GEOGRAPHY SESSION 5: THE HEALTH GAP

Age range: 11–16 years

Outline
Learners will create infographics to represent inequalities in health and health care between Ethiopia, Viet Nam and the UK. They will explore in-country health gaps by looking at how access to safe drinking water, sanitation and electricity can be affected by living in an urban or rural area. Learners will then discuss a range of different perspectives on health care in Ethiopia and Viet Nam from: young people in the Young Lives communities, government officials, health workers and Young Lives research officers. Finally learners will solve a 'mystery' about why one of the Young Lives young people finds it difficult to access good healthcare.

Learning objectives
- To develop skills in analysing and presenting data.
- To recognise some inequalities in health and health care between Ethiopia, Viet Nam and the UK and to describe the consequences of lack of access to drinking water, sanitation and electricity on health.
- To recognise that access to public service provision can be affected by place of residence.
- To explore some of the local, national and global causes of inequality in health care provision.

Learning outcomes
- Learners will identify some inequalities in health and health care between Ethiopia, Viet Nam and the UK.
- Learners will identify the effects of ethnicity and geographical location on public service provision.
- Learners will use infographics and bar charts to present data.
- Learners will assess different causes of inequality in health care provision in Viet Nam.

Key questions
- What inequalities in health and health care are there between these three countries?
- How does living in an urban or rural area affect access to drinking water in Ethiopia?
- What do you think are the main barriers to health care in these countries?
- What do you think the solutions might be?

Resources
- *Geography B slideshow* (slides 27-33)
- Resource sheets:
  - *Between-country health gaps*
  - *In-country health gaps – Tables, Bar charts 1* and *Bar charts 2*
  - *Talking about health care in Ethiopia* and *Viet Nam*
- Activity sheets:
  - *Thinking about in-country health gaps*
  - *Health care mystery cards*

Curriculum links

England
KS3 Geography
Pupils should be taught to:
- Develop greater competence in geographical skills in analysing and interpreting different data sources.

Human and physical geography
- Understand geographical similarities, differences and links between places through the study of human and physical geography of a region within Africa, and of a region within Asia.
- Understand the key processes in human geography relating to: population and urbanisation; international development; economic activity in the primary, secondary, tertiary and quaternary sectors; and the use of natural resources.

Wales
KS3 Geography
Understanding places, environments and processes
- Explain the causes and effects of physical and human processes and how the processes interrelate.
- Explain how and why places and environments change and identify trends and future implications.

Communicating
- Develop opinions and understand that people have different values, attitudes and points of view on geographical issues.

Range
- Study the rich and poor world: economic development in different locations/countries.
- Study tomorrow's citizens: issues in Wales and the wider world of living sustainably and the responsibilities of being a global citizen.
- Ask – how do environments and people interact?

Scotland
Social studies
- I can compare the social and economic differences between more and less economically developed countries and can discuss the possibilities for reducing these differences.
  SOC 3-11a
- Through discussion, I have identified aspects of a social issue to investigate and by gathering information I can assess its impact and the attitudes of the people affected.
  SOC 3-16a /4-16b
- I can analyse the factors contributing to the development of a multicultural society and can express an informed view on issues associated with this.
  SOC 4-16

Note:

- *The total time required to complete all the activities in this session is over two hours. As with other geography sessions, you may decide to omit some activities depending on the time available and your learners' existing knowledge, understanding and needs. The material is intended to support your teaching rather than guide it. Additional teaching input may be required to develop learners' knowledge, skills and understanding of some of these concepts.*

Activity 5.1 *(45 min)*

Between-country health gaps

Note: If time is limited, learners could create bar charts and infographics from the data as a homework activity.

- Discuss ways in which the health of people in a country and the quality of its health care can be measured. Examples are provided on slide 28.
- Organise learners into pairs and give each pair a copy of *Between-country health gaps*. Explain that this data gives clues about people's health and the level of health care in Ethiopia, Viet Nam and the UK. Ask learners to look through the data. Discuss their responses as a whole group:
  - *What inequalities in health and health care are there between these three countries?*
  - *Does any of the data surprise you? Which data and why?*
  - *What do you think might be the reasons for some of these inequalities?*
- Ask learners how else this data could be presented rather than in a table. Discuss the advantages and disadvantages of different ways of presenting data, such as bar charts or infographics.
- Explain that learners are going to be working in their pairs to create infographics to represent one or more of these health indicators. Note that learners use infographics to explore educational inequalities in *Geography activity 4.1*.
- Ask learners to create their infographics by hand or on the computer. Some useful web-based infographic tools include:
  - Datawrapper: datawrapper.de
  - Infogr.am: infogr.am
  - Piktochart: piktochart.com
- Allow time for learners to share and compare their infographics at the end of the activity. Learners could display their infographics in their classroom or elsewhere in their school to raise awareness of these inequalities.

Activity 5.2 *(45 min)*

In-country health gaps

- Tell learners that the health indicators provided in *Activity 5.1* are all averages across the total population of each country. Ask learners why this might be a problem. Draw out the point that

there is often inequality within countries as well as between countries. These averages don't reflect these inequalities.

- Ask learners what factors they think might affect an individual's health and the health care they are able to access. Possible factors include socio-economic status, gender, ethnicity and living in an urban or rural locality.
- Explain that the Young Lives researchers investigated how different factors such as gender, ethnicity and living in an urban or rural area can affect the opportunities that people have.
- Give each learner a copy of *In-country health gaps – Tables*. Explain that the data shows how access to sanitation, drinking water and electricity is affected by living in an urban or rural area (in Ethiopia) or ethnicity (in Viet Nam). The data was collected in the Young Lives communities in 2009 and again in 2013.
- Ask learners how they think access to drinking water, sanitation and electricity affects the levels of health in a community. Use the cloze exercises on slides 29 and 30 to draw out the key points.
- Ask learners to present the in-country health data in a series of bar charts, choosing appropriate scales for their axes. If you are short of time, you might like to give learners copies of *In-country health gaps – Bar charts 1* and *2* instead.
- Organise learners into pairs and ask them to look at their graphs and discuss any trends in their pairs. They could answer the questions in *Thinking about in-country health gaps* to support their discussions.
- Draw out the point that living in a rural area or belonging to an ethnic minority group in the Young Lives communities can often (but not always) increase the likelihood of a family living in poverty. You might like to share the following facts with learners.
    - 70% of the world's 1.4 billion extremely poor people live in rural areas.[1] 81% of the population of Ethiopia live in rural areas (in the UK this figure is 18%).[2]
    - The Kinh people are the ethnic majority group in Viet Nam, but there are 54 ethnic groups in total. Poverty is increasingly concentrated among ethnic minority groups. Ethnic minorities account for 39.3% of all poor people in Viet Nam, despite representing only 12.6% of the total population.[3]

[1] *Rural Poverty Report,* International Fund for Agricultural Development (IFAD), 2011: www.ifad.org/rpr2011/report/e/rpr2011.pdf

[2] *World Bank Open Data* (2014 data): data.worldbank.org

[3] *Viet Nam Round 2 Survey Report. Initial Findings,* Le Thuc Duc et al., Young Lives, 2008.

Differentiation

- *Make it easier: Ask learners to produce a bar chart for just one of the tables.*
- *Make it harder: Ask learners to produce four bar charts to represent the data in each of the tables. Alternatively, produce a combined bar chart for each country which shows the data for both 2002 and 2013. Reference copies of these bar charts are provided in* In-country health gaps – Bar charts 1 *and* 2.

Activity 5.3 *(20 mins)*

Talking about healthcare

- Organise learners into groups of four and ask each group to separate into two pairs. Give each pair an A3 copy of *Talking about healthcare*, one pair should have the resource sheet for Ethiopia and the other pair for Viet Nam. Explain that these resource sheets include a range of different perspectives on healthcare in each country. The images accompanying these perspectives are provided on slides 31 and 32. You might like to point out here that these observations come from Young Lives' qualitative data and explain the difference between this type of data and quantitative data.
- Ask learners to read the different perspectives and discuss the following questions in their pairs:
  - *Do you think levels of healthcare are the same across all communities in this country?*
  - *What similarities and differences in healthcare are there between this country and the UK?*
  - *What do you think are the main barriers to quality healthcare in this country?*
- Now ask each pair to share their findings and ideas with the other pair in the group and to discuss similarities and differences in healthcare between Ethiopia and Viet Nam.
- Briefly discuss learners' ideas as a whole group.

Activity 5.4 *(40 min)*

Why might H'Mai have trouble getting all the health care she needs?

Note: This activity is called a 'mystery' because learners piece together clues written on separate cards to solve a problem. Mysteries are an excellent tool for developing critical thinking skills, and this one enables learners to explore a range of local, national and global causes of poor health care provision. This activity can be used as a starting point for understanding the wider principle of how multiple factors interact with one another to create a range of different in- and between-country inequalities. By the end of the activity, aim to ensure that learners understand that the actions of many people, groups and government policies – national and international – contribute to both the problem and the solutions. For further information, see Background notes for Activity 5.3*. For further information on the global causes of inequality such as those in health care provision, see* Background notes for teachers*.*

Organise learners into groups of three or four and explain that their task is to solve a mystery by answering a central question: *Why might H'Mai have trouble getting all the health care she needs?*

- Show slide 33 and remind learners that H'Mai is 13 years old and lives with her family in a poor, rural area in Phu Yen province, Viet Nam.
- Give each group a copy of *Health care mystery cards 1* or *1* and *2 (see differentiation)*. The cards contain a set of clues, some of which may be more useful than others. Learners should cut out the cards and then work as a group to consider their response to the question: Why might H'Mai have trouble getting all the health care she needs?
- The task is for learners to solve the mystery by organising the information provided by the clues on the cards. They should be encouraged to look for links between the clues and to group the clues in ways that help them explain as fully as possible the various reasons H'mai may have

difficulty getting health care. They may omit some cards if they do not feel the information is relevant and you may provide them with blank cards to add extra points of their own. Emphasise that learners will need to be ready to justify their answers to others and encourage them to discuss causes, effects and the connections they are making with the rest of the group.

- When learners have completed the task, allow time for each group to feed back its response to the rest of the class. Depending on the outcome of the discussion, aim to review the following points:
    - *Was H'Mai's lack of access to good health care anyone's fault? Why?*
    - *Who do you think was responsible? Why?*
    - *What causes health care to be worse in some rural parts of Viet Nam?*
    - *Which factors originate in Viet Nam? Which factors involve organisations or governments outside Viet Nam? (To engage with this question fully, learners will need to have been exposed to the information on the additional clues)*
    - *Is it possible to separate factors in this way?*
    - *What solutions are there to reduce inequalities in health care provision between rural and urban areas and between different ethnic groups?*
    - *Which solutions are individuals or small groups responsible for and which solutions require intervention by the government of Viet Nam or by international organisations and/or other country governments?*
    - *What can you learn from this activity about the impact of inequality on poorer people?*

You could then ask learners to produce an extended piece of writing, using a writing frame, to give a full response to the question of why H'Mai might have trouble getting all the health care that she needs. The writing frame could include headings such as:

- *Introduction to H'Mai, her family and their situation*
- *What are some of the challenges that H'Mai faces when getting health care?*
- *What has caused some of these challenges (or made them worse?)*

Very important update about H'Mai's situation

Remind learners that this activity is based on H'Mai's situation when the Young Lives research team interviewed her. However, there has been some recent good news for H'mai and her family. They have recently been able to join the government's health insurance scheme as part of the government's efforts to make it easier for poorer people to join the scheme. Her mother told the Young Lives research team that: "The insurance card helped a lot. We didn't need to have lots of money." She described how when anyone in the family is sick, "We'll take the card and go for the check-up." H'Mai's mother added: "We're grateful. Frankly speaking, I'm happier to receive the card than money or gold."

Emphasise that this does not solve all the problems that have been identified by the activity and that there remains a long way to go to ensuring that all of Vietnam's poorest people, especially those living in rural areas who are members of minority ethnic groups, are able to get all the health care they need. It does, however, show how government policies can make a real difference.

Differentiation

- *Make it easier: Give learners* Health care mystery cards 1*. You can still make use of the information provided in the additional clues on the next page for providing additional context and stimulating discussion when debriefing the activity.*
- *Make it harder: Give learners* Health care mystery cards 1 *and* 2*. You may still wish to provide a framework or headings to help learners organise the information and present their findings – or you could leave it more open-ended while explaining to learners that they are going to be presented with a lot of complex information and the challenge is for them to at least to begin making sense of it.*

Further ideas

- Give learners one of the two *Talking about health care* sheets (enlarged to A3) and select some to hot-seat or write a diary entry in role as one of the characters.
- Ask learners to investigate health care in the other Young Lives countries (India and Peru). Useful data sources include:
  - data.worldbank.org
  - hdr.undp.org/en/data
- To explore the causes of inequality further, play Christian Aid's trading game here: learn.christianaid.org.uk/YouthLeaderResources/trading_game.aspx

Terms of use

Between-country health gaps

Health care indicator	Ethiopia	Viet Nam	UK
Life expectancy (years)	64	76	81
Amount of money spent on health care per person each year (current US$)	25	111	3,598
Percentage of the total population with access to an improved water source*	57	98	100
Percentage of the total population with access to improved sanitation facilities	28	78	99
Number of children dying before their first birthday per 1,000 live births*	41	17	4
Number of doctors per million people*	2	1190	2809
Percentage of the total population living in extreme poverty*	34	3	No data

Data source: *World Bank Open Data*: data.worldbank.org *(Data collected from 2010 to 2015).*

**to the nearest whole number.*

In-country health gaps

Tables

Ethiopia

Living in an urban or rural area

In 2002

	Access to sanitation (% of Young Lives population)	Access to drinking water (% of Young Lives population)	Access to electricity (% of Young Lives population)
Urban	34	84	90
Rural	15	37	6

In 2013

	Access to sanitation (% of Young Lives population)	Access to drinking water (% of Young Lives population)	Access to electricity (% of Young Lives population)
Urban	52	63	94
Rural	70	33	36

Viet Nam

Ethnicity

In 2002

	Access to sanitation (% of Young Lives population)	Access to drinking water (% of Young Lives population)	Access to electricity (% of Young Lives population)
Kinh – ethnic majority group	54	59	90
Ethnic minority groups	19	7	53

In 2013

	Access to sanitation (% of Young Lives population)	Access to drinking water (% of Young Lives population)	Access to electricity (% of Young Lives population)
Kinh – ethnic majority group	81	92	99
Ethnic minority groups	43	64	97

Data source: Young Lives: www.younglives.org.uk

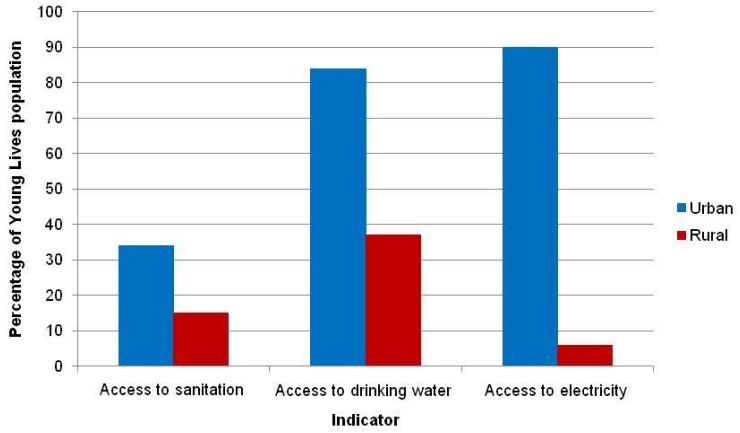
In-country health gaps

Bar charts 1

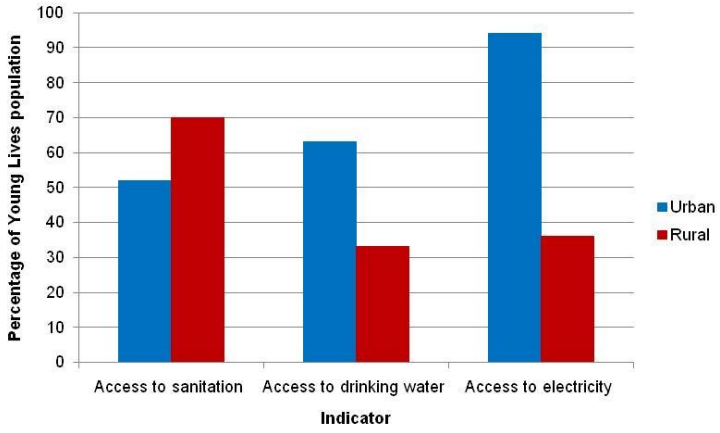
Ethiopia

Living in an urban or rural area

In 2002



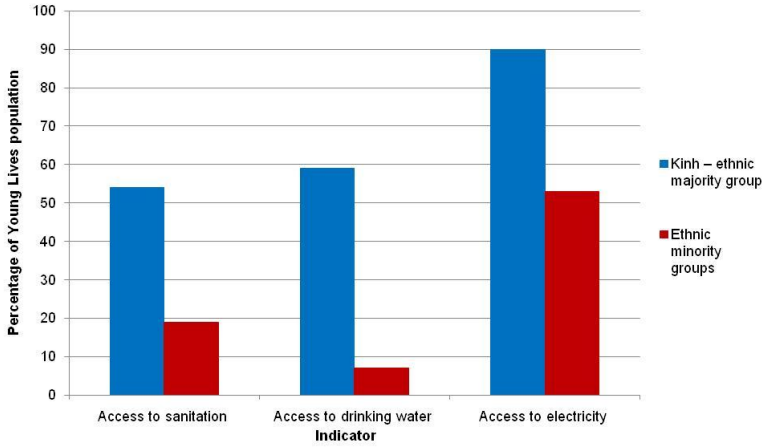
In 2013



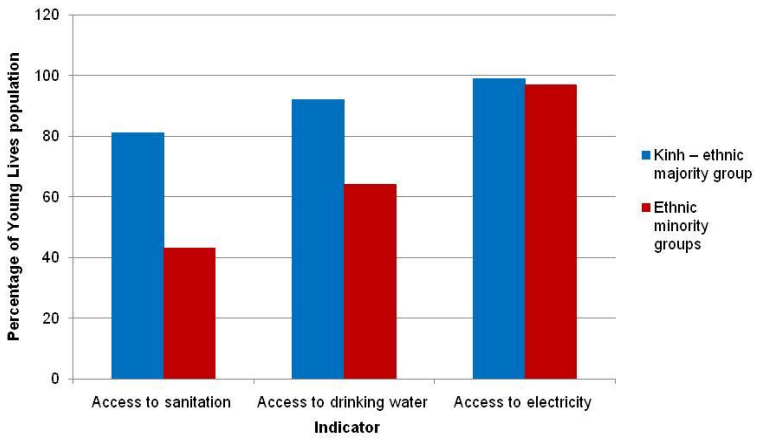
Viet Nam

Ethnicity

In 2002



In 2013

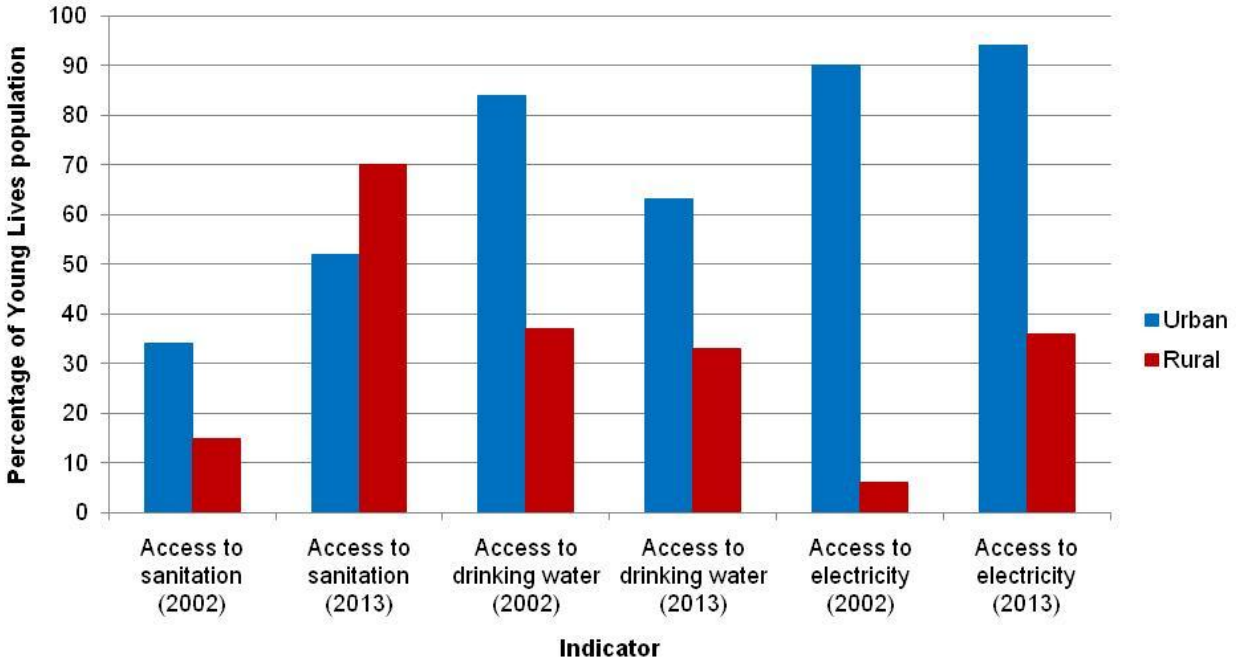


In-country health gaps

Bar charts 2

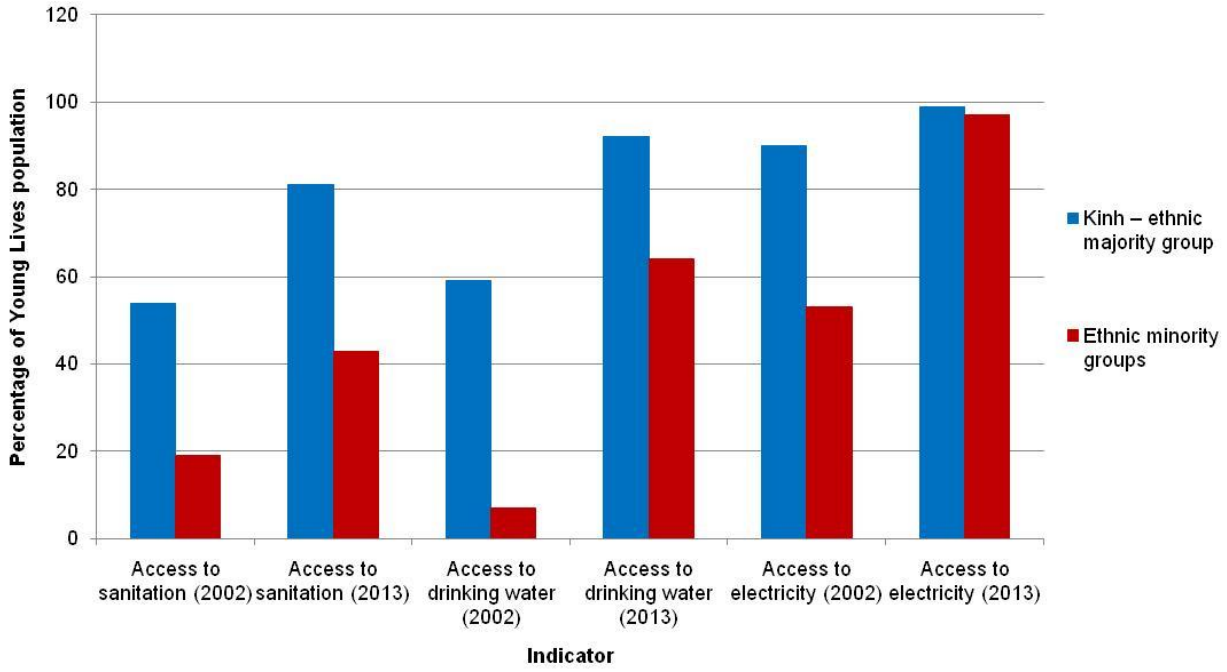
Ethiopia

Living in an urban or rural area



Viet Nam

Ethnicity



Thinking about in-country health gaps

Ethiopia

Is access to sanitation higher in urban or rural areas?	
Is access to drinking water higher in urban or rural areas?	
Is access to electricity higher in urban or rural areas?	
What do you think might be the reasons for the differences in access between urban and rural areas?	
How did access to sanitation, drinking water and electricity change from 2002 to 2013?	
Did the differences in access between urban and rural areas get bigger or smaller from 2002 to 2013?	
What do you think might be the reasons for some of these changes?	

Viet Nam

Is access to sanitation higher for people from the ethnic majority group (Kinh) or from the ethnic minority groups?	
Is access to drinking water higher for people from the ethnic majority group (Kinh) or from the ethnic minority groups?	
Is access to electricity higher for people from the ethnic majority group (Kinh) or from the ethnic minority groups?	
What do you think might be the reasons for the differences in access between people from the ethnic majority group and those from the ethnic minority groups?	
How did access to sanitation, drinking water and electricity change from 2002 to 2013?	
Did the differences in access between people from the ethnic majority group and those from the ethnic minority groups get bigger or smaller from 2002 to 2013?	
What do you think might be the reasons for some of these changes?	

Talking about health care in Ethiopia

Netsa (urban)
In our community there is a private health clinic and a hospital. People have to pay to go them. There is no government health centre in our area so many people go to other parts of the city to access health services.

We have health extension workers in our community who teach people about sanitation and ways of preventing diseases. Most of the households in our community have piped water but some families buy water from their neighbours. The area is crowded and confined. Many of the houses do not have their own kitchen or toilet and some people use one room for more than eight or nine family members. Most of the houses are getting very old and are about to fall down.

Haymanot (rural)
I used to go to school but I had to drop out in the grade 5. I have to do paid work, such as watering trees, digging and building fences with stones. I suffered from malaria a lot last year. I get sick when I work a lot. I got treatment at a health centre in another village, which is two hours away. We had to go there on foot. My mother has been treated at the health centre as well. She also went to a traditional healer three times. It costs 10 *birr* (approximately 30p) a visit. They did a traditional operation called *mehgomo* where they use a razor blade to let the unnecessary blood flow out.

Health extension worker
I am 25 and I am a health extension worker. Like many people in Ethiopia, I live in a rural area. My community is isolated and the closest health centre is very far away. I had to go through a special one-year training programme for my job, which is to help prevent disease and raise health awareness. I teach people about good hygiene and ways of preventing diseases. I make sure that children are up to date with their vaccinations and I test for and help to treat diseases and conditions such as diarrhoea, pneumonia and malaria. I also look out for any malnourished children who need extra support and give advice about family planning.

Under Ethiopia's Health Extension Programme, approximately 38,000 health extension workers are now working across the country and I am proud to be one of them.

Photo credit: Robin Hammond/PANOS

Government official
The quality of our health services is lower than in other countries for a number of reasons. Many people in Ethiopia live in isolated, rural communities and aren't able to get to a health centre. Health centres often have poorly maintained buildings and there aren't enough trained health workers. On average, there is approximately one doctor for every 50,000 people in Ethiopia. However this ratio varies across the country. Many doctors and nurses live in the capital, Addis Ababa, but 82% of Ethiopia's population live in rural areas. It can also be difficult to get the medicines and pharmaceutical supplies which people need.

Despite all these barriers, Ethiopia is making some excellent progress with improving its health care. Ethiopia reduced its under-five mortality rate by two-thirds between 1990 and 2012 which means that it will meet Millennium Development Goal 4. In 1990, one in five Ethiopian children could be expected to die before reaching the age of five. Today, the figure is close to 1 in 15.

Young Lives research officer
Access to health services in Ethiopia has been improving rapidly over the last 15 years. Now in every village there are two women health extension workers. These community workers give advice to households about sanitation, healthy nutrition and how to prevent illnesses. When we first visited the young people in 2002, only 22% of families had a toilet or pit latrine; by the time of our fourth visit in 2013 this figure had almost tripled to 63%.

Although this progress is remarkable there are still major differences between urban and rural areas and between rich and poor. The Ethiopian government and international organisations recognise that improvements in access to health care are very important achievements. However, this is not enough to guarantee that children grow up healthily; more needs to be done to improve the quality of health services to ensure the well-being of children and their families.

Photo credit: Sven Torfin/PANOS

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Talking about health care in Viet Nam

H'Mai (rural)

People in my community get water from a variety of sources such as the government water company, private and communal wells, the river, ponds and streams. Many of the public water sources have been polluted by waste from people and animals. About 40% of households have toilets inside their homes; the waste from people without a toilet ends up in fields, bushes, the river or the canal.

Our family are generally healthy, which is a good thing as the nearest clinic is 5km away and the closest hospital is 9km away. The road to the clinic and the hospital is not very good so it can be difficult to get there. Children under six get free treatment at the clinic and my mother takes my younger brother and sister there for regular check-ups. There are private doctors in the area but I don't know many people who use them. We also sometimes use traditional medicines and doctors. There are two traditional healers in our village. We don't have to pay them anything; we just give them chicken or pork.

Phuoc (urban)

Our community has a relatively good health centre. It offers different programmes such as vaccinations, Vitamin A for children, examinations and treatments. Poorer households in the community are provided with medical insurance cards so that they can benefit from free treatment and medicines.

Hung (peri-urban)

There is a private clinic near my home but the main health centre is 2.5 kilometres away. About 50% of the children at my school have private medical insurance but my family don't. We have to pay for health services though sometimes we contribute rice instead.

Government official

Overall the quality of health in Viet Nam is relatively good when you look at indicators such as life expectancy and infant mortality. There is both public and private health care. Currently most people in Viet Nam have to pay for some or all of their health care, particularly if they use private services. Social health insurance was first introduced in Viet Nam in 1992 and the Vietnamese government wants everyone in the country to have health insurance. By law, any employee has to contribute to a health insurance scheme. Children under 6, ethnic minorities and poor people in rural areas get free health insurance. We have made huge progress and over half of the population now have health insurance. However, there are still over 35 million people in Viet Nam who are uninsured.

Young Lives research officer

Viet Nam has made significant progress in its health care in recent years. More and more private health facilities are appearing in Viet Nam but most people still go to public hospitals. This means that these public hospitals are often overcrowded and the quality of service is lower. Our data shows that there has been an overall improvement in children's health, though there has also been an increase in the proportion of children without health insurance. The cost of insurance schemes can deter poorer families who are not eligible for free insurance. Sometimes the registration process for insurance can be lengthy and complicated, which makes it difficult for families to apply. If families don't have health insurance they have to cover the medical costs themselves, and these costs can be high.

Photo credit: Peter Barker/PANOS

Photo credit: Unless otherwise stated, all images © Young Lives/Nguyen Quang Thai, Trinh Van Dang & Pham Viet Anh

Health care mystery cards 1

H'Mai is 13 years old and is the second oldest of four children.
H'Mai's family is from a disadvantaged ethnic minority group.
H'Mai's family live in a rural area where there are high levels of poverty.
The nearest health clinic to H'Mai's home is 5km away and the hospital is 9km away. The road to reach these facilities is not good.
When H'Mai had to go to hospital before, H'Mai's mother had to borrow money from her mother and mother-in-law to pay the fees.
Health insurance is when people pay small amounts regularly to make sure that they can get health care without suddenly having to find large sums of money when they are ill.
The government of Viet Nam has been running a health insurance scheme since 1989 to help ensure that more people can get health care when they need it.
Most people in Viet Nam have to pay for some or all of their health care in one way or another.
Queues at clinics and hospitals can be long, and hospitals are often overcrowded.
H'Mai's family is among the 35 million people in Viet Nam who do not have health insurance.
Health clinics in rural areas of Viet Nam are often poorly equipped and sometimes run out of medicines.
People from ethnic minority groups in Viet Nam are more likely to be living in poverty than those from the ethnic majority Kinh group.
Doctors and nurses often prefer to work in cities where there are usually more opportunities and higher salaries.
Poorer families may not be able to afford health insurance.

Health care mystery cards 2

During the late 1980s, the government started charging people fees for health care.
The Viet Nam government is now planning to expand its health insurance scheme so that everyone in the country can use it in future.
There are 12 doctors for every 10,000 people in Viet Nam (compared with 288 per 10,000 in the UK and 30 per 10,000 in Afghanistan).
Children under six years old now get free treatment at H'Mai's nearest health clinic, so H'Mai's mother takes her younger children there for regular check-ups.
Until the mid-1980s, the Viet Nam government tried to provide free basic health care for everyone. However, the government did not have enough money to meet everyone's health care needs.
From 1986 onwards, the Viet Nam government decided to make the country wealthier by attracting more foreign companies to set up in Viet Nam and by trading more with other countries.
Viet Nam suffered devastating wars between the 1940s and the 1970s which set back the development of health care and other services.
65% of the people who have health insurance have still paid bribes to health staff for treatment.
Lots of international companies operating in Viet Nam have used cunning ways to avoid paying taxes to the country's government.
National governments can use money from taxes to fund health care and to make health insurance schemes more affordable for the poorest people.
There is increasing inequality between the ethnic majority (Kinh) group and the minority ethnic groups, and also between urban and rural areas.
Since the 1980s the percentage of people living in extreme poverty in Vietnam has fallen dramatically.
Most of the ethnic minority population of Viet Nam lives in rural areas.

Background notes for Activity 5.3

There is no single cause of H'Mai's lack of good health care provision: it is a complex interaction of local, national and global factors. It is beyond the scope of this activity for learners to tease out the precise nature of all these causes and effects but it will help learners to understand that there are many different causes of health care inequality and that governments – local, national and international – are in a position to effect change. For further information about the global causes of inequality and Oxfam's suggested solutions, see *Background notes for teachers*. You might find the following information about the specific case of Viet Nam useful for this activity.

Healthcare in Viet Nam

Viet Nam experienced a great deal of conflict during the twentieth century, especially during the Viet Nam war, known in Viet Nam as the 'American War'. This lasted from 1957 until 1975. Viet Nam was then in conflict with Cambodia and China for much of the late 1970s and throughout the 1980s. Since the market-oriented economic reform of the late 1980s, Viet Nam has embraced private investment in public services. This change of policy shifted a large part of the financial burden of health care from the state onto individuals as the health sector began charging fees and privatised drug sales.

For some social groups – predominantly wealthier ones – health care provision in Viet Nam is better than it was in 1989, most notably because treatment standards have improved, leading to improvements in life expectancy and child mortality. However, these benefits have not been shared equally and many poorer people – especially those living in rural areas and those, such as H'Mai, who also belong to minority ethnic groups – have been excluded from these positive changes.

Although the national health insurance scheme currently covers an estimated 60% of the population, and despite the Vietnamese government's ambition to achieve universal coverage, there are around 35 million Vietnamese people without insurance, including, until very recently, H'Mai's family[i]. Many of these people are at high risk of falling into poverty when they encounter major medical expenses. Meanwhile, even among the 53 million who are insured, poor and exempted groups still find services unavailable without paying so-called 'informal fees' (bribes) to doctors, nurses, midwives or other health staff. A recent national survey showed that 65% of respondents experienced corruption at local health services and 70% of medical staff interviewed admitted that they had asked patients for bribes[i].

Problems in Viet Nam's health sector have been compounded by pharmaceutical companies lobbying for their drugs to be included on health insurance lists. If successful, these companies often increase drug prices by at least 30% over the market price and encourage doctors to overprescribe expensive medications and laboratory tests.[i] This increases the cost incurred by the Vietnamese National Health Insurance Fund (VHIF) that is currently running at a loss and at risk of bankruptcy.

Public spending on health care provision is very uneven: about 70% of government health care funds are spent on curative care at the central and provincial level at the expense of primary care and preventive services in rural areas[i]. The signs are that private and informal payments for health care will continue and that the government will struggle to extend insurance provision to an increasingly vulnerable population. Matters are not helped by the fact that many international companies operating in Viet Nam have found ways to avoid paying taxes to the government, resulting in reduced funds available to spend on public services such as healthcare.[ii]

While Viet Nam is now a middle-income country with a successful economic growth path of over five per cent between 1990 and 2010, there is a growing gap between the wealth of the very poorest and the very richest people. Ethnic minorities in particular are being left behind, partly because they are more likely to be living in rural areas which are often under-funded by the government and partly because minority groups are more likely to experience the effects of discriminatory and exclusive policies.[iii]

[i] *Vietnam's healthcare system suffers on policy failure* (Marriott, 2011)
[ii] *Firms evade taxes with transfer pricing ruse* (Viet Nam News, 2012). Information is based on a Viet Nam government investigation.
[iii] *Inequality and the end of extreme poverty* (Oxfam, 2015)