, 1999).

Table 2: Government and donor expenditure on selected health programs, 1996-98

	1996	**1997**	**1998**	**Remarks**
Health expenditure on MOH civil works (Billion Dong)	208	397	331 (-16%)	(MOH Health Statistics & Information Division)
MOH expenditures on equipment (Bill.ion Dong)	103	110	100 (- 9 %)	(MOH, Dept of Equipment)
Average budget/capita for medicines from MOH	?	USD 5.0	USD 5.7	(MOH Health Statistics & Information Division)
Donor funding of 11 national vertical programs (million.USD). (Taken from a Table prepared 26/3/99.	16.279	26.355	25.199 *	(MOH, Dept of Planning)
Donor spending in health: (as a share of total health expenditure) PHC Curative care	 27% 0.45%	 6.3% # 0.33%	 ? ?	(Deolalikar AB, 1999) #: a trend? a one yr. Anomaly?

*****: At the end of 1998, there were 179 donor projects covering the whole health sector. 70% were through the MOH, 2% directly through provinces; the rest covered the National Comm for Pop and FP, the National AIDS Comm., MOH institutes directly, the Red Cross, the Comm for the Protection and Care of Children and the Women's Union. There were 19 bilateral donors , 4 from the UN, the WB, the ADB and the EU. By 1998, the 179 projects had committed a total of USD 669 million (at the end of 1997, USD 187 million had been disbursed and it was estimated that 80 million would be disbursed in 1998).

Other pertinent health expenditure data include the following:

- In 1998, the curative/preventive ratio of health expenditures was still 5:1 when the internationally recommended standard is 2:1 (Deolalikar AB, 1999).
- About 50% of the government's health expenditure is allocated to hospitals (Deolalikar AB, 1999).
- Fees collected from hospitals only cover 5-7% of all health expenditures (Deolalikar AB, 1999).
- On the other hand, it is estimated that hospital fees collected cover up to 50% of the same hospitals' expenditures (Hung PM, 1999).
- Provincial governments foot the bill for 54% of all public sector health expenditures in the country (Deolalikar AB, 1999).
- The provincial health budget per capita (nationwide average) was around USD 2 in 1997 and USD 1.8 in 1998, a decline of 10% (MOH, Health Statistics and Information Division).
- In 1997, 80% of total expenditure for all health services (public and private) was covered by households' out-of-pocket expenditure, 19% was provided by the government, and 1% by donors (Deolalikar AB, 1999).
- The number of private health facilities doubled from 1996 to 1999, more so in the richer provinces (Hung PM, 1999). In 1999, there are an estimated 36,000 private health practitioners in Vietnam, of whom about 4,600 are unlicensed (Dahlgren G, 1999).
- No data were found on expenditures of the National AIDS Committee.

Service coverage and utilisation

It is quite obvious that the ability of the public health sector to deliver basic health services has not suffered significant disruption during the last 3 years.

From 1993 to 1997 there was a drop of 25% in inpatient admissions nationwide, (Deolalikar AB, 1999). However, the total number of consultations, outpatient visits, and inpatient admissions increased in 1998 compared with 1997 (MOH, Health Statistics & Information Division, 1997 & 1998).

Overall, health service utilisation, of both public and private services, appears to be closely related to income in Vietnam. Twenty percent of the population is considered to be poor (lowest income quintile) in Vietnam and 28% near poor, (Lieu NH, 1999). The income differential between the highest and the lowest income quintiles in Vietnam is sevenfold (Hung PM, 1999). The poor appear to have low utilisation of both private and public facilities and this is declining. Between 1993 and 1999, the proportion of all health contacts made by the lowest income quintile declined from 16% to 9% for private practitioners and from 9% to 6% for public health facilities (Deolalikar AB, 1999).

In 1998, 45% of the users of public hospitals were in the top income quintile compared with 36% in 1993. Only 6% of users were in the lowest income quintile. Three quarters of all hospital users are drawn from the richest 40% of the population, (Deolalikar AB, 1999).

In 1998, health care expenditure by the lowest income quintile was 27% of their total non-food expenditures, up from 22% in 1993. In 1998, only 13% of all health contacts were in government health facilities, (Deolalikar AB, 1999).

Preventive programs

No major changes in antenatal clinic (ANC) consultations were reported (3.296 million in 1997 and 3.301 million in 1998). TT2 vaccination coverage fell from 83.5 to 82.5%, a difference that is not statistically significant (MOH, Health Statistics & Information Division, 1997 & 1998). Coverage of other EPI vaccines remains steady at very high rates by global standards (Table 3).

The contraceptive prevalence rate (CPR) remained unchanged in 1998 (MOH, Health Statistics & Information Division, 1997 & 1998).

Table 3: EPI coverage (%), 1996-98 (MOH, Health Statistics & Information Division)

	1996	**1997**	**1998**
BCG	95%	96	93.5
DPT 3	94	95	93.7
Polio 3	94	95	93.8
Measles	96	96	96.2
Fully immunised	95	95	95.5

Health worker training

The MOH funding for training activities actually increased 14% from 1997 to 1998 (MOH, Health Statistics & Information Division, 1997 & 1998).

Health Outcomes

Morbidity/mortality

- No significant changes in morbidity and mortality have been identified since the onset of the Asian financial crisis in 1997. Some changes in the nationwide top five reported causes of morbidity and mortality did occur, but these data are considered

highly unreliable (MOH, Health Statistics & Information Division, 1997 & 1998). The number of reported measles cases doubled from 6,500 in 1997 to 11,690 in 1998 (MOH, Health Statistics and Information Division, 1997 & 1998). No further information is available on this increase; however, there is no evidence that it is due to any decrease in program coverage.

Changes in morbidity patterns during the past few years have occurred but cannot be linked to the crisis, for example:

- Reported TB cases have steadily increased in the last four years from 100,000 cases in 1995 to 142,000 cases in 1998 (MOH, Health Statistics and Information Division, 1997 & 1998).

- Reported malaria cases have been decreasing from 1996 (533,000 cases) to 1998 (383,000 cases); this represents a drop in the morbidity rate from 707 to 491 cases/100,000 population (MOH, Health Statistics and Information Division, 1997 & 1998).

Nutrition

Overall trends in nutritional status during the past few years have been positive. For example, the prevalence of growth faltering (low weight-for-age) among children less than 5 years of age decreased from 44.9% in 1994 to 39% in 1998 (MOH, National Institute of Nutrition, 1999). Likewise, the prevalence of stunting (low height-for-age) has declined from 46.9% in 1994 to 34.4% in 1998. No surveys have revealed any change in this trend since the onset of the Asian crisis.

Health Care Costs

- Out-of-pocket expenditure for a visit to a hospital for an uninsured person has increased 36% (in real terms) between 1993 to 1998 (Deolalikar AB, 1999).

- In a 1998 MOH survey in 30 district hospitals, 43-63% of patients did not have the money to pay hospital fees and needed to obtain a loan or sell off assets to meet the bill. In Vietnam, a high percentage of households fall into poverty because of illness (Hung PM, 1999).

- The highest income quintile spends 2.3 times more on outpatient care and 3.9 times more on inpatient care than the lowest quintile (Hung PM, 1999).

- In 1998, 13% of the users of commune health stations were from the highest income quintile, 19% were from the lowest, (Deolalikar AB, 1999).

- Health insurance coverage is disproportionately large among the rich, (Deolalikar AB, 1999).

No data on costs of health care services were available to compare trends between 1997 and 1998/99.

Cost of consumables

No major changes in drug prices were reported in 1998 (MOH, Department of Pharmacy). The same is probably true for contraceptives, vaccines and cold chain supplies. The estimated drug expenditure per capita increased from USD 5.2/yr in 1997 to USD 5.5 in 1998 (MOH, Health Statistics and Information Division, 1997 & 1998).

Distribution costs

Provincial health departments cover the expenses for program logistics at the local level. Anecdotally, provincial governments had more problems finding funds for routine operations during 1998 (per capita budgets decreased by 10%); however, we found no data on changes in real costs.

Section 3: Responses and Gaps

Health policy changes

A major new policy was launched in Vietnam consistent with the government's aim to eradicate poverty. In early 1999, it was decided to distribute 4,000,000 free health insurance cards to poor recipients. Implementation by the Ministry of Labor, Invalids, and Social Affairs began in April 1999 and by June 1999, 200,000 cards had been distributed. MOH officials are now worried they may not find the funding to complete this distribution and reach the goal of 4 million free cards. Lobbying is now going on to increase allocations in the 1999-2000 fiscal budget for this specific purpose, (Lieu NH, 1999). This initiative cannot be linked directly or indirectly to the Asian economic crisis.

The MOH continues to have an open attitude towards the further development of the private health sector, particularly to care for those sectors of the population who now can pay for services.

Effectiveness and appropriateness of the responses

One cannot really speak of 'responses' to the Asian economic crisis in the health sector in Vietnam, because the crisis has not been recognized as having had an adverse effect on health YET. This situation may change in the near future if indicators begin showing significant downturns. In light of experience in other affected Asian countries, the ADB has recommended that Vietnamese authorities carefully monitor changes in the following indicators:

- availability of drugs, drug price increases above the overall rate of inflation and a further increase in self-medication,
- further reductions in the collection of user fees and fee increases,
- shifts in health care seeking from private providers to public health facilities,
- shifts away from professionally attended births, and

- decline in household expenditure on health (reflecting delays or avoidance of medical care as a coping mechanism).

The same experience in other countries shows that it is unlikely that EPI coverage and contraceptive prevalence rates will decline significantly. Other health outcomes are also unlikely to show convincing changes attributable to the consequences of the crisis, at least in the short-term.

Gaps

One cannot speak of gaps in the response to the crisis since, as noted above, there have been no specific interventions by the Government or donors to address the effects of the crisis. In Vietnam, this period could be viewed as a continuation of longer-term trends; however, diminished export income and foreign investment will lead to declining public revenue and a likely stagnation in public sector health investment. The crisis merely reinforces the need for continuing reform of the health sector, especially to increase both cost-efficiency and equity of access, and further foreign assistance in the health sector. AusAID's recently released health sector strategy reflects these long-term trends and the priorities for donor action. Recommendations listed respond in the large part to chronic needs rather than acute problems created by the Asian financial crisis.

Recommendations

- Specific initiatives related to the impact of the Asian economic crisis are probably not relevant for Vietnam, beyond strengthened impact monitoring systems. Donor support should rather focus on addressing long-term trends in health indicators, expenditure, and the nature of health care services that reflect changes both in the nature of the disease burden and the capacity of the public sector to maintain effective health services. Given the likely slowdown in government revenue growth, it is unlikely that major new public investment in the health sector will be possible.

- The donor community should consolidate its assistance to the health sector in Vietnam while encouraging reforms that promote cost-efficiency but protect equity of access to health services. Progress has been made in addressing some of the conditions that make up what WHO calls the "unfinished agenda" of communicable disease control. The impact of control efforts has been documented most significantly on malaria. TB, HIV/AIDS, and Hepatitis remain critical public health issues that require continued or expanded support from donors.

- Donor support should be strengthened for initiatives that will have greater longer-term effects on health indicators than medical, or clinical, services. Most government expenditure is allocated to the treatment of diseases; however, health promotion and disease prevention programs are more cost-efficient in reducing the burden of disease, especially as the epidemiological transition gathers pace in Vietnam. Non-communicable diseases and injuries will increasingly be important causes of morbidity and mortality. It is unlikely, given the current stagnant economic situation, that the Government will greatly increase allocations to health promotion programs; therefore, donors should lead these initiatives. Initial needs include relevant health research on disease burden, behavioural risk factors, and cultural attitudes to behaviour change. Health promotion institutions need strengthening of their capacity to conduct research, pilot interventions, and manage and evaluate health communication programs.

- There should be support for a social impact monitoring system and focused studies on the social effects of Asian economic crisis in Vietnam, especially among vulnerable

groups such as the urban and rural poor and certain ethnic minorities. The monitoring system should track trends in the key indicators recently recommended by the ADB as critical. Unlike other countries that have been more severely affected by the crisis, this system need not be separate but rather an extension of a strengthened national public health surveillance system. The extensive network of development NGOs and bilateral project staff could contribute to the implementation of an ongoing monitoring system.

- The government health surveillance and monitoring system is weak, focussing on morbidity trends and coverage of certain public health programs, such as immunisation. Long-term assistance is probably required to enable the generation of reliable, timely, routine data for the assessment of trends in other key health indicators, such as mortality, and health service access and utilisation.

- Utilisation of health care services by the poor, both public and private, has been declining in recent years. The government initiative to develop a scheme of free health cards demonstrates a commitment to equitable access to health care services. However, this program is still in its infancy with low coverage achieved during 1999. In addition to support for this initiative, donors might support other mechanisms to ensure health care access, including co-payment schemes, such as the Voluntary Health Card scheme in Thailand. In the long-term, access to health services will probably be maintained only if comprehensive health insurance schemes can be implemented. These should be developed within the country based firmly on the capacity of rural and poor urban communities to contribute. These schemes have often failed in other countries because they were introduced in haste without adequate attention to community consultation and training in the requisite management skills.

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