HEALTHCARE SEEKING BEHAVIOUR IN ASIAN TRANSITIONAL ECONOMIES: A LITERATURE REVIEW AND ANNOTATED BIBLIOGRAPHY*

Development Bibliography 17

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CONTENTS

ACRONYMS AND INITIALS

BI	Bamako Initiative
CHC	cooperative healthcare
CHS	commune health station
CMS	Cooperative Medical System
HCSB	healthcare seeking behaviour
HI	health insurance
HIL	health insurance leigislation
LSIS	Lao Social Indicator Survey
MoPH	Ministry of Public Health
OTC	over the counter
PDR	People's Democratic Republic
PHC	primary healthcare
PHS	private health sector
PPA	participatory poverty assessment
VLSS	Vietnam Living Standards Survey

INTRODUCTION

The focus of this literature review and bibliography is household healthcare seeking behaviour (HCSB) in poor rural communities of Asian transitional economies in general and Vietnam in particular. Nine countries classify as Asian transitional economies (Glewwe and Litvack 1998): four in East or Southeast Asia – China, Vietnam, Laos, Cambodia; and five in Central Asia – the former Soviet Union countries of Uzbekistan, the Kyrgyz Republic, Turkmenistan and Kazakhstan; and Mongolia. The literature search found that household healthcare seeking studies are few and far between in these countries, particularly those of the former Soviet Union. As a result, a few pertinent articles are included from research carried out in other non-Asian transitional economies, where the findings relate to the impact of economic reform on the potential users of health systems.

The bibliography incorporates literature generated from the time of economic reform to the present day: for China from the early 1980s; for Vietnam since *doi moi* was launched in 1986; since 1985-86 for the New Economics Mechanism of Laos People's Democratic Rrepublic (PDR); since 1989 in Cambodia; and from the 1990s for the five Central Asian republics.

The bibliography gives the objectives; study type (i.e. review article, research report, empirical study); data source and methodology employed; study findings; policy implications; and conclusions for the literature reviewed. Literature has been culled from appropriate journals, secondary references and databases such as Medline. There are inevitably other sources of literature under-represented in this review, one being the 'grey' literature produced by non-governmental organisations. Such studies are often difficult to locate unless referred to by larger institutions. Time has precluded seeking access to this literature.

LITERATURE REVIEW

The Asian transitional economy countries featured in this literature review differ markedly. They are in different stages of economic transition, have different political and economic structures and differ in the structure, finance and organisation of their health services. In countries where the process of economic reform is more established (i.e. China and more recently Vietnam) research has addressed the impact of economic and health sector reform on household healthcare seeking, perhaps because the repercussions for poorer households have become a more evident political and policy issue. In other transforming countries (e.g. of the former Soviet Union), literature focuses understandably on how to restructure and finance the health sector. Little attention has been paid, until recently, to the impact on users of, or the influence of users on, the reform process (McKee, Figueras and Chenet, 1998; World Bank 1999a, 1999b). In Cambodia, long standing political instability has meant that little research of this kind is currently available, existing health data are unreliable and the effect of any economic policy on household health behaviour is extremely difficult to discern. However, at least two studies of healthcare seeking in Cambodia are currently under review by the Ministry of Health, so it may be possible in the near future to glean something of households' responses to illness in that country (Wilkinson 1999).

HCSB is defined as decision making for healthcare at the household level wherein the decisions made encompass all available options: public and private, modern and traditional. HCSB studies also accommodate the decision **not** to take up available health services, wherein the use of home remedies or the decision to utilise no healthcare option at all may be exercised. Studies of HCSB incorporate, but are wider than, research on health service utilisation. Utilisation studies focus on the end point of the decision-making process – the action ultimately taken – and often represent one type of healthcare provision (generally the public sector) and one sector of the user population (usually those who can afford to access public health services).

The objective of HCSB studies is to understand the process of decision making for health and how it is influenced by household, individual, illness and provider characteristics. In the context of economic reform, where incomes may rise or fall and thus influence the ability of households to afford social services, cost and affordability are particularly important variables. Most of the research on HCSB currently available uses quantitative methods and these place significant limitations on the study of multi-faceted issues such as affordability, quality of care and decision-making for health. Qualitative approaches are still relatively rare, as are studies that use a complementary mix of quantitative and qualitative methodologies (Tipping and Segall 1996). However, recent qualitative work by the World Bank (1999a, 1999b, 1999c), using participatory methods to assess and understand poverty, and by Segall, Tipping, Dao and Dao (1999), using a combination of methods to explore equity in access to healthcare in Vietnam, is a move in the direction of research aimed at better representing the decision-making processes of poor households.

An earlier DFID funded review and bibliography on HCSB in developing countries identified a wide range of research, the bulk of which pertained to central and sub-Saharan Africa (Tipping and Segall 1995). The 1995 review discussed a number of methodological issues that compromise the comparison of HCSB studies. These issues are summarised below since they are similarly pertinent when reviewing transition economy country studies. The issues are (i) how to compare the results of longitudinal studies, which record the process of HCSB (Tipping, Truong, Nguyen and Segall 1994; Vinard 1994; Mbugua 1993), with cross-sectional studies, which provide a snapshot of healthcare behaviour and can be compromised by the problem of respondent recall (Berman, Ormond and Gani 1987; Henderson, Akin, Zhiming, Shuigao, Haijiang and Keyou 1994; Swenson, Thang, Nhan and Tieu 1993); (ii) how to compare the findings of exit-based (usually public sector) facility studies (e.g. Ministry of Health 1991a, 1991b) with the more comprehensive healthcare seeking data that can be found in household based research (Berman *et al.* 1987; Tipping *et al.* 1994); and (iii) how to reconcile the very different interpretations of HCSB found in small-scale primarily qualitative studies (e.g. Hunte and Sultana 1992; Tunyavanich 1992) versus larger scale quantitative research (e.g. Becker, Peters, Gray, Gultiano and Black 1993; Henderson *et al.* 1994).

In addition to these methodological issues that may compromise the study of HCSB, research may be further complicated by the massive and rapid political and macro-economic changes inherent in the process of economic transition with all their repercussions at the level of the household. The shift from a centrally planned economy, in which the state historically organises, finances and delivers primary healthcare (PHC)

services (as in China and Vietnam), to a market economy in which other non-state provider options are allowed to flourish or evolve passively (Segall 2000) increases the complexity of decision making for health.

It is this process of change from virtually monopolistic state provision to a market place of healthcare options that makes decision making for household health of value to study. HCSB is the result of a complex weighing of provider, patient, illness, and household characteristics (Tipping *et al.* 1995). If we can understand what underlies an individual's decision to act in response to illness, then it may be possible to assess the extent to which healthcare needs (in particular those of the poor) are being met by public (and private) health sectors. Services may then be adapted appropriately. It is also worth stating that while health sector reform may widen the options available to the healthcare consumer and pare down inefficient or over-staffed public sector services, it also usually hands over part of the finance of healthcare to households and therefore raises issues of affordability and equity of access. Vulnerable groups of the population, such as the poor, the elderly, women and children, are especially compromised during economic transition. Social safety nets may deteriorate, if they existed at all, and mechanisms to hold the private sector accountable for affordability and quality of care may be rudimentary or non-existent. How vulnerable households cope with the ramifications of illness episodes is therefore a particularly salient issue during economic transition.

Despite its intrinsic value, there is little research on how people exercise the novelty of provider choice in transitional economy countries and less on the specific nature of healthcare seeking amongst economically vulnerable households. Typically, the focus of much research in this area is the impact of health sector reform on provider, rather than user behaviour (Bloom 1997; Guldner 1995; Smithson 1993).

How then do household consumers decide what to do in response to illness episodes, given this state of flux in transition economy healthcare sectors? A summary of the main issues is given below. As stated above, the primary focus is on research and studies conducted in Vietnam, with findings from other Asian transitional economies included where relevant and available.

Economic transition, incomes and equity of access to healthcare

The process of economic reform affects household incomes which in turn affect access to health services, particularly when services are no longer provided free of charge or have (increased) associated costs (e.g. transportation, drug fees and informal payments). In Central Asian economies, average incomes have declined substantially, whereas average incomes have, on the whole, risen in East Asian economies (Glewwe *et al.* 1998). In Vietnam, rapid economic growth (an average annual growth rate of 8 per cent in the 10 years since the market reforms were adopted in 1986) has raised household incomes across the country's seven regions and across both urban and rural areas, enabling people to buy what were previously state subsidised healthcare services (Glewwe *et al.* 1998). However, not all households are enjoying this increase in income. While it cannot be said that the reform process in Vietnam has enabled the 'rich to get richer and the poor more poor', recent poverty analysis suggests that the poor are not becoming less impoverished as quickly as the rich are becoming wealthier (World Bank 1995; Glewwe *et al.* 1998; Segall *et al.* 1999).

However, the impact of this upward trend in household income on equity of access is less clear, as there remain economically vulnerable households for whom the benefits of economic reform are limited

(Glewwe *et al.* 1998). Recent research by Segall *et al.* (1999) in Vietnam has identified that poor households have difficulty accessing social and health services, the cost of which represents a disproportionately high proportion of household income. In particular the research found that the official and unofficial cost of higher level hospital services prevents the poor from accessing services. Preliminary analysis of the second Vietnam Living Standards Survey (General Statistical Office 1994) conducted in 1998 also suggests that access to hospital care is inequitable. The poor, with their disproportionately low share of health insurance (HI) cover, find accessing hospital services, especially inpatient care, very difficult, whereas the non-poor, by having the lion's share of HI coverage, make greater use of higher level hospital services and so benefit more from state subsidies for healthcare (Deolalikar 1999).

Meanwhile of greater concern may be that even the cost of **commune** level healthcare can prove prohibitive for poor households (Segall *et al.* 1999).

In China, research has shown that increasing income differentials negatively affects equity of access. A cross-sectional study of equity and use of medical care by Yu, Cao and Lucas (1997) found little difference in the utilisation of outpatient services by income group, but greater differences at higher levels of care. The poorest group was more likely not to use any services and to avoid hospital inpatient care due to an inability to pay. This erosion of China's pre-reform equality of access to health with the increase in income inequalities is also reported by Tang, Bloom, Feng, Lucas, Gong and Segall (1994).

Economic transition, the price of healthcare and affordability

In countries where economies are contracting, the price of public healthcare under economic reform is likely to rise since governments have fewer resources with which to subsidise services. Where transition has lead to economic growth, such as in Vietnam and China, the pressure to increase prices may be less. But as Glewwe *et al.* (1998) suggest, the move to a market economy usually involves shifting at least part of the costs of healthcare provision to users of services. The introduction or increase of user fees in the public health system may create inequalities in access to services, particularly where compensatory exemption systems do not exist or provide inadequate safety nets for the poor and vulnerable (Segall *et al.* 1999; Ensor and Pham 1996b; Wilkinson 1999; World Bank 1999c). Where exemption mechanisms are in operation, inequities may be exacerbated by ineffective targeting, as well as significant administrative, economic and informational barriers to their implementation (Russell and Gilson 1997).

Analysis of Vietnam Living Standards Survey (VLSS) data showed that the cost of services affects decision-making for health. Seventy per cent of the poorest quintile was found to use the cheaper option of self-medication as opposed to 54 per cent of the wealthy (Gertler and Litvack 1998). Similarly, research in Vietnam in 1992–93 (Tipping *et al.* 1994) found an inverse relationship between the average cost of a range of healthcare acts and the frequency with which they were used; over-the-counter (OTC) drug outlets were the cheapest and most often used healthcare option and hospital care the most expensive and largely avoided option, especially by the poor. Research in Laos by Vinard (1994) and by Holland, Phimphachanh, Conn and Segall (1995) also reports greater reliance on the cheaper option of self-medication by the poor. Similar coping strategies by the poor are reported in Cambodia (Wilkinson 1999).

Drug costs in Vietnam (formerly government subsidised) represent the largest proportion of household health expenditures at 80 per cent (Glewwe *et al.* 1998). That this is so even for poor households (General Statistical Office 1994) suggests a willingness on the part of Vietnamese households to pay the full cost of drugs (Glewwe *et al.* 1998). Research in the Kuba district of Azerbaijan (Guseynova, Chakoury and Eerens 1996) similarly reports a high proportion (62 per cent) of household health expenditure spent on drugs. While part of this expenditure may be attributed to the cost of prescribed medicine, a significant portion reflects households' purchase of OTC medicines. A combination of polypharmacy and the commonly held public belief that several kinds of drug enable a quicker, more effective treatment than one drug, means that household expenditure on medicines may well be unnecessarily high. This reliance on OTC medicines, especially by the poor, has implications for treatment efficiency and drug safety (Heaver 1995; Wolffers 1995). It also holds broader ramifications since the move away from curative care services at the primary level and toward OTC medicines means loss of access to those services that can provide both preventive care and information (Gertler *et al.* 1998).

Healthcare expenditure as a proportion of household income is a useful indicator of ability to pay and therefore of equity of access. Analysis of the VLSS data of 1992–93 shows that a trip to a commune health station (CHS) costs the poorest group 8 per cent of their annual non-food consumption and a hospital outpatient visit costs 26 per cent, in comparison with 3 per cent and 5 per cent respectively for the wealthy (World Bank 1995). A disproportionately high expenditure on health by the poor was also found in Vietnam by both Ensor and Pham (1996b). The poor spend over 19 per cent of annual per capita income on healthcare in comparison with less than 4 per cent by the wealthy. Segall, Tipping, Lucas, Truong, Nguyen, Dao and Dao (2000) found expenditure by the poor for ambulatory care was 13.4 per cent of annual household income as opposed to 3.2 per cent for the non-poor. In China, Yu *et al.* (1997) found that 31 per cent of annual per capita net income is spent on health by those in low income groups versus 7 per cent for the high income group, and an earlier study by Yu (1992) also reports a higher percentage expenditure on healthcare for China's rural poor. Guseynova *et al.*'s (1996) study in Kuba district, Azerbaijan, reports expenditure on health by the poorest group to be 25 per cent of total household expenditures against 17.5 per cent for the wealthiest, and in Cambodia, Wilkinson (1999) states that the urban poor spend a high percentage of annual income (28 per cent) on what is generally perceived to be poor quality healthcare.

Although studies vary in terms of their parameters of analysis (i.e. income per capita or per household; expenditure for the whole study sample or those reporting sick; expenditure for all healthcare seeking acts or per single healthcare act), similar findings of a greater proportion of annual income spent on healthcare costs by the poor than the non-poor are reported (Ensor *et al.* 1996b; Yu *et al.* 1997; Fabricant, Kamara, and Mills 1999).

The poor cope with this unaffordable expenditure by borrowing, reducing their consumption of essential goods or selling assets (Ensor and Pham 1996a; Segall *et al.* 1999; Wilkes, Yu, Bloom and Gu 1997). A recent participatory poverty assessment (PPA) in Vietnam by the World Bank (1999c) finds the economic shock of ill health to be a cause of poverty in all study sites. This was particularly the case when illness resulted in the death of a family member who had been a labourer, or when the household had to buy higher

level health services. Sale of assets, borrowing money or food and withdrawing children from school to work were some of the coping strategies employed to deal with the economic shock to the household. However, in the highland study site of Lao Cai and in Ho Chi Minh City, many of the poor reported living with chronic ill health because the costs of seeking treatment were simply unaffordable (World Bank 1999c). Being able to access affordable healthcare services was central to the problems prioritised by the poor in this study. In the Kyrgyz Republic and in Uzbekistan, PPAs (World Bank 1999a; 1999b) showed that healthcare had become increasingly difficult to afford since the time of economic reform, with ill health perceived as a major contributor to household poverty.

The poor are thus greatly disadvantaged in terms of the impact of health costs on the household economy. The consequences are a preference for lower cost, payment flexible options at primary level of service. Private practitioners may be more expensive than public sector providers, but they often offer greater flexibility over how and when payments can be made (Prescott 1997; Segall *et al.* 1999). Higher level care options, with their formal and informal costs (such as food, loss of earnings and under-the-table payments), are often unaffordable or liable to chronically burden the household with debt (Segall *et al.* 1999; Ensor *et al.* 1996b; Yu *et al.* 1997). However, even primary level provision can incur a high proportion of expenditure by the poor (Segall *et al.* 2000), a finding which is less readily apparent since studies tend to analyse household expenditure for an aspect of primary care, such as fees (McPake 1993), or for the more expensive costs associated with hospital admission (Yu *et al.* 1997). That primary level care is an economic burden for poor households is evidence in support of the fact that though the poor may be willing to pay for healthcare, they may find it an economic burden on scant household resources (Russell 1996).

The value of the hour and the importance of convenience

Convenience is a determinant of choice and has a number of interpretations. A provider may be chosen not only because it is conveniently located near the household, but because it provides out of hours care or home visits and thus reduces the opportunity cost of time lost from work. In market economies the value of the hour increases as income rises. In Vietnam, households are now agriculturally self-employed and therefore time spent seeking healthcare must be paid for by the households, unlike pre *doi moi* when the cooperative structures subsidised this necessity. In Vietnam where 94 per cent of rural residents have a CHS in their commune (Prescott 1997), the issue of the opportunity cost of time spent getting to a commune public provider is probably minimal, even for the poor (although access in highland areas is much more difficult [World Bank 1999c]).

The issue is more pertinent for access to higher level hospital services. VLSS data show that only 6 per cent of the poorest quintile of households live in communes with a hospital nearby (where the distance to the hospital is still, on average, more than 11 km) as compared with 12 per cent of the wealthiest households (Prescott 1997). However, despite the broad availability of commune level care, time spent seeking healthcare still entails loss of income and so use of nearby private drug sellers and OTC drug outlets may be more convenient options for users than health stations or more distant higher level facilities (Segall *et al.*

2000). Where drugs are retailed in market places, the opportunity cost for women's time, in particular, represents an important reason for choice (Tipping *et al.* 1994).

Public health expenditure and quality of care

Changes in the level of public health expenditure are likely to affect the quality of services and therefore the extent to which they are used. Countries with negative economic growth (e.g. those of Central Asia) and which implement budgetary restraint may find significant decline in the quality of services, whereas economic growth may lead to improvements in service quality with positive impact on utilisation. However, much depends on how financial resources are allocated across the social sectors. The increasing drain of scant resources away from rural healthcare services to urban, hospital-based care, and the movement of qualified health staff to urban areas or the private sector leads to a de-skilling of rural PHC services. In China, studies show that this has had an impact on service quality as well as access and affordability (Gong and Wilkes 1997; Tang 1997).

Research in Laos indicates a mistrust of, and dissatisfaction with, public sector facilities, suggested by the greater use of OTC drug outlets and private services and the low level use of public sector facilities (Ministry of Public Health 1993; Laos Social Indicator Survey 1994). This is attributed to poor quality care, equipment and drug shortages, and low paid, unmotivated staff (see Holland *et al.* 1995; Vinard 1994). In Vietnam, commune level care, upon which the vast majority of rural residents depend (Prescott 1997), is also perceived to be of lower quality than higher level hospital services (Gertler *et al.* 1998; Tipping *et al.* 1994) because drugs may be in short supply, equipment lacking or sub-standard, and health staff relatively under-skilled and poorly qualified. However recent research suggests that quality of care in some health stations in Vietnam may be improving in the post reform period and thus re-attracting users (Carlson, Than, Le and Grady 1996; Segall *et al.* 1999).

The high dependence on OTC medicines, especially by the poor, has major implications for quality, given the poor selling practices of many drug outlets and the uninformed home consumption of such medicines (Stenson, Tomson and Syhakhang 1997; Zhan, Tang and Guo 1997). Quality of care as regards drug selling and prescribing also requires appropriate formal sector prescribing, which itself rests on an appropriate essential drugs policy, training and supervision of medical staff, and the effective regulation of private sector services.

However, quality is not only a reflection of technical skills in diagnosis and treatment, but of the provider's 'bed-side' manner, for which the degree of empathy and patient consideration shown is most important (Tipping *et al.* 1995; Carlson *et al.* 1996). Thus quality of care is a key determinant of provider choice and will over-ride price considerations in some cases. For example in Azerbaijan, Guseynova *et al.* (1996) found that people were willing to pay towards the cost of healthcare providing the quality improved and more drugs were available.

The burgeoning private sector

During economic transition and contraction of public sector services, the private sector can take up a dominant role in the finance and delivery of healthcare. A combination of public sector downsizing, demobilisation of army medical staff (as in Vietnam), moonlighting by public sector employees in order to supplement low salaries as well as a burgeoning of informal drug sellers and retail drug outlets can lead to a broad cadre of health personnel providing services, many of which are 'unlicensed, illegal and largely unregulated' (Segall 2000). This passive process of privatisation is evident in Vietnam where less than a third of all provider contacts are in the public sector and more than 80 per cent of health expenditures are out-of-pocket (Glewwe *et al.* 1998). However, the increased utilisation of private sector services is not matched by developments in the monitoring and regulation of their services, with governments unclear about what role the private sector should, and could, have (Pham 1996).

The lack of regulatory frameworks means that the quality of private sector care is difficult to monitor. The heavy reliance of households on self-medication and the increasing reliance of households on private pharmacies and drug vendors magnifies the risk of inappropriate drug consumption patterns (Gertler *et al.* 1998). Access to professional prescribing is being overshadowed by the wider selection of drugs available in the private sector and the relative ease with which they can be bought and sold.

In terms of healthcare seeking, however, the private sector can offer a more responsive service to users by providing more flexibility over how payments are made and a more accessible service in terms of out-of-hours care and home visits (Segall *et al.* 1999; Aljunid 1995; Heaver 1995). As noted above, a recent World Bank study (1999c) also showed that poor households often preferred the private sector because private practitioners would make house calls and provide treatment on credit. The trade-off for greater convenience and flexibility of payment may be the risk of sub-standard levels of care and higher prices (Gertler *et al.* 1998; Segall *et al.* 1999).

Rural health insurance

Attempts are being made in many Asian transitional countries to introduce HI mechanisms as a way of making health services more accessible and affordable. Yet HI systems are often difficult to implement for a variety of reasons, at least some of which relate to household decision-making for health. In sparsely populated or remote areas HI may be of little benefit to households if access to hospital facilities is prohibitive due to the time costs of travel and the cost of transport, accommodation and food. HI may also be of little benefit if quality of care, once services are reached, is unsatisfactory.

Where HI mechanisms are in operation (whether state run or local), the people insured are often not those most in need of assisted payments. The Government of Vietnam established a compulsory HI scheme for state workers and employees of state and private enterprises in 1993 (Ensor 1995). The insurance covers inpatient and outpatient treatment costs at government facilities, although in reality insured patients may still have to pay some of the formal (and informal) costs. Preliminary analysis of the VLSS data for the period 1993–98 show that the poor have a disproportionately small share of HI cover. Analysis indicates that over the five-year period the percentage of the poor with HI (of all kinds) increased from 6 per cent to 8 per cent,

while that of the non-poor rose from 29 per cent to 37 per cent (Deolalikar 1999). In fact HI in Vietnam appears to have increased inequality in health services utilisation by benefiting the richest segment of the population, since contributions are disproportionately spent on financing urban hospital services to the neglect of the rural health system (Ensor 1995).

It is also difficult to collect subscriptions in remote, rural settings and potential insurees, especially the poor, may doubt the return on the investments. Imposing compulsory contributions on households may be viewed as yet another tax, providing little benefit, and evaded or paid in part (Ensor and Rittman 1997). Voluntary payments may be viewed with similar scepticism. In Vietnam qualitative research showed that people had little interest in the voluntary HI scheme, mainly because the need for hospital treatment was rare, the insurance premium was high and patients with HI could still face hospital charges (Segall *et al.* 2000). (A similar lack of enthusiasm for voluntary insurance is reported in Kazakhstan by Ensor *et al.* (1997)). In addition, most health expenditure by the poor is at commune level (Segall *et al.* 2000) where voluntary HI schemes do not, by and large, provide cover.

In China there is a long tradition of cooperative healthcare (CHC) schemes (Tang *et al.* 1994; Bogg, Hengjin, Keli, Wenwei and Diwan 1996) designed to provide the rural poor with affordable and accessible healthcare. The CHC schemes collapsed after economic reform in the 1980s. Recent efforts to reinstate them are faced with problems of equity: the uninsured receive less healthcare and yet, due to the increase in fee payments, use a greater share of their incomes for healthcare than the insured (Kutzin and Barnum 1992). Whilst the CHC prepayments are deemed affordable for most rural households, the small sums involved may nevertheless be a financial burden for the 10 per cent of China's rural population living in poverty and for whom exemption from prepayments is no longer reliably available (Tang *et al.* 1994). Achieving equitable access to services for the uninsured poor is therefore a key issue in transitional economy countries (Bloom, Lucas, Cao, Gao, Yao and Gu 1995; Chernichovsky and Potapchik 1997; Nguyen, Le, Rifkin and Wright 1995; Ensor 1995; Ensor *et al.* 1997; Yu 1992).

Informal payments

'Under the table' payments for healthcare are an increasingly endemic feature of service provision in transitional economy countries, as in developing countries generally. These are a pre-requisite for users to receive prompt, quality care and a means by which health staff can boost low salaries. The extra expenditure to households can make services unaffordable, particularly for the poor, but the burden of these payments is often difficult to assess (Ensor and Savelyeva 1998). In the private sector, informal payments may be hidden in the total treatment costs or patients may choose, or negotiate, to make payments in kind, making the monetary value of the informal payment opaque. Similarly, in the public sector, informal payments can be disguised by a higher mark-up on drug sales through which health staff derive a portion of income (Tipping *et al.* 1995). On the other hand, informal payments may be overtly demanded**,** as reported in Kazakhstan, Uzbekistan and other countries of the former Soviet Union, even for government subsidised services (World Bank 1999b; Ensor *et al.* 1998; Wilkinson 1999).

Payments to healthcare providers at higher levels of care can be especially prohibitive, as they may be expected or demanded before treatment is delivered. This has serious implications for access to higher level services, especially for the poor (Segall *et al.* 1999; Ensor *et al.* 1996b). The informal payment system has implications both for national expenditure on health, on attempts to reform health sectors and for the access to, and affordability of, services by users (see Ensor *et al.*'s (1998) work on the informal payment system in Kazakhstan).

CONCLUSION

There is little research on HCSB in Asian transition economy countries and little of a qualitative kind. Much of the available information is derived from quantitative studies in which issues of affordability, quality of care and decision-making for health are difficult to measure. The PPA studies implemented by the World Bank (1999a, 1999b, 1999c) are a positive step towards representing the voice of the poor using more appropriate methods. The acceptance of participatory and qualitative methods by the World Bank for studying poverty may mean that more research of this kind will be financed and pursued in the future. In the meantime, few other qualitative studies on HCSB exist (Segall *et al.* 1999).

It is evident that economic reform can have a negative impact on poor and vulnerable households and make access to health services problematic. Some patterns are clear, such as the heavy dependence by the poor on the use of self-medication and their inability to afford hospital services. However, it is not only existing economically vulnerable households that are at risk. Ill health in a family that is economically stable can reduce the household to poverty: by loss of assets, loss of labour power and indebtedness. Access to essential healthcare is a human right which governments of transition economies need to accommodate with appropriate policies. Poor households may require targeted assistance if equity of access is to be achieved. The conclusion to date may be that while economic reform can offer economic benefits to many, these benefits are not evenly spread. Unless public sector health provision is financially safe-guarded and/or interwoven with the capacity of the private sector to offer affordable and adequate healthcare, the economic benefits of reform will not be matched by improvements in the health status of the poor. If the provision of healthcare is such that the poor cannot afford to use services when needed, then equity of access will continue to be an unresolved social and political issue.

In summary, little is known about how access to healthcare is negotiated by the poor and about the decision-making processes that take place both within households and between users and providers. Equally, the relative advantages and disadvantages of the range of providers available, issues of affordability and methods of payment, particularly for vulnerable households, are relatively unexplored areas. Much of this information is outstanding because methodologies employed are not designed to capture such information. Complementing HCSB studies with qualitative research methods and longitudinal approaches would allow these issues to be better addressed.

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ANNOTATED ENTRIES

Author(s)	Aljunid, A.
Title	The role of private medical practitioners and their interactions with public health services in Asian countries
Source	1995, **Health Policy and Planning**, Vol 10 No 4: 333–49
Objectives	To examine evidence on the role of private (allopathic) practitioners and their interactions with public health providers in developing countries, focusing primarily on Asia.
Study type	Review article.
Data source & methods	Not applicable.
Findings	Evidence on the distribution of healthcare facilities, manpower, health expenditures and utilisation rates shows that private practitioners are significant healthcare providers in many Asian countries. The paper reviews factors influencing HCSB, including characteristics of the patient, the illness and the provider. The author states that limited information has been published on interactions between public and private providers despite their coexistence. Issues related to enforcement of regulations, human resources, patient referrals and disease notifications are examined.
Policy implications	Reviewer's comment: The vast majority of studies reviewed in this paper are not from Asian transitional economies. However, the issues raised are nevertheless relevant since any private health sector (PHS) that becomes a strong alternative choice for public sector healthcare seeking raises issues of quality control, monitoring and regulation, issues which are central to health sector reform programmes. The paper also contributes to an understanding of the barriers to healthcare seeking faced by service users with policy implications for equity in access to healthcare services.
Conclusions	The author states that more research is required to document and analyse the existing interactions between public and PHSs if policies are to be developed which identify the appropriate role of private practitioners and encourage good quality, cost-effective care in the private sector.

Author(s)	Bloom, G.
Title	Primary health care meets the market: Lessons from China and Vietnam
Source	1997, **Working Paper** No 53, Brighton: IDS
Objectives	To review health sector reform in China and Vietnam and to outline the key points that may benefit policy makers and researchers in other low and middle income countries which are considering radical health sector reforms.
Study type	Working paper.
Data source & methods	Not applicable.
Findings	Both Vietnam and China developed low cost rural health services during the early 1950s and mid-1970s and both have strongly influenced international health policy on PHC. A process of economic liberalisation has been underway in both countries for several years and this has effected their health services in different ways. Those who can afford to pay have a wider choice of health services but costs have risen and there are greater differences in access to medical care. The Chinese and Vietnamese governments are seeking strategies to make their health services more cost effective and equitable. The author describes for China and Vietnam: (i) the impact of economic reforms on the health system; (ii) changes in health system performance, including increased inequality in access, rising costs and the impact on preventive care services; and (iii) the restructuring of the health sector, which subsumes issues of equity, cost-effectiveness, efficiency and responsiveness to users needs.
Policy implications	Reform options should be addressed in terms of their likely impact on the achievement of policy objectives. Special attention should be paid to the influences on provider behaviour, such as financial incentives, government supervision and regulation, and mechanisms to make providers accountable to users.
Conclusions	The conclusion is that one of the most important determinants of the kind of health sector that emerges during the transition to a market economy will be a government's preparedness to create a service that meets priority needs and its capacity to develop strategies in order to fulfil this.

Author(s)	Bloom, G., Lucas, H., Cao, S., Gao, J., Yao, J. and Gu, X.
Title	Financing health services in poor rural areas: adapting to economic and institutional reform in China
Source	1995, **Research Report** No 30, Brighton: IDS
Objectives	To improve understanding of the impact of economic and institutional change on health services in poor rural areas of China and to identify possible strategies for adapting rural health services to the new situation.
Study type	Research report.
Data source & methods	Literature review. Routine reports and data from the statistical bureaux, governments and health facilities of three poor rural counties: Donglan, Shibing and Xunyi. Interviews with county and township health and political authorities. Focus group discussions with health workers and service users.
Findings	The report presents the findings of studies of health expenditure and finance in the three counties. It reviews the government's attempts to encourage local governments to establish health prepayment schemes. It concludes by drawing lessons from China's experience with health sector reform for policy makers in other countries. The situation differed greatly in the three counties, reflecting the enormous variation between study regions. Changes in the system of health finance have altered the environment within which health service providers function. These providers earn more money by favouring curative care and selling large quantities of drugs: this has contributed to a rapid rise in the cost of healthcare. The paper concludes that in the effort to encourage local governments to establish prepayment schemes, the Ministry of Public Health (MoPH) has focused heavily on generating additional revenue from 'voluntary' household contributions to the detriment of other health sector functions. Strengthening incentive structures for the provision of priority services and monitoring and regulation systems are required.
Policy implications	The policy implications of the research report are directed to policy makers in other transitional economy countries as 'lessons to be learned'. These lessons derive from China's efforts to adapt rural health services to economic and institutional change and the impact such changes have had on health and health services, and from China's efforts to formulate reform strategies.
Conclusions	Strategies for structural change in the health sector should be formulated on the basis of a strategic analysis which: (i) recognises the complexity of the health sector; (ii) assesses policy options on the basis of their likely impact on the achievement of health sector priorities; (iii) develops strategies that recognise the link between the health sector and other economic and institutional factors; and (iv) recognises the political nature of health sector reform.

Author(s)	Bogg, L., Hengjin, D., Keli, W., Wenwei, C. and Diwan, V.
Title	The cost of coverage: rural health insurance in China
Source	1996, **Health Policy and Planning**, Vol 11 No 3: 238–52
Objectives	The long-term objective (over four years) is to study the impact on equity of the changes in healthcare financing in China. The current paper aims to study the allocative efficiency of cooperative HI, with implications for equity in healthcare utilisation and health outcome.
Study type	Empirical study.
Data source & methods	A controlled natural experimental design to analyse health expenditure trends in two 'twin' counties of Jiangso province, China, one of which has a health financing system based on user fees, the other on HI. Study period 1986–94. The study uses accounts data and interviews.
Findings	The authors assume that different financing systems yield different healthcare expenditure profiles and will differ in their impact on equity in terms of who bears the cost of, and who enjoys access to, healthcare. A fundamental issue is therefore to understand which parameters in the financing system are the explanatory variables: the relative mix of user fees, budgets and insurance; payment modes and levels; or the relative price of different services. The present study analyses cooperative HI versus user fees as explanatory variables, with inflation adjusted per capita healthcare expenditure, curative expenditure, preventive expenditure and higher level curative expenditure as dependent variables. The hypothesis is that a system based on voluntary HI will contribute to a higher level of healthcare expenditure and increasing share of both curative care and tertiary care expenditure. Findings show that cooperative HI will induce higher growth in healthcare expenditure and lead to a shift from preventive medicine to curative medicine. A higher (county) level of tertiary curative care expenditure (the latter consuming most of the public funding but used mainly by higher income level patients) is also indicated.
Policy implications	World Bank health financing policies that propose that user fees, privatisation, decentralisation and HI together will improve allocative efficiency and reduce inequities in access to healthcare are contradicted by the present study.
Conclusions	Cooperative HI leads to an escalation of healthcare expenditure and a shift away from preventive medicine to curative care at higher levels of service.

Author(s)	Carlson, J., Than, T.T.H., Le, K.D. and Grady, H.
Title	Report on the financing and delivery of basic services at the commune level in Ky Anh, Ha Tinh, Vietnam
Source	1996, Oxfam UK/I, Vietnam Programme, Hanoi, Vietnam
Objectives	To study trends in local livelihoods, basic services delivery, and the effects of rapid economic growth in two communes. The focus is on changes in the health and education sectors.
Study type	Research study using quantitative and qualitative methods.
Data source & methods	Semi-structured interviews with household members and local health and political authorities, conducted in 1996. Five days' fieldwork.
Findings	For current purposes, only information on the health sector is reviewed below. The report summarises the facilities, organisation and staffing of district and commune level public healthcare services. The budget for healthcare at district level and below as well as fee collection is reviewed. The implementation of national health programmes is described. Data on the utilisation rates of district and commune health services show a steady increase since 1993 when government nationalised health worker salaries. Qualitative data on the public's perceptions of healthcare services since the economic reforms suggest that commune level services have improved, with staff and drugs more readily available, but that the attitude of some doctors is still wanting and the poor feel especially disparaged. Hospital costs are prohibitive, especially for the poor. The paper presents useful data on district and commune revenue and expenditures, including data on revenue from local 'contributions'.
Policy implications	The authors state that the administration of the government's poverty alleviation programme needs addressing in order to improve the reimbursement of healthcare providers for free healthcare services provided to the poor. Policies on the provision and financing of basic services need refining in order to reduce the over-reliance on drugs as a source of income for CHSs and to address the inability of the very poor to afford user fees for healthcare. The regressive nature of household 'contributions' for the poor also requires attention.
Conclusions	Local and national officials must look beyond creating programmes that target and ameliorate the situation of the poor, to making public investment decisions that are pro-poor in their conception.

Author(s)	Chernichovsky, D. and Potapchik, E.
Title	Health system reform under the Russian health insurance legislation
Source	1997, **International Journal of Health Planning and Management**, Vol 12: 279–95
Study type	Discussion paper.
Data source & methods	Not applicable.
Objectives	To discuss the reform framework for health insurance legislation (HIL) in Russia and to put forward a comprehensive set of potential solutions to the problems and issues surrounding implementation of the HIL.
Findings	The Russian HIL, amended in 1993, initiated far-reaching reform in the financing, organisation and management of the Russian health system. However, the implementation of the legislation has been slow and unstructured due to a lack of appropriate administrative and financial mechanisms: these concern entitlement to care, private-public mix, financial responsibilities of government at all levels, investment instruments, reimbursement and compensation systems, and a well defined role of government. The authors discuss these issues in the context of the Russian economy, the state of the health system and the effort to reform the HIL. While the paper's main focus is on the reform framework, the implications for health system users – for example, as regards quality of care, health costs, equity of access and protection for the voluntarily insured – can be seen.
Policy implications	Many of the weaknesses in the Soviet health system can be attributed historically to the weak and ambiguous role of the state in the health system. As the Russian Federation moves from a highly centralised to a decentralised federal system, there is an even greater need to redefine the role of government in the health system.
Conclusions	Redefining the role of the state may be a highly problematic issue for Russia given the innate fear and distrust of the (Soviet) 'State', but one that has critical repercussions for progress in health sector reform.

Author(s)	Community Health Research Unit, Hanoi
Title	Assessment of primary health care projects in Vietnam
Source	1993, Red Cross of Vietnam and Danish Red Cross
Objectives	To report on the implementation of PHC activities in three pilot communes of Thai Binh Province, Vietnam, and the current and potential role of the Red Cross in these activities. The study aims to identify: (i) human and material resources for PHC provision; (ii) constraints and problems to PHC implementation; (iii) priority needs of the community, especially women and children; and (iv) key individuals and organisations for facilitating PHC implementation.
Study type	Research study using participatory methods.
Data source & methods	Data derives from households (i.e. those with pregnant or postnatal women, children under five, sick, disabled or very poor), local health, social and political authorities. Twelve days' fieldwork
Findings	The report provides a broad review of the pilot communes, including demographic and socio-economic structure; structure and provision of health services (public and private); morbidity data; commune social and political structures and their role in PHC activities; community participation in health; and utilisation of health services.
Policy implications	No policy implications drawn.
Conclusions	Commune specific recommendations are made for improving commune health status, for implementing PHC activities, and for augmenting the role of the Red Cross in PHC activities.

Author(s)	Ensor, T.
Title	Introducing health insurance in Vietnam
Source	1995, **Health Policy and Planning**, Vol 10 No 2: 154–63
Objectives	To describe the overall design of HI in Vietnam and to discuss issues relating to implementation that must be addressed by individual provinces.
Study type	Discussion paper.
Data source & methods	Not applicable.
Findings	Vietnam has introduced social insurance as part of its reform of the healthcare system. Ensor describes the current status of HI. The scope for compulsory payroll insurance is limited due to the small size of the formal sector. Provinces are beginning to experiment with pilot models of voluntary insurance. Ensor discusses issues relating to extension of both compulsory and voluntary HI schemes and raises problems associated with maintaining equitable access to good quality care for the poor. Current systems of reimbursement of providers are discussed. The development of contracts between hospitals and insurance centres and the need to account for healthcare services is a major change in the health system and is challenged by the inadequacy of basic equipment, and low wages and incentives for health staff. Ensor discusses three ways in which these difficulties can be alleviated.
Policy implications	The way in which the HI system is developed in Vietnam will critically shape the way healthcare is delivered to the population in the future. Policy makers must consider: (i) how to maintain control of insurance expenditures to avoid over burdening the economy; (ii) how to best finance HI through taxation whilst taking into account the strength of the economy and the need to redistribute revenue to avoid regional inequalities; and (iii) how to maintain equitable access to services for the uninsured poor.
Conclusions	Vietnam can benefit from the errors of other countries and shape a social insurance system that maintains a high level of access to basic healthcare, allows for national redistribution of funding and permits control over national expenditure.

Author(s)	Ensor, T. and Pham, B.S.
Title	Access and payment for healthcare: the poor of northern Vietnam
Source	1996a, **International Journal of Health Planning and Management**, Vol 11 No 1: 69–83
Objectives	To examine the impact of user fees on the rural poor.
Study type	Research study using quantitative methods.
Data source & methods	A 1995 survey of 1,024 households in northern Vietnam on health charges, exemptions and the utilisation of services. The survey used questionnaires and semi-structured interviews.
Findings	Findings suggest that the poor generally delay treatment, make less use of government health facilities and pay more for each episode of illness at commune health centres than the rich. It appears that the poor may be discriminated against either in the amount they pay for treatment or in the type and quantity of treatment that is prescribed. The study shows that a significant proportion of the poor (and non-poor) find charges a burden and have to borrow to meet costs, reduce consumption of essential goods such as food or fuel, or sell assets. A significant minority is deterred from using facilities altogether because of cost. Exemption from health fees is largely independent of income and many of the poor do not qualify for assistance.
Policy implications	The current system of exemption fails to provide adequate protection to the poor; a revision of the system of exemptions is required. Since it is the poor in poorer communes that are most effected by high user fees, a policy that targeted 50 per cent of the poorer communes would capture over 80 per cent of those in difficulty and it is to these areas that any assistance from government or donors should be targeted.
Conclusions	With the adoption of user charges as part of health sector reform policy, the importance of adequate exemption mechanisms is imperative if the poor are to be able to access basic healthcare services.

Author(s)	Ensor, T. and Pham, B.S.
Title	Health charges and exemptions in Vietnam
Source	1996b, Bamako Initiative Operations Research Programme, **Research Paper** No 1, New York: UNICEF
Objectives	The main objectives were: (i) to assess the way in which health services at commune and district levels makes provision for those not able to pay charges for medical care; (ii) to examine how much households pay for both public and private healthcare services, and to examine the role of price and income as barriers to consuming healthcare relative to other factors such as distance to facilities and household characteristics; (iii) to assess the impact of economic and non-economic factors on the utilisation of services; and (iv) to test the feasibility of developing an improved instrument for identifying those unable to pay user charges. While the focus of the research programme is on the Bamako Initiative (BI), the project also studied non-Bamako areas.
Study type	Research study using quantitative methods.
Data source & methods	Full details of a household survey in northern Vietnam conducted in 1995 with 1,024 households of health charges, exemptions and the utilisation of health services, the main results of which are summarised in Ensor and Pham (1996a).
Findings	For full details of findings, see report. The main points are that in comparison with the wealthy, the poor spend a greater proportion of income on healthcare; pay more for each visit to hospital or health centre for treatment; are more likely to be ill; are less likely to seek early treatment; are less likely to seek treatment at hospital or a health centre; and have a lower level of self-reported health. Current exemption mechanisms appear inadequate in ensuring equitable access to healthcare. No clear benefit of the BI programme could be found; reasons for this are provided. Since households put money aside to pay for future healthcare, the need for effective and local prepayment schemes is supported.
Policy implications	An exemption system that encourages the poor to seek early treatment is needed. The system should be based on average commune income combined with the use of commune records and statistical tools to identify the poor and monitor the system. The current burden of health fees for the poor suggests that the BI should be broadened to put more emphasis on effective healthcare as well as targeting it at areas most in need. The existing voluntary HI scheme could be encouraged with some subsidy for the poor and creation of a system for identifying those requiring assistance.
Conclusions	The authors conclude that there are advantages to combining a system of prepayments with exemptions and the managerial and motivational effects, on both staff and households, of a properly monitored BI programme. Since direct payment is now an essential feature of healthcare in Vietnam, it is important that steps be taken to ensure that access to quality services for the poor is maintained and even increased.

Author(s)	Ensor, T. and Rittman, J.
Title	Reforming health care in the Republic of Kazakstan
Source	1997, **International Journal of Health Planning and Management**, Vol 12: 219–34
Objectives	To describe the background and introduction of medical insurance in Kazakstan and discuss two major issues in the reform process: (i) coverage of rural areas; and (ii) the role of the insurance system in contributing to more fundamental health system reform.
Study type	Review paper.
Data source & methods	Not applicable.
Findings	In the context of declining health status and deteriorating public finances, the government of Kazakstan in 1995 introduced a system of compulsory HI. The paper discusses the impact of the financial crisis on patients as shown by the increase in informal contributions to health staff by patients, as well as semi-official contributions by patients of medical supplies, fees for hospital services and a developing private sector. The paper then discusses in detail the background to, and introduction of, medical insurance in Kazakstan and discusses how the reforms will affect medical care in rural areas. Industrial-style insurance schemes are inappropriate for rural areas. Alternative options such as partial insurance coverage, a more effective contribution assessment and collection or voluntary community schemes are possible. The potential impact of the insurance fund on wider health sector reform will be greatest if the following problems are addressed: unequal access to healthcare, poor and inappropriate quality of care, technical inefficiency and limited patient choice.
Policy implications	Health sector reform is changing the role required of state institutions and requires a different regulatory and strategic role than currently exists. Future planning depends on a definition of the relative roles of these state bodies.
Conclusions	Alternative solutions for establishing rural HI schemes are required to those designed for urban areas. Community participation in the funding and organisation of healthcare, and a system that draws on a variety of funding methods whilst ensuring access to the population majority, may be the key.

Author(s)	Ensor, T. and Savelyeva, L.
Title	Informal payments for health care in the Former Soviet Union: some evidence from Kazakstan
Source	1998, **Health Policy and Planning**, Vol 13 No 1: 41–49
Objectives	The paper addresses the issue of informal, under-the-table, payments for healthcare, which are a key feature of healthcare systems of the former Soviet Union and Central and Eastern Europe.
Study type	Research paper.
Data source & methods	Not applicable.
Findings	In Kazakstan, informal payments have escalated since the start of the transition period and can significantly boost the income of medical staff. The paper reviews some of the causes of the growth of this informal payment system and looks at the types of informal payments (i.e. cash or kind, to practitioner or health facility). It reviews the scant empirical evidence on how widespread the informal medical economy is and discusses the different approaches to, and difficulties of, researching this line of enquiry.
Policy implications	The issue has potentially significant policy implications. Informal payments may lead to greater inequities in access to healthcare, for the poor, for women and for rural areas, but the reality is highly complex and little empirical data exists as yet to clarify the situation. The informal payment system may also lead to inefficient and inappropriate service provision and could also cloud attempts to devise new incentives within the formal payment system. It also reduces the imperative for governments to prioritise decisions about service provision.
Conclusions	The impact of attempts to reform systems using Western models could be reduced unless the effect and size of the informal payment system is taken into account. In conclusion, a series of research questions to address this unexplored issue is given.

Author(s)	General Statistical Office
Title	Vietnam Living Standards Survey. 1992–1993
Source	1994, Hanoi: State Planning Committee – General Statistical Office
Objectives	To assess the effects of economic reform on household welfare.
Study type	Quantitative research.
Data source & methods	First nationally representative survey of 4,800 urban and rural households using questionnaires for households, for communities and for recording market prices. Households are divided into five income quintiles.
Findings	For full details see report. Only the summary of HCSB is reported here (see Tables 3.1.1 to 3.10.2). Of the 27.6 per cent of people reporting illness in the four weeks prior to interview, 54 per cent sought a consultation with a doctor, 33 per cent with an assistant doctor and 10 per cent with a nurse. There is a heavy reliance on self-medication (73 per cent of the poorest self-treat compared with 55 per cent of the wealthy). The consultation rate ranges from 2.9 for the poorest quintile to 3.4 for the wealthiest quintile. The poorest quintile use private providers (16 per cent) more than public sector services (12 per cent), in contrast with the wealthiest quintile (26 per cent and 18 per cent respectively). As incomes rise people opt for higher quality hospital care rather than public clinics and shift away from the use of paramedics to higher quality private doctors. Average annual per capita health expenditure is 82,500 VND, which is over 6 per cent of consumption expenditure. Health expenditure in the top income band is almost six times higher than the lowest income band. Average per capita income is 4.4 times greater in the top income quintile than in the bottom (see Tables 7.1.1–7.6.4).
Policy implications	The survey was designed specifically to inform policy and research about socio-economic conditions of households in Vietnam.
Conclusions	A broad summary is given for each section of data. See report to extrapolate findings from tables. Specific to the above findings it can be concluded that: (i) the poor have less access to high quality providers (public hospitals and private doctors) than the wealthy; (ii) the probability of seeing a high quality provider varies from less than 10 per cent in the poorest quintile to over a third in the wealthiest; and (iii) the private sector is a more important service provider for the poor than is the public, with implications for access to preventive care services and curative care of monitored quality.

Author(s)	Gertler, P. and Litvack, J.
Title	Access to health care during transition: the role of the private sector
Source	1998, in D. Dollar, P. Glewwe, and J. Litvack. (eds), **Household Welfare and Vietnam's Transition**, Washington, D.C.: World Bank Regional and Sectoral Studies: 235–55.
Objectives	The chapter examines the extent to which private health providers in Vietnam are filling the gaps left by the contraction of the public sector in the mid-1980s, following government policies to open up the PHS and increase the real budget for the public sector health system. Areas where government policies could improve access to, and benefits from, medical care are identified.
Study type	An empirical review and secondary analysis of health data that draws largely on the VLSS data of 1992–93.
Data source & methods	Not applicable.
Findings	The chapter notes the large increase in out-of-pocket expenditures by households on healthcare during the transition period, of which private sources make up the greater share. Also noted is the percentage of health expenditure spent on drugs, all out-of-pocket, and again primarily from the private sector. Findings from the VLSS survey on access to health services are reported, which include the dominant use of self-medication, especially by the poor; the greater use of private, rather than public, providers by all, but especially the wealthy; and the shift in the use of public sector services with increasing income whereby the poor rely more on CHSs and the wealthy on better quality hospital care.
Policy implications	The allocation of public resources to curative and preventive care needs revising in order to meet the needs of the poor and to better complement what the private sector can offer. The lack of regulation and monitoring in the private sector is causing significant health and financial problems for households. Improving quality in the public sector requires major investments. Ways to improve access to professionally prescribed drugs are needed.
Conclusions	The private sector has become dominant in both the finance and delivery of healthcare during the transition period but the lack of regulatory mechanisms requires attention. The pattern of public spending benefits the poor the least. Reallocation of public subsidies away from hospitals to health stations would benefit the poor and improve service quality. The private sector is, to some extent, filling the gaps, but less so for the poor who are relying on self-prescription and self-diagnosis with their attendant dangers.

Author(s)	Glewwe, P. and Litvack. J.
Title	Provision of health care and education in transitional Asia: key issues and lessons from Vietnam
Source	April 1998, **Working Paper** No 147, UNU/WIDER, Helsinki, Finland: The World Bank
Objectives	Examines the impact of the transition to a market economy on health and education outcomes in transitional Asia with particular focus on the case of Vietnam.
Study type	Empirical review.
Data source & methods	Not applicable.
Findings	From a review of the empirical evidence, the authors conclude that healthcare services appear to be generally better than they were prior to the introduction of *doi moi* policies and that increases in income enable most people to pay for health services despite price increases. The authors deduce that quality has probably improved although there is no hard data for this. The fact that income mortality has steadily declined suggests that the effect of *doi moi* has not been negative as regards the health status of the population.
Policy implications	Efforts to ensure access to healthcare for people with such low incomes that they cannot afford to pay the private costs associated with access, especially to hospital care, are needed. The authors suggest that Vietnam should take note of the healthcare issues that confronted China during its transition to a market economy such as: hospitals taking up the lion's share of spending; neglect of the implication of equipment purchase and new construction on future recurrent costs; and the high proportion of health expenditures that are due to drug consumption, with implications for staff salaries and drug pricing.
Conclusions	In relation to health: protecting and improving health outcomes depends on the success of economic reforms in generating income growth; strong economic growth generally increases outcomes. The nature of the economy before the reforms has an important role in determining their overall impact. Small-scale experimentation of specific policies should be done before implementing them on a larger scale. Governments need to develop medium- to long-term plans for blending public and private provision of health services. Because some groups will inevitably face serious problems, identifying and protecting vulnerable groups is an important task of the government post reforms.

Author(s)	Gong, Y. and Wilkes, A.
Title	Health human resources in rural China
Source	1997, **IDS Bulletin**, Vol 28 No 1: 71–79
Objectives	To analyse and review the major problems regarding human health resources in poor rural areas of China.
Study type	Research article.
Data source & methods	Draws on data from a 1993 National Health Services Survey by the MoPH, China.
Findings	The availability of health workers in rural China is high in comparison with other countries as a result of government policy to ensure that the rural population has access to basic healthcare services. However, data from a national survey show that many are poorly trained, poorly educated and have low workloads. A growing labour market for skilled personnel in the last 15 years has meant that over 80 per cent of qualified doctors have left rural areas for county or urban hospital posts. Less qualified or untrained personnel are allowed to provide services without supervision and have been promoted by rural health facilities to compensate for staffing losses. But this has neither stopped the outflow of better qualified personnel, nor improved the quality of care amongst those remaining.
Policy implications	To ensure that health personnel of adequate quality are available in rural health facilities, the following policies are discussed: adopting a rural orientation policy for training; preventing loss of well trained personnel by an incentives system; implementing legal regulation of promotion and employment; and raising quality and productivity of staff through a system of subsidies that relates staffing needs to workloads. Effective personnel management policies are required.
Conclusions	In order to bring the existing personnel up to a level of expertise that matches their position, a massive national in-service training scheme is required, the success of which will depend on the allocation of substantial financial resources and the integration of training strategies with wider health planning activities.

Author(s)	Guldner, M.
Title	Health care in transition in Vietnam: equity and sustainability
Source	1995, **Health Policy and Planning**, Vol 10 (supplement): 49–62
Objectives	To suggest ways to safeguard the sustainability of the Vietnamese health sector in the context of economic and political reform.
Study type	Review article.
Data source & methods	The paper is based on a 1992 case study of sustainability in the Vietnamese health sector, prepared for Save the Children Fund (UK). See Guldner, M. and Rifkin, S., 1993, 'Sustainability in the health sector, part 1: Vietnam case study', London: The Save the Children Fund, for full details.
Findings	A critique of the reform process in Vietnam and its impact on the health service. While there is no information on the impact of reform on the users of health services, the article offers a perspective on the health sector reform process itself. Seven issues related to sustainability in the health sector are raised and discussed: lack of appropriate information; under-funding; need for policy frameworks; need for regulatory frameworks and institution building; coordination and integration; community involvement; and the appropriateness of donor investment.
Policy implications	See conclusions.
Conclusions	Three themes are used to illustrate the problem of sustainability in Vietnam: (i) fragmentation of the health system, which is undermining the development of frameworks to guide the transition process in the health system; (ii) an internal capacity to manage the process of change which requires both an assessment of the impact of change and the institutional capacity to direct change; and (iii) a redefinition of roles and responsibilities within the health system to avoid the diminution of public health services and to ensure their sustainability. Read in relation to Smithson, P. (1993).

Author(s)	Guseynova, Z., Chakoury, S. and Eerens, P.
Title	Study of health care demand and healthcare expenditure in Kuba district, Azerbaijan
Source	1996, **Bamako Initiative Technical Report Series** No 35, New York: UNICEF
Objectives	To conduct a study of household HCSB and health expenditures prior to design and implementation of a UNICEF assisted health sector reform plan.
Study type	Research study using quantitative methods.
Data source & methods	A household survey (n=736) in Kuba district, Azerbaijan conducted in 1994 using questionnaires.
Findings	The average healthcare expenditure per person per year is US$10.4, of which 61 per cent is spent on drugs, 16 per cent on unofficial consultation fees, 11 per cent on transport and 12 per cent on diagnostic tests, food and other costs. Findings show that 43 per cent of sick patients have to borrow money and 13 per cent have to sell assets to pay for healthcare. Of patients referred to hospital, less than half are admitted because of the difficulty they have affording hospital costs. Many households (64 per cent) express a willingness to contribute to health costs, providing quality of care is improved and the availability of drugs ensured. A prepayment scheme, with exemptions for the poor and disabled, is the preferred method of contribution. In the context of the proposed reforms, the cost of a basic package of health services covering more than 80 per cent of health problems at the health centre level is estimated at US$3 per person per year. If households were to pay this cost in full, the report states that this would represent savings of about 70 per cent of actual household health expenditures; savings could be higher with the government budget taken into consideration.
Policy implications	A policy and strategy for the rational use of drugs is required to reduce the high drug expenditure. Policy on the introduction of user fees needs to consider how much households can afford to spend on healthcare and to promote the system as a first step towards a prepayment scheme. Appropriate exemption mechanisms need to be established for the poor, with communities involved in identifying households that require support.
Conclusions	The quality and responsiveness of services and the regulation of health worker activities need improving. Communities are prepared to contribute towards healthcare providing quality of care and drug supplies are ensured. However, there is evidence to suggest that some households have difficulty accessing or affording healthcare: appropriate safety nets are required.

Author(s)	Henderson, G., Akin, J., Zhiming, L., Shuigao, J., Haijiang, M. and Keyou, G.
Title	Equity and the utilisation of health services: report of an eight-province survey in China
Source	1994, **Social Science and Medicine**, Vol 39 No 5: 687–99
Objectives	To look at equity with respect to the provision and use of health services in China.
Study type	Research study using quantitative methods.
Data source & methods	A 1989 China Health and Nutrition Survey of 3,800 households in eight provinces. Analysis of a sub-sample of 6,513 people, aged 20–45, on any illness or accident in the four weeks prior to being interviewed.
Findings	Multivariate analyses were performed on data from 669 adults, 85 per cent of whom sought care for their illness/accident. Utilisation of services was classified as inpatient, outpatient and 'other'. Beyond the level of illness severity, only a few individual-level factors were related to service use: gender (female) and employment in state-run enterprises were associated with higher patterns of use. Age, education, per capita household income, insurance coverage and distance all appeared unrelated to seeking care. The authors suggest that China has achieved a wide distribution of health services at the local level, which are widely used by those who need them and which are accessible and reasonably inexpensive. However, analysis of working age adults only may identify variables that differ from those influencing the response to illness of younger or older age groups. There was also much variation in the quality of facilities: across facilities as well as amongst those of the same type. But the potential influence of quality on utilisation was not analysed. No data on the nature of the illness/accident reported or on the restriction it imposed on normal daily activities was recorded. Nor was time spent travelling to the service(s) actually used for the illness episode analysed, rather the time to the most commonly used facility. These issues are rectified in later survey instruments.
Policy implications	No policy implications drawn
Conclusions	The authors' conclusion is that, in contrast to recent reports of declining accessibility to services, there appears to be relatively equal access to healthcare, a finding which is in contrast to other comparable studies and may be due to methodological factors of the present study.

Author(s)	Holland, S., Phimphachanh, C., Conn, C. and Segall, M.
Title	Impact of economic and institutional reforms on the health sector in Laos: implications for health management
Source	1995, **Research Report** No 28, Brighton: Institute of Development Studies
Objectives	To study the impact of economic and institutional reforms on the health sector in Laos and make recommendations for developing a sustainable and integrated public health system.
Study type	Research study.
Data source & methods	The current study is part of a larger project on the health sector reform in Laos PDR. Data derives from case studies of two health programmes in four sites in 1993–94 and from interviews with and information from health and political authorities.
Findings	The package of reforms designed to stimulate economic development, and public sector management and service provision are discussed. The features and impact of the New Economic Mechanisms are presented. Institutional reform is described and administrative reform in the sense of a civil service restructuring and sequential moves from a centralised system of administration to decentralised government and then back to fiscal centralisation are examined. The impact of the economic crisis and reform programme on the health sector is described. There is special focus on public health sector expenditure, including cost recovery schemes and household healthcare spending. Alternatives to public sector services are described, as well as patterns of household healthcare seeking. It appears that self medication or a private consultation are the first options for choice; use of public sector services are secondary and this pattern prevails regardless, largely, of illness severity. The low-level utilisation of public health posts reflects poor quality care, in addition to a lack of drugs and equipment, inaccessibility of facilities and cultural and linguistic barriers to use for ethnic minority peoples. Health workers are low paid and demotivated. The continuing low level of government expenditure on health, the maldistribution of available resources to urban over rural areas and the focus on preventive over curative care services compound the situation. Research findings from case studies of the health programmes are reviewed.
Policy implications	A range of policy implications is evident. Specific to the impact of reforms on the health sector and therefore on users of public and private health services, there needs to be considerable strengthening in national capabilities in health policy formulation, donor management, health service planning and management, and PHS regulation.
Conclusions	While Laos clearly needs more resources, the authors suggest that better use could be made of the resources already available. The authors propose reforms to the systems of health policy formulation, health planning and resource allocation, and health system management, in order to empower provincial and district health structures to plan and execute health services appropriate to local conditions and which utilise community involvement.

Author(s)	Hsiao, W.
Title	Marketisation – the illusory magic pill?
Source	1994, **Health Economics**, Vol 3: 351–67
Objectives	To examine the empirical results of a number of countries that embraced a free market approach to the finance and provision of health services.
Study type	Guest editorial.
Data source & methods	Not applicable.
Findings	The paper reviews four countries that have embraced market principles in reforming their health systems: Chile, the Philippines, Singapore and South Korea. While these countries are not the focus of the present bibliographic review, the paper is included as it highlights critical issues for health sectors that are run according to market principles. The author reviews the health system of each country and contrasts centrally planned health systems with free-market health systems. Hsiao concludes that a complex mixed system may be the best solution.
Policy implications	Marketisation is a complex system of regulated markets. The principles and practices evident from countries having undergone marketisation illustrate how states can structure a system to bring out the positive market forces.
Conclusions	Efficient marketisation is a challenge for those developing nations that lack the financial and human resources to fund basic healthcare, design the regulatory mechanisms and manage market competition. But marketisation could be piloted in areas in order to ascertain what combination of state and market roles may work best within that nation's culture, socio-economic and political structure, all the time taking into account the adverse effects of marketisation.

Author(s)	Lao Social Indicator Survey, 1994
Title	Women and children in the Lao PDR: results from the Lao Social Indicator Survey
Source	Vientiane: National Statistical Centre, Committee for Planning and Cooperation
Objectives	To better understand the health and demographic status of the Lao population.
Study type	Research study using quantitative methods.
Data source & methods	The Lao Social Indicator Survey (LSIS), undertaken in 1993, was part of the Lao Expenditure and Consumption Survey, a representative household survey interviewing village heads, household heads and female household members of reproductive age in urban and rural areas by poverty group.
Findings	The report describes the healthcare providers available and the average distance to them. Nurses are the most accessible providers and hospitals the least. Within two kilometres, 69 per cent of villages have a medical practitioner, 49 per cent a pharmacy and 38 per cent a hospital. Utilisation of services by pregnant women and by children for common illnesses is reported. There is a much greater utilisation of private services by women in urban areas and greater reliance on government hospitals by rural women. Rural women are more likely to do nothing, or to self-treat, than women in urban areas. A high reliance on pharmacies for the treatment of children in both urban and rural areas is noted.
Policy implications	None drawn.
Conclusions	None extrapolated. Survey results are presented for relevant government departments to interpret.

Author(s)	Li, J., Cao, S. and Lucas, H.
Title	Utilisation of health services in poor rural China: an analysis using a logistic regression model
Source	1997, **IDS Bulletin**, Vol 28 No 1: 24–31
Objectives	To explore the determinants of health services utilisation in poor rural areas of China in order to inform policy makers on effective targeting of services to those in most need and on the design of risk-sharing schemes to protect the poor from health expenditure shocks.
Study type	Research study using quantitative methods.
Data source & methods	Analysis of household income data from 2,694 households (12,509 people) in three counties. Study used 14 day illness recall.
Findings	The study analyses self-reported morbidity and use of health services by means of a logistic regression model using a combination of indicators to reflect predisposing characteristics (age, sex and education), enabling characteristics (household income and distance to the nearest provider) and perceived severity of illness (the number of days spent bed-bound). The results indicate great variation in the utilisation of health services between the three study counties, even when controlling for a number of factors which may be assumed to influence demand which, the paper suggests, may reflect differences in service provision across the three counties. Of the predisposing characteristics, age appears to be the most powerful predictor of service use, with illness among the youngest family members precipitating a decision to seek care, in contrast with illness in the elderly who are less likely to seek care.
Policy implications	None drawn.
Conclusions	Income appears to pay a significant role in the decision to use health services, which appears contrary to the authors' expectations, since they assume that the majority of the sample have access to local, low cost village doctors. It is difficult to extrapolate from these findings because the kind of healthcare provider sought and expenditure on seeking care is not included in the analysis. The authors suggest that the finding may be explained by a relationship between income and supply-side factors that is not captured in the regression model. They state that there is likely to be a strong correlation between average household incomes in a county and the finance available for health services in that county.

Author(s)	McKee, M., Figueras, J. and Chenet, L.
Title	Health sector reform in the former Soviet Republics of Central Asia
Source	1998, **International Journal of Health Planning and Management**, Vol 13: 131–47
Objectives	To discuss the key elements of the proposals for health sector reform developed in the former Soviet Republics of Central Asia.
Study type	Review article.
Data source & methods	WHO data and the WHO Health Systems in Transition profiles for 1995 and 1996.
Findings	While the six republics reviewed have many aspects in common, such as financing based on social insurance, there are also many differences, reflecting national political, economic and historical circumstances. Most attention to date has focused on the design of the proposed reform system and less on the potential barriers to implementing reform packages. These barriers, such as the numerous adverse factors in the context in which reform is taking place, weaknesses in the process of reform itself, or failure to involve groups (users, providers, policy makers and interest groups) on whom the success of reforms may depend, are discussed.
Policy implications	The context of policies must be examined alongside the context within which policy is being implemented as well as the key actors involved in the process.
Conclusions	The authors suggest that governments and advisors together take better account of the obstacles to implementation and be more cognisant of the national context – economic, political and cultural – within which reform is to take place.

Author(s)	Ministry of Health, S.R. of Vietnam
Title	Final report on health survey in Bac Thai and Yen Bai Provinces
Source	1991a, Report 10-1991, Department of Planning, Ministry of Health, Hanoi, Vietnam
Objectives	To examine: (i) the utilisation of health facilities; (ii) users' willingness to pay for services; (iii) the current quality of health services as perceived by both users and providers; and (iv) the main problems facing health service providers. The results are tabulated.
Study type	Research study using quantitative methods.
Data source & methods	World Bank commissioned survey of 147 health providers in 106 communes of two mountainous provinces in Vietnam. A user exit survey was conducted; interviewers were public sector medical doctors.
Findings	Main findings: (i) commune health centres and polyclinics were favoured by low income households whereas high income groups opted for a traditional medical consultation; (ii) 70 per cent of health service users were adults; (iii) the majority (>80 per cent) came for curative care, primarily for symptoms of fever, cough, headache and depression; (iv) health workers had low rates of daily contact with patients, no time was allocated to preventive care, health education or outreach activities, and the quality of diagnostic and treatment skills was poor; (v) health workers identified their key problems to be low salaries, a lack of instruments and drugs, and difficult working conditions. An increase in the use of private physicians and a decrease in the use of public facilities were noted.
Policy implications	None stated.
Conclusions	Few differences in service provision and service utilisation were found between the mountainous study areas of the current report and the plains of the Ministry of Health study, 1991b. The report suggests that patient satisfaction is high and that services meet the needs of the mountainous population. But quality of care is also reported as poor, services are inefficient and drug supplies and instruments inadequate. Living conditions for health workers are poor and many resort to private practice. The trend of people towards use of the private sector grows, whilst use of the public sector shrinks.

Author(s)	Ministry of Health, S.R. of Vietnam
Title	Final Report on health survey in Quang Nam - Da Nang, Cuu Long and Hai Hung Provinces
Source	1991b, Report 5-1991, Department of Planning, Ministry of Health, Vietnam
Objectives	To examine: (i) the utilisation of PHC services; (ii) users' willingness to pay for PHC services; (iii) the current quality of PHC services as perceived by both users and providers; and (iv) the main problems facing health service providers. The results are tabulated by province, urban/rural area, sex, age, and type of provider.
Study type	Empirical study using quantitative methods.
Data source & methods	A World Bank commissioned survey of 386 health providers in an urban and a rural district of three provinces in the plains area of Vietnam. A user exit survey was conducted. Interviewers were public sector medical doctors.
Findings	Main findings: (i) 70 per cent of health service users were adults, the vast majority (>90 per cent) opting for curative care services for the treatment of, primarily, fever, cough, aches and pains and dizziness; (ii) relative to per capita income health costs were perceived to be expensive; (iii) despite high levels of user satisfaction with service quality (95 per cent), diagnostic skills and preventive care services were weak; and (iv) health workers identified their key problems to be low salaries, inadequate supply of drugs and equipment and poor facilities. Health workers identified a need to integrate private health workers into the public health arena.
Policy implications	None drawn.
Conclusions	Three main issues need addressing: (i) staff salaries; (ii) drugs, equipment and facilities; and (iii) the integration of traditional medicine into PHC service delivery. More information about private sector services is needed as well as a more thorough evaluation of the quality of care of health service providers.

Author(s)	Ministry of Public Health
Title	Toward a national drug policy: report from the national drug seminar 'Towards a NDP' in Lao PDR, 1992
Source	1993, Vientiane, Stockholm and Bangkok: Lao MoPH, Karolinska Institute, and the National Epidemiological Board of Thailand
Objectives	To use the National Drug Seminar to formulate a national drug policy.
Study type	Conference proceedings.
Data source & methods	Not applicable.
Findings	A situational analysis of the rational use of drugs is given. The majority of the study sample referred to (60 per cent) buy drugs without prescription from pharmacy shops staffed largely by untrained dispensers. Poor prescribing practices and polypharmacy were frequently found. The problems associated with the shift to a market economy for drug distribution and procurement are noted. A need for policy regarding the regulation, utilisation and monitoring of traditional medicines was also reported.
Policy implications	Findings point to the need for comprehensive national drugs policy and a clear plan of implementation.
Conclusions	A revised draft of a national drug policy for Laos PDR.

Author(s)	Nguyen, H.T., Le, H.H.T., Rifkin S.B. and Wright, E.P.
Title	The pursuit of equity: a health sector case study from Vietnam
Source	1995, **Health Policy**, Vol 33: 191–204
Study type	Review paper.
Data source & methods	Not applicable.
Objectives	To review the issue of equity within the context of health sector reform in Vietnam and to discuss the effect of policy, legislation and human resources on the pursuit of equity in access to healthcare.
Findings	The paper reviews the Vietnamese health system and the effect of the current political and economic context on equity in access to healthcare. The impact of fees for service on equity and the inability of the government's exemption system to support the poor are discussed. Recent policy developments, including that of HI are critiqued and the lack of effective coordination between and within government and donor activities for the health sector are noted. Legislation for the regulation of fees and drugs costs is of particular importance, especially as regards the pharmaceutical sector. The impact of human resource development on equity is discussed, such as the effect of low salaries and poorly motivated health staff on the quality of service delivery.
Policy implications	Efforts to redress the growing inequalities of access depend upon: (i) the formulation and implementation of policy (in particular policy on HI and policy on cooperation between donors and government in health assistance); (ii) legislative power to enforce policy (for taxation of private practice and regulation of the pharmaceutical sector); and (iii) human resource development.
Conclusions	The pursuit of equity is not only a matter of more money but of addressing a range of related issues that impact upon achieving equity.

Author(s)	Pham, H.D.
Title	The political process and the private health sector's role in Vietnam
Source	1996, **International Journal of Health Planning and Management**, Vol 11: 217–30
Objectives	To review the current situation of the PHS in Vietnam.
Study type	Review article.
Data source & methods	A 1992 study of the PHS in eight provinces; case study of PHS growth in Ho Chi Minh city 1992–95 and a rapid appraisal on PHS growth in 53 provinces in 1995. Interviews with policy makers.
Findings	The paper describes: (i) the legal basis for development of the PHS; (ii) the growth of the PHS; and (iii) policy-makers' perceptions of PHS development. Mixed views about the PHS prevail amongst policy makers, which the author suggests are rooted in ideological conflicts as well as issues of efficiency and equity. Recommendations are made for appropriate support to private practitioners and improvements in the health system.
Policy implications	Development of the PHS could serve to release public funds to help redress growing problems of equity in access to services and should accompany the need for government to focus on the health priorities of the poor.
Conclusions	Legislation to develop the informal private sector has been slow to materialise for a variety of reasons. Future developments must be carried out within the context of an integrated public and private national health system.

Author(s)	Prescott, N.
Title	Poverty, social services and safety nets in Vietnam
Source	1997, **World Bank Discussion Paper** No 376, Washington, D.C.: World Bank
Objectives	To examine the changing role of the public sector in financing and provision of social services and safety nets in Vietnam and to assess its efficiency in targeting public resources to the poor in the context of Vietnam's economic reforms.
Study type	Discussion paper.
Data source & methods	Report draws upon data from the VLSS of 1992–93.
Findings	As regards health, the paper outlines the declining utilisation of health facilities and the inequitable access to quality services by the poor. The heavy reliance on self-medication, particularly by the poor, is noted as well as the dependence of the very poor on private, more than public, providers. As regards public sector provision, the very poor make greater use of commune health centres than the non-poor. A shift in the choice of provider from commune health centres to hospital services and from private paramedics to quality private practitioners with increasing income is noted.
Policy implications	Better targeting of public expenditure to priority areas and priority health programmes is needed if the inequitable access to services by the poor is to be addressed. This involves reducing the barriers to utilisation of distance, service costs and quality of care.
Conclusions	There is a threefold 'quality gap' between the poor and non-poor in the probability of seeing a high quality (hospital or private) provider. The poor face lower quality and higher prices for basic healthcare at public facilities. Better targeting of public subsidies is needed.

Author(s)	Segall, M.M., Tipping, G., Dao, X.V. and Dao, L.H.
Title	Economic reform, poverty and equity in access to health care: case studies in Vietnam
Source	1999, **Research Report** No 34, Brighton: Institute of Development Studies
Objectives	To investigate and pilot different ways of increasing the access of poor households to PHC services: (i) by looking at the access of the rural poor to essential healthcare and the adequacy of existing fee exemption systems; (ii) by testing the feasibility of developing collaboration between public and private health practitioners at the commune level; and (iii) to pilot the development of a financially sustainable and locally owned village health worker system in remote mountainous villages.
Study type	Research report.
Data source & methods	Action research in six communes of northern Vietnam using quantitative, qualitative and participatory methods (see also Tipping, Truong, Nguyen and Segall 1994).
Findings	Hospital costs are a recognised burden for poor households but the research reports that poor households have difficulty accessing even commune health services; debt and disinvestment are common coping responses and no clear exemption policy exists at commune level to assist the poor. A benchmark cost of a possible policy to subsidise the poor for the cost of drugs at health stations was calculated and feasible sources of finance proposed. The piloted collaboration between the public health sector and retired private practitioners showed that the private health workers were willing to be involved as post-reform village health workers and to help provide a more integrated network of PHC services, especially to the poor. Issues facilitating the collaboration are discussed. The success of the development of a network of village health workers for the remote villages arose from emphasis upon local decision making and community ownership of the village health workers scheme and upon finance from local political authorities. While this was evidently sustainable a year into the project the long-term viability needs to be monitored. Issues related to problems of sustainability are discussed.

Policy implications	Better targeting of exemption mechanisms for the poor are needed, particularly at commune level. A more flexible policy to incorporate private health workers into public sector health activities would provide more integrated and responsive PHC services, especially to the poor. For village health worker schemes to be sustainable, reliable sources of local finance are required as well as community support for village health workers services.
Conclusions	Market reforms have made most people better off but a minority has benefited only slightly and are experiencing difficulty accessing essential health services even at commune level. The cost of subsidising the poor for commune level essential drugs is relatively small and could be met from a variety of sources of finance. Private practitioners may be willing to act as post-reform village health workers and to collaborate with the public health sector in return for official recognition and the right to work legally. The remote village health worker network succeeded due to community participation and the willingness of local authorities to finance it. The sustainability of the scheme depends largely on how the communities perceive the value of village health workers' services.

Author(s)	Segall, M., Tipping, G., Lucas, H., Truong, V.D., Nguyen, T.T., Dao, X.V. & Dao, L.H.
Title	Health care seeking by the poor in transitional economies: the case of Vietnam
Source	2000, **IDS Research Report 43**, Brighton: Institute of Development Studies
Study type Data source & methods	Baseline and intervention studies on HCSB in six rural communes of northern Vietnam between 1992 and 1998, using a combination of quantitative, qualitative and partcipatory methods. See Tipping, Truong, Nguyen and Segall (1994) and Segall, Tipping, Dao and Dao (1999) for methodological and study details.
Objectives	The overall objective was to identify ways of increasing the access of poor households to PHC services of good quality and responsiveness. For the current report, the objective was to carry out secondary analysis of research findings and to consolidate conclusions for policy formulation.
Findings	The research addressed: (i) the problem of affordability of healthcare for poor households in the context of economic reform; and (ii) the determinants of household choice of healthcare option, with special reference to poor households. The study reports that economic reforms have made most people better off, but they have left a minority of households still in poverty, for which the benefits have been only modest. These poor households are burdened by debt and are very vulnerable to economic shocks of all kinds. Compared with the non-poor, poor households used less formal healthcare and incurred less healthcare expense, especially at lean times of the year. But the differential in these respects was much less than that in the ratio of healthcare spending to household income. The poor stretch their resources much more to obtain healthcare and in the process put their household economies under great strain. A hospital admission is a massive financial burden for the poor leading to serious disinvestment and/or debt. Treatment is avoided if possible. However, most healthcare spending by poor households is at the commune level where costs are mainly for drugs. Even this expenditure is a burden for poor households and disinvestment and/or debt is common. Exemption of the poor from charges is rare in commune public services and there is no clear official policy on this subject. The study calculated a benchmark cost of a policy of exempting poor households from paying for essential drug treatment by CHSs which would add about 15 per cent to the public funding of CHS services and could be financed by the poverty alleviation programme, local government general revenue, and/or a commune health tax. The differential preference for (ambulatory) healthcare providers by the poor and non-poor are described and analysed in relation to the main considerations of cost, convenience and perceived quality of service. Interventions at the commune level to (i) increase the responsiveness and accountability of the CHS to service users and (ii) to create a coordinated public/private mix of commune healthcare are described.

Policy implications	The purpose of the research was to identify ways of increasing the access of poor households to PHC services of good quality and responsiveness in Vietnam. The study's conclusions, summarised below, have broad applicability to other transitional economy countries, especially the developing transitional economies of Asia, and also to many low-income countries generally.
Conclusions	General conclusions: (i) The use of complementary methods to study demand and supply sides together gave a depth of understanding of health related behaviour impossible to achieve with the use of either methodological approach alone and allows triangulation to cross-check data validity. (ii) The use of a longitudinal household illness record gave a complete and accurate record of illness events, provided a measure of illness incidence, as distinct from prevalence, and encompassed seasonal changes in HCSB. (iii) For primary as well as hospital care, there is a need to estimate cost and identify funders since the poor greatly burden themselves with the cost of illness, especially for hospital care, but even for primary care. (iv) Proposals for exemption policies should be costed for feasibility and their potential funding sources identified. (v) Primary level fee exemption policy should be linked to the promotion of rational drug use to avoid the unnecessary purchase (via polypharmacy) of drugs by the poor. (vi) The technical quality and, especially, the user friendliness of the public health system need to be improved. (vii) Private practitioners can be involved in the public health system by exchanging a legal recognition to work with agreement to comply with monitoring and regulation activities, as a means of improving quality of care.

Author(s)	Smithson, P.
Title	Sustainability in the health sector, Part 2: Health financing and sustainability in Vietnam
Source	1993, paper prepared for Save the Children Fund (UK), London.
Objectives	This report forms part of SCF's programme of research into health sector sustainability, which constitutes a series of case studies analysing sustainability in terms of the historical context of health sector development, technical capacity and the economic and political framework in which decisions about resource allocation and management take place.
Study type	Research report.
Data source & methods	Case study carried out in Vietnam in 1992.
Findings	The report discusses the health sector in the context of the country's transition from a command to a market economy. It explores the distinction between public and private healthcare provision and the relative scale and role of each. The financing of public health services, systems of public revenue collection and expenditure allocation are described with emphasis on the relationship between different levels of government. An overview of expenditure on public sector health services at all levels is given. Possible reasons for the decline in the utilisation of public health services are discussed; a deterioration in financing is refuted as the likely explanation. The author suggests that increasing cost to patients precipitated by the introduction of user fees coupled with the growth of 'private' work in public facilities and the poor prescribing practices that often result, is the most likely cause for the decline in utilisation. The allocation of resources in the health sector between geographical areas, levels of the health service, and between wage and non-wage expenditures is examined; qualitative constraints to effective resource management are mentioned briefly. A review of the role of external assistance is given and finally evidence on the severity of under-funding facing the health sector is summarised.
Policy implications	Policy implications are implicit in the findings and in the conclusions below.
Conclusions	Given the timing of this study and the imminent lifting of the embargo, a major conclusion of the paper is the anticipated rapid rise in external assistance. The author cautions that the meagreness of local recurrent resources will place limitations on the amount of investment which can be absorbed on a sustainable basis and a significant amount of donor expenditure will need to be devoted to recurrent support if financially unsustainable investments are to be avoided. Effective coordination of donors as regards the financing for health is essential. Equally, the power balance for policy dialogue, given the predicted increase in assistance to health sector financing, puts donors in a very influential position, but one which may threaten to distort or disempower domestic health policy.

Author(s)	Stenson, B., Tomson, G. and Syhakhang, L.
Title	Pharmaceutical regulation in context: the case of Lao PDR
Source	1997, **Health Policy and Planning**, Vol 12 No 4: 329–40
Objectives	To describe and analyse the system of drug regulation in Lao PDR in relation to the public social goals of equity and quality of care.
Study type	Empirical study.
Data source & methods	Review of official documents, 30 interviews with key informants and 15 surveys of pharmacies in 1996.
Findings	The massive increase in private pharmacies in Lao PDR. Means that more than 80 per cent of all drugs are distributed through the private sector, primarily through for-profit private pharmacies. There are serious flaws in the dispensing and use of drugs as a result of the low level of expertise amongst pharmacy staff, the work of unregistered private practitioners, the purchase of drugs without prescription, polypharmacy and the over-use of antibiotics and injections. Efforts to regulate this growing private market for drugs are underway in order to achieve goals of equity and quality of care. However, total drug expenditure may be as low as US$1 per person per year making it difficult to achieve reasonable access to drugs for all. So far the regulatory system has focused on entry into the pharmaceutical drug market and on issues of product quality and conditions of sale. An enforcement system including sanctions is being developed; other policy instruments such as information and economic means are largely unused.
Policy implications	The government faces a trade-off between achieving the goals of quality of pharmaceutical services and geographical equity of access.
Conclusions	The likelihood of moving towards a more practice-oriented regulatory system for drug control will depends on the socio-economic development of Lao PDR, on the availability of resources, on a thorough understanding of the issues involved and on political will.

Author(s)	Swenson, I.E., Thang, N.M., Nhan, V.Q. and Tieu, P.X.
Title	Factors related to the utilisation of prenatal care in Vietnam
Source	1993, **Journal of Tropical Medicine and Hygiene**, Vol 96: 76–85
Objectives	To analyse the influence of selected individual and community characteristics on the utilisation of prenatal care.
Study type	Research study using quantitative methods.
Data source & methods	Analysis used data from the 1988 Vietnam Demographic and Health Survey and 1990 Vietnam Accessibility of Contraceptives Survey.
Findings	Specific analysis of the impact of health services availability and other development characteristics of the community (e.g. availability of electricity and public transport) on utilisation of prenatal care was done on a rural sub-sample. The women's educational level and total number of living children were the most important predictors of prenatal care utilisation. Age independent of parity did not significantly affect the use of prenatal care. Rural women and women living in provinces with the highest infant mortality rates were significantly less likely to use prenatal services than their counterparts in the urban areas and provinces with low infant mortality rates. Non-physician healthcare providers were the main sources of prenatal care for women in both rural and urban areas.
Policy implications	Attempts to encourage women of limited education to use prenatal services are called for. The accessibility and availability of prenatal services need to be increased.
Conclusions	Given the strong association between women's educational achievement and utilisation of prenatal care services, the imperative is to promote the educational achievements of women.

Author(s)	Tang, S.-L.
Title	The changing role of township health centres
Source	1997, **IDS Bulletin**, Vol 28 No 1: 39–47
Objectives	Analyse the impact of economic reform on the performance of township health centres in China.
Study type	Research article.
Data source & methods	Draws on data from a case study of township health centres in Donglan County, China.
Findings	Township health centres, as providers of a range of curative and preventive healthcare services as well as training and supervision, have a key position in China's rural healthcare system. A case study of health centres in a poor rural county shows that the performance of many functions declined during the 1980s. Utilisation rates have dropped as many health centres are unable to compete for patients in the developing market for medical care. The variety and quality of services has decreased with the loss of qualified personnel and a lack of medical equipment. Increased user charges, poor service attitude and a less responsive service relative to other provider options have reduced public confidence in health centre services. The performance of other important functions, such as immunisation, disease prevention and maternal and child healthcare programmes has been undermined by financial constraints, as has training, supervision and routine reporting. The focus has shifted to programmes that allow income generation.
Policy implications	Discussion in China of policy options to address this situation focuses on whether investment in health centres should be increased, or whether the role of health centres should change to reflect existing constraints.
Conclusions	The author puts forward a strategy for strengthening health services at the township level, namely, to reorganise rural health services at the township level by identifying 3–5 key health centres to be given priority in the allocation of personnel, financial and physical resources by county governments. Such a model depends on political backing and technical support; in-service training to improve quality of care; appropriate funding of preventive care programmes; and lastly, effective staff management to ensure quality staff stay in post.

Author(s)	Tang, S.-L., Bloom, G., Feng, X., Lucas, H., Gong, X. and Segall, M.
Title	Financing health services in China: adapting to economic reform
Source	1994, **Research Report** No 26, Brighton: Institute of Development Studies
Objectives	To discuss and review China's adaptation of its rural health services to the programme of economic reforms.
Study type	Research report.
Data source & methods	Review of empirical and policy material. Includes data from a 1988 study on health finance conducted with households, medical facilities, health authorities and health cadres (pp 66–107).
Findings	As regards service utilisation (see pp 89–107), the study uses three indicators of access to care: the average level of utilisation relative to reported morbidity; the proportion of people needing care but not receiving it; and the extent to which non-use of services is attributed to cost. These indicators are compared for people in rich and poor counties with and without HI cover. Findings showed significant non-use of services especially by the elderly of rich and poor counties and the young of poor counties. High costs were often cited as the explanation though utilisation did not differ by insurance cover. The cost of hospital inpatient care was a significant barrier for the poor, and represented over half the average income per capita of a poor household.
Policy implications	In relation to the changes in the organisation of rural healthcare services, the resulting problems of equity of access to services for the poor and the loss of collective resources to finance health services, the report discusses the organisation and implementation of the MoPH's policy for cooperative healthcare schemes (see Chapter 6).
Conclusions	The authors argue that any effort to establish a new system of rural health finance must be linked to other aspects of the rural health system, particularly to the system of payment of health providers and the mechanisms for health sector planning, coordination and regulation.

Author(s)	Tipping, G. and Segall, M.M.
Title	Health care seeking behaviour in developing countries: an annotated bibliography and literature review.
Source	1995, **IDS Development Bibliography** No 12, Brighton: Institute of Development Studies
Study type	Annotated bibliography and literature review.
Data source & methods	Literature published between 1984 and 1994 on household HCSB reviewed for the countries of sub-Saharan Africa, South Asia and Southeast Asia.
Objectives	To review the literature on HCSB in developing countries.
Findings	The review discusses the methodological approaches for studying HCSB and the issues that compromise comparison of studies. Determinants of HCSB are reviewed (e.g. socio-economic variables, convenience, cost, quality of care, social status of women, illness type and severity, etc.) and the determinants of specific healthcare options summarised. Studies that address issues of quality assessment and assurance are reviewed. Bibliography of 114 studies/articles.
Policy implications	See studies for policy implications.
Conclusions	A number of methodological factors compromise the comparison of studies on HCSB, which are in themselves relatively few. HCSB is a multi-faceted decision-making process for which cost, convenience and quality of care together may be the most important issues. Qualitative studies, or studies which complement quantitative methods with a qualitative dimension, would facilitate an understanding of the processes by which people access healthcare services.

Author(s)	Tipping, G. and Segall, M.M.
Title	Using a longitudinal illness record to study household health care decision making in rural communes of Vietnam
Source	1996, **Health Policy and Planning**, Vol 11 No 2: 206–11
Objectives	The paper aims to describe one of the research methods used to study household HCSB in rural communes of Vietnam. The principal aim of the research was to acquire a view of PHC service delivery from both user and provider perspectives. The method described is a longitudinal illness record (IR) designed to assess household healthcare decision-making.
Study type	Household based study utilising a combination of quantitative, qualitative and participatory methods.
Data source & methods	Research was carried out in four rural communes of northern Vietnam from 1992 to 1994 on a sample of 664 households. The longitudinal IR method was implemented over a four-month period.
Findings	The paper reviews the methodological issues associated with HCSB studies and describes the design and implementation of the IR. Advantages and disadvantages of the IR are given. The paper gives an overview of the study findings and discusses them in relation to household poverty and the ability to pay. It reports that households choose healthcare providers on the basis of perceived quality of care, convenience of service and affordability. Poor households (defined by food shortage) used commune public services more often, and higher level services less often, than non-poor households and had more frequent difficulty in meeting healthcare costs (defined as the need to take loans, defer payment or sell assets).
Policy implications	For policy implications of the research see Tipping, Truong, Nguyen and Segall (1994).
Conclusions	The authors conclude that the IR was a valuable household-based instrument for providing quality information on household illness episodes and decision making. It appeared methodologically robust. By monitoring illness events over time, the likelihood of inaccurate and incomplete recall is minimised; decision-making processes can be recorded in detail; and incidence, rather than prevalence rates, can be calculated. Its disadvantages are the organisational logistics and running costs, and the demand for a level of local expertise and participation. It is best used in parallel with qualitative soundings of community opinion.

Author(s)	Tipping, G. and Truong, V.D.
Title	Rural health services in Vietnam: their contemporary relevance to other Asian transitional economies
Source	1997, **IDS Bulletin**, Vol 28 No 1: 110–15
Objectives	To review the impact of economic reform on PHC in Vietnam.
Study type	Review article.
Data source & methods	Not applicable.
Findings	While the current transitional period has undermined the financial base of PHC in Vietnam and made the delivery and quality of services vulnerable, particularly at the commune level, the government of Vietnam is responding in various ways to try and safeguard public health provision. The paper looks at some of the measures taken by the government to preserve the delivery of PHC, such as nationalising commune health worker salaries and subsidising health services in remote highland areas. The paper discusses changes in utilisation of services, government policies to safeguard access to essential services for the poor, the role of the private sector in PHC delivery and the impact of economic reforms on the financing of healthcare.
Policy implications	Reliance on 'voluntary' household contributions to bolster the finance of social funds, including health, is widespread. This form of community finance is only tenable if the majority of households can afford to pay. Since much of the financing of commune level healthcare currently depends on local political will and the ability of users to afford health fees, there is a need to encourage PHC as a political priority in all communes and to ensure equitable access to health services for all.
Conclusions	The authors argue that the government of Vietnam's political commitment to public health both past and present, and its propensity to adapt to change, may sustain the provision of basic healthcare services during the current period of rapid economic reform.

Author(s)	Tipping, G., Truong, V.D., Nguyen, T.T. and Segall, M.M.
Title	Quality of public health services and household health care decisions in rural communes of Vietnam
Source	1994, **Research Report** No 27, Brighton: Institute of Development Studies
Objectives	To develop and apply methods for evaluating the quantity and quality of commune health services and for studying household healthcare decisions and their determinants. To investigate how the quality of PHC could be improved and the service made more responsive to users in the context of economic adjustment and reform in Vietnam.
Study type	Research study using quantitative and qualitative methods.
Data source & methods	Research conducted in 1992–93 in four rural communes of northern Vietnam. The methods included a cross sectional household survey (n=664), a four month longitudinal illness study, interviews and focus group discussions with female household members, in-depth study of four CHSs and their services, and semi-structured interviews with health and political authorities.
Findings	Assessment of the quality of CHS service delivery showed that the rank order of CHS performance was not the same as that of commune prosperity, but of the level of health worker salaries and allowances. Better performance was related to the political and financial priority afforded to health by local political authorities. The subjective assessment of the CHSs by household respondents mirrored the clinical evaluation of CHS services. The HCSB study showed that illness episodes were treated half by self-care and half by healthcare consultation (of which half were with commune public services). The main determinants of healthcare decision making were cost, convenience, and the perceived professional skill and personal attitude of health providers. Providers that offered out of hours care and home visiting were sought after. CHSs offered a less flexible service than private health workers or drug sellers. A good standard of facilities, equipment and drugs also influenced household decision-making. The main costs in ambulatory care were for drugs with the rank order of cost the reverse of the frequency with which households chose to use the healthcare options. Poor and non-poor households reported similar rates of illness and made similar healthcare decisions, but poorer households sought commune public services more often and higher level services less often than non-poor households. Poor households were more likely than non-poor households to sell assets, borrow or defer payment.

	While households preferred to attend the CHS, some CHSs fared poorly on key criteria such as health worker skill and attitude and the standard of facilities. CHSs need to rearrange shifts in order to extend their opening hours and health workers should be more prepared to make home visits.
Policy implications	Restoration of the CHS would have positive implications for the quality of PHC, the take up of preventive services and affordability, especially for the poor.
Conclusions	Three factors would probably restore the CHS to its position as the most popular healthcare option at the primary level: (i) a greater political and financial commitment by the government and commune people's committees; (ii) enhanced accountability of the health station to the community; and (iii) improved supervision and in-service training of commune health workers by the district health centre.

Author(s)	Tunyavanich, N.
Title	Vietnamese family health practices: an in-depth study of family health seeking behaviour at the commune level
Source	1992, UNICEF, Health Education and Communication Project H72, Hanoi, Vietnam.
Objectives	To study health seeking and health practices with special focus on curative and preventive healthcare practices and the uptake of health education information and activities in families with children under five years.
Study type	Research study.
Data source & methods	A descriptive study based on a sample of 34 households with children under five years (total population 169 people) in one commune of northern Vietnam.
Findings	A broad brush of information is given including the socio-political structure of the commune, the range of available health providers, health education activities and a resume of the preventive health programmes implemented by the health station. Recall of recurrent illness, of illness in the five weeks preceding the study and during the four-week study period is reported. Of the 122 reported illnesses, 56 per cent were in children under five, mainly respiratory illnesses. The study does not report the kind of practitioner sought, but details the number of stages in the healthcare seeking process (1–3+) and summarises the type of illness (acute respiratory illness, diarrhoeal diseases, 'other') in relation to the use (or otherwise) of antibiotic drugs. To summarise, the main illness response is to buy antibiotics, usually OTC, typically for a respiratory illness. The relative strengths and advantages of private practitioners are summarised and the shortfalls in health education and communication detailed.
Policy implications	Health education programmes and personnel require appropriate training and technical and material support, with materials designed to suit the needs of the audience, if the level of knowledge of health users, particularly women, is to be improved. Information should be targeted to the audience as well as to priority health issues.
Conclusions	Conclusions are made in relation to maternal child healthcare and the utilisation of health services by women. Women's health knowledge is poor, attributed to inadequate or non-existent health education programmes. The most common treatment strategy of women is to buy drugs OTC and self-treat; opportunities for disseminating health education information are therefore minimal. The private sector offers more skilled and convenient services but focuses only on curative care.

Author(s)	Vinard, P.
Title	Enquetes sur le recours aux soins et les dépenses de santé en République Démocratique Populaire du Lao. Résultats préliminaires [Research on healthcare seeking and healthcare costs in the Democratic People's Republic of Lao. Preliminary findings]
Source	1994, **BI Technical Report Series** No 27, World Bank/UNICEF, Vientiane
Objectives	To investigate healthcare seeking and healthcare costs.
Study type	Research report.
Data source & methods	A household based healthcare seeking study of 785 households in five districts of Lao PDR, carried out by UNICEF in collaboration with the Laos Ministry of Health.
Findings	Using a three-month illness recall period, 83 per cent of households reported at least one illness. The characteristics of the illness episodes are described. Home remedies were often used but as an adjunct to other sources of help. Self-medication, the first source of treatment in 51 per cent of cases, was preferred by the young and used for non-serious illnesses. Twenty nine percent of illness episodes had a second 'act', primarily a private consultation if affordable, a spiritual healer for the poor, or a hospital consultation for the more serious illnesses and for those for whom hospital care was accessible. The poorest households were less likely to use a second option. Third acts were rare. Determinants of choice, and the advantages and disadvantages of each type of healthcare option, as perceived by users, are discussed. The importance of the cost of healthcare, ability to pay, method of payment and the relation to household wealth is discussed
Policy implications	Implications for the apparently well regarded, but minimally used, public sector health stations and for monitoring the private sector, are discussed.
Conclusions	The use of self-medication and private sector providers as PHC seeking options is stressed. Household expenditure on healthcare is an important issue especially for the poor. There is a demand for better quality public sector services. As the principle of fee payment appears to be acceptable to households, there exists a new source of revenue for public sector care to finance such improvements. There is a need to promote the public sector as well as regulate the private sector, in order to control household expenditure on healthcare.

Author(s)	White, J.
Title	Of Spirits and Services. Health and healing amongst the hill tribes of Rattanakiri province, Cambodia
Source	July 1995, mimeo, Health Unlimited Rattanakiri Integrated Health Programme, London
Study type	Anthropological study of one hill tribe (a Kreung village, Sruk Kreh, in O Chum district) over period of a year and brief comparative studies in villages of two other hill tribes.
Data source & methods	See above.
Objectives	To increase the Health Unlimited project's understanding of the lifestyle of the ethnic minority groups with emphasis on health related issues, of which HCSB is one component.
Findings	The study describes the common health problems, beliefs about illness causation and HCSB of the Kreung. The different indigenous treatments which the Kreung use as a primary response to illness are described. Western medicine, sought from *phet khums*, market pharmacies and district hospitals, is popular and often viewed as cheaper and 'stronger' than some traditional therapies. The use of multiple therapies is a common pragmatic coping strategy for illness, but spiritual beliefs still strongly influence behaviour. Government health services are under-utilised not only because of the strength of indigenous belief systems but because of access problems. Western medicine tends not to be sought from the health providers supported by Health Unlimited (the *phet khums* and district hospitals). This is primarily due to a lack of awareness of the health providers' activities and drug supplies; a lack of faith in the health workers' abilities and role; low expectations on the part of both providers and users; and poor quality care.
Policy implications	None identified.
Conclusions	Extrapolating from the study, some of the conclusions are that all sectors of village society need to be involved in any process of health education and that, because of the nature of the indigenous belief system for illness, good communication and a mutual understanding between the formal health sector and the indigenous health system is needed, as well as a community based health worker who is trusted enough to bridge both health systems.

Author(s)	Wilkes, A., Yu, H., Bloom, G. and Gu, X.
Title	Coping with the costs of severe illness in rural China
Source	1997, **Working Paper** No 58, Brighton: Institute of Development Studies
Objectives	To study households that had spent a large proportion of their 1993 annual income on medical fees in order to investigate, in 1996, how they had mobilised resources to cope with costs and whether costs had impoverished them. (The poorest households are excluded from the study on the grounds of existing poverty.)
Study type	Research study.
Data source & methods	A follow-up study in 1996 of a 1993 survey on health services utilisation and expenditure in rural China (see Yu, H., Cao, S. and Lucas, H., 1997, 'Equity in the utilisation of medical services: a survey in poor rural China,' **IDS Bulletin,** Vol 28 No 1: 16–23). Current study sample is 24 households.
Findings	The methodological problems associated with using an illness event recall period of three or more years are discussed. The study reports that most households could finance the high medical costs without drastic opportunity costs and were able to maintain production and income. Outside family resources, especially those accessed through social networks, were important sources of labour and financial support. Many households were able to finance subsequent unanticipated expenditures. The use of formal and informal loans, use of savings, delayed repayment of debt, reduced consumption or investment, and increased demands on household members (often children) to compensate for the lost labour power of the sick are some of the coping strategies reported. A small number of households with fewer options available were less able to cope; those which lost either core assets or lacked social connections were the most vulnerable to the impact of subsequent financial shocks. It is these and the poorest households that require a more efficient system of safety nets.
Policy implications	There is a need for improved funding of hospital services for the very poor; possibilities include higher government subsidies for health facilities or greater funding for current systems of financing services for the poor, such as social relief or medical fee exemption.
Conclusions	It is the poorest households, such as those which are vulnerable to loss of core assets, which have limited access to social networks, in which there is chronic or repeated illness, or in which there is a sole earner or low initial income, that require a more efficient system of safety nets in order to cope with the impact of subsequent financial shocks.

Author(s)	Wilkinson, S.
Title	The right to basic health care – tackling urban poverty in Cambodia
Source	December 1999, **Options News**, Newsletter No 4: 3
Study type	Comprehensive HCSB study of the urban population of Phnom Penh conducted in April 1999 as part of the Phnom Penh Urban Health Project, one component of Cambodia's national Health Sector Reform III programme.
Data source & methods	Full project details and findings forthcoming.
Objectives	To improve the quality of affordable care in Phnom Penh particularly for poor communities.
Findings	Preliminary findings suggest that the urban poor pay almost 28 per cent of annual income for what is generally perceived to be poor quality healthcare. To meet health costs people are forced to take out loans that greatly exacerbate existing financial hardship. Access to services is poor; people cannot afford to spend the time needed to queue for treatment at hospitals, where they are charged official and unofficial fees. Accessing the government's exemption system is difficult and only a small percentage of those living below the poverty line receive subsidised care. People resort to untrained drug sellers and traditional medicine. Private practitioners practice polypharmacy to increase fees and the quality of their care is poor.
Policy implications	Success of the urban health project's initiatives will inform overall health policy development for Cambodia in terms of a comprehensive urban health strategy for the country and the scope for public/private partnerships.
Conclusions	The findings of the study on HCSB are shaping initiatives to improve the quality of affordable healthcare, especially for the urban poor.

Author(s)	Witter, S.
Title	'Doi Moi' and health: the effect of economic reforms on the health system in Vietnam
Source	1996, **International Journal of Health Planning and Management**, Vol 11: 159–72
Objectives	To analyse the changes that have taken place in the health system in Vietnam since the economic reform process began in the late 1980s.
Study type	Review article.
Data source & methods	Not applicable.
Findings	Witter states that while economic liberalisation has lead to growth and increased choices for many, it has also increased income and regional disparities and made access to social services problematic for the economically vulnerable. The reality is one of increasing health costs for patients in the form of official and unofficial payments to staff and payments for drugs. The public sector is faced with dramatic decreases in the utilisation of public facilities, a shift towards self-prescription, increased private practice by public employees, and increasing reliance on foreign donors to support preventive programmes.
Policy implications	Government policy stresses equity and free access to healthcare for the poor yet the evidence points to rising costs and decreased use of public sector facilities, which challenge current policy and planning in the health sector.
Conclusions	The author concludes by measuring the changes that have taken place in the health sector against four key criteria. (i) Where costs have risen and utilisation decreased, the poor are prohibited from accessing services. With increasing income inequalities, access is a critical issue. (ii) While funding levels are inadequate to meet the health needs of the population, private spending on health has increased, as has external aid. The key issue is the effective use of resources. (iii) Some improvements in efficiency are evident such as the shift towards the use of population norms for resource allocation, but improved training and supervision, increased pay, regulation of the private sector and a stronger focus on commune level services are also needed. (iv) Improvements in health outcomes are hard to assess in relation to the impact of economic reform, but health indicators do not appear to have changed much over the period. Rates of malnutrition remain unacceptably high, however. Expertise in health financing, management, training, supervision and communications are paramount to deal with the changes imposed by the reform process.

Author(s)	Wolffers, I.
Title	The role of pharmaceuticals in the privatisation process in Vietnam's health care system
Source	1995, **Social Science and Medicine**, Vol 41 No 9: 1,325–32
Objectives	To discuss the role of pharmaceuticals in the privatisation process in Vietnam's healthcare system.
Study type	Review article.
Data source & methods	Not applicable.
Findings	The paper describes the changes in the Vietnamese healthcare system and in the supply and demand for drugs before and after the economic reform process was launched in 1989. Wolffers argues that in the transaction between users and private providers, drugs are the tangible goods exchanged and around which a price can be negotiated, in contrast to advice (which is difficult to cost) or medical tests (for which equipment and skill may be lacking). The author discusses pharmaceuticals in the context of the history and development of Vietnam's health system and as a marker for social and political change.
Policy implications	None drawn.
Conclusions	The author argues that the attitude of both purchasers and providers of health services toward pharmaceuticals is a metaphor for the changing healthcare system of Vietnam, an understanding of which is critical to better planning of essential drugs programmes.

Author(s)	World Bank
Title	Kyrgyz Republic: Consultations with the Poor
Source	1999a, prepared for the Global Synthesis Workshop, Poverty Group, PREM, World Bank
Objectives	PPA study undertaken to inform the World Development Report 2000/1 on Poverty and Development.
Study type	PPA to provide information on well-being and trends in well-being over time; on prioritised problems of the poor; on coping strategies; institutional relations and responsibilities; and changes in gender relations at household and community levels.
Data source & methods	A range of group discussions and interviews were conducted in nine sites in the three poorest *oblasts* of the Kyrgyz Republic and the capital city.
Findings	The incidence and depth of poverty has increased in the last ten years. Inequality has increased and market reforms only benefit the wealthy. Many people now cannot afford to pay the cost of healthcare (or education), previously provided free by the state. This clearly differentiates the rich from the poor. See report for detailed information on poverty assessment.
Policy implications	No policy implications are drawn; the information gathered speaks for itself.
Conclusions	Transition has engendered many problems especially for the poor. Factors related to the economic crisis, such as unemployment and high prices, etc, have made the poor even more vulnerable. There is a lack of governmental support for the vulnerable. Formal institutions such as health and education services are inadequately funded and as a result cannot function effectively; they are poorly regarded. The poor turn to the community for support since formal institutions are failing to deliver assistance.

Author(s)	World Bank
Title	Uzbekistan: Consultations with the poor
Source	1999b, prepared for the Global Synthesis Workshop, Poverty Group, PREM, World Bank
Objectives	PPA study undertaken to inform the World Development Report 2000/1 on Poverty and Development.
Study type	PPA to provide information on well-being and trends in well-being over time; on prioritised problems of the poor; on coping strategies; institutional relations and responsibilities; and changes in gender relations at household and community levels.
Data source & methods	A range of interviews and group discussions were conducted in three sites in three regions of Uzbekistan.
Findings	As regards healthcare, the study finds that people perceive the quality of services to have deteriorated since economic reform. Unofficial payments in cash or kind to health staff for services and drugs are increasingly rife. Even services subsidised by government incur unofficial costs. Exemption systems do not assist the vulnerable because of bureaucratic obstacles. Illness therefore threatens the financial stability of households and the sick are now regarded as a vulnerable segment of the population. The implication for children whose families cannot afford to pay the unofficial costs charged for a range of preventive care services, including inoculations for preventable diseases, is especially serious.
Policy implications	No policy implications are drawn; the information gathered speaks for itself.
Conclusions	Overall findings are summarised (pp 6–9). Regarding healthcare services, people perceive that under economic reform, the quality of care has deteriorated, services are expensive and unaffordable for many. Equity is under threat, especially for children.

Author(s)	World Bank
Title	Vietnam: Consultations with the poor. A synthesis of participatory poverty assessments from four sites in Vietnam: Lao Cai, Ha Tinh, Tra Vinh and Ho Chi Minh City
Source	1999c, prepared for the Global Synthesis Workshop, Poverty Group, PREM, World Bank, by Vietnam-Sweden Mountain Rural Development Programme, Action Aid, Save the Children Fund (UK) and Oxfam (GB)
Objectives	PPA study undertaken to inform the World Development Report 2000/1 on Poverty and Development.
Study type	PPA to provide information on well-being and trends in well-being over time; on prioritised problems of the poor; on coping strategies; institutional relations and responsibilities; and changes in gender relations at household and community levels.
Data source & methods	A range of interviews and group discussions were conducted involving over 1,000 households in four sites in Vietnam.
Findings	As regards healthcare seeking: livelihoods and living conditions have improved, in the minds of the poor, over recent years. However, even better-off households fear illness episodes which incur high expenditure and reduce household capacity to earn. Ill health is the most commonly cited reason for household poverty in recent years, leading to disinvestment of assets and the need to take out informal sector loans, with their long term impact on household livelihoods. Avoidance of medical treatment is also a coping strategy for the poor. Prioritised problems include the need to improve access to affordable healthcare, especially for the elderly. A preference for private practitioners was often cited because they offer home visits and treatment on credit.
Policy implications	No policy implications are drawn; the information gathered speaks for itself.
Conclusions	The poor cannot afford the high direct and indirect costs of seeking treatment, are more likely to be ill, and suffer greatly when a family member falls sick. As a result, recommendations to make public health services more affordable and accessible to poor households were made in all of the PPA site reports.

Author(s)	World Bank
Title	Vietnam Poverty Assessment and Strategy
Source	January 1995, the World Bank, Country Operations Division, Country Department 1, East Asia and Pacific region, Hanoi, Vietnam
Objectives	To develop a consistent nation-wide poverty profile using the VLSS data of 1992–93 to strengthen the government of Vietnam's design and targeting of poverty reduction policies. To examine the changing role of the public sector in financing and provision of social services and safety nets in Vietnam and to assess its efficiency in targeting public resources to the poor in the context of Vietnam's economic reforms.
Study type	Report.
Data source & methods	The report is based upon data from the VLSS of 1992–93, a nationally representative household survey of living standards based on 4,500 households and 23,000 people in urban and rural areas of Vietnam's seven geographic regions.
Findings	As regards the utilisation of health services and poverty (see pp 95–108), the report outlines the declining utilisation of health facilities and the inequitable access to quality services by the poor. The heavy reliance on self-medication, particularly by the poor, is noted as well as the dependence of the very poor on private, more than public, providers. As regards public sector provision, the very poor make greater use of commune health centres than the non-poor. With increasing income a shift in the choice of provider from commune health centres to hospital services and from private paramedics to quality private practitioners with increasing income is noted.
Policy implications	Better targeting of public expenditure to priority areas and priority health programmes is needed if the inequitable access to services by the poor is to be addressed. This involves reducing the barriers to utilisation of distance, service costs and quality of care.
Conclusions	There is a threefold 'quality gap' between the poor and non-poor in the probability of seeing a high quality (hospital or private) provider. The poor face lower quality and higher prices for basic healthcare at public facilities. Better targeting of public subsidies is needed.

Author(s)	Yip, W. C., Wang, H. and Liu, Y.
Title	Determinants of patient choice of medical provider a case study in rural China
Source	1998, **Health Policy and Planning**, Vol 13 No 3: 311–22
Objectives	To analyse the factors influencing patient choice of medical provider
Study type	Research study using quantitative methods.
Data source & methods	The study is based in Shunyi county of Beijing in 1993 and analyses household survey data of 1,877 outpatient treatment cases.
Findings	The study is the first attempt to identify and quantify the individual factors determining patient choice of provider in rural China. Provider choice relates to China's three tier healthcare system of village health posts, township health centres and county (and higher level) hospitals. It is analysed in relation to three factors hypothesised to affect patient demand: insurance status, income and disease pattern. The study shows that relative to patients who pay fee-for-service, those with HI (government or Labour Health Insurance beneficiaries) are more likely to use county hospitals, while patients insured under the rural Cooperative Medical System (CMS) are more likely to use village level facilities. High-income patients are more likely to use county hospitals than low-income patients, who use village level doctors. Disease patterns appear to have a significant impact on provider choice and patients with chronic illness were more likely to use county hospitals than village health posts (the study does not control for illness severity).
Policy implications	Good CMS coverage at the village level would encourage utilisation at that level and deter overuse of higher level providers (if accompanied by resources directed towards improving village level quality of care). CMS coverage also increases the likelihood of seeking formal treatment, which for the poor may reduce the risk of serious illness that is associated with delayed seeking for help. It might therefore reduce illness costs. The study shows that patients' HCSB must be taken into account in service planning and resource allocation.
Conclusions	The authors conclude that China's pattern of economic growth is changing provider choice dramatically with increasing numbers of people willing to pay higher out-of-pocket costs in order to use the higher quality, county level, hospital services. This coupled with the epidemiological transition in rural areas has important implications for the organisation of healthcare finance and delivery in rural China.

Author(s)	Yu, D.
Title	Changes in healthcare financing and health status: the case of China in the 1980s
Source	1992, **Innocenti Occasional Papers**, **Economic Policy Series** No 34, Florence, Italy: UNICEF International Child Development Centre
Objectives	To review development of healthcare policy in China and the impact of health sector reforms on healthcare.
Study type	Review paper.
Data source & methods	Not applicable.
Findings	The paper quotes data on the utilisation of health services post-economic reform in relation to the distribution of healthcare resources and the increases in the cost of medicines and user fees. The author cites studies to show the reliance of rural households on health services at sub-county level, services that were receiving diminishing financial support. Studies of the urban-rural shift in user payments as a share of total health expenditure show service coverage in rural areas to be impaired and service utilisation decreasing. Medical expenses as a proportion of average annual income are shown to be a greater burden for rural than urban incomes. Issues of equity of access to health services, especially for the poor in rural areas, are highlighted.
Policy implications	The author suggests that China's health sector reforms were implemented without consideration either for the nature of healthcare services or how best to finance them: by the government as public goods, from user fees or a mixture of the two. The author states that healthcare in China has yet to be recognised as a basic human right and as an investment in people and in the development of human capital.
Conclusions	The author summarises the necessary steps to be made in the finance, organisation and delivery of health services which may then lead to improvements in health status. A greater focus on rural healthcare services is required. Suggestions to make the healthcare network more efficient and cost-effective are made. The conclusion is that reform is an on-going process.

Author(s)	Yu, H., Cao, S. and Lucas, H.
Title	Equity in the utilisation of medical services: a survey in poor rural China
Source	1997, **IDS Bulletin**, Vol 28 No 1: 16–23
Objectives	To examine equity in the utilisation of curative medical care services in poor rural China, focusing on the HCSB of those living below the poverty line.
Study type	Research study.
Data source & methods	A 1994 household survey of three study counties of China, covering 2,722 households. Questionnaires on household characteristics, illness episodes, use of services and medical expenditures in 1993.
Findings	The study categorises households into three income groups using per capita household income and State Council definitions of poverty. Data on the use of outpatient services (based on two-week illness recall) is analysed relative to these three groups. Limited evidence is found of a differential use of services by the three income groups, but a much greater variation is found in the use of inpatient care. Poorer households are significantly more likely **not** to seek medical care when sick, mainly due to the burden of cost. This, the authors conclude, may indicate that user charges for outpatient care are acting as a deterrent, especially for the poor. Similarly, cost prohibits the poor from entering inpatient facilities: expenditure per hospital admission for the low income-group cost 318 per cent of the net income per capita and 59 per cent of their net income per household.
Policy implications	Since the main factor influencing the non-use of services is the patient's inability to pay for care, this indicates a need for improved strategies to ensure access to basic healthcare services for all, especially the poor.
Conclusions	The paper concludes that the relatively equal access to healthcare that existed before the economic reform programme in China has been eroded as inequality in household incomes has increased. In particular there has been a considerable impact on access to inpatient services by poor households, for whom healthcare expenditure may exceed total annual income and lead to further impoverishment.

Author(s)	Zhan, S., Tang, S.-L. and Guo, Y.
Title	Drug prescribing in rural health facilities in China: implications for service quality and cost
Source	1997, **IDS Bulletin**, Vol 28 No 1: 66–70
Objectives	To report the results of a survey of drug prescribing by facilities in three poor rural counties in China.
Study type	Research study.
Data source & methods	Analysis of drug use at county and township level health facilities in three poor rural counties in China. Analysis of 7,182 prescriptions.
Findings	Excessive and inappropriate prescribing of drugs was found which exposed patients to risk of ineffective treatment and adverse side effects and contributed to unnecessarily high medical costs. Inappropriate prescribing behaviour by health providers was also complicated by the public's beliefs about the greater effectiveness of imported drugs over local drugs, of injections over tablets, of expensive drugs over cheaper ones, coupled with the inability of poor households to afford a full course of prescribed drugs.
Policy implications	A programme of reforms aimed at providing the population with access to effective care at reasonable cost must include measures to improve drug use.
Conclusions	The authors argue that strategies for improving prescribing practice will have to include changes in health workers' financial incentives, improved training and supervision of health workers' dispensing of drugs, as well as regulation of the right to prescribe and sell certain types of drugs.

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