GLOBALIZATION AND ITS EFFECTS ON HEALTH CARE AND OCCUPATIONAL HEALTH IN VIET NAM

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I. INTRODUCTION

During the past two decades world trade has tripled and global trade in services has increased more than 14-fold (UNDP, 1996), increasing production of information, knowledge and technology. This leads to worker's average production of 9160 dollars annually (UNDP, 1996). However, not all are benefiting from this change. Globalization under liberalized markets has generally benefited the industrialized or strong economies and marginalized the weak economies. For example, the difference in annual average GNP per head between high-income countries and low-income countries is 12 times and between 1960 and 1990 contribution of the poorest countries to world trade reduced from 4% to 1% (UNDP, 1996).

Poor countries may find it hard to develop the capacity and contacts needed to take part in international investment or trade. The danger is that they may compete with each other to keep a small part of the world trade by lowering wages and making other trade concessions. Debts can increasingly consume scarce domestic resources and reduce development capacity (Onimode B. et al, 1994). Currently, income of one fourth of the world population is falling and even in the same region and within a country inequity occurs in economic opportunities and wealth. Many countries are urgently conducting research on the effect of globalization on people's living standards and health care (Rene Loewenson, 2001).

This report discusses the impact of globalization on health care, focusing on the negative impacts, and recommends some solutions for reducing these negative impacts on inequality in health care in Viet Nam.

II. DEFINITION OF GLOBALIZATION AND ITS IMPLICATIONS FOR LABOUR

1. Definition of globalization

Currently, there are many different definitions of globalization. According to Ali Taqi, globalization means the increasing integration of national economies into a world market through trade, investment and other financial flows. Putting it another way, the increasingly intense and complex worldwide interchange of goods, services, finance, productivity and working people (Ali Taqi, 1996). Prof. Samir N.Banoob-President of International Health Management, Inc. Florida, USA defines Globalization as free, comprehensive and rapid mobility, exchange and transfer of information, knowledge, funds, goods and persons among member countries of the world (Samir N.banoob, 2002). Globalization is not a simple phenomenon and nor is it only an economic process, rather it contains alongside the new trends in economies also major changes and redistribution of work and re-organization and relocation of enterprises (J. Rantanen, 2001).
While there is no formal consensus on the definition of globalization, there is broad agreement that globalization is a form of accelerated transnational economic activity that finds expression in the increased movement of information, capital, goods and services (Bayan Tabbara, 2002). It is a dynamic process, rather than aphenomenon, that involves and transforms many aspects of financial, technological, economic, social, cultural and geopolitical activity. This process is being institutionalized by an international polity of openness and enforced by international agreements on trade, technology and capital movements whereby millions of decision makers influence prices and allocate resources, including labour, in a manner that erodes the control of national authorities.

According to Do Nguyen Phuong (Former Minister of the Vietnamese Ministry of Health), globalization derives from the development of communication and world transport, sharing of community rights and responsibilities (Phuong §o Nguyen, 1999). The globalization trend presents a unified will, the human union in preventing unjust social and nature disasters. The globalization trend in the health care sector has extended from individual's matters to communities' matters, from technical health care issues to social ones. The relationship between individual doctor and patient now becomes the relationship between doctors and the community. The relationships within the social-economic systems and the combination of social values creating health care systems.

2. Labour trend in globalization in the world

The about 100 million enterprises of the world have faced globalization in the form of worldwide competition (J Rantanen, 2001). Processes of globalization and technological advance promise to bring about a more efficient and productive world economy that will deliver faster growth in output and ultimately rises in living standards. But they have also given rise to serious problems and anxieties. Increased competitive pressures have impelled widespread economic restructuring that has caused increased unemployment and income inequality. Unemployment and job insecurity have become widespread and long lasting. Mergers between big companies have been occurring widely in the

industrialized world. Mergers are always associated with rationalization, closing part of factories, moving activities from one country to another and radical re-engineering of companies. All these imply unemployment for a part of personnel. The possibilities for workers to protect themselves against the risk of unemployment are rather limited in such situations.

The ILO estimates that the number of people unemployed or underemployed in the world today exceeds 800 million (Ali Taqi, 1996). This amounts to nearly one-third of the labour force. Unemployment leads to emigration, especially illegal emigration that causes economic and social disorder in many countries. It is widely feared that globalization does not reduce unemployment and emigration but makes them more serious.

The process of globalisation also leads to a growing number of short-term and fixed-term employment contracts. As the world economies are developing in a more turbulent direction and simultaneously human labour becomes the most important and costly investment of the company, and as the material investments made are difficult to undo, enterprises need to find new sources of flexibility. If a recession threatens, companies seldom have any alternative to dismissing people in order to adapt to the new market situation. Large companies prepare for such changes by employing just the strategic core staff and by subcontracting the less central activities to other companies (which than need to dismiss workers in recessions). The total impact of such development is the fragmentation of employment contracts, higher turnover of workers and elevated risk of unemployment when the previous contract has been terminated. It also leads to a growing uncertainty among workers in the labour market, not only for those whose contracts are fragmented but also for those who are permanently employed.

3. Changes in enterprise structure and labour distribution in Viet Nam

The policy of "doi moi" in Viet Nam was extraordinarily effective in galvanizing the energy of millions of Vietnamese individuals who diversified and expanded their agricultural production rapidly, and set up many micro household enterprises as well as private small and medium enterprises (SMEs). Foreign firms invested in majority-owned joint ventures or in wholly foreign-owned enterprises. In 2000 there were 3.5 million workers in state sector and 33.3 million workers in private sector (Table 1) (General Statistics Office, 2002).

Table 1: Labour distribution by economic sector (million persons).

	1988		1993		2000	
	State	Private	State	Private	State	Private
Total	4.05	24.87	2.97	29.75	3.501	33.2

Source: General Statistics Office, 2002.

During last 15 years of innovation, the Viet Nam private economy developed fairly quickly. There were 494 private enterprises and companies in 1991, 15,276 in 1995 and 30,500 in 1999 (Kieu Vu Tran, 2002). One year after the Business Law was issued in January 2000, there were 51,468 enterprises in the whole country, by 30 September 2001

there were 66,071 enterprises and by August 2002 about 80,000 enterprises had been established.

The share of the private sector in total GDP in 1998 was 51 per cent (see Table 2) (General Statistics Office, 1998). During the 1995-98 period the domestic private sector, despite its many constraints, grew at 9 per cent a year, only a percentage point lower than the growth of the state-owned sector.

Table 2: Private Sector's Share in 1998 GDP (per cent)

	Total GDP	Manufacturing GDP
State Sector	49	54
State-Owned Enterprises	n.a.	n.a.
Private Sector		
Foreign Invested Sector	10	18
Domestic Private Sector	41	28
Of which		
Household Enterprises/ Farmers	34	18
Private SMEs	7	10

Source: General Statistics Office, 1998.

In 1998, there were around 600,000 micro enterprises in manufacturing, constituting a quarter of all micro-enterprises, and 5600 private SMEs in manufacturing accounting for 10 per cent of manufacturing GDP. Private SMEs (World Bank, May 1999) in manufacturing, especially the larger ones, are highly export-oriented. Around 457 private manufacturers with more than 100 full-time workers (Mekong Project Development Facility, 2001) operate mainly in labour-intensive sectors like garments, footwear, plastic products, seafood and so on.

The issuing of the Foreign Investment Law in 1988 marked a new development of technology transfer and foreign investment in Viet Nam. Thousands of foreign investment projects have been licensed with a total investment capital of billions of $US. Many joint venture and foreign investment firms have been established. Many large industrial, joint venture and processing zones have been established in many cities and provinces. Number of licensed foreign investment project from 1988 to 2001 was 3672; only in 2001 there were 502 projects. These projects focus mainly on industry, agriculture, forestry, construction, hotel and tourism. Countries with high number of the projects are Taiwan (749 projects), Korea (388), Honkong (338), Japan (336), China (150), America (144)... (Tæng Côc thèng k[a], 2002).

Foreign invested enterprises (World Bank, 1999) now play an important role in the economy, accounting for a fifth of manufacturing output, and employing 300,000 workers. There has been a slight trend away from joint-ventures with state enterprises, and an increase in wholly foreign-owned investments (See Table 3) (Foreign Investment Advisory Service, April 1999).

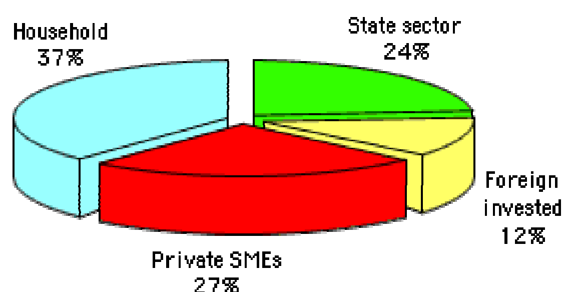
Table 3: Forms of Foreign Investment Inflows (per cent)

Share in % Implemented Capital	1994	1995	1996	1997	1998	Total 91-98
Majority joint ventures	51.0	52.0	59.0	65.0	51.0	56.2
Wholly foreign owned	16.0	18.0	27.0	33.0	17.0	23.7
Business co-operation contract	33.0	30.0	14.0	2.0	32.0	20.0

Source: Foreign Investment Advisory Service, April 1999

The domestic private sector is by far the most labor-intensive. In 1997-1998, household enterprises and private SMEs employ more than 64 per cent of industrial workers while SOEs, accounting for the bulk of industrial output, employ only 24 per cent. (World Bank, March 1999) (see Figure 1).

Figure 1: Industrial Employment by Sector: 1997-98



Source: GSO: Viet Nam Living Standard Study 2, 1999

The state sector in Viet Nam has traditionally accounted for a very small portion of GDP. In 1996 Viet Nam's state sector produced only 29 per cent of GDP, mostly through manufacturing and other industries (Mekong Project Development Facility, 2001). Total debt by state enterprises is worth about $30 billion—20 per cent more than the entire turnover of the state sector and equal to the country's total GNP in 1997. This situation underscores the need for Vietnamese government officials to push ahead with reform of state enterprises. Initial reform of state enterprises included the liquidation or merger of many small and unprofitable companies (5,000 of 12,000 state enterprises were eliminated in 1989) as well as the combination of many surviving state enterprises into larger business groups or conglomerates.

III. HEALTH EFFECTS OF GLOBALIZATION IN VIET NAM

1. Changes in Vietnamese people's disease pattern

There have been changes in disease patterns in Viet Nam with the rapid reduction of infectious, communicable diseases particularly vaccine-preventable diseases of children. The risks of dengue, malaria, pneumonia and water-related diseases, however, remain high because the public health environment and sanitation have not been improved yet. In the period of the development of economy and society, some health problems are

emerging such as injury, sexual transmitted diseases include HIV/AIDS, metal heath, cancer and heart diseases especially health problems caused by drug, tobacco (see table 4).

Table 4: Trend of morbidity and mortality (%)

Disease	1976	1986	1996	2001
1. Communicable diseases:				
Morbidity:	55.5	59.2	37.63	25.02
Mortality:	53.06	52.1	33.13	15.06
2. Non-communicable diseases				
Morbidity:	42.65	39.00	50.02	64.38
Mortality:	44.71	41.80	43.68	66.35
3. Accident, injury, poisoning				
Morbidity:	1.84	1.80	12.35	10.61
Mortality:	2.2	36.10	23.20	18.05

Source: MOH, 2001a (page 119).

According to Health Statistic Year Book (MOH, 2001a), there is a trend increase in non-communicable diseases in term of both mortality and morbidity from 42.65% and 44.71% in 1976 to 64.38% and 66.35% in 2001 respectively. Recently, accident, injury and poisoning have been also had significant increasing trend. In 1976 there were 1.84% cases in term of morbidity and 2.2% cases in term of mortality, but in 2001 the morbidity was 10.61% and the mortality of injury was 18,05%.

HIV/AIDS**:** The movement of two million people each day across national borders due to the ease of rapid international travel and the growth of international commerce are inevitably associated with transfers of health risks. To the end of 1995, there were 3 915 positive cases diagnosed in Viet Nam, of which there were 425 AIDS cases and 255 deaths cases caused by AIDS. Number of provinces reporting HIV/AIDS cases also increased to 43/53 provinces (81%). By December 31st, 2001, there have been 28,661 cumulative HIV positive cases diagnosed in the whole country, of which there were 4728 AIDS cases and 2510 deaths due to AIDS. The process of HIV/AIDS epidemic in Viet Nam is complicated and rapidly causing difficulties in the disease control.

Accident, injury, poisoning

Globalization affects the economic development of every country, particularly traffic development. Recently, the transport system by land, water (sea and river) and air-ways has been strongly developed. Means of transport have increased rapidly particularly in urban area. according to Ministry of Transport data, in 1996, the number of trucks (not include military ones) registered was 372,010 and in 1998 there were 443,000 (MOH, 2002a). Annually, the number of motorbikes rises 15% to 18% on average. Before 1990, there were 80-90% urban population using bicycle for travelling, while at present 90% of people use motorbikes.

Exhaust from traffic has been the main source of environment pollution in the urban areas and big cities such as Ha Noi, Ho Chi Minh, Hai Phong, Da Nang. Recently, traffic injury also has been sharply gone up along with the growth of traffic means. In 1994, number of accidents was 13,760 with 14,174 injured and 5,897 deaths. In 2001, number of accidents (26,874) increased twice, number of injury cases increased 2.1 times and death cases increased 1.7 times compared to 1994 (see table 5).

Table 5: Traffic injuries from 1994-2000

Year	Number of accidents	Injury cases	Death cases
1994	13,760	14,174	5,897
1995	15,999	17,167	5,728
1996	19,638	21,718	5,932
1997	20,262	22,340	6,148
1998	19,975	22,975	6,067
1999	21,538	24,179	7,095
2000	23,866	27,083	7,840
2001	26,874	30,175	10,548

Source: MOH, 2002a.

2. Changes in workers' disease pattern

Globalization leads to changes in production models, enterprise models, and structure of enterprises and also changes in technology as discussed in the above section. Changes in production models lead to changes in working environment in term of both better and worse conditions. Workers in non-state enterprises have not been covered by good supervision and the ensuring of safety at workplaces. New work-related hazards and diseases have emerged.

Beside the benefits of technology transfer, there have been many new risk factors and hazards emerging in technology transfer. For example many new chemical substances have been introduced in industries such as organic solvents in footwear industry and pesticide use in agriculture. It is estimated that there are 5000 - 10.000 commercial chemicals that are toxic, of which 150-200 chemicals are known as possible causes of cancer (Binh Vu Nam, 2000). In 2001, among 18,821 toxic gas samples measured at 2400 enterprises (with 168 workers exposed to chemicals), there were 34.8% of samples exceeding threshold limit value of chemical gas (Dept. of Preventive Medicine-MOH, 2001a). The number of occupational disease due to chemical poisoning has increased.

Table 6: Number of occupational disease cases due to chemical poisoning which received compensation in the period 1993 - 2000

Occupational diseases	1996	1997	1998	1999	2000
Silicosis	667	923	656	970	1698
Lead & lead compound poisoning	4	5	30	26	87
TNT poisoning		1		34	12
Nicotine poisoning			46*	32	43
Manganese poisoning			1*	11*	
Pesticide poisoning				36	178

* Diagnosed, not being under medical expertise for occupational disease
Source: Dept. of Preventive Medicine-MOH, 2001a

There have been some chemical incidents that impacted severely on the population's health and caused environment pollution. For example there was an incident with the chemical treatment system of UIC Company Viet Nam (Godan Industry) that caused dispersion of SO2 and SO3 gas into resident area and caused symptoms such as shortness of breath, itching eyes, and nausea. In 2002, there was another incident in Nam Cuong Shoe Company due to spraying formaldehyde solutions for preserving skins during working hours. The spraying was done in a storage unit located inside a production workshop that did not have ventilation or proper partitions. The consequence was that there were 120 poisoned workers and one death case (Center of Preventive Medicine of Binh Duong province, 2002)

Results of a survey done by the Department of Preventive Medicine in 9 chemical using and producing enterprises showed that the number of worker directly exposed to chemicals, mainly solvents, accounted for 41.3% of total surveyed workers of whom 77.5% were female and 0.6% were pregnant (Dept. of Preventive Medicine-MOH, 2001b).

A study of behaviour changes among 58 workers exposed to glue containing a compound of an organic solvent in a shoe producing workshop after a shift work showed that:

- Toluene concentration measured at checking and assembling locations was three times higher than PEL.
- Simple reaction time prolonged and short memory capacity reduced significantly ($P < 0.001$).
- Exposed workers also presented emotional disorders such as depression, anxiousness, irritability ($P < 0.001$, 0.02, 0.05) and had higher rate of symptoms such as headache, nausea, difficulty falling asleep ($P<0.001$, 0.005).

Asbestosis

Exploring and processing asbestos in Viet Nam is completely manual; the small size of plans and their productivity did not meet industry needs. Therefore, for many years, asbestos has been imported from Russia (former USSR) and China for industrial activities.

More than 90% of the imported and produced total of asbestos has been used to produce construction materials such as fibro-cement roofs, with annual production of 50 million square metres,consisting of 50,000 tons of chrysotile and 500,000 tons of cement (Institute of Science and Labour Protection, 2000). Due to its cheapness and long life, fibro-cement becomea favoured material appropriate to Viet Nam social and economic conditions.

Results of asbestos fibre analysis, at grinding, mixing, conveying asbestos sites in Dong Anh fibro-cement roof company in 2000, showed that asbestos concentrations in the air exceeded PEL (PEL: average of 0.5 fibre/ml in one hour) (Table 7) (Kiem Le Manh. *2002*).

In 2001, there has been one case notified as asbestosis. There has not been any lung cancer or mesothelioma related to asbestos reported in Viet Nam. The reason is that most of occupational health services in Viet Nam do not have the technical equipment for asbestosis diagnosis.

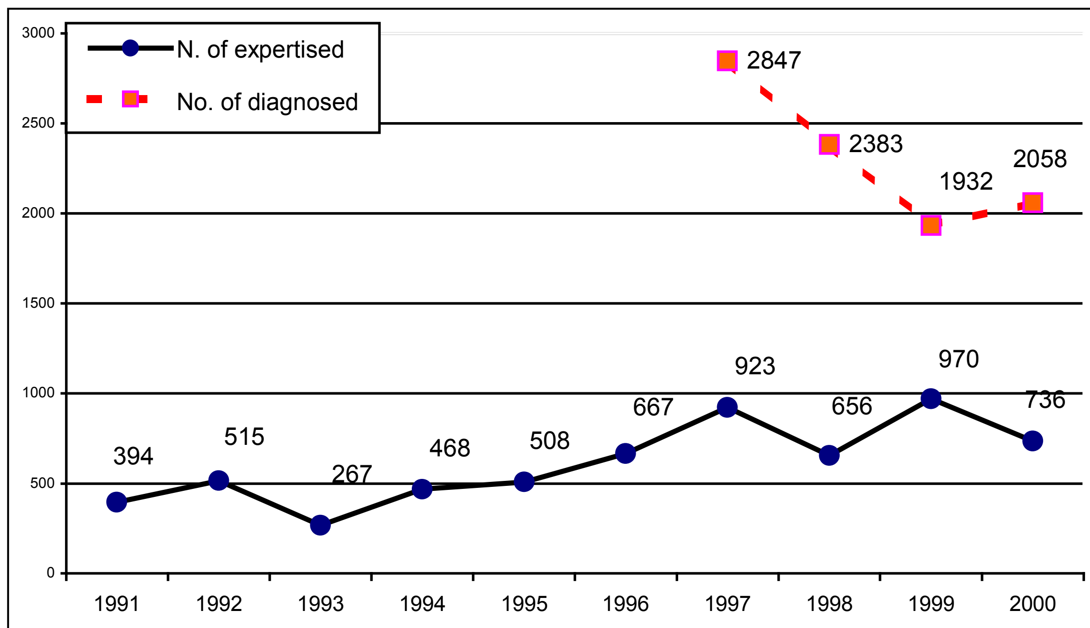
Table 7 : Dust concentration (fibre/ml) at Dong Anh Company

No	Locations	Air volume	Fibre/counted field	Concentration (Fibre/ml)
1	Grinding room	10	110/37	11,3
2	Next to asbestos grinding machines	35	616/20	33,7
3	Next to materials mixing machine (Cement and asbestos)	15	72/100	1,8
4	Starting point of conveyor	10	92,5/100	3,5

Humidity: 93% Temperature: 11C Wind Speed: 0.3-0.5 m/s Collecting time: 1 hour
Source: Kiem Le Manh. *2002*

Silicosis

Figure 2: Silicosis situation in the period 1991-2000



Source: Dept. of Preventive Medicine-MOH, 2001a

According to 10-year review of OSH activities, the number of occupational diseases has been increasing, particularly silicosis. In 2000 the number of silicosis cases was 2.432 (100 cases more than in 1999). Figure 2 shows that number of silicosis cases re-examined increased during the period of 1991 - 1999. It decreased a little in 2000.

Lead and arsenic poisoning

Urine tests were done for workers working at enterprises exploring and processing coloured metal as well as some teachers living near the enterprise area from 1997-1998. The results showed that in 1997, there was 7.92% among 744 tested workers having urinary ALA indicator >= 10 mg/l. and in 1998, the rate was 11.99% among 642 tested workers. In the processing area, the rate of over exposure to lead was high, at 18.22%. Due to polluted environment there were 3 of 12 teachers having a urinary ALA indicator from 14-17 mg/l.

Acute pesticide poisoning

In Viet Nam, more than 90% of pesticides used in agriculture currently imported. There are only two pesticide factories in Viet Nam that can manufacture four out of 300 types of pesticides. All others only do the work of processing imported pesticides, and then fill in the bottles and pack.

Due to the market economic mechanism, many farmers have abused pesticides in agriculture. Farmers have not obeyed regulations, or technical requirements in using

pesticides, for example the isolation period of pesticides after spraying has been not followed. According to statistical data of the southern provinces, in vine grow areas of Ninh Thuan province farmers used pesticides many times in a season (70-80 times/a season); in vegetable grow areas out of Hanoi, many farmers even used forbidden pesticides such as Methamidophos. Further more, to benefit by arbitrary use of pesticides some shops have sold pesticides without labels or untrue/unintelligible labels. Farmers also tend to use pesticides that are cheap and have strong effect regardless of safety. Furthermore, farmers do not use personal protective equipment during spraying pesticides. Many users of agriculture products have therefore engaged pesticide poisoned.

In the five years from 1997 to 2000, the total number of people hospitalized with acute pesticide poisoning was 35,406 cases (Dept. of Preventive Medicine-MOH, 2001a). Death cases were 1,338 constituting 3.7% of total poisoning cases. The pesticide poisoning incidence gradually increased from 1997 to 1999, and it evidently decreased in 2000, but this rate increased again in 2001. From 1997-1999, the average death cases were about 300 per year.

Table 8: Pesticide poisoning in 1997-2001

Year	No of Cases	No. of person	No. of death	Main causes of pesticide poisoning					
				Occupational		Suicide		By mistake	
				No. of cases	No. of death	No. of. cases	No. of death	No. of. cases	No. of death
1997	3385	6103	292	748	18	4536	240	819	34
1998	7003	7676	331	489	2	4987	272	1788	57
1999	4500	8808	345	359	4	6866	299	1256	42
2000	2212	5394	193	196	0	4478	177	720	16
2001	6798	7425	177	266	0	6420	168	687	9
Sum	**23898**	**35406**	**1338**	**2058**	**24**	**27287**	**1156**	**5270**	**158**

Source: Dept. of Preventive Medicine-MOH, 2001a

Musculo-skeletal disorders

The intensification of work in the global competition does not affect the psychological aspects of work only, but also the musculo-skeletal system is under risk of overload in both manual works an in VDU works. Besides, many imported techniques or machines with inappropriate size (too large) for Vietnamese anthropometry have caused ergonomic problems. Furthermore, in a situation of "technical explosion" in the world, many dust-producing or backward industries are imported to developing countries such as Viet Nam, and they have polluted the work environment and been harmful to worker's health.

The shoe industry in Viet Nam is considered a key industry in development strategy because of good export prospects. Up to the year 2000, there were 178 shoes companies including 73 state managed businesses, 51 private units and 54 joint venture enterprises with 100% of foreign investment budget (Cong Nguyen The, 2001). The results of environment survey in 12 shoes companies in 5 provinces showed the relationship

between the working posture and the severity of musculo-skeletal pain (Cong Nguyen The, 2001). The pains were resulted from automatical industrial chain, repetitive manipulation , bending, rotation actions, etc. These daily pains result in chronic arthritis, especially in workers suffering from musculo-skeletal disorders. The rate of musculo-skeletal disorders among female workers is higher than that among male workers.

Stress related diseases

Psychological stress and psychological overload are growing due to the information overload, over workload, the thread of violence, and the declining work ability of ageing workers. The results of a study on occupational stress showed among 31 medical staffs in an intensive care department of a state hospital that 22.6% of staff had high stress assessment scores, 41.9% had moderate SAS and 35.5% had low SAS (Ha Nguyen Thu, 2000). Stress affects the function of the central nervous system, the cardiovascular system, manifested by increasing simple reaction time, decreasing short term memory and concentration ability, changing mathematical and statistical index of heart rhythm after work shift and night duty in comparison with the index before work shift. There were many causes of stress and its related factors such as not allowing mistakes, too much work, a high intensity of work, poor wages and food allowances for their service.

Occupational viral hepatitis B

Health care personnel are increasingly exposed to new microbial agents due to the growing mobility of people in globalization. High rates of hepatitis B antigen positive have been shown among health care workers who are in contact with migrants from endemic areas. Investigation on viral hepatitis B among 694 health care workers in 9 hospitals and , 1998). The HbsAg carrier rate and the prevalence for viral Hepatitis B on health care workers were higher than those in the population $p<0.05$.

Up to December 2001, there were accumulatively 226 cases of occupational viral Hepatitis B of which 23.4% was examined. In 2001 there were 3 cases per 12 examined people (Dept. of Preventive Medicine-MOH , 2001a).

Table 9: Occupational viral Hepatitis B

Year	1998	1999	2000	2001	2002
Number of diagnosed cases	94	101	28	3	226
Number of expertise? case		22	28	3	53
Rate of expertise? case/diagnosed case		21.8%	100%	100%	23.4%

Source: Dept. of Preventive Medicine-MOH, 2001a.

HIV/AIDS

Globalization, among other factors, leads to increase in the rate of HIV/AIDS in Viet Nam in general and working population in particularly. According to data of Dept. of Preventive Medicine-MOH, HIV infection in workers is on a rising trend. Up to October 2002, there was a cumulative total of 412 HIV cases identified among workers accounting for 0.74% of HIV infection cases in the whole country. The number of

workers suffering from AIDS was 57 cases out of a total of 8393 cases in the country accounting for 0.68%, the number of deaths from AIDS was 13 cases per total of 4602 cases accounting for 0.28% (Dept. of Preventive Medicine-MOH. *10/2002)*.

Table 10: HIV cases found in workers

	93-95	1996	1997	1998	1999	2000	2001	Oct 2002	Total
HIV cases	3	8	21	21	31	101	129	98	412

Source: Dept. of Preventive Medicine-MOH. *10/2002*

IV. ECONOMIC AND HEALTH REFORM IN VIET NAM

Vetnam launched its multifaceted renovation policy, called *Doi Moi*, in 1986 when the nation's old economic mechanisms became obsolete and constituted an obstacle to development and the quick global change in socio-economy. *Doi Moi* policy aims to maximize every resource, both internal and external, building a modernized, strong and prosperous country, creating a peaceful and wealthy life for the people, and establishing a just, democratic and advanced society.

1. Economic reform.

The renovation policy, *Doi Moi*, extends to the improvement of economic conditions. In 1986, the Government made some of the most important and comprehensive macro-economic reforms in its modern history (Embassy of the Socialist Republic of Viet Nam. 02/12/2003):

- The shift from a centrally planned economy (it is also called command economy or co-operative production period. In the planned economy period, industry and trade were controlled by the state and agricultural production was collectivised through co-operatives) to a multi-sector market economy with socialist orientation under state management.
- Creation of favorable conditions for business activities to ensure domestic and foreign investments. Development and diversification of international economic relations.
- Administrative reforms with a legal framework for the market economy developed step by step.

The Vietnamese Government encourages the development of all economic sectors. The Enterprise Law, in effect since 2001, assures the business activities of private enterprises. (Farmers, household micro-enterprises, private SMEs and relatively large foreign invested enterprises comprise the private sector in Viet Nam.). The Government also seeks to make state-owned enterprises more efficient through the equitization I'm not sure what that is? Issuing some private equity? - yes] process. Revisions of the 1992 Constitution approved in Dec. 2001 reaffirmed Vietnams consistent policy of a market economy with a socialist orientation based on state ownership, cooperative and private ownership.

2. Health sector reform

The existing structure of the health system was established during the planned economy period. At the central level there are the Ministry of Health, specialized institutes responsible for national health programs, and central hospitals. Health services at the provincial level are run technically by their respective provincial heath bureaus and the political responsibility of provincial governments – the provincial people's committee. Provincial health services consist of general and specialised hospitals and preventive medicine centers. The district health centre is the lowest tier of the state health system, which consists of the district hospital, intercommunal polyclinics (outlying outpatients branches of the hospital), the district pharmacy, and preventive health teams. The district heath centre is under the political authority of the district people's committee, but it managed technically by the provincial health bureau.

As part of the planned economy, every district had to have its own hospital and district bed number were planned according to service norms, rather than on the criteria of local need and efficiency. A large number of small district hospitals was built, and these have suffered from diseconomies of scale. Bed occupancy rates are often low and lengths of stay excessive. The basic administrative unit in Viet Nam is the commune run by the commune people's committee (CPC). About 90 per cent of communes have a commune health station responsible for the delivery of primary preventive and curative. The health station is under the administrative control of the CPC, but is supervised technically by the district health centre. Rural communes are divided into villages. During the period of co-operative production, commune health services were the financial responsibility of the CPCs and co-operatives. Many communes had a network of part time village health workers (VHWs).

Before the economic reforms, public health care was provided virtually free of charge. Patients paid only for drugs at a highly subsidized price. (at the time Viet Nam was provided with subsidized pharmaceutical products by the Soviet Union and east European countries) (Malcolm Segall, Gill Tipping, et al. 4/2000). Private medical practice and sale of drugs were officially prohibited, although health workers often practised informally from home and drugs were sold privately on the black market (Pham, H.D., 1996). Resource levels in the health service were low, but access to essential curative and preventive health care was good in most places.
As a consequence of all these factors, Viet Nam has a well-developed public health system with extensive rural coverage. The problems with the system have been more with function than structure.

In 1989 the Ministry of Health introduced major reforms to the health sector. Among the most important health sector reforms were the introduction of user fees for health services at higher-level public health facilities (viz., hospitals), health insurance, legalization of private medical practice, liberalization of the pharmaceutical industry, and deregulation of the retail trade in drugs and medicines. The health insurance and hospital user fee programs have had important effects in generating additional resources for the health sector, especially at the secondary and tertiary level of curative care, and have allowed these facilities to provide services beyond what state subsidies can support.

Preventive service and treatment administered under national health programs were to continue to be free of charge. The referral was liberalised so that patients could attend any facility of their choice. In the following years, as part of a public sector reform programme, efforts were made to rationalise hospitals and downsize government and CHS staffing levels through early retirement. Efforts were also made to reduce the intake of health training institutions.

Private medical practice and the retail sale of drugs were sanctioned for university level medical and pharmacy personnel, as well as traditional medical practitioners. Initially in the form of ministry regulations, these reform were confirmed in law in 1991 and 1993 and the policy of a public/private mix of health care provision and financing was adopted officially by the Communist Party in 1993. Many forms of private health care services were established, including: private hospitals, general health examination centers, community health centers, private surgery centers, traditional medicinal centers, private health care equipment company, private pharmaceuticals, family doctors etc.

<u>Foreign investment increase in health sector</u>

Health care services with foreign investment were also established, for example: Viet Nam-Japan Hospital, Viet Nam-France Hospital . There were very few NGOs in Viet Nam-about 10-during the period from the late 1960s to the late 1980s. All of these NGOs had a health component and concentrated on relief and reconstruction efforts and the supply of medicines and hospital equipment, all of which were badly needed at that time. During this period, NGOs could only work with the central government as a counterpart.
At least until the start of doi moi in 1986, many NGOs were still mainly providing supplies to hospitals and supporting the Ministry of Health directly. However, some were also sending Vietnamese health staff abroad for training, so there was some attention to structural development and institution building. The total support in 1988 by all NGOs (including those from socialist countries) amounted to about US$70 million, and it was the health sector that received, by far, the greatest proportion of that amount (An NQ, Phuong NK, 12/2001).

With the opening up of the economy in the late 1980s, international NGOs began coming into Viet Nam in large numbers. Many opened representative offices in the country.

<u>Mechanization in diagnosis and treatment</u>

Before 1994, medical equipment provided for diagnosis, treatment, training and research centers within the health care sector were deficient, out of date and therefore could not satisfy health care requirements. Since 1994, with support from the Government, the Ministry of Health has been implementing a project on improving medical appliances with a total budget of 118,08 billion Vietnamese Dong (Tinh Duong Van, 2002). Apart from medical equipment purchased using the budget from central and local governments, provinces have also been provided with equipment from foreign investment projects such as ODA (UK), World Bank. The results from a recent study carried out in Northern Plain Region showed that Central general hospitals at these provinces have been equipped with modern appliances, for example: Imaging Diagnosis Department (Tinh Duong Van, 2002).

- Radiography – machine 500Am, several provinces have been equipped with television-light enforced – Radiology – machines.
- Hanoi, Haiphong and Haiduong now already have CT-Scanner Machines
- Various provinces and cities have purchased Color Ultrasonic Doppler Machines, for example: Hanoi, Haiphong and Vinhphuc.

Hospitals at central levels mainly placed at Hanoi and Hochiminh cities have already been provided with modern and sophisticated medical equipment such as the Nuclear Resonance Machine that are resulted from the Governmental policy on developing these two high-tech centers.

Health care worker differentiation according to the market economy

Viet Nam currently has approximately 3,000 medical graduated students still unemployed in public services (Phuong Do Nguyen, 1999). The majority live in urban areas, working for some private pharmaceutical companies, working voluntarily without payments at some big hospitals and waiting for the chance to be employed permanently, or working for some foreign companies. There are several reasons why they do not want to go and work at community levels. Some of these are: they are not willing to live far from their family, to lose permanent inhabitant rights in urban areas, afraid of losing their learned knowledge if working in an inadequate environment (lack of facility and modern technology), low salary that does not ensure them a relatively comfortable life, low chance for continuously training, and may be impossible to change to a more appropriate work position.

All of these reforms had profound effects on the health sector and on household health-seeking behaviour.

V. IMPACTS OF GLOBALIZATION ON HEALTH CARE FOR PEOPLE IN VIET NAM

5.1. Inequities in health care for people

5.1.1. Negative impacts of health insurance:

a. Description of health insurance

Health insurance (HI) began in Viet Nam in 1993, following a decree issued in 1992 that set up two separate insurance schemes:

- The compulsory scheme covers primarily current and retired civil servants and employees of state and large (i.e., having more than 10 employees) private enterprises. This scheme provides both inpatient and outpatient care benefits, and also pays for drugs used in inpatient treatment.
- The voluntary scheme is aimed at the remainder of the population, viz., farmers, school students, and family members of compulsory scheme enrollees.
- Humanitarian health insurance (for poor people): In 2002, Government introduced Health Insurance for Poor People in Decision No 139/2002/QD-TTg dated 15 October 2002. Poor people are provided health insurance card valued 50,000 dong/person/year.

Premiums in the compulsory scheme are paid from 3% of minimum monthly basic salary plus allowances for employees, which is shared by employers (two-thirds) and employees (one-third), and 3% of monthly pension if retired or disabled. Enrollees in the voluntary scheme pay fixed annual premia that vary across provinces and according to benefit coverage chosen.

Health facilities are reimbursed by the insurance scheme on a fee-for-service basis for both inpatient and outpatient care delivered to enrollees. Until recently, only government health facilities were accredited to deliver the benefits covered by the insurance program. Outpatient benefits are typically provided by hospital-based clinics or outpatient departments at hospitals, except in the case of employees in special resource sectors, such as transportation, communication and mining, who tend to use health facilities operated by the ministries governing these sectors.

b. Population Coverage

Membership in VHI increases at 2.6 times-rate from 1993 to 2000, but has since slowed down considerably (see table 11) especially for compulsory health insurance (CHI). The compulsory scheme has been successful in terms of expanding coverage of its target population. In 1993, CHI covered only 4.98 % of population. Up to the end of 2000 this rate was 8.25%.

Table 11: The number of compulsory health insurance enrollees 1993 –2000

	1993	1994	1995	1996	1997	1998	1999	2000
Compulsory HI (million people)	3.47	3.72	4.87	5.56	5.73	6.04	6.28	6.4
%/ population	4.89	5.13	6.58	7.38	7.58	7.87	8.10	8.25
Total HI enrollees (million people)	3.8	4.3	7.1	8.9	9.5	9.79	10.5	10.63
%/population	5.4	5.9	9.6	11.8	12.4	12.46	13.77	13.94

Source: MOH, 2000

In 1999, there were a total of 10.5 million enrollees, of whom 38 per cent (3.7 million) were enrollees in the voluntary program (MOH, 2000). Most of the enrollees (more than 90%) are pupils and students since it is easier to propagandize this group participating in and this group normally has better health (Ministry of Health. 2002b).

Table 12: The number of voluntary health insurance enrollees 1993 –1998

	1993	1994	1995	1996	1997	1998
Voluntary HI	325,569	543,933	2,234,178	3,073,077	3,816,267	3,742,127
Compared with 1993 (%)		67	585	843	1,071	1,049

Source: Ministry of Health, 2002b

There was a decline (albeit small) in membership in the voluntary scheme between 1997 and 1998, in part because of increases in premium charged and because of competition

from the Bao Viet Insurance Company (private company) for student health insurance. Indeed, the voluntary scheme is still in its infancy and covers a mere 5% of pupils and students.

The number of humanitarian enrollees fluctuates a great deal from year to year, as insurance policies for these enrollees are provided by a variety of organizations, including government at the national and local levels, donors and charity organizations, such as the Red Cross (Nga, Nguyen Nguyen, 1997).

Table 13: Composition of voluntary health insurance scheme membership, 1993–97 (%)

Year	School children	Humanitarian (free cards)	Other members (e.g., farmers)	Total voluntary scheme membership
1993	0.00	26.07	73.93	100.00
1994	44.49	6.17	49.35	100.00
1996	91.79	6.15	2.07	100.00
1997	90.77	5.48	3.75	100.00

Source: Nga, Nguyen Nguyen. 1997

Regional Variations. Viet Nam's health insurance program currently covers about 13.94 per cent of the country's population, with large variations across geographical regions. In the early years, membership in health insurance were mainly from large cities (Ministry of Health. 2002b). In following years, HI enrollees from provinces in delta zone have increased considerably

Demographic Composition. There is a difference in the demographic composition of enrollees in the compulsory and the voluntary health insurance schemes. While 46 per cent of all enrollees in the compulsory scheme are over the age of 60 years, the large majority (over 90 per cent) of enrollees in the voluntary scheme are students, who are typically aged 5-19 years (VHIA, 1999). It was noted that people with aged 60 and over have the highest utilization rates of health services in Viet Nam, while school-age children have the lowest rates.

c. Equity in Health Insurance

Economic Composition of Enrollees. The economic background of health insurance enrollees can provide an indication of which income groups benefit most from the social health insurance program. Enrollees in the CHI scheme are from Government, private and foreign investment organizations located mainly in large cities and delta zone (MOH, 2002b). Their income is fairly high. Therefore it is likely that enrollees in the CHI scheme are significantly better off than the general population, which is largely rural.

Table 14: The number of enrollees in CHI by jobs and regions, 1997

	Large cities (4 large cities)		Delta zone (38 provinces)		Rural areas (19 provinces)	
	Number	%	Number	%	Number	%
Enrollees in CHI	1,340,993	23	3,246,134	57	1,147,433	20
Classification of enrollees in CHI						
- State administrative management	224,500	4	738,755	13	296,097	5
- Goverment firms	553,333	9	706,301	12	245,302	4
- Private firms	56,600	1	20,735	1	1,194	0
- Foreign investment firms	48,600	1	63,033	1	2,836	0
- Retired and disabled people	362,660	6	811,508	14	419,625	8
- Social regime beneficiaries	95,300	2	905,802	16	182,349	3

Source: MOH, 2002b

As noted earlier, 90 per cent of enrollees in the voluntary scheme are pupils and students. The present time the voluntary scheme covers only a fraction of all pupils and students in the country. It is likely that it is the better-off students who enroll in the voluntary scheme, as their parents are able to pay the annual health insurance premium. However, there is no data to confirm this hypothesis.

Additionally, the health insurance programme can not fully cover health expenditures. The percentage of those who are poor who are insured (8%) is much lower than rich group's percentage (37%). Development of the compulsory health insurance scheme based on deducting a certain amount from the salary is limited because 70-80% of people living in rural areas do not have a salary.

The Health Insurance for Poor People scheme displays many continuing problems as follows:

- In the poor provinces, not only the is budget is small but also the number of poor is very high. This fund will therefore have no financial capacity to provide HI card for all poor people.
- The value of HI card for poor people is 40% of average value of compulsory HI card, while poor have a higher demand for health care. The Funds of Compulsory and voluntary HI have therefore to subsidize partly to the HI Fund for Poor though it still faces limits on financial capacity.
- Due to lack of money, the HI programme can not provide HI card free of charge for all members in one poor household, usually for only an ageing or vulnerable person.

In some cases, poor people do not use HI card when they go to see physician because they worry that health staff will not pay attention to them.

Equity across Compulsory and Voluntary Enrollees. While voluntary enrollees constituted about 31.9 per cent of total enrollees in 2000, they accounted for only 7,4 per cent of the total premiums. This meant that the average premium is about 6.6 times as high for compulsory enrollees as for voluntary enrollees (MOH, 2000) (Table 15). The service usage of compulsory enrollees is also proportionately greater. The number of

inpatient is 6.6 times as large for compulsory enrollees as for voluntary enrollees, while the number of outpatients is 38 times greater.

Table 15: Enrollees in Health Insurance, premium and expenditure, 2000

Variable	Compulsory scheme	Voluntary scheme	Humanitarian scheme	Total
Enrollees in HI (millions)	6.4	3.39	0.84	10.63
Total Premium Billion Vietnamese dong)	848.63	69.70	25.45	943.78
Average premium per enrollee (1000 VND)	132.598	19.970	30.297	
Total number of inpatients (1000)	1,072.88	161.80	44.72	1.279,41
Total number of outpatients (1000)	13,332.55	348.41	447.25	14.128,21
Expenditure for patients (billion VND)	584.74	48.52	17.37	650.64
- Inpatients (billion VND)	284.75	28.69	10.15	323.59
- Outpatients (billion VND)	299.99	19.83	7.22	327.05
Average expenditure for inpatient (1000 VND)	285.38	177.38	226.95	
Average expenditure for outpatient (1000 VND)	23.49	14.83	16.16	

Source: MOH, 2000

d. Level of Utilization of Health Insurance Fund

Across Provinces. Since membership in compulsory health insurance are civil servants and salaried employees of large firms, they derive most of the benefits of the health insurance program. Benefits of the HI programme may be highly concentrated in a few provinces having large urban centers where large numbers of individuals buy compulsory health insurance. For example, Hanoi and Ho Chi Minh City alone account for 29 per cent of national health insurance expenditure, even though they account for 10 per cent of the national population (see table 16).

Table 16: Shares of 10 provinces in national health insurance expenditures, 1997

	Share in		Cumulative share in	
Province	national health insurance expenditure	national population	national health insurance expenditure	national population
Hanoi	14.67	3.05	14.67	3.05
Ho Chi Minh City	13.98	6.67	28.65	9.72
Haiphong	5.16	2.24	33.81	11.96
Thanh Hoa	3.29	4.70	37.10	16.66
Nghe An	3.25	3.80	40.35	20.45
Nam Dinh	2.76	2.56	43.12	23.01
Quang Ninh	2.18	1.24	45.29	24.25
Ha Tay	2.16	3.13	47.45	27.38
Thai Nguyen	2.13	1.28	49.58	28.66
Dong Nai	2.11	2.60	51.69	31.25

Source: VHIA 1998.

The 10 provinces receiving the largest health insurance reimbursements account for more than one- half of aggregate national health insurance reimbursements but account for only 31% of the national population (VHIA, 1998).

Across Levels and Types of Health Facilities. Health insurance enrollees from large cities highly use both inpatient and outpatient treatment services in Central health facities. For example, in Thua Thien Hue province, the number of insured inpatient in Central hospitals is higher than that of district hospitals (MOH, 2002b).

The number of insured inpatient and outpatient at district health facilities accounts for about one-half of total number of insured inpatients and outpatients in health facilities at all levels. The number of insured people using commune health facilities is very low as the health insurance programme has not been widely expanded in provinces (see table 17).

Table 17: The utilization of health services at different levels, 1998

	Total	At Central level		At provincial level		At district level		At commune level	
		No of patients	%	No of patients	%	No of patients	%	No of patients	%
Outpatient	12,515,000	250,300	2	3,625,350	29	7,136,550	57	1,502800	12
Inpatient	1,028,000	44,204	4	421,480	41	503,720	49	58,596	6

Source: MOH, 2002b

There is an evidence that HI enrollees use more health services than general population. Table 18 shows that the average number of health service admission per year per HI enrollees is higher than that of general population (MOH, 2002b). However, it can be explained that health insurance programme pays treatment expenditures for insured people.

Table 18: Utilization of health services of insured people and general population, 1993-1998

Indicators	1993	1994	1995	1996	1997	1998
The number of outpatient contacts of HI enrollees (million persons)	2	5.3	9	10	12.8	13.7
Average number of health service admission per year per enrollee	0.53	1.24	1.26	1.16	1.34	1.42
Average number of health service admission per year per capita (general population)	0.67	0.76	0.92	1.17	1.21	-
The number of inpatient contacts of HI enrollees (million persons)	0.2	0.5	1	1	1.2	1.3

Source: MOH, 1999.

5.1.2. Negative impacts of User fees

A fee system was introduced in the three levels of the health care delivery system: district, provincial and national, in 1989. The system requires patients to pay at least a minimal part of their health care. The handicapped, orphans, individuals able to produce certification of indigence from the Commune People's Committee, and patients suffering from mental problems, leprosy, and BK-positive tuberculosis are to be treated free of charge.

In 1995, the Ministry of Health issued user fee schedules for each type of consultation and each type of diagnostic test as well as procedures need to be performed in clinics and hospitals. For inpatient services, there is an additional daily bed charge. The user fees indicated in the Schedule vary by hospital types. In addition, the schedule specifies a range of charges - not a single fixed charge - for each type of service (WB, AUSAID, AUDS. 2001).

Most fees are required to be paid in advance by noninsured patients and patients not eligible for fee exemption. Almost all of patients are responsible for the purchase of drugs themselves, either from a private pharmacy or a pharmacy run by the public facility or the public premises. There are two important things to be noted with regard to user fees.

- First, because the price schedule issued by the government only indicates a range of fees for health care services that can be charged, hospitals have some discretion over the user fees they can charge, especially for technical services and laboratory tests. Central hospitals normally apply the highest price indicated in the price schedule, while lower-level hospitals charge the lowest price. There are also differences in fee levels across regions. In the South, user fees tend to be higher than in the North for comparable services.
- Second, the user fee schedule that is in use today was developed in 1995, even though the general price level has increased by about 23 per cent since then (An NQ, Phuong NK, 2001). Total user fee collections have grown rapidly over time, in part because of an increase in the number of patients seen at public facilities but also in part because of an increase in the number of laboratory and radiology tests performed per patient.

a. Burden of User Fees on the Poor

Excessive Out-of-Pocket Costs. Currently, average out-of-pocket costs for a health service contact, especially for hospital care, remain large and unaffordable for the poor. While 20% of population at the poorest level has to pay 23 per cent of their income for health care services, 20% of population at the richest level pays only 9 per cent of their income for health care services (MOH, 2002b). Average user fees for a single inpatient contact equals 45 per cent of non-food expenditure for a family in lowest quintile while the highest quintile pays only 4%. Even a single visit to a regional public hospital takes up 9 per cent of all non-food expenditure for a year for a typical person in the lowest quintile (Claession et al. 2001). An 8-day inpatient treatment for a 3rd class operation in the 4th class public hospital costs 50% of non-food expenditure per year for a person in the lowest quintile (1997/1998) while it costs only 5% for the highest quintile (Viet Nam Living Standard Survey, 1997/1998).

Poor people are not able to pay hospital fees, even when they have free exemption. One of the most important problems is that they have to pay informal extra fees. The extra fees include transportation fees, foods, under table money, etc. as followings (M. Segal, G.Tripping, et al, 4/2000):

- Transportation cost: the distance from houses of patients to commune health station is at least 4.34 km, district hospital is 10.07 km, and provincial hospital is 34.98 km. This is the geographic difficulty in access to health services.
- Under the table money: extra allowances from patients for medical staff, giving gifts for medical staff, buying extra drugs or using extra heath services (mainly laboratory tests, diagnosis by modern equipment such as CT-scanner, color ultrasonic doppler) outside of hospital basic services according to suggestion of physicians, etc.
- A range of other costs: for hiring people to take care of patient, their children at home, house and "opportunity cost" (patient and their relatives can not work, risk of losing job, interest on their loan, selling their productive equipment cheaply)

An investigation in six provinces showed that although patients received free of charge all medical examinations, each patient had to pay in average 179,000 Vietnamese dong, mainly for food, transportation and VND 100.000 for giving gifts to medical staffs. Some patients spent from VND 1.000.000 to VND 2.000.000 (not known for which expenditure) (An NQ, Phuong NK, 2001).

The financial sources that poor people draw upon for medicines and specialized services are showed in table 19.

Table 19: The financial source spent by poor people for medical treatment

Financial source	Number of patients (n=99)	Rate %
- Using available money (saving money and capital)	27	27.3%
- Borrowing, paying interest	37	37.4%
- Asking for help from relatives	45	45.4%
- Selling property	25	25.2%

Source: MOH, 1997

Among interviewed patients, 11 patients used available money for medical examination and treatment, in which the highest expenses were from VND 100,000 to VND 147,000, while the minimum was some thousands Vietnamese dong (MOH, 1997). Although some patients had to pay only 15,000 dong, they still had to ask for help from relatives and neighbors. These extra fees can therefore be "poverty trap" for most of low-income group/poor people. The poor become poorer. It is estimated that there are 28 million people in the lowest quintile, who can not afford to pay hospital fees. But they are not poor enough to get fee exemption. The tragedy of the "poverty trap" becomes more serious when the poor have to pay for unnecessary laboratory tests and improper drugs.

Besides, the poor may force their children to quit school in order to reduce educational expenditures and increase labour for the family. Poor people do not dare to go to hospital when ill or escape from hospital because of inability to pay hospital fee. The poor mainly access the health care at commune health stations and self-buy drug at private pharmacy.

Table 20: The percentage of utilization of health care service by income

Health facilities	20% of population in the lowest quintile	20% of population in the highest quintile	Total
Public hospital	5.33	15.45	9.38
Commune health station	8.33	3.23	5.61
Other	0.75	1.8	1.04
Total of public facilities	14.31	20.48	16.03
Private health clinic	15.81	24.16	19.52
Pharmacy	69.32	53.79	63.44
Traditional healer	0.56	1.13	0.84
Other	0	0.45	0.18

Source: MOH, 2002b The columns do not ad to 100 because people may go to more than one provider.

Fee exemptions for the poor.

Viet Nam has approximately 20% of the population living in poverty, and of these 4-6% live in extreme poverty. These people usually have poorer health. Therefore, their needs for health care services are higher. The Decree No. 95/CP issued on 27/08/1994 by the Government regulates that extremely poor people do not have to pay a part of diagnosis and/or treatment fee. Recently, The Health Ministry, The Finance Ministry, and The Labor – Disabled veteran – Social Ministry have issued a Circular, which defines the grant of Health Insurance Cards for people living in extreme poverty. In addition, the Health care Sector encourages medical facilities to provide free diagnosis and treatment services for poor people who do not have Health Insurance Cards. Fee exemption is aimed at certain classes of people, such as the poor, handicapped, war veterans, orphans, and individuals suffering from certain ailments (such as tuberculosis and leprosy), from user fees. In addition, children are supposed to receive free of charge services provided through the vertical programs, funded directly by the central government or aid agencies.

There are two types of exemptions that are typically given: exemption from commune health center charges (typically for drugs) and exemption from district hospital charges. In their survey of 32 communes in 1995, Ensor and San (1996) found that only six communes reported giving exemptions to individuals at the commune health center. The reason is that the commune has to bear the cost of exemptions itself. The second type of exemption is exemption from charges at hospitals. Since the cost of these exemptions is

borne by the hospital, these exemptions are given out more generously than exemptions from commune health center charges.

However, table 21 shows that the variations in the rate of exemptions across economic groups are not as large as one would expect a priori from a program targeted mainly to the poor (VLSS 1993 and 1998). Exemptions from payment for drugs are nonexistent in commune health centers and public hospitals (VLSS 1993 and 1998).

Table 21: Per cent of users who reported paying nothing for a visit to a government health facility, 1993 and 1998

	Per capita consumption expenditure quintile					
Health provider	**Lowest**	**Second**	**Third**	**Fourth**	**Highest**	**Average**
	1993					
Government Hospitals						
% paying no fees	60	57	57	55	58	57
% paying nothing for drugs	7	4	2	2	5	4
Commune Health Centers						
% paying no fees	94	90	98	90	77	91
% paying nothing for drugs	13	3	5	3	0	5
	1998					
Government Hospitals						
% paying no fees	50	42	42	41	38	42
% paying nothing for drugs	0	0	0	0	0	0
Commune Health Centers						
% paying no fees	90	83	78	79	75	82
% paying nothing for drugs	0	0	0	0	0	0

Source: VLSS 1993 and 1998.

The data reported by nine hospitals in the country on the percentage of fee exemptions they offered over the period 1993-97 showed that there were large inter-hospital variations in the fee exemptions (MOH, 1999c). In some hospitals, such as Bach Mai, Viet Tiep, Dong Da and Son Tra, fee exemptions and reductions are offered to only 2-5 per cent of patients. But in other hospitals, such as Khanh Hoa and Da Nang, fee exemptions appear to be given out liberally. It may be explained that the fee-exempting mechanism is not applied consistently by different hospitals.

Table 22: Percentage of fee exemptions and reductions in selected hospitals, 1993–97

Hospital	1993	1994	1995	1996	1997
Bach Mai	-	4.0	4.0	4.5	5.0
Cho Ray	24.5	21.7	27.4	24.2	25.3
Thai Nguyen	40.3	30.7	22.5	27.8	16.3
Da Nang	28.0	28.5	29.9	28.1	29.8
Khanh Hoa	-	-	-	38.9	30.2
Viet Tiep	-	-	2.8	2.6	2.1
Dong Da	2.9	2.1	2.0	2.0	1.8
Hai Chau	13.4	14.4	10.8	12.8	14.6
Son Tra	2.9	2.8	4.3	6.9	7.7

Source: MoH 1999c.

b. Equity in Provincial Distribution of User Fees

According to Nga, Nguyen Nguyen, 1999 user fee revenues across provinces indicate large interprovincial variations in user fee collections per capita. User fees per capita ranged from VND 910 (in Hung Yen province) to a high of VND 8,960 (in Ho Chi Minh City) (Nga, Nguyen Nguyen, 1999). User fee collection greater than VND 2,000 per capita is in only 17 provinces out of 61 (Nga, Nguyen Nguyen, 1999). It seems that better-off provinces collect more user fees per capita than do poorer provinces.

c. New regulation on Preventive medicine fee

The Decree No 21/2000/QD - BTC was promulgated by Financial Minister dated 21/2/2000 on regulation of preventive medicine fee and charge. The Decree introduced preventive medicine fee and charge level for some preventive medicine activities including tests for disease diagnosis; drinking water, waste water and air sample tests; frontier health quarantine; licencing for use and production of vaccines; vaccination; licencing for use of domestic and exported chemicals with strictly occupational health requirements; insecticides and disinfectants for domestic and medical uses. 90% of preventive medicine charge and 40% of preventive medicine fee will be retained for preventive medicine activities.

Several preventive medicine centers of large cities (10%) have collected high preventive fee (about 800 -900 millions VND per year) such as Ha noi, Ho chi minh city, Can tho, Dong nai, Hai phong. 30% of centers have collected 300-500 millions per year including Da nang, Binh duong, Nam dinh...However, the other centers have collected only a small amount of money (10 - 50 million VND/year) such as Ha tinh, bac giang, Cao bang, Bac can...

5.1.3. Private clinics and providers- Out of control

Currently there has been a rapid growth in the number of private providers, especially drug outlets and private pharmacies. There are two types of private providers:

- Full-time providers
- Part-time private providers who are the staff of public health facilities but work in private practice during off-hours.

According to the estimates of the Ministry of Health the number of licensed private health personnel in the country was 25,698, which was about a tenth of the 213,099 public health personnel in 1996 (Nga, Nguyen Nguyen, 1999). There were a total of 34,018 private pharmaceutical and medical facilities, including drug outlets and sales agents for pharmaceutical companies in 1998 (Table 23) (MOH, 1999b). General practitioners' clinics made up the largest proportion of private health facilities, followed by infirmaries and private pharmacies or drug outlets.

Table 23: Number of private health facilities, by type (as of October 1998)

No.	Type of facility	Number
Private health facilities		
1	General hospitals	4
2	Maternity homes	264
3	Polyclinics	98
4	Consulting rooms of general practitioners	7,005
5	Specialized clinics	3,423
6	Dental clinics	2,305
7	Lab tests and functional exploration	240
8	X-ray examination	197
9	Cosmetic surgery	42
10	Infirmary	5,569
11	Rehabilitation and nursing care	125
12	Family planning services	550
13	Foreign-invested health facilities	5
Private pharmaceutical facilities		
14	Private pharmacies or drug outlets	5,192
15	Sales agents for pharmaceutical companies	8,822
TOTAL		33,850

Source:MoH 1999b.

Private health clinics and providers contribute to increase accessibility of the population to health facilities. Besides, there are many private providers working without license. A mail survey of private health providers indicated that approximately 12.6 per cent of private health facilities were unlicensed (Dung, PH 1999).

Table 24: Licensed and unlicensed private health facilities in 44 of 61 provinces, by rural/urban areas, 1999

Sector	Licensed private health facilities		Unlicensed private health facilities		Total private health facilities	
	Number	%	Number	%	Number	%
Urban	22,007	86.5	3,445	13.5	25,452	100.0
Rural	9,835	89.5	1,155	10.5	10,990	100.0
Total	31,842	87.4	4,600	12.6	36,442	100.0

Source: Dung 1999.

According to the MOH, 1,805 out of 19,836 private clinics and providers (9.1%) were administratively fined because of regulation violations. According to reports from Institute for Drug Quality Control and 59 cities and provinces, 22 expired drug samples out of 46311 drug samples were found. The quality of care including infection control, hygienic practices, and standards of practice protocols varies considerably across private providers. Diagnostic methods are often inconsistent. In the Hai Phong study of private reproductive health providers, it was found that many providers treated RTIs by syndromic management without laboratory confirmation (Nga, Nguyen Nguyen, 1999).

Table 24 also indicates that about 70 per cent of the private health facilities are in the urban areas, and remaining 30 per cent in the rural areas. This tends to increase the existing inequalities in the rural-urban distribution of public health facilities and public health workers.

5.1.4. Pharmaceuticals and Drugs abuse

After 1989, pharmaceutical factories were informed that they could no longer rely on government subsidies. Drugs and medicines were dispensed free through the public health network to all patients. The Government began to allow pharmaceutical factories to open retail pharmacies and sell drugs and medicines to individuals, hospitals and health centers directly. Qualified pharmacists could apply for licenses to open private pharmacies. Up to the end of 2001, there were 34,300 retail pharmacies in the whole country, in which there are 7,161 state and 8,019 private pharmacies, 10,367 sole agents, 8,760 counters in the commune health station (MOH, 2002b). In 1999, there were a total of 8,000 registered drugs in the market, of which 5,000 were produced domestically and the remaining 3,000 imported (Nga, Nguyen Nguyen, 1999). In addition, another 1,200 traditional medicines are registered for sale in the Viet Nam market (Nga, Nguyen Nguyen, 1999).

There have been three major impacts of the deregulation of drugs and pharmaceuticals on the consumer.

- Drug availability. Commune health centers in the rural areas, which used to be short of drugs, have adequate supplies of drugs for sale to patients. Even the smallest village has its own drug shop.
- Lowered prices of domestic drugs. Higher levels of domestic production, greater imports, and a more competitive distribution system all have contributed to a decline in drug prices.
- Consumer purchases of drugs. With easier availability and lower prices, consumer purchases of drugs, particularly for self-medication, have increased considerably. Drug vendors are the most frequently used health provider in Viet Nam, accounting for two-thirds of all health service contacts (Nga, Nguyen Nguyen, 1999). While an average of annual service contacts per capita with drug vendors and pharmacy shops in 1993 was 2.1, the number had increased to 6.8 annual contacts per capita by 1998 (Nga, Nguyen Nguyen, 1999).

The Viet Nam Living Standard Surveys (VLSS) 1998 data indicated that 93 per cent of all drug vendor contacts for obtaining medicines were without a prescription. This means that consumers self-treat their illnesses with some advice from the drug vendor.

A study of 1,833 patients in two pharmacies in Hanoi during a two-week period in 1994 showed that the majority of patients visiting pharmacies do not have medical prescriptions (Nga, Nguyen Nguyen, 1999). 94.9 per cent had already decided which drug they would be purchasing before they arrived at the pharmacy. 4.3 per cent asked for advice from the salers at the pharmacy (Nga, Nguyen Nguyen, 1999). The most commonly dispensed drugs were antibiotics, vitamins, analgesics, tranquillizers and drugs for eye infections (Nga, Nguyen Nguyen, 1999).

Nearly 50 per cent of all individuals purchased an antibiotic course of only 2½ or fewer days. Only 2 per cent purchased antibiotics to last the recommended 10-day course. Combination drugs were also found to be popular among customers. The proportion of combination products is higher in Viet Nam (22.2 per cent) (Chuc and Tomson 1996). Combination drugs can have dangerous side effects. Two combination drugs that were among the most commonly dispensed drugs in the Hanoi study were APC (aspirin, phenacetin, and caffeine) and HHTK (phenobarbital, phenacetin, aspirin) that have known to have dangerous side effects, including kidney damage and drug dependence.

A survey by Primary health care programme of Ministry of Health in 9 provinces: Son la, CIO bang, Nam ha, Vinh phu, Ha noi, Hue, Da nang, Can tho, Long an showed that (Tu Nguyen, Thanh Nguyen Thi. *12/2001)*:

- Abuse of antibiotic drug is main problem: 34-37% use antibiotic to treat cold, 78% for headache and nervous ache. Money for antibiotic drug is (42%) in commune health station is higher than in district hospital (35.41%) (Survey in 72 provincial/district hospitals, 1996)
- The most used antibiotic is Amoxiciline (Hue 41%, Son la, Cao bang 6%), Penicillin (Hue 27%, Son la 12%, Cao bang 31%). South province tender to use Gentamicine, Ciprofloxacine, Cefalicine.
- Abuse of Corticoid: for cold 17,6%, for clinic sore throat, cough; use of dexametazon is 26%.

5.1.5. New problems in Medical ethic

In recent years, the social classes were classified into rich and poor because of the market economy. This will have negative impacts on medical ethics since money was put in the middle between physicians and patients, while under the table fees were not prevented effectively (Phuong Do Nguyen, 1999). These fees violate medical ethic (and are not popular), with the result that the attitude of physicians to patients and those caring for patients is not good enough, physicians take insufficient responsibility , errors in treatment still remain, and administrative procedures are too complicated (Tu Nguyen, Thanh Nguyen Thi. *12/2001)*.

In addition, doctors have some contracts with pharmacies and only write prescriptions for the medicines being sold by those pharmacies, In this way doctors get commission, despite the fact that the medicines being prescribed are very expensive or unnecessary. This leads to waste of money, may be harmful to the public and increase the prevalence of antibiotic resistant microorganisms.

5.1.6. Poor co-ordination in foreign investment in health sector

Thirteen per cent of total health budget comes from overseas development aid and foreign loan projects (MOH, 5/1998). At the end of 1998, there were 179 assisted projects in health sector with a total commitment of US$668 million (MOH, 5/1998). 70% of donor projects were through the MOH, 2% directly through provinces; the rest covered the National Committee for Population and Family Planning, the National AIDS Committee, MOH institutes directly, the Red Cross, the Committee for the Protection and Care of Children and the Women's Union. (Department of Planning, MOH). There were 19 bilateral donors, of which 4 were from the UN, the WB, the ADB and the EU (Department of Planning, MOH).

At the same time, donors sometimes are reluctant to change their policies in the process of donor coordination. This has led to following results:

- some donor-assisted projects have not always reflected government priorities in the health sector,
- there has sometimes been overlap, duplication, and inconsistency among different donor and government programs, and
- implementation of donor-financed projects has suffered as the local partners have not always felt ownership of the projects.

5.2. Inequity in health care for workers:

Previously, the health care activities for workers were mainly implemented in the state and large enterprises and at provincial level. The trend of globalisation increases the number of micro household enterprises, private SMEs and foreign invested enterprises.
According to reports of preventive medicine center from 44 provinces/cities in 2002, 64% of joint venture and foreign invested enterprises did not set up OSH (occupational safety and health) profile according to the regulations; 55.81% did not organize periodic medical examination for workers and 65.14% did not monitor annually working conditions.

Table 25: Situation of implementing OSH in joint venture and foreign invested enterprises (reports from 44 provincial preventive medicine centers)

	No. of Joint venture	No. of Foreign invested enterprises	No. of workers	Do not have OSH profile	No periodic medical examination	Do not monitor working environment
Total	158	367	228.341	336	293	342
Percentage				64%	55,81%	65,14%

In addition, it is a challenge for the health sector because a great number of enterprises are scattered and located in households and rural areas. At district level, on average there are 50 small and medium sized enterprises per a district with 1000-2000 employees. So, one medical employee at commune level serves in average 2,693 people and about 500 employees.

Most agricultural laborers do not have access to the occupational health services. According to recent survey on health examinations for female agricultural laborers by the Preventive Medicine Department (4/2001), most of agricultural female labours did not have their health examined (80.5%), 71.9 % had their health examined at commune health station, 12.6% at district/provincial hospitals and 3.1 – 5.9% at multi-clinics, private health facilities and others (Dept. of Preventive Medicine-MOH, 4/2001).

At grassroots level, commune health stations provide directly primary health care services for agriculture and SMEs labourers. However, many of them do not have a medical doctor. The quality of primary health care is limited.

Table 26: Health organization at enterprise level

No	Type of enterprises	Health organization at enterprises		
		Number of health workers	Number of enterprises having health station	Number of enterprises without health worker
1	LSEs (> 200 workers)	2,325	1,330	1,139 (24%)
2	MSES (51-200 workers)	747	151	3,236 (78%)
3	SSEs (< 50 workers)	77	15	27,074
	Total	***3,149***	***1,496***	***31,449***
	Percentage (%)	***8.7***	***4.1***	***87.2***

Source: Dept. of Preventive Medicine-MOH*, 2001a*

Table 26 shows that almost all of SSEs do not have health workers. Agriculture workers and farmers are not included in the table.

The quality of occupational health workers is still poor. Training activities at provincial level are limited. Only 41.2% of occupational health staff have the certificate of occupational health and 35.3% have the certificate of occupational diseases. The budget for retraining is limited so many health workers at local level have not been trained (Dept. of Preventive Medicine-MOH, 2001a).

Many provinces have not got an Occupational Health Section and Occupational Diseases Examination Room (36.1%) so occupational health activity is still very weak.

Occupational health equipment at local level still lacks occupational health equipment. There are 5 provinces that are not been provided any occupational health equipment and there are 9 provinces having less than 5 occupational health equipment. Equipment at some provincial preventive medicine centers is backward and out of operation due to lacking of budget for repairing or upgrading. Although stipulated functions and tasks at district level require some quick test equipment such as equipment monitoring light, noise, micro climate as well as collecting dust and chemical samples, equipment used for monitoring working environment is mostly not provided at this level.

Table 27. Situation of occupational health equipment at provinces/branches

No.	Essential equipment	Number of provinces/branches	Provinces	Branches
1	None	5 (7.4%)	4	1
2	Having from 1 to 5 items of equipment	9 (13.2%)	9	0
3	Having from 5 to 10 items of equipment	40 (57.4%)	39	1
4	Having more than 10 items of equipment	15 (22%)	9	6
	Total	***69***	***61***	***8***

Source: Dept. of Preventive Medicine-MOH, 2001a

Management and monitoring of the working environment.
Working environment monitoring is given more attention in the area of large enterprises and medium scale enterprises. In small scale enterprises and several enterprises located in Industrial Zones and Export Processing Zones, working environment monitoring has frequently been not implemented. The shortage of occupational health equipment causes the limitation of monitoring working environment at provincial level.

Management of workers' health and diseases.
Periodic medial examination and occupational disease examination for workers have not been paid proper attention by employers. At presently, number of workers who are periodically given a medical examination constitutes 20% of total number of workers, and only 10% of workers exposed to high risk of occupational disease had occupational diseases examined. Process of medical re-examination for occupational diseases has been still complicated and due to lack of manpower for medical expertise so the rate of expertised/diagnosed is 40%. Occupational diseases re-examination has not been implemented.

Investment in occupational health.
Investment in occupational health doesn't meet the requirements. Ministries, branches and enterprises have not properly implemented legislation and have not actively invested in reducing pollution and eradicating occupational diseases.

Impact of health insurance and fee exemption scheme. As discussed in section 2.2, over 90% of enrollees in voluntary health insurance are school children. So far, the scheme has had limited success in enrolling farmers, workers in micro household enterprises, private SMEs. That affects accessibility to health care services.

About 53% of working population is agriculture workers living in rural areas. In fact, 80% of population living in rural areas has low income. Many agriculture workers can not therefore afford to pay hospital fee, but they are not poor enough to be given fee exemption. Thus, they have less access to health care services.

VI. CONCLUSION

The Vietnamese people's health has been significantly improved in the past decades. The health care system from the central to grassroots level has been strengthened and developed. Preventive health care, primary health care and national health programs have been in place nationwide. The curative health system has also been consolidated with more investments, which enables gradually improve quality of services to meet people's increasing needs of health care.

During the transitional period characterized by socio-economic development and globalization as a general trend, the need for health care in Viet Nam has also been experiencing significant changes. The disease pattern has transformed from a poor country-specific one, which is dominated by communicable and infectious diseases and malnutrition into a developed country-specific disease pattern characterized by non-communicable diseases such as cardio-vascular diseases, cancers, mental diseases, poisoning, accidents, injuries... Despite the fact that communicable diseases in Viet Nam have been gradually placed under control, there is still a potential threat of return of some diseases and epidemics, especially in some poor regions. In addition, new health problems have increasingly emerged, which places a *"double burden"* on the task of health care.

Determinants of health have also been experiencing changes. Some unhealthy lifestyles and habits (such as illegal drug addiction, alcohol misuse, and smoking) have been on the rise, entailing the development of sexually transmitted diseases (including HIV/AIDS), violence, accidents and injuries as well as stress and depression of different types.

In parallel with socio-economic development, health services have been improved on a broader scale. However, benefits are not proportionately distributed across various population groups. The utilization rate of hospital services and hightech medical services is far higher among the better off than among the poor. The main reasons explaining the low utilization rate of hospital services by the poor are financial barriers (high medical expenses, poor ability to pay), geographical barriers (poor people living in the outback and mountainous areas) and even cultural barriers.

Health economics is a very important area that is given great attention by the health sector. Given the limited Government budget for health, people's financial contributions to health care are necessary. One of the modes of contribution is via direct user fees. The revenue from user fees in the past few years has played a very important role in the hospital financing, especially in big and urban hospitals. However, recent studies show that direct user fees also place negative effects that should be concerned. For instance, user fees place a heavy financial burden on the poor when they use health services, which generates inequities in health care and user fees are also one of the causes of poverty. Therefore, hospital-financing policies in general and user fee policy in particular should be renovated with consideration to social policy beneficiaries, poor groups and low-income rural population.

Developing universal health insurance is defined in the Resolution of the 91h Communist Party Congress. Health insurance has been in action in Viet Nam for 10 years, yet it has covered only 15% of the total population and it mainly is compulsory health insurance covering Government staff. Voluntary health insurance is generally limited to students and schoolchildren. International experiences and trends show that in addition to Government budget, health insurance is the most equitable financial source for health. Thus, developing health insurance in general, especially rural health insurance schemes, is the priority in health care financing in the coming time.

Since the introduction of the market economy, the problem of drug shortage, especially shortage of essential drugs, has been addressed. Drugs are now available everywhere, which facilitates the convenience, and the quality of drugs has been improved with a more stable price. False drugs are curbed. In addition to constraints related to drug production and supply, an emerging problem in Viet Nam in the current context is associated with drugs use. Irrational and unsafe use of drugs is commonly found, including the use of drugs in health facilities and especially in private ones. This situation involves the responsibilities of physicians, drug suppliers, the management system and users. The problem of drug abuse in curative care is quite common.

Process of globalization and technological advance brings more efficient and productive economy. But it has also given rise to serious problems for health of workers. The pollution of working environment by dust, noise, toxic gas, microclimate in workplaces are at high level, which have not been controlled timely and are considered to be the causes affecting workers' health and inhabitant community. The situation of diseases related to occupations and occupational diseases of workers such as pneumoconiosis, occupational deafness, chemical-poisoning disease have been detected and increased yearly. The unsafe use of pesticides is the cause of poisoning in working, food poisoning and self-made poisoning from inhabitants.

The health sector is confronting challenges that emerge during the period of joining the global community and globalization in terms of medicine. Considering the current globalization trend, most of health problems should not only be recognized and addressed from a national perspective. Globalization and international integration also generate new challenges that the health sector of Viet Nam has to face, for instance, issues related to price, quality and competition.

VII. SOME MEASURES TO LIMIT THE NEGATIVE IMPACTS OF GLOBALIZATION IN HEALTH CARE

With the above changes in socio-economic and health care needs, reforming and developing the health system to suit the new situation shall be a priority of health sector reform in the coming years (MOH, 2002b). The following points are indicated in the Vietnamese Health Report (2002).

The health system should be comprehensively reviewed in order to identify next steps of renovation to better meet people's increasing needs of health care in terms of both

quantity and quality. The basic health care network will be strengthened in accordance with Directive No. 06/Cf by the Central Party Executive Committee. Primary health care and health programs will continue to be promoted. In parallel with enhanced efficiency, equity in health care in general and equity in health care for the poor in particular should also be secured. The administrative reform process in the health sector should be strongly promoted. Appropriate health policies should be developed. The regulatory role of the Government should be fostered and inspections and monitoring should be strengthened to improve the performance effectiveness of the health sector.

The Party and Government, in recent years, have stated many policies targeting the poor and the populations in the outback and mountainous areas as well as ethnic minorities. These policies have gradually facilitated better access to basic health care services for the poor in the whole country. However, health care for the poor, populations of remote and mountainous areas, ethnic minorities and for those who rendered meritorious merits to the country should be further strengthened. Priority policies in relation to resource allocation for health to poor regions and poor population groups as well as to preventive and primary health care should be made so as to facilitate more benefits for the poor.

One of the important issues of the health sector is full and sound calculation of medical costs, especially of hospital services. The orientation is to develop an efficient and equity-oriented health care financing system. The share of Government budget for health will gradually be increased. People's payments for health care services will be better arranged. Universal compulsory health insurance will be developed. User fees are only a stopgap solution and should be recalculated accordingly. Equity in allocating the existing financial resources to the health sector should be enhanced. Priority should be given to increasing the allocative index of budget for the basic health care network and for remote, mountainous areas as well as for ethnic minority populations. The management and utilization of the budget allocated to the health sector should be strengthened.

The health care system in Viet Nam, like the ones in most other countries, is characterized by the combination of the public and private sectors. The non-public medical and pharmaceutical sectors in Viet Nam are rapidly developing, but they only limit in small-sized entities which provide mainly curative care services and concentrate in urban areas. In the coming years, the health sector will continue to develop in the direction of "social mobilization" and "diversification" of health care services, including the strengthening and development of the non-public medical and pharmaceutical systems in parallel with the consolidation of the management and monitoring to protect patients' benefits and increase the contribution of the non-public health system to the overall health care and protection objectives.

The problem of drug abuse in curative care is quite common. In order to address this problem, in addition to carrying out activities of information, education and communication of rational and safe use of drugs, it is important to have strict regulations and good organization related to consultation, prescription and drug sales.

The intervention measures in recent years have contributed to preventing working environment pollution, raise of awareness at all levels and workers and promote working health services. It is essential to set up a National Program on OSH - occupational disease prevention in order to ensure workers' health, to speed up productivity contributing to the development of industrialization and modernization in Viet Nam.

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